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"Suicidology, counselling and identity exploration: an investigation of postvention strategies for suicide survivors"

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A dissertation submitted for MSc in Guidance and Counselling

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September 2000

"Survivor victims of such deaths (suicides) are invaded by an unhealthy complex of disturbing emotions: shame, guilt, hatred, perplexity. They are obsessed with thoughts about the death, seeking reasons, casting blame, and often punishing themselves."

Edwin Shneidman

"We need to be reminded that to work in suicide prevention is risky and dangerous and there are casualties and that is to be expected."

Robert E Litman

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Abstract

This research investigated therapeutic postvention strategies for people bereaved by the suicide of a loved one. It was believed that a suicidal loss experience was traumatic and identity-determining. Survivors were thought to be more likely to take their own lives than the general population. Six survivors volunteered to participate as a target group and two non-suicidal mourners volunteered to participate as a control group. The research explored the impact that suicidal loss had on the sense of identity of survivors using Content Analysis and Identity Structure Analysis (ISA). Semi-structured informal interviews together with IDEX (Identity Exploration for Windows, V3.0) were used to analyse issues surrounding suicidal loss including its impact upon the well-being of survivors, the meaning that they attached to their loss and how it came about and personal and family aftercare in a quality of life context. The effect upon survivors' belief and value systems was of particular interest. The results showed that some target group survivors were at a greater but unquantified risk of suicide than non-suicide mourners but that effective counselling could have positive therapeutic benefits. It was also demonstrated that survivors who successfully integrated their loss represented a potentially valuable therapeutic resource that was underused in therapeutic postvention programmes. The results have implications for research related to survivorship including the training and deployment of survivors in mutual survivor support work, exploration of suicide survivor identity within a longitudinal study using ISA and into the costs of suicide, funded at a level consistent with the mortality and morbidity that suicide produced particularly in survivors, relative to other diseases.

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Acknowledgements

I want to thank each of the eight participants for their contribution to this work. All – both survivors and non-suicide mourners – trusted me enough to welcome me into their homes. All showed courage in openly sharing many of their deepest feelings about the losses in their lives and about their aspirations too. It is my earnest hope that they may have found some healing and some peace of mind in talking about themselves and their lives and about their hopes and fears.

I also want to acknowledge the contribution of those suicide survivors who contacted me but who for personal reasons did not participate in this research. I hope that they too are able to find peace of mind.

I was in contact, in person by letter and telephone with many individuals and with a range of organisations – private, voluntary, public, political and statutory - throughout the period of the research. Many expressed interest and asked to be advised about my findings.

I wish to record my sincere gratitude to my supervisor, Doctor Ann Long. I benefited from Dr Long's close interest in my progress. Her insightful feedback and helpful suggestions shaped my approach to the work and influenced its outcome. I am grateful for her support, patience and courtesy.

Finally may I record my warm thanks to my son and to those close personal friends who encouraged me to complete the work. I have been changed by this research experience. I know myself a little better now and have more compassion for myself and for other suicide survivors.

Chapter 1: Introduction

1.1 Background

In the course of fieldwork for a pilot study of bereavement by suicide a Belfast mother who had suffered the loss of her two sons by suicide made telephone contact with the investigator. While the present study was being formalised media reports confirmed that two brothers had apparently taken their own lives on separate but proximate dates in Co Antrim. The investigator's family history included completed suicides of two of his brothers and attempted suicide by one other sibling. His decision to progress the current study was made as a contribution to research into the prevention of self-harm by those bereaved by the suicide of a close family member: these individuals were now known by the generic term 'suicide survivors'.

1.2 Aim of the study

The study was an investigation of postvention strategies for suicide survivors.

Shneidman (1984) defined postvention as consisting of:

'activities that reduce the aftereffects of a traumatic event in the lives of the survivors. Its purpose is to help survivors live longer, more productively, and less stressfully than they are likely to do otherwise' (*Shneidman* (1984), cited in *Stillion and McDowell*, 1999: 229).

Suicide postvention consisted of two overlapping elements: diagnostic activity to confirm that a person's death was self-inflicted without participation by a third party, and therapeutic activity 'with the survivors over several months in order to help them to work through their special type of grief' (*Stillion and McDowell*: 1996: 229,230).

Diagnostic activity or 'psychological autopsy' (*Faberow and Shneidman* (1961), cited in *Shneidman*: 1994: 39) was generally carried out immediately a suspicious death

was reported to police authorities. There was no formal interface between the current study and any legal, medical or statutory authorities. It focused on the survivor's predicament and any reference to such authorities was through the filter of survivors' perceptions, expectations and experiences. The study did not involve a detailed assessment of that element of postvention and this was not an objective of the study.

The study's purpose was to examine therapeutic aspects of postvention strategies for suicide survivors in Northern Ireland as a contribution to research into suicide prevention.

1.3 Objectives of the study

The objectives of the study were to investigate the impact upon each participant's identity of their loss experience. Lukas and Seiden (1990) considered that while the suicide survivor suffered grief and sadness as in normal bereavement, she/he also experienced 'more guilt, anger bordering on rage and (psychological) pain...that go on for years'. Tragically survivors were believed to be more likely to kill themselves than the general population (*Lukas and Seiden*, 1990: 5).

Objective No 1: To examine the proposition that suicide survivors are more likely to take their own lives than the general population, in dialogue with a target group of survivors and a control group of non-suicide mourners.

Counselling, counselling psychology and psychotherapy were regarded as effective therapies for helping people to help themselves to accommodate to changed circumstances in their lives, including normal bereavement. Humans had a learned capacity 'that leaves us in a suspended state to mourn the loss...and...make the psychological adjustments' (*Goleman*: 1996: 70), where losses and changes were capable of being anticipated, experienced and subjected to grief process. But when a

sudden, traumatic change occurred as in a suicidal loss, therapeutic intervention could often be helpful for effective resolution (*Leick and Davidsen-Nielsen*, 1996: 7-9).

Objective No 2: To examine the proposition that suicide survivors who are traumatized by their loss and who engage in counselling therapy, achieve loss integration more quickly and more fully than survivors who do not benefit from an effective counselling relationship.

Survivors often had valuable insights into their own experiences of loss and adjustment. 'Survivorship' was a developing research field that was only now being studied (*Faberow*: 2000: 2). It offered the prospect of recognising survivors as a valuable therapeutic resource for self-help and for the support of other survivors.

Objective No 3: To examine the proposition that suicide survivors' experiential insights are a potentially effective therapeutic resource for self-help and for supporting other survivors.

1.4 Research activities and targets

Research activities and targets designed to achieve the study's aim or purpose were set out below.

Activity No 1: To review current developments in suicidology, counselling and identity exploration.
Activity No 2: To consider the available research paradigms.
Activity No 3: To design and apply an appropriate research methodology.
Activity No 4: To identify a sample group of suicide survivors who were willing to participate in the research study as volunteer respondents.
Activity No 5: To identify a sample group of non-suicide mourners who were willing to participate in the research study as volunteer control respondents.
Activity No 6: To report the results of the research.
Activity No 5: To discuss the research study's findings.
Activity No 8: To summarise the research study's conclusions and recommendations.
Activity No 9: To publish the research study by the due date.

Chapter 2, Section 1: Suicide and Suicidology

2.1.1 Introduction

A considerable literature on suicide, its causes, consequences and approaches to its prevention existed. 'There is a huge mass of material on the topic and it grows larger every year...Nearly everyone has his own ideas about suicide' (*Alvarez*, 1974: 12,14). 'Suicidology' was understood to describe the scientific study or investigation of the human suicide phenomenon. But what suicide actually meant, that is:

'our current definitions (and our current conceptualisations) of suicide... that we see in textbooks, use in clinical reports, read in newspapers, and hear in everyday talk' [was the focus of a text investigating] 'the age-old topic of suicide' (*Shneidman*, 1994: vi, 4).

Shneidman's (1994) formal definition emerged as follows:

'Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived to be the best solution' *(Shneidman,* 1994*: 203).*

Shneidman's (1994) use of the term 'conscious act' raised the issue of 'retrospective inferring of intention' that was 'incredibly complex and fraught with technical difficulties' (*Kreitman* (1977), cited by *O'Connor and Sheehy*, 2000: 11). However, Camus' (1985) often-cited statement implied a philosophical scenario in which decisions by persons contemplating suicide were considered ones where judgement was carefully exercised:

'There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental questions of philosophy' (*Camus*, 1985: 11),

This echoed the opening line of Hamlet's soliloquy's 'To be, or not to be, that is the question' (*Shakespeare,* 1996: 60). It was suggested by later writers that 'active' euthanasia, but not 'passive' euthanasia, should be viewed as suicide. They added:

'We accept Shneidman's definition because it clearly recognises that any definition of suicide is "time bound" and relative to the society in which it takes place' (*Stillion and McDowell*, 1996: 17).

More recently writers noted Shneidman's (1994) definition while acknowledging that:

'There is no universally agreed definition of suicide or attempted suicide... Intuitively, suicide involves the intentional taking of one's life... Diekstra (1994) defined suicide as a "self-chosen behaviour that is intended to bring about one's death in the short(est) term"' (*O'Connor and Sheehy*, 2000: 10).

A review of the literature by an Irish counselling psychologist recently sounded a pessimistic note in relation to the contribution of research to prevention:

'Significant research has taken place in Ireland in relation to suicide and parasuicide... Suicide prevention methods have not been strikingly effective. No specific method has been proven to be universally effective' (*Daly*, 2000: 2,5).

He further reflected that:

'all of us have been touched by a suicide in some way, directly or indirectly through the death of a family member, relative, close friend, community member or society icon' (*Daly*, 2000: 2).

In an earlier article on male suicide in Ireland, it was argued that:

'at times of crisis many men work extra hard to further distance themselves from the support of others. This can have fatal effects on the lives of too many men' (*Hogan*, 1999: 28).

Aftercare for those affected by suicidal loss was the focus of two recent Irish publications. The Irish Barnardos organisation, reporting on youth suicide in Ireland, quoted from the Report of the National Task Force on Suicide (1998):

'Relatives and friends of the deceased may have mixed and confused emotions ranging from shock to grief, anger to guilt consequent on the event... There is no universally right way of handling the aftercare of those affected by suicide. Each step in the process may require a different response' (*Kenny*, 1999: 11).

In the Northern Ireland context, the North and West Belfast Health and Social Services Trust, in association with the West Belfast Partnership, commented:

'Once a suicide occurs in a community, it raises very strong feelings... particularly among the extended family... which may... include a sense of loss, rejection, anger and disillusionment' (*McIlroy et al,* 1999: 19).

2.1.2 Survivors of Bereavement by Suicide

The term 'suicide survivor' required careful definition, since it was distinct from parasuicide (or attempted suicide, deliberate self-harm or self-injury) that distinguished a fatal act of self-destruction from an attempt at self-destruction that the perpetrator survived. Accordingly:

'a survivor of suicide is someone left behind to deal with the psychological distress and daily turmoil in the aftermath of a completed suicide... a survivor of suicide is typically *not* someone who has attempted suicide (*Carter and Brooks* (1991), cited in *Leenaars*, 1991: 231, 232).

Family members bereaved by suicidal loss were collectively described as the 'suicide survivor' family. The 'suicide survivor' family was:

'subjected to extra pressures compared to the ordinary bereaved... It is not surprising... how the anniversary of an earlier family death reactivates the bereavement, which at the extreme can further add to the suicidal toll' (*Pritchard*, 1995: 145).

Following ten years work with 950 people with grief and crisis reactions, two therapists identified three categories of bereaved people who are at risk of pathological grief after a suicide: (i) young people whose parents have committed suicide, (ii) parents whose grown-up children died by suicide and (iii) people whose spouses killed themselves. The first and second of these groups:

'have been affected in such a way that the bereaved will always be in the risk group' [in relation to pathological grief] 'and ought to be offered grief help or grief therapy in order to prevent a pathological development' (*Leick and Davidsen-Neilsen*, 1996: 71).

This subset of the 'suicide survivor' family comprising parents, children, and spouses/partners of suicides, together with siblings of suicides, were the particular concern of the current investigation in relation to suicide postvention strategies.

2.1.3 Risk Factors

Shneidman (1996) proposed ten common features (commonalities) that regardless of individual circumstances were present in at least 95% of all completed suicides:

1.3.1 The common purpose of suicide is to seek a solution.

1.3.2 The common goal of suicide is cessation of consciousness.

1.3.3 The common stimulus of suicide is unbearable psychological pain.

1.3.4 The common stressor in suicide is frustrated psychological needs.

1.3.5 The common emotion in suicide is hopelessness-helplessness.

1.3.6 The common cognitive state in suicide is ambivalence.

1.3.7 The common perceptual state in suicide is constriction.

1.3.8 The common action in suicide is escape.

1.3.9 The common interpersonal act in suicide is communication of intention.

1.3.10 The common pattern in suicide is consistency of lifelong styles.

(*O'Connor and Sheehy*, 2000: 63)

It was suggested that what influenced risk levels in relation to suicide across the human life span included biological, psychological, cognitive and environmental risk factor categories (*Stillion and McDowell*, 1996: 20). These writers developed a:

'Suicide Trajectory Model, which... captures and organizes much of the burgeoning literature that attempts to explain suicidal behaviour' (*Stillion and McDowell*, 1996: 20, 21).

Suicidal ideation was born when the 'combined weight of these risk factors reaches the point where coping skills are threatened with collapse'. This condition fed upon itself, might be exhibited in warning signs and might be intensified by triggering events. But a suicide attempt if and when executed occurred because of the contributions of the four risk factors (*Stillion and McDowell*, 1996: 21).

Shneidman (1996) referred to 'psychache', the psychological pain which precipitates suicide: 'All of us could find ourselves in a situation where suicide appears to be the solution to our psychache' (*O'Connor and Sheehy,* 2000: 63). It might therefore be surmised that individual circumstance – biological, psychological, cognitive and environmental – could, in principle, at some point in time place many human beings at positive risk, that is at greater than zero risk, of suicide. 'Data from the Central Statistical Office show that 1 in 12,500 of the population of the UK is liable to commit suicide each year' (*Long et al,* 1998: 4).

'Suicide is a selfish event of relatively infrequent occurrence in a race of individuals almost every one of whom, at one time or another, suffers some psychological insults and existential emptiness that might be grounds for committing suicide - but doesn't do so' (*Shneidman*, 1994: 38).

In fact 'successful' suicide, resulting in the death of the perpetrator, was relatively rare when set in that context.

'Suicide accounts for 1% of all deaths in the UK (5542 in 1992). Suicide is defined by a coroner however, and for a variety of reasons the above figure is considered conservative. Other estimates suggest that it is up to 50% higher in practice particularly when 'undetermined' deaths are included...Men are twice as likely as women to kill themselves overall...suicide...is now the second most common cause of death for 15-34 yr old men...There are generally higher levels of suicide in Northern Ireland, than there are in Scotland, than there are in turn in England and Wales. Certain occupational groups are at special risk with vets three times at greater risk than average. This is followed by pharmacists, dentists, farmers, GPs and therapists respectively' (*The Skills Development Service*, c.1995: 1).

Each of the four risk factor categories mentioned above was explored further.

2.1.4 Biological Risk Factors

Evidence for three biological risk factors existed in relation to research into depression, genetic factors and male behaviours. The brain chemical, serotonin, was known to have a function in regulation of emotion. A serotonin deficiency was found in the brains of some people who committed suicide leading to speculation regarding

drug approaches for treating suicidal people. It was maintained by Akiskal and McKinney (1973) following research into depressive disorders that there was always a biological component to true depression such that if sufficient distress was experienced, its biological expression could:

'change the chemistry of the brain... adding a physical component... the "final, common pathway," to depressive and suicidal behaviour' (*Stillion and McDowell,* 1996: 22, 24).

The American Foundation for Suicide Prevention (1996) found that one of the most common questions asked by survivors of suicide was whether suicide runs in families. Researchers at Pittsburgh, PA, USA:

'found a four-fold elevated risk for suicidal behaviour in the relatives of suicide victims even after we controlled for the increased rates of psychiatric disorder and assaultive behaviour in the families of suicide victims... this is the first definitive demonstration that suicidal behaviour aggregates in families above and beyond the familial aggregation of any other psychopathological factor... there may be a familial, perhaps genetic factor predisposing to suicide (*Brent*, 1996: 1).

However these researchers stressed that for survivors of suicide,

'a four-fold increased risk does not mean that suicide is their destiny... an awareness of an increased risk can make recognition of the signs of psychiatric disorder and suicidal risk more likely, and so prevent suicide in the family members of a suicide victim'(*Brent*, 1996: 2).

Although Stengel (1977) and Shannon (2000) – see reference at par 9 below – disputed this, some support was apparently found 'for a genetic component in suicidal behaviour', including possible inheritability of suicide, through work by Gold (1986) and Blumenthal and Kupfer (1986), in relation to families with a history of suicide, identical and fraternal twins, adoptees and Amish people, respectively (*Stillion and McDowell,* 1996: 24). More recently Canadian researchers:

'found that depressed people with a mutation in a gene that encodes for a serotonin 2A receptor – a chemical linked to mood – were more than twice as likely to commit suicide than depressed people without the mutation' (*McKie*, 2000: 1).

But critics from the London Institute of Psychiatry, expressed doubt that any breakthrough had been made:

'What... about those people who possess this "suicide" gene but who do not kill themselves? Did this occur because of life experiences, or their families, or therapy, or what?' (McKie, 2000:1).

Finally it was surmised that since:

'human males... display higher levels of aggression... than... females [and] if suicide can be viewed as aggression turned inward, it would follow that male suicides would outnumber those of females' (*Stillion and McDowell*, 1996: 24).

2.1.5 Psychological Risk Factors

Psychological risk factors included:

'depressed mood, feelings of helplessness and hopelessness, poor self-concept and [false] self esteem, poorly developed ego defence mechanisms and coping strategies and existential questions concerning the meaning of life' (*Stillion and McDowell,* 1996: 25).

Research evidence increasingly indicated that hopelessness was the major psychological factor ahead of both depression and negative self regard in leading to suicide. When hopelessness was high and coupled with feelings of helplessness suicidal risk was greatly increased. The remaining psychological factors implied that suicidal people had reached the limit of their existing coping strategies. They might also exhibit self-destructive nihilism in relation to their life's purpose and meaning (*Stillion and McDowell,* 1996: 25, 26).

2.1.6 Cognitive Risk Factors

Cognitive risk factors consisted of three major parts: firstly, an individual's cognitive attainment level; secondly, the messages that individuals issued to themselves about their place in the world, referred to as 'self-talk'; and finally an individual's 'rigidity of thought'. Regarding the first part of the cognitive risk category:

'Understanding which stage a child or adolescent is at is important in assessing suicide risk... For example a suicidal child... in the preoperational stage of cognitive development may be at special risk because children at this stage do not understand that death is permanent and irreversible' (*Stillion and McDowell*, 1996: 26).

Regarding the second part of the cognitive category:

'Meichenbaum (1985) has identified these messages as "self-talk" [and] maintains that poor adjustment is fostered by negative self-talk and that positive self-talk can promote better adjustment. Suicidal people tend to carry on continuous negative self-talk, which reinforces an already negative mind-set and accelerates suicidal ideation' (*Stillion and McDowell*, 1996: 26).

The third and final element in this cognitive risk category, 'rigidity of thought', influenced depressed and suicidal people:

'Individuals who think in this way tend to see the world as presenting black or white, good or bad, live or die choices. They are unable to see the shades of grey or to imagine multiple outcomes... [such] people typically engage in three types of thinking that may predispose them to developing suicidal ideation ... overgeneralization, selective abstraction, and inexact labelling (*Stillion and McDowell*, 1996: 26).

By *overgeneralizing*, they tended to perceive the world pessimistically and 'to pile negatives upon negatives'; through *selective abstraction*, they tended to focus upon the negative and to ignore the positive; and by *inexact labelling*, they placed a negative label upon themselves and acted upon that instead of reacting to the situation at hand (*Stillion and McDowell*, 1996: 26, 27).

2.1.7 Environmental Risk Factors

Research demonstrated that disadvantaged home environments contributed to suicidal behaviour across the life span.

'Negative family experiences [are] correlated with suicidal thoughts and behaviour... In the families of suicidal children, abuse and neglect are common, as are parental discord and disorganization in the homes of suicidal adolescents... Suicidal adults are much more likely to be living in a discordant home or to be single, divorced or widowed than to be happily married... suicidal elderly people... suffer loneliness or isolation (*Stillion and McDowell*, 1996: 27).

A second environmental factor leading individuals towards suicidal ideation, that is to imagine, conceive or form suicidal ideas, involved the self-destructive impact of negative life experiences especially those involving serious personal loss:

'Loss of any kind, whether a relationship, a job, prestige, or a loved one through death, triggers a depressive reaction in nonsuicidal people. For those already considering suicide, such losses particularly when they come close together, may be the final blows in destroying their weakened or fragmented coping techniques' (*Stillion and McDowell*, 1996: 27).

A final environmental factor was relative ease of access to 'instruments of self-destruction':

In many suicides, it is the availability of firearms that makes a suicide attempt easy-and fatal... One authority [argued] that the rise in suicide in the last three decades can be accounted for almost entirely by the rise in deaths caused by handguns (Hudgens, 1983)' (*Stillion and McDowell*, 1996: 27).

2.1.8 Risk Levels for Suicide Survivors

A preliminary literature review by the investigator confirmed that, in general, suicidologists did not dispute that survivors of suicide were at higher risk of suicidal behaviour than the general population: some contrary views existed, which are described below. However it would be difficult to isolate or even to dissociate any of the four risk factor categories described above from the impact on the individual of her/his experiences of family. Indeed 'suicides in the family' was included in a list of fourteen 'criteria indicative of an impending suicidal act' by a suicidology authority (*Stengel,* 1977: 61, 62). One case study illustrated the potential lethality of this risk to suicide survivors of earlier experiences of suicide in the family. A suicide bereavement counsellor researched a 'grief integration' concept by working individually and in-group with four women each of whom had experienced the suicide of a close male family member. The reaction of one of these women, *Connie*, on hearing of her brother's suicide, was cited: 'It made me think of it more; for a

while...I thought maybe I had to, too, for some reason' (*Canetto and Lester*, 1995: 259). Tragically *Connie* suicided two years after close contact with the researcher concluded (*Canetto and Lester*, 1995: 268).

However, earlier research challenged the 'suicide survivor syndrome' including the assumption that survivors had an increased chance of suicidal behaviour. The impact on the survivor of bereavement after suicide was contrasted with the grief reaction of the survivor of bereavement caused by fatal road traffic accident. Research findings referred only to the short-term effects of loss although researchers regarded short-term reaction as a reliable predictor for adjustment in the future. It was concluded that bereavement:

'risks must not be exaggerated in the case of suicidal loss so that all survivors of suicide have to expect devastating consequences. This can lead survivors to worry unnecessarily, and care-givers can react with over-anxiousness... the much feared suicide survivor syndrome can become a self-fulfilling prophecy' (*Van Der Wal et al* (1989), cited in *Platt and Kreitman* 1989: 223, 224).

A suicidal loss experience impacted traumatically upon children and young people: '...a suicide death poses for children and adolescents...the highest possible stresses, often resulting in post-traumatic stress disorder' (*Leenaars*, 1991: 316). It was further reported that

'up to five percent of suicides in young people are "cluster suicides", that is they occur soon after a friend or relative has killed themselves' (*Bagley and Ramsey*, 1997: 236).

However alternative views also existed.

'Professional concern and research attention into adult (and child) survivorship after suicide began primarily within the last decade. [This] exposes... a number of myths; for example... that for the most part the widely held ideas of special aspects of bereavement in suicide is not true' (*Farberow* (1991), cited in *Leenaars*, 1991: 316).

Farberow's (1991) qualifying phrase 'for the most part' ensured that the debate remained open. Indeed, in a separate contribution to the discussion, this writer asked three fundamental and profound questions and highlighted:

'the need for further study in those areas:

(1) Does suicide bereavement differ from the bereavement in other types of death?

(2) Does bereavement differ in kind and in intensity depending on the kinship of the survivors to the suicide? and

(3) Do the survivor programs work and if so how?'

(*Farberow*, 1991: 261, 262)

The interaction of two related phenomena, namely taboo and stigmatisation appeared significant in relation to the process whereby suicide impacted upon survivors. One Irish writer believed that suicide:

'stigmatises the family, affected generations to come and with every suicide at least forty persons are immediately affected' (*Bhamjee* (1996), cited in *Spellissy*, 1996: 7).

Taboo aspects involved 'setting apart...as accursed' people affected by suicide (*Spellissy*, 1996: 127). Survivors coped with the consequent sense of alienation, by using various strategems including Freudian defence mechanisms such as denial, repression and fantasy (*Burton and Davey* (1996), cited in *Woolf and Dryden*, 1997: 122). The defence mechanism of denial was illustrated by the survivor searching out and clinging to any and all other possible explanations for their suicidal loss including accident, murder by person/s unknown and so on. This denial could become buried, but alive, in the unconscious memory. Thus a suicidal death that was proved beyond all reasonable doubt by an impartial inquest to be the intentional outcome of a self-destructive act by the deceased, could be transformed in the mind of a distraught survivor into an unfortunate accident or an unacknowledged murder by an unknown assailant. The end result might be replacement of the reality of the suicide by a

fantasy of death by a more acceptable mode, leading to the suppression of a truth too painful to acknowledge much less accept:

'The bereaved family often help to produce *distorted communication* by talking about the death in euphemisms as a tragic accident. In some families the cause of death becomes a secret which sets a distance to those family and friends who do not know it. In that way the secret contributes to the grievers' isolation' (*Leick and Davidsen-Neilsen*, 1996: 69).

Such defective coping was one generator of the damaging stuff of 'family secrets' concerning past suicidal deaths:

'Secrecy can be either positive or negative [but] some secrets are *always* destructive. For example, incest, battering, alcoholism, murder, and any other form of violence to another's person are always deadly secrets... some secrets are always constructive, such as those that protect one's dignity, freedom, inner life and creativity... many people carry secrets either about ungrieved deaths of family members or in relation to a family suicide over which they feel powerlessness and shame (*Bradshaw*, 1997: 6, 14, 15).

2.1.9 Family Secrets

'Family secrets' might be described as past events, linked to family tragedy or misfortune such as a suicidal death, that were concealed or distorted.

'Every family has secrets. Some are benign and constructive, protecting the family and/or its individual members and aiding in their growth and individuality. Other secrets are toxic and destructive, destroying trust, intimacy, freedom, personal growth, and love. What you don't know can really hurt you' (*Bradshaw*, 1997: ix).

So-called 'family secrets' had a powerful underlying influence on current family situations and across the generations.

'The effects of *secrets* and *silence* can have a devastating result on family members. It can be a very isolating experience - a deprivation of sharing fears and concerns' (*Middleton*, 1995: 9).

In contrast:

'If a family has a relatively open system – that is, its members are free to comment on what happened and pass it on through family stories – the family is less likely to become bound in shame' (*Middleton*, 1995: 10).

One case study reported how a mother went to enormous lengths to protect her son from the 'ghosts' of his father's suicidal death. When he 'behaved like his father had done' this almost precipitated another tragedy. It was suggested that although such deceptions were 'relatively rare', survivors required 'our special understanding and the most sensitive support and help, lest we add to the damage' (*Pritchard*, 1995: 153, 154). 'Suicides are often concealed, under-reported or misrepresented by relatives, friends and police' in Ireland (*Spellissy*, 1996: 110). This was despite Stengel's (1977) finding that there was no evidence to support the theory of some families having an innate or 'genetically inherited predisposition to suicide' (*Shannon*, 2000: 8) – see related reference at par 4 above. Nevertheless family secrets about relatives who committed suicide were widespread because of a double denial that combined the suicide stigma and the fact that as Spellissy (1996: 126) put it: 'the subject of death is a taboo subject in the modern world'.

2.1.10 Support for suicide survivors

Faberow (1996: 1) asserted that bereavement for the loss of a loved one was a complicated and idiosyncratic experience. Survivors mourned in their own way and in their own time regardless of whether the loss was due to natural causes, accident, homicide or suicide experience. But clinical observations confirmed that the suicide survivor's experience was different: it was more difficult, more complicated and more intense. The next section considered the potential contribution of some counselling therapies to the support of individuals, groups or families bereaved by suicidal loss of their loved one.

Chapter 2, Section 2: Counselling, Counselling Psychology and Psychotherapy

2.2.1 The Meaning of Counselling

'Counselling' had 'different meanings' (*McLeod*, 1998: 3). It included:

'work with individuals and with relationships which may be developmental, crisis support, psychotherapeutic, guiding or problem-solving' (*BAC* (1984), cited in *McLeod*, 1998: 3).

It was:

'designed to help clients to understand and clarify their views on their lifespace, and to learn to reach their self-determined goals through meaningful, well-informed choices and through resolution of problems of an emotional or interpersonal nature' (*Burks and Stefflre* (1979), cited in *McLeod*, 1998: 3).

Counselling involved a 'disciplined relationship...a distinctive activity undertaken by people agreeing to occupy the roles of counsellor and client'. It was:

'a service sought by people in distress or in some degree of confusion who wish to discuss and resolve these in a relationship which is more disciplined and confidential than friendship, and perhaps less stigmatising than helping relationships offered in traditional medical or psychiatric settings' (*Feltham and Dryden* (1993), cited in *McLeod*, 1998: 3).

Counselling, counselling psychology and psychotherapy could be understood therefore as terms used to describe a range of approaches, theories and disciplines, methods, techniques and styles, deployed by therapists in helping individuals and groups to process issues brought to the former by the latter for exploration and possible resolution. Counselling psychology was defined as 'the application of psychological knowledge to the practice of counselling' (*Woolf* (1996), cited in *Woolf and Dryden*, 1997: 4). Psychotherapy was described as 'the upmarket version' of counselling 'which is provided by practitioners who are usually very highly trained specialist professionals, often with a background in medicine' (*McLeod*, 1998: 4). Whatever 'counselling' was, therefore, it was by these definitions contained in both

counselling psychology and psychotherapy. For the purposes of this investigation, it was not necessary to rehearse further the various answers to the question 'what is counselling' offered by the literature. It was perhaps sufficient to acknowledge that counselling was 'an interdisciplinary activity...psychological, in part, but...also social, cultural, spiritual, philosophical, aesthetic and much more' (*McLeod*, 1998: 1).

Of more relevance was careful consideration of the appropriateness and efficacy of counselling therapies in suicide postvention strategies, in order to explore questions about contrasts between suicide bereavement and other forms of bereavement, the effect of suicide survivor kinship on bereavement intensity and the efficacy of survivor programs (*Farberow*, 1991: 261, 262).

2.2.2 Counselling: Attachment, Loss and Grief Therapy

'A death by suicide is a terrible tragedy; the loss of a loved one leaves the family deeply shocked and traumatized. It is fair to say that communities are also traumatized to some degree by a suicide, unfortunately other suicides may occur in the area leading to a cluster of suicides' (*Daly*, 2000: 4).

The natural death of a human being advanced in years who had arrived at the end of her/his earthly journey represented one end of the spectrum of attachment and loss. 'Suicide is now the second most common cause of death, after road traffic accidents, among 15 to 24 year old Irish males' (*Kelleher* (1996), cited by *Kenny*, 1999: 1) Death by suicide of young people barely at the threshold of their lives, without delivering more than a miniscule fraction of their human potential represented the other extreme.

'People can be attached to a multiplicity of things: human beings, money, job, prestige, home, land and other possessions. Appearance and health are often taken for granted, but if someone loses a breast or an arm or becomes seriously ill, then they understand the great importance of their attachment to the body and its condition' (*Leick and Davidsen-Neilsen*, 1996: 7).

Personal experience of attachment loss led the researcher to recall an ex-girl friend's ominous words: 'You never miss the water 'til the well runs dry' after their relationship ended and he was experiencing the loss of her presence to which he was strongly attached (*Murray*, 1968).

The work of Bowlby (1969, 1973, 1980), Erikson (1968), Freud (1917), Lowen (1983), Lindemann (1944), Yalom (1980), Alice Miller (1986, 1987) and Murray Parkes (1972, 1985) on affinity, attachment, loss, trauma and grief underpinned the 'open grief-group' therapeutic approach to grief resolution incorporating individual treatment in a group, developed by Leick and Davidsen-Neilsen (*Leick and Davidsen-Neilsen*, 1996: 2, 7). It was important to explore the contributions of each of these writers in order to appreciate their considerable influence upon current approaches to grief trauma and healing strategies.

2.2.3 Bowlby: attachment and loss

The human infant from birth, indeed from conception, was totally dependent upon her/his mother and then on 'others' including father, grandparents, siblings, child-minders and so on. S/he had the ability to behave so as to obtain her/his mother's attention by crying, smiling, holding tightly, seeking, calling and so on. The baby's goal in relation to this 'contacting behaviour' was to obtain the most security. Bowlby (1969, 1973, 1980) regarded 'close attachment to one or more people as just as important as food and drink.' Hence the notion of 'flexible optimum distance'- which related to how secure the child, and later the adolescent and the adult, felt in being alone – provided insight into her/his assumptions about the reliability of her/his primary attachments to people.

Bowlby's 'attachment period', the first three years of life, corresponded to Erikson's (1968) first two stages of psychosocial development each of which contained a developmental crisis requiring an emotional dilemma to be solved. In the first stage, from birth to about 18 months, the dilemma was how to achieve a *'feeling of basic trust versus mistrust'* in order to develop a basis for 'hope'.

'Basic trust arises through affinity with those closest, often the mother. This attachment is created if the child could securely expect that his mother will return when she goes away, will be there when she is needed, and that if the child cries, calls or looks for her, he will be able to get hold of her' (*Leick and Davidsen-Neilsen*, 1996: 8).

In the second stage, from about 18 months to three years, the child was 'combating a feeling of doubt and shame', as its next dilemma was achieving a *'feeling of independence versus doubt and shame'* in order to develop a basis for 'will'. The child began to discover that s/he could control her/his own behaviour and gradually developed a sense of independence. The dilemma here lay in achieving a balance between exercising her/his own independence while maintaining dependence upon her/his parent/s. The parent's ability to acknowledge the child's 'liberty in some areas' while laying down firm norms in others would be reflected in the child's tolerance and self-confidence. How the child resolved these dilemmas determined how in future s/he would be able to attach her/himself to other people and how flexible s/he was in finding optimum distance (*Leick and Davidsen-Neilsen*, 1996: 8, 9). Bereavements inflicted injury to feelings of affinity and attachment. People who experienced difficulty in their attachment process could be expected to have difficulty in living through grief emotions in a healing way. If they always lacked adequate basic trust, they would find it difficult to cope with closure, to welcome new contacts and to make effective use of a social, healing network in their grief work.

The work of Bowlby (1969, 1973, and 1980) and Erikson (1968) illuminated why bereavement was invariably stressful for human beings since it involved loss of attachment figures (*Leick and Davidsen-Neilsen*, 1996: 8, 9).

2.2.4 Freud: mourning and melancholia

Freud (1917) introduced important concepts for understanding the nature of grief. By 'object loss' he described losing something or someone to whom one was attached. Grief work was the psychological input from, or process engaged in by, the griever who was the subject of the loss, to break the bond with the deceased who was the object that was lost (*Leick and Davidsen-Neilsen* 1996: 9).

In relation to suicide, Freud (1917) theorised that:

'no neurotic harbours thoughts of suicide which he has not turned back upon himself from murderous impulses against others... the analysis of melancholia now shows that the ego can kill itself only if... it can treat itself as an object – if it is able to direct against itself the hostility which it relates to an object and which represents the ego's original reaction to objects in the external world' (*Freud* (1917), cited in *Wolpert*, 1999: 72).

Freud (1917) compared depression with bereavement and emphasised the self-reproach and loss of self-esteem of depressives:

'... the distinguishing mental features of melancholia [depression] are a profoundly painful dejection, cessation of interest in the outside world, loss of capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment. This picture becomes a little more intelligible when we consider that with one exception, the same traits are met with in mourning. The disturbance of self-regard is absent in mourning' (*Freud* (1917), cited in *Wolpert*, 1999: 85).

Reactive depression was thought to be caused by life events with a negative psychological consequence while endogenous depression was considered to have a mainly biological origin: this distinction was regarded as unsatisfactory since these categories were not mutually exclusive but overlapping:

'In endogenous disorders, symptoms are caused by factors within the individual person, and are independent of outside factors. In reactive disorders, symptoms are a response to external stressors' (*Gelder et al,* 1994: 227).

Ironically, reactive - also called affective or exogenous - depression, as opposed to endogenous – also called clinical - depression was believed to be a more lethal mental state, in relation to suicidal behaviour. This was possibly due, directly or indirectly, to the likelihood that the clinically depressed were under closer and more responsive medical/psychiatric supervision:

'On the one hand there are those who are particularly prone to the illness itself. On the other hand there are the rest who have a whole variety of personal stress factors which trigger off a depressive reaction of sufficient intensity to make them wish to terminate life' (*Dominian*, 1976: 196).

Depression, in whatever form or intensity, was invariably 'the most common accompaniment and the background to all attempts at self-destruction' (*Dominian,* 1976: 181).

'Social isolation... depressive disorders, alcoholism and abnormal personality are particularly prominent factors' in suicide causation. (*Gelder et al,* 1994: 483)

2.2.5 Lowen: weeping – a healing therapy

The importance of weeping in grief work following serious loss was fundamental in its relieving effect on the stress produced by loss and trauma. According to an old Jewish story, the tear was designated 'the most precious treasure, a costly pearl, because when someone is in great grief, his heart is in pain, and his mind is heavy, tears flow from his eyes. And behold! The grief eases'. Two types of weeping were identified – shallow 'calling' weeping and deeper 'letting go' weeping. Bowlby (1969, 1973, 1980) described the former as an attempt to hold on to the person or thing that was lost. It did not bring the same relief to the griever as the latter 'which occurs when someone begins to let go of the deceased' (*Leick and Davidsen-Neilsen,* 1996: 10). Bioenergetic principles held that deep relieving weeping did not come until

the griever was 'finally willing to let go of what one has lost' (*Leick and Davidsen-Neilsen*, 1996: 12).

Tears had a deeply relieving effect on the stress produced by loss and trauma:

'Weeping accompanied by sobbing is the first and deepest release of tensions. Children can weep almost from the moment of birth and weep without trouble in connection with all the stress influences that produce a state of tension in the body. First the child's body is tensed, then its jaw trembles, and immediately afterwards it breaks out in a convulsion-type release of tension. Man is the only animal that can react to stress and tensions in this way.' (*Lowen* (1983) cited in *Leick and Davidsen-Neilsen* 1996:11)

Bowlby (1969, 1973, 1980), Erikson (1968) and Lowen (1983) all stressed the harm done by adults when they discouraged their children from weeping and releasing their tears. This impaired their 'children's ability to grieve and thus to resolve the stresses in a wholesome and natural way' (*Leick and Davidsen-Neilsen*, 1996: 11). Weeping was beneficial and healing because it facilitated the releasing of tensions in the body. The trauma of a serious loss generated bodily tensions as the muscles contracted in defence against both physical and mental pain inflicted by the trauma. Contraction occurred at the moment of trauma to protect against overwhelming pain. When the acute situation passed, the body became aware of the pain as the muscles began to relax. Resisting that pain, by inability through conditioned fear to feel the pain and to weep, involved holding on to trauma-related tensions with their damaging consequences (*Leick and Davidsen-Neilsen,* 1996: 11). Because many people found it difficult to weep, it was important to examine what blocked the weeping response and how it might be safely and therapeutically released. Weeping was:

'an important part of our healthy mental equipment [for healing] the wounds in the psyche which losses and traumas cause' (*Leick and Davidsen-Neilsen,* 1996: 12).

2.2.6 Lindemann: normal and pathological grief

Lindemann's (1944) seminal work with bereaved people following a fire disaster in which 500 people died, resulted in descriptions of the physical and mental symptomatology of acute grief and demonstrated that 'reaction patterns when grief is released are remarkably uniform' (*Leick and Davidsen-Neilsen*, 1996: 9). This facilitated discrimination between normal and pathological grief. The three phases of normal grief were:

(i) deliverance from *the past* by recognition of the significance of the loss in all its facets;

(ii) re-building *the present* with a new life that contains what is left with some necessary changes; and

(iii) an experience of having *a future* with new possibilities, new pathways.

(*Leick and Davidsen-Neilsen,* 1996: 9, 10).

Only if the bereaved were unable to use their normal coping abilities, becoming psychologically challenged, perplexed and dependent upon the help of others to be able to manage, did this normally long, tough and painful process merit the term pathological grief.

2.2.7 Yalom: death, freedom, isolation and meaninglessness

Examination of Yalom's (1980) work demonstrated four concepts – death, freedom, existential isolation and meaninglessness - representing 'four basic conflicts, which each person must face in the course of his life because they are the givens of existence.' His existential psychotherapeutic approach regarded 'neurosis and malfunction as a result of an individual's inability to come to terms with one or more of the four conflicts.' The open grief-group therapeutic approach surmised that 'grief work is so demanding and so frightening' because the mourner had 'to confront all four conflicts at once' (*Leick and Davidsen-Neilsen*, 1996: 22, 23).

Death. People knew intellectually that one day they would die. But this only became 'an emotional reality' for most people by the experience of another person's death. For practical reasons in their daily lives, humans behaved as though they were inviolable.

Freedom. Humans claimed that that they valued freedom but arranged their lives within 'relatively narrow boundaries.'

Existential isolation. Humans knew they were born alone and that they would die alone. However close they were to other people, even those with whom humans were intimate, they were existentially alone. Most people avoided facing this painful and frightening reality for as long as possible.

Meaninglessness. For Yalom (1980) life did not have a simple meaning that all humans could share.

'Each person must face a sense of emptiness and meaninglessness in their life, and emerge with a personal solution' (*Leick and Davidsen-Neilsen,* 1996: 23).

'The confrontations with the givens of existence are painful, but ultimately healing.' (*Yalom* (1980), cited in *Leick and Davidsen-Neilsen*, 1996: 23) But unless grieving was totally avoided, there was no escape from Yalom's (1980) four dilemmas. Bereaved people were ultimately alone, challenged in a most potent fashion with their 'own mortality and with the apparent meaninglessness of life'. The hard work of healing and recovery must be carried out when mourners were at their lowest ebb in relation to energy and motivation. According to Yalom (1980), it was

'paradoxical that the process of life makes the strongest demand on the individual at the time when he feels most exhausted and overwhelmed' (*Leick and Davidsen-Neilsen*, 1996: 23).

As mourners could not believe any longer in their own inviolability or an ultimate rescuer, and facing their separateness from all other beings, they must accept ultimate responsibility for their own lives, knowing that the choices they made shaped their individual destinies. Perhaps this explained the grieving process as:

'a turning point for better or worse in the life of any human being. The Danish author Isak Dinesen says it this way... 'Frei lebt wer sterben kann' ("He who is prepared to die is free") (*Leick and Davidsen-Neilsen*, 1996: 24).

2.2.8 Alice Miller: psychic wounds and healing grief work

Alice Miller's three texts – *For Your Own Good* (1983), *Thou Shalt Not Be Aware* (1986) and *The Drama of Being a Child* (1987) – greatly influenced the open grief-group therapeutic approach to grief resolution. Examination of Miller's work demonstrated independently that she agreed with Bowlby (1969, 1973, 1980) that what was critical to a child's development was not external losses and traumas but 'the way the parents accommodate the child's emotional reaction to the loss or trauma' (*Leick and Davidsen-Neilsen,* 1996: 15). Parents who allowed their child to express their feelings clearly and plainly – whether:

'of joy or sorrow, but also of jealousy, greed, meanness and so on... [enabled] the child learn for himself to know and thus to shape his true self, his true identity' (*Leick and Davidsen-Neilsen*, 1996: 15).

So loss and trauma in childhood did not necessarily predict inadequate emotional development.

'If a child is given the opportunity with an understanding adult to express his grief and anger, then the wound left by the loss or trauma will be healed... [but] the denied trauma is a wound that can never form a scar and which can at any time begin to bleed again. Given understanding surroundings this wound can become visible and be healed' (*Leick and Davidsen-Neilsen,* 1996: 15).

The emotions expressed in adult pathological grief reaction were anxiety, depression, emptiness and indifference. But these mirrored the emotions of the child who had to submerge his own feelings and emotions in childhood in order to hold on to his mother. 'When the mother cannot tolerate the child's emotions, the child then effaces these emotions and thus loses part of his soul' (*Leick and Davidsen-Neilsen*, 1996:16). Miller (1987) propounded eight points in 'The Drama of Being a Child' that agreed with Erikson's (1968) first two life stages. These were:

(i) It is a fundamental need in a child to be regarded, respected and taken seriously as the person he is at any given time, and as the centre of his own activity. This is a narcissistic but legitimate need, whose fulfilment is crucial for a healthy self-image (healthy narcissism).

(ii) The young child's emotions and 'internal sensations' form the nucleus of the self. It is the centre and point of crystallization of the self-image.

(iii) In an atmosphere of respect and tolerance for the child's feelings, the child can, in the separation phase give up symbiosis with his mother and take the step to personality development and independence.

(iv) For these prerequisites for healthy narcissism to be present, these children's parents must themselves have been respected as children.

(v) Parents who were not respected as children for the people that they were, are narcissistically deprived; that is they seek all their lives for what their parents could not give them at the right time: a person devoted to them, taking them quite seriously, admiring them and watching them.

(vi) This quest cannot of course be completely successful, for it is addressed to a situation in the past that cannot be recalled, that is, the first period of self-formation.

(vii) A person who has an unsatisfied or unconscious need is under constraint to try to get that need satisfied with surrogates.

(viii) One's own children are best suited to this role. A neonate is left to the mercies of his parents, and as the baby's existence depends on obtaining their attention, it will do everything not to lose this. From the very first day it will exploit all its possibilities, like a tender plant that turns towards the sun to survive (*Leick and Davidsen-Neilsen*, 1996: 16).

Miller's (1983, 1986, 1987) therapeutic process sought to guide clients back into contact with their original genuine feelings. But an emotionally deprived childhood needed to be grieved over since its loss was irrevocable: it could never be lived over again. This therapy might be lengthy because 'idealization of the inaccessible parents' needed slowly to be 'broken down before recognition of the painful reality of childhood could emerge.' If people were not shown acceptance as children, they would seek it in adulthood from other people, including their partner and their children. If they were not given it here then they might 'find solace in alcohol, pills, work and so on' (*Leick and Davidsen-Neilsen*, 1996: 17).

Finally the personality traits Miller (1987) described as resulting from the repression of the self, paralleled those that Bowlby (1969, 1973, 1980) and Murray Parkes (1972, 1985) found in people with pathological grief. This offered clues to the childhood experiences of people threatened with pathological grief development. In short, they had problems with attachment to other people: either the attachment was much too close or symbiotic, or much too distant or remote, showing apparent indifference, or

alternatively too close and too distant or ambivalent (*Leick and Davidsen-Neilsen* 1996: 17).

2.2.9 Loss, grief reaction and identity change

Each human death represented a unique loss to each individual survivor of bereavement, the extent and impact of the loss being dependent on the degree of intensity of their attachment to the deceased in their lifetime. Similarly each survivor's grief reaction to her/his loss was as unique. However the focus of the current investigation was into postvention strategies in view of the potential lethality of some suicide survivors' pathological grief reactions. The following section considered the concept of human identity and how one's identity might be affected by a traumatic life event such as a suicidal loss experience.

Chapter 2, Section 3: Identity Exploration

2.3.1 The Meaning of Identity

Identity has been said to encompass 'all things a person may legitimately and reliably say about himself – his status, his name, his personality, his past life' (*Klapp* (1969), cited in *Black*, 2000). But:

'the ME can mean many things; the ME of yesterday, today, or tomorrow, or the ME of everyday, the ME in this particular action or situation, or the ME in all actions and situations' (*Reizler* (1950), cited in *Black*, 2000) **[so] 'one's concept of oneself is situated within the social context of one's family and the broader community within which one experiences the trials and tribulations of everyday life'** (*Weinreich*, 1992:-2).

Undoubtedly the loss of a loved one by suicide affected the suicide survivor's sense of self: 'It may be that your self-image and your image of the person you loved have been damaged' (*Shannon*, 2000: 6). Identity exploration techniques offered insights into how a person's identity was changed by the potentially traumatizing impact of suicidal loss. Recovery from suicide-related trauma involved acknowledgement of such identity changes inter alia by the application of tailored counselling therapies designed to help suicide survivors to cope with their predicament. A definition of identity had emerged as follows:

'A person's identity is defined as the totality of one's self construal, in which how one construes oneself in the present expresses the continuity between how one construes oneself as one was in the past and how one construes oneself as one aspires to be in the future' (*Weinreich*, 1992: 29).

However Identity Structure Analysis (ISA) developed by Weinreich (1980, 1983, 1986, 1989) could be used to analyse identity formation. ISA offered:

'an open-ended metatheoretical framework of concepts and postulates about content, structure and process relating to identity' (*Weinreich* (1985a, 1986a), cited in *Black*, 2000).

The outcome of the application of ISA in the ideographic (or case study) mode, was an assessment of an:

'individual's appraisal of self and others in a way that takes account of the wider social context and self's idiosyncratic ways of relating to that context... It is custom designed to reflect the uniqueness of the individual' (*Weinreich*, 1992: 2).

ISA was used in the present study as one of two complementary research instruments – the other being evaluation of an audiotaped interview – to explore relationships between identity changes linked to post-suicide trauma in suicide survivors and the contribution of counselling in postvention strategies for suicide survivor families.

2.3.2 Identity exploration and counselling approaches

The ISA's metatheoretical framework employed:

'concepts in the psychodynamic approach, social comparison theory, reference group theory, symbolic interactionism, personal construct theory and cognitive-affective consistency theory' (*Black and Weinreich,* 2000: 28).

Many of these concepts were constituent elements across a range of counselling approaches: indeed some ISA-related concepts could be described as fundamental underpinnings to a deeper understanding of counsellor-client interactions. These theories were discussed further in order to highlight their contribution to ISA and also to understand their influence in counselling approaches for healing pathological grief resulting from post-suicide trauma.

2.3.3 The Psychodynamic Approach

The psychodynamic approach was ultimately derived from Freud's (1901, 1909, 1910, 1917, 1933) psychoanalytic theory. His key assumptions were that

a) emotional problems have their origins in childhood experiences,

b) people are usually not conscious of the true nature of these experiences and

c) unconscious material emerges indirectly in counselling through the transference reaction to the counsellor and in dreams and fantasy (*McLeod*, 1998: 58,59).

But Erikson (1950), a neo-Freudian, and other recent writers in the psychodynamic tradition, broke away from Freudian theory to encompass the social as well as the unconscious. He emphasized 'the psycho-social development of the child rather than the sexual or biological aspects' (*McLeod*, 1998: 35). This offered psychodynamic insights to identity development including the notion of 'inner self' or ego. Erikson (1994: 108) used the term 'ego identity' to denote

'certain comprehensive gains which the individual, at the end of adolescence, must have derived from all of his preadult experience in order to be ready for the tasks of adulthood'.

He restated this as follows: 'In the social jungle of human existence, there is no feeling of being alive without a sense of ego identity' (*Erikson*, 1963: 240, cited in *Black*, 2000).

There were four aspects that described the complicated inner state that was preserved by a sense of ego identity: (i) a sense of individual identity; (ii) a criterion for the silent doings of ego synthesis; (iii) a continuity of personal character and (iv) a maintenance of inner solidarity with a group's ideals and identity (*Erikson*, 1994: 109).

Erikson (1994) conceptualised an eight-stage model of psychosocial development involving at 'each successive step...a potential crisis because of a radical change in perspective' *(Erikson,* 1994: 37), and incorporating three main categories – childhood (four stages), adolescence (one stages) and adulthood (three stages).

(Childhood)

Stage 1: Basic trust vs. mistrust. 0-18 mths – *Hope* – Trust in mother or central caregiver and in one's own ability to make things happen. A key element in an early secure attachment.

Stage 2: Autonomy vs. shame. 18mths-3yrs – *Will* – New physical skills lead to free choice; toilet training occurs; child learns control but may develop shame if not handled properly.

Stage 3: Initiative vs. guilt. 3-6yrs – *Purpose* – Organise activities around some goal; become more assertive and aggressive; Oedipus conflict of parent with same sex may lead to guilt; development of conscience.

Stage 4: Industry vs. inferiority. 6-11yrs – *Competence* – Absorb all the basic cultural skills and norms, including school skills and tool use. Learn technical skills that prepare children for adult roles.

(adolescence)

Stage 5: Identity vs. role confusion. Puberty-20's – *Fidelity* – Adapt sense of self to pubertal changes, make occupational choice, achieve adult like sexual identity, and search for new values. A questioning of old values.

(adulthood)

Stage 6: Intimacy vs. isolation. 20's-40's – *Love* – Form one or more intimate relationships that go beyond adolescent love; form family groups. Fear of competition in relationships leads to isolation.

Stage 7: Generativity vs. self-absorption and stagnation. 40-60yrs – *Care* – Bear and rear children, focus on occupational achievement or creativity, and train the next generation; turn outwards from the self to others.

Stage 8: Ego integrity vs. despair. 60yrs onwards – *Wisdom* – Integrate earlier stages and come to terms with basic identity. Accept self.

The fifth stage, *adolescence,* was crucial to the process of identity formation, in resolving the psychosocial conflict between identity and role confusion as the adolescent integrated her/his past experiences into a new whole.

'The emerging ego identity... bridges the early childhood stages, when the body and parent images were given their specific meanings, and the later stages, when a variety of social roles become available and increasingly coercive' (*Erikson,* 1994: 96).

Marcia (1966, 1980) identified four identity statuses within adolescence of which there are two key parts, a crisis and a commitment. These were:

Identity achievement: The person has been through a crisis and reached a commitment to ideological goals;

Moratorium: A crisis is in progress, but no commitment has yet been made.

Identity Foreclosure: The individual has not experienced a crisis but nevertheless is committed in her/his goals and beliefs largely as a result of choices made by others: the young person accepts a parentally or culturally defined commitment.

Identity diffusion: The person is not in the midst of a crisis but may have experienced one in the past; s/he has not made any commitment to a vocation or set of beliefs. Hence diffusion may represent either an early stage of the process (before a crisis) or a failure to reach a commitment after a crisis. (*Marcia* (1966), cited in *Coleman and Hendry*, 1993: 63)

The latter status offered the greatest challenge to therapists whose task was to help the individual to integrate 'disparate identity elements into a coherent, meaningful identity structure' (*Marcia*, 1987: 168).

2.3.4 Social Comparison Theory

Festinger's (1954) social comparison theory offered insights into human beings awareness of others' views including how humans compared themselves with those they perceived as being similar to themselves (*Weinreich*, 1992: 2). He suggested that people had an inner drive to validate those opinions and abilities that they used to function effectively in the world. He argued that opinions, beliefs and attitudes were 'correct' to the extent that they were anchored in a group of people with similar beliefs, opinions and attitudes (*Festinger* (1950), cited in *Black*, 2000). Absence of physical or social comparisons rendered the individual's self-evaluation unstable until a suitable comparison was found.

2.3.5 Reference Group Theory

Reference group theory suggested that individuals make comparisons using positive and negative reference groups for estimating their social standing or deciding whether to be satisfied or dissatisfied with their predicament (*Merton* (1957), cited in *Black*, 2000). Significantly, Merton (1950: 65) suggested that when levels of aspiration or degrees of determination were being compared, 'the individual must necessarily take the role of the other in order to make a comparison'.

2.3.6 Symbolic Interactionism

Cooley (1902) postulated that people learn about themselves from others, using the notion of the 'looking-glass self' to describe the development of self-concept. Mead (1934) believed that 'perspective taking' was the basis for self. The theory of social interactionism was concerned with understanding the socialisation process whereby individuals learned about themselves from the characteristics and values attributed to them by others.

Mead argued that individuals become socialised when they adopt the perspective of others and imagine how they appear from other people's point of view. For Mead, this perspective taking ability is synonymous with the acquisition of self' (*Brown*, 1998: 83).

Development of this important ability depended upon an individual's skills in communicating with symbols and in play. Initially individuals adopted the perspective of particular others towards self. Later they adopted the perspective of an abstract generalised other. At this stage self was fully developed and socialisation was said to be complete. Mead (1934) emphasised cognition rather than affective processes as central to self:

'Self consciousness, rather than affective experience provides the core and primary structure of the self, which is thus essentially a cognitive rather than an emotional phenomenon' (*Mead*, 1934: 173).

In contrast to Mead, Goffman (1959) presented short-term selves based upon roles acted out in social settings. The self interacted with society in short episodes:

'in which the script is followed to the end, but when the "play" is over the individual sheds one costume and dresses himself up in another' (*Burns*, 1979: 17).

Finally Stryker (1984) developed an 'emerged structural symbolic interactionist framework' where identities were derived from roles, such that an individual could have several identities arranged hierarchically in terms of salience:

'Commitment to the role dictates the salience [or conspicuousness] attached to the identity it confers and salience subsequently shapes role performance' (*Breakwell*, 1986: 30).

2.3.7 Personal Construct Theory

Personal construct theory was based upon the philosophical assumption of 'constructive alternativism', which stated that 'all of our present interpretations of the universe are subject to revision or replacement' (*Kelly*, 1955: 15). Constructivism:

'refers to a family of theories that share the assertion that human knowledge and experience entail the (pro)active participation of the individual' (*Mahoney* (1988), cited in *Winter*, 1997: 219).

In other words people actively construct their own worlds and 'the maintenance of one's perceived identity becomes as important as life itself' (*Guidano* (1987), cited in *Winter*, 1997: 219). Kelly's (1955) Personal Construct Theory examined the individual's idiosyncratic construal - or interpretation - of their world: 'not only do we construct our worlds but, as the client may discover in counselling, we can reconstruct them' (*Winter*, 1997: 220). Kelly's 'scientist' metaphor saw the self formulating hypotheses about themselves and the world, and testing and revising those hypotheses in the light of experience. A person tested this understanding:

'by predicting future events. If these events are consistent with prediction, the construct is said to be validated. If the events are inconsistent with prediction, the construct is invalidated and the person experiences pressure to change the system' (*Leitner*, 1985: 83).

The essentially anticipatory nature of human functioning was expressed in the fundamental postulate of personal construct theory:

'A person's processes are psychologically channelized by the ways in which he anticipates events' (*Kelly*, 1955: 4).

Kelly elaborated his fundamental postulate in eleven corollaries that explain the process of construing. Each individual, according to Kelly, developed a system of bipolar constructs. Bipolarity meant that each construct offered 'a pathway of movement' for each individual (*Kelly*, 1955: 128). For example, one individual employed a construct contrasting being assertive with being reasonable. He was resistant to moving down the path of becoming more assertive because of its implication of also becoming more unreasonable.

'In choosing which pole of a construct to apply to an event, the person will select that option which is most likely to increase his or her capacity to anticipate the world. This notion may make even the most self-destructive behaviour comprehensible ... stutterers would not trade stuttering for fluency until the

latter carried as many ... possibilities for anticipating their world, as did stuttering (*Winter*, 1997: 220).

The ability to interpret another person's construction processes was the essence of intimate relationships, or to use Kelly's term, role relationships. Personal construct theory was also a theory of experiencing. In 'experiencing', our bodies and 'we' were one. Kelly believed that body and mind did not work as different systems: learning equated with experiencing:

'We learn – we successively reconstrue – we experience. Experience is more than the moment-to-moment awareness of our existence. We enter ever new pastures when a sequence of our psychological processes completes a cycle of experience [which] starts with anticipation and ends with reconstruction' (*Francella and Dalton*, 1990: 10).

Thus Kelly's was a theory of change: placing constructions on human experience was not entirely about 'thinking' and 'feeling' – it was the act of discriminating.

Kelly's critics have referred to his emphasis upon cognition and intellect at the expense of affect or emotion: Kelly's

' dryly scientific theory omits most of the characteristics that seem vitally and distinctively human: love and hate, passion and despair, achievement and failure, inferiority and arrogance, sexuality and aggression... If emotion is unimportant, it is unclear why the prospect of revising major constructs should be anxiety-provoking or threatening' (*McEwen*, 1998: 373).

2.3.8 Cognitive-Affective Consistency Theory

Kelly's (1955) emphasis on cognition was balanced by recent writers who devoted more attention to the emotional aspects of personality.' Kelly's cognitive approach needed to be complemented with the emotional and affect-laden qualities of people's experiences' (Weinreich, 1989a: 48). Bipolar constructs could 'be associated with both those desirable states to which one aspires and others that represent those features of life one wishes to avoid' (*Weinreich*, 1989a: 49).

'The cognitions that a person holds about himself and others may be consonant, that is consistent and harmonious. On the other hand, they may be dissonant, that is to say inconsistent or contradictory' (*Irvine*, 1994: 79).

Those cognitive – affective consistencies might be uncomfortable psychological states that motivated the individual to resolve inconsistencies and achieve consonance (*Festinger*, 1957; *Rosenberg and Abelson*, 1960; *Osgood and Tannenbaum*, 1955; *Weinreich*, 1969). Weinreich (1989a: 49) stressed that 'in conceptualising identity', affective dimensions were incorporated in relation to the cognitive categories used by people to interpret both other's behaviour and their own experiences.

2.3.9 Application of Identity Structure Analysis (ISA) to participants

At par 1 above, it was suggested that potential changes in the identities of research participants, associated with suicide trauma might be appraised using Identity Structure Analysis. Information about the application of ISA to participants was therefore provided in the next chapter (Chapter 5: Methodology). This included an explanation of the design for the ISA instrument that was used, how data was gathered and analysed using Identity Exploration Software (IDEXWIN) and the underlying concepts and terminology used in interpreting respondents' ISA results including:

(a) belief and value systems;

(b) identification processes including role model identification, empathetic identification and conflicted identification;

(c) theoretical postulates regarding resolution of conflicted identifications and formation of new identifications;

(d) structural pressure;

(e) theoretical postulates concerning constructs regarding core evaluative dimensions of identity, conflicted dimensions of identity and unevaluative dimensions of identity;

(f) identity diffusion;

(g) self-evaluation; and

(h) identity states including negative identity state, diffused identity state and foreclosed identity state (*Weinreich,* 1992: 1-36).

2.3.10 Suicide, counselling and identity

This study investigated the impact of suicide trauma on intimate survivors of suicide. Its principal focus was the formulation of postvention strategies for suicide survivor families. It was argued that these innocent people were so changed by post-suicide trauma experience that they could be exposed in their subsequent lives to an enhanced risk of suicidal behaviour. Changes in the identities of survivor respondents were therefore explored using Identity Structure Analysis. This complemented the systematic evaluation of an in-depth, semi-structured interview that offered respondents opportunities to reflect upon *what happened*, their *health and well-being*, the *meaning* of what happened, their *self-care* strategies and their *quality of life*..

The study's methodology was described in the next chapter.

Chapter 3: Methodology

3.1 Introduction

This chapter examined the strategy, approaches and methods employed in this research to generate data and information relevant to the investigation.

3.2 Research strategy: Case study approach

A tentative hypothesis was postulated at the commencement of this investigation, based upon the outcome of a pilot study completed by the researcher (*O'Keeffe*, 1999: 8). This hypothesis stated:

If an enhanced risk of suicide existed among survivors of bereavement by suicide, then effective subvention strategies, including counselling therapies and mutual befriending by other intimate suicide survivors, moderated that risk and contributed to an enhanced quality of life for survivors.

An ideographic (case study) approach was adopted as a research strategy for the current study in order to obtain primary evidence from survivors about their realities as exemplified in their personal, experiential response to suicidal loss. When studied in depth and in detail, each suicide survivor's loss experience was likely to be as unique to that person as her/his individual coping response. Consequently each volunteer survivor's response to suicidal bereavement and loss might be similar to those of other survivors in only two aspects: firstly, in the stark fact of each survivor's experience of a calamitous and catastrophic conclusion, by suicide, to the life of a loved one and secondly, in suicide survivors' propensity to attempt to kill themselves.

'The American Association of Suicidology... states that survivors are much more likely to kill themselves than the rest of the population' (*Lukas and Seiden*, 1990: 41). **'There are claims that suicide among survivors is between 80 and 300 per cent higher than in the general population. In our own work, about one third of the families we talked to had more than one suicide within succeeding generations. If migraines, alcoholism, stomach ailments and numerous psychological problems follow a family member's suicide, so might suicide itself'** (*Lukas and Seiden*, 1990: 103).

Only a case study approach was capable of recognising the special nature of each survivor's incalculable and intimate anguish.

'It may be that a variety of factors operate to push a survivor in the direction of suicide and we are left not knowing which may be the crucial one' (*Lukas and Seiden*, 1990: 104).

This investigation was aimed as ascertaining what these factors were and how effective postvention strategies might be implemented. These factors included:

(i) Survivor's mental health – did the survivor also exhibit Bipolar Affective Disorder symptoms?

(ii) Permission to break the suicide taboo – did one suicide give 'permission' to remaining family members to follow suit?

(iii) Idealization of the dead person – did a survivor emulate suicidal behaviour through pathological over – identification with the deceased? and

(iv) Anger and hostility turned against self – did a survivor suffer pathological guilt and depression based upon introjected anger and hostility towards the deceased? (*Lukas and Seiden*, 1990: 104).

'Freud fathered the psychological explanations of suicide...the major psychoanalytical position on suicide was that it represented unconscious hostility directed towards the introjected (ambivalently viewed) love object. Psychodynamically, suicide was seen as murder in the 180th degree' (*Shneidman*, 1994: 34).

In qualitative research, which is 'more intuitive, subjective and deep', hypotheses were usually developed as the investigation proceeded and not at its outset (*Bouma and Atkinson*, 1997: 208, 216). Consequently the above hypothesis was cited more for scene setting and structuring purposes than as a sole or exclusive focus for the investigation.

3.3 Research Design

3.3.1 Data collection instrument: Semi-structured interview

The major data collection measure in the investigation was a semi-structured interview on audiotape. This approach was chosen as the most appropriate device for facilitating each volunteer to disclose that part of their personal biography that was impacted upon by their suicide survivor experience. (A common schedule of themes used by the researcher in all interviews is attached at Appendix 1.) A transcript of each interview was prepared to facilitate content analysis. There was 'no simple correct way to undertake content analysis' and the investigator had to judge what was most appropriate for the purposes of this research project (*Weber* (1994), cited in *Hickey and Kipping* 1996: 91).

3.3.2 Content analysis

The investigator therefore devised an idiosyncratic analytical method involving the generation of ***issues and emergent themes*** from which ***linked concepts*** were derived. These concepts were initially tabulated sequentially, with an indication of their occurrence frequency. Those concepts occurring more than once were then re-tabulated in descending order of frequency. The investigator then integrated recurrent key concepts into an objective narrative summary of the participant volunteer's reported experiences. The investigator became more familiar with this analytical tool as content analysis proceeded and this skills development appeared to be reflected in more lengthy narratives as analysis of the eight transcripts proceeded.

3.3.3 Evaluation: Theoretical discussion

The most widely used of the several epistemological paradigms (models or prototypes) for addressing the fundamental question for all research: 'How does one

get at truth? (*Guba and Lincoln,* 1983: 53) were the scientific paradigm and the naturalistic paradigm. (NOTE: The terms 'constructivism' and 'constructivist' had exactly the same meaning as the terms 'naturalist' and 'naturalistic' in relation to evaluation paradigms (*Guba and Lincoln*, 1989: 19)). But other paradigms existed and these were briefly considered as to their relevance in the current investigation.

i) Logical paradigm: relied upon analysis as a fundamental technique and viewed truth as demonstrable. For example, a geometry theory was 'proved' by showing how it followed logically from other proved theorems and ultimately from basic axioms and definitions. *Mathematics was a typical example.*

ii) Judgmental paradigm: relied upon sensing as a fundamental technique, which viewed truth as recognizable to persons of appropriate background and competence. *Judging wine or athletic performance were typical examples.*

iii) Adversarial paradigm: relied upon cross-examination and triangulation as fundamental techniques, which viewed truth as emergent, or resulting from a balancing of the cases made by a protagonist and an antagonist. *The hearing of a trial before a jury was a typical example.*

iv) Modus operandi paradigm: relied on sequential tests as a fundamental technique, viewing truth as trackable along the 'characteristic causal chain' of an event. *Forensic pathology was a typical example.*

v) Demographic paradigm: relied upon indicators as a fundamental technique, viewing truth as macroscopically determinable...through the study of indicators that transcended...random behaviour of individual persons,

agencies or institutions. *Economics was a typical example* (*Guba and Lincoln*, 1983: 53-55).

A common sense interpretation of these paradigms excluded them. None of the 'typical examples' were obviously close to the investigation's subject area, viz. personal reflections of survivors' post-suicide experience. There was no overt exercise by the researcher that was reminiscent of mathematical analysis, performance assessment, trial by jury, forensic analysis or generalising from individuals' behaviour.

3.3.4 Evaluation: Scientific paradigm

The scientific paradigm relied on:

'experimentation as a fundamental technique, which views truth as confirmable; that is, truth is a hypothesis that has been confirmed by an actual experiment. The hypotheses are derived by deduction from an *a priori* theory; when enough hypotheses deriving from a particular theory have been verified, the theory itself is believed to have validity. *Physics was a typical example'* (*Guba and Lincoln*, 1983: *55*).

This was the traditional method of the 'hard sciences' and the life sciences that had acquired 'a patina of orthodoxy' and was also widely adopted and emulated in the social-behavioural sciences as well (*Guba and Lincoln*, 1983: 56). Use of the ISA software in conjunction with two identity exploration instruments devised by the investigator, in principle amounted to theory testing, based upon the work of Weinreich (1988, 1992) and Weinreich and Ewart (1997). Consequently the scientific paradigm was relevant to this project where ISA software was used to analyse participants' responses to the investigator's identity exploration instruments, prior to their interpretation by the investigator. Further information is provided at par 5, 'Research Instruments (B)' below.

3.3.5 Evaluation: Assessment of paradigms

This investigation obtained primary data and information directly from interviewees in their own words as responses to their voluntary but focused reflections on their experience of suicidal loss and their responses to the investigator's identity exploration instruments. It was accepted that the scientific paradigm was implicit where ISA was used.

However the constructivist/naturalistic paradigm was the emergent paradigm that merited consideration as the 'best fit' model in relation to the use of transcripts of audiotapes of semi-structured interviews as a research instrument in the investigation. This paradigm was therefore examined in detail to confirm its relevance and appropriateness.

3.3.6 Evaluation: The naturalistic/constructivist paradigm

This paradigm relied upon field study as a fundamental technique, which viewed truth as ineluctable, that is, as ultimately inescapable. Sufficient immersion in and experience with a phenomenological field yielded inevitable conclusions about what was important, dynamic and pervasive in that field. *Ethnography, history, political science, counselling and social work were typical examples* (*Guba and Lincoln*, 1983: 54, 55). In what follows the constructivist paradigm is contrasted with the scientific paradigm to demonstrate the specific advantages of the former in socio-behavioural research.

3.3.7 Evaluation: Basic assumptions for the naturalistic/constructivist paradigm

(i) Reality:

Naturalistic/constructivist inquirers substituted multiple 'truths' for the scientific paradigm's assumption about 'the' truth.

'Scientific enquirers... view phenomena... as existing in... the real world and as fragmentable into discrete or independent subsystems that can be dealt with a few variables at a time, so that the inquirer can converge upon the truth (without quotation marks.) Naturalistic/constructivist inquirers make virtually the opposite assumptions. They focus upon the multiple realities that like, the layers of an onion, nest within or complement one another. Each layer provides a different perspective of reality and none can be considered more "true" than any other. Phenomena do not converge into a single form, a single "truth", but diverge into many forms, multiple "truths"...The naturalistic inquirer tends to view the phenomena with which he deals as more likely to diverge than to converge as they are more fully explored' (*Guba and Lincoln*, 1983: 57).

ii) Inquirer – Subject relationship

Rather than attempting to shield the inquirer from 'the reactivity of subject to inquirer', the naturalistic/constructivist paradigm assumed 'that all phenomena were characterized by interactivity'. It was important to acknowledge the human investigator's perceptions and the effect of those perceptions on the developing information (*Guba and Lincoln*, 1983: 58).

iii) Truth statements

Scientific enquiry led to the development of a nomothetic knowledge base, i.e. one that focused on general laws. But the alternative naturalistic/constructivist position acknowledged 'multiple realities and complex interactions' between the inquirer and the enquiry's objects. This led the naturalistic/constructivist model towards 'thick descriptions' and 'working hypotheses' rather than generalizations (*Guba and Lincoln*, 1983: 58). Hence naturalistic/constructivist inquiry led to the development of an ideographic knowledge base, i.e. one that focused on the understanding of particular events or cases (*Guba and Lincoln*, 1983: 59).

iv) Views of reality

The social-behavioural inquirer investigated 'social reality' experientially. In this context, the latter was neither singular, nor convergent, nor fragmentable.

'Virtually all the phenomena with which the social-behavioural inquirer deals exist in the minds of people - what they take to be problems, their perceptions of one another and of the meaning of their environments, the extent to which they value anything, and so on' (*Guba and Lincoln*, 1983: 59).

(v) Subject-Object dualism

Reactivity of respondents to investigators and the reactivity of investigators to respondents or to the investigation situation were inevitable. 'It is impossible to believe that investigations that involve people can occur without some kind of interaction taking place (*Guba and Lincoln* 1983: 60). While it was important to minimize respondent reactivity, in order to facilitate genuine respondent feedback, total investigator objectivity might not be either achievable or desirable.

'One of the virtues of an open-ended interview... is that the investigator need not return to ground zero at the beginning of each successive interview; he will have learned something from each that can be verified or....expanded in subsequent interviews... it is doubtful whether an investigator would want to lose all potential for interaction with his (respondents) even if he could. To do so would be to trade the potential for this successive learning' (*Guba and Lincoln,* 1983: 60,61).

(vi) Generalizability

'Cronbach makes the point that after a time every generalization is less science than history (*Guba and Lincoln*, 1983: 61). This led the investigator to be wary of generalizations especially in the behavioural science field. Human behaviours could only begin to be understood when placed in their particular context.

'It is virtually impossible to imagine any human behaviour that is not heavily mediated by the context in which it occurs. **One can easily conclude that generalizations that are intended to be context free will have very little to say that is useful about human behaviour** (*Guba and Lincoln*, 1983: 62).

3.3.8 Evaluation: Conclusions

Although the scientific paradigm was considered to be somewhat flawed in relation to any application to behavioural science, there was 'no guaranteed path to ascertaining truth' since there was no way of proving one paradigm superior to others. On balance the naturalistic/constructivist paradigm was the 'method of choice' when dealing with human behaviours (*Guba and Lincoln*, 1983: 62, 63). However the current investigation enjoyed the advantages of both paradigms.

3.3.9 General characteristics of the naturalistic/constructivist paradigm

(i) Preferred techniques

Although not mandatory, there was a strong tendency for the naturalistic / constructivist inquirer to lean most heavily on qualitative – as opposed to quantitative – methods. The basis for this might lie in the more open-minded and exploratory nature of naturalistic/constructivist enquiry:

'...when concepts or characteristics have yet to be discovered, it is not possible to state them precisely beforehand and measurement is impossible since an entity must be detected before its size can be assessed' (*Guba and Lincoln*, 1883: 64-66).

(ii) Quality criterion

In relation to what constituted excellence in the pursuit of effective inquiry, there was a need, in the naturalistic/constructivist paradigm, to reflect the scientific paradigm's focus on rigor but not at the expense of relevance (*Guba and Lincoln*, 1983: 66,67).

(iii) Source of theory

Rather than seeking to prove a priori theory, a more useful approach was thought to be 'to derive theory not from a priori reasoning but by grounding it in real-world data from the start' (*Guba and Lincoln*, 1983: 67,68).

(iv) Questions of causality

Cause-effect relationships were involved in this investigation in terms of *verstehen* (or understanding) rather that in relation to prediction and control. It was not possible

with certainty to predict an individual suicide nor was it humanly possible to prevent a particular suicide:

'...the complexity and the interaction of risk factors feeding into suicide across the lifespan...often frustrates those who want a simple model for predicting suicide...' (*Stillion and McDowell*, **1996: 197). 'Naturalistic/constructivist inquirers are less interested in what can be made to happen in a contrived situation (as in the scientific paradigm) than in what does happen in a natural setting'** (*Guba and Lincoln*, 1983: 68).

(v) Knowledge types

The alternatives were propositional knowledge and tacit knowledge. The former is defined as 'knowledge that can be stated in language form' while the latter consisted of 'intuitions, apprehensions, or feelings that cannot be stated in words but are somehow "known" by the subject'. A useful analogy was the difference between the denotations, i.e. the particular or explicit meaning of a word, and connotations, i.e. suggestions or implications associated with a word beyond its literal meaning.

'Naturalistic/constructivist enquiry permits and encourages connotative or tacit knowledge to come into play, for the sake of both contributing to the formation of grounded theory and improving communication back to information sources in their own terms (*Guba and Lincoln,* 1983: 70).

(vi) Stance

Scientific inquirers took 'a reductionist stance', with preformulated questions and hypotheses that sought information to answer those questions or test those hypotheses. Naturalistic/constructivist inquirers took 'an expansionist stance': they sought 'a perspective that would lead to the description and understanding of phenomena as wholes or at least in ways that reflect their complexity. They enter a field and build outward from whatever the point of entry happens to be. Each step in the inquiry is based on the sum of insights gleaned from previous steps' Rather than 'a structured, focused, singular stance', they took 'an open, exploratory, and complex stance' (*Guba and Lincoln*, 1983: 70-72).

(vii) Purpose

The purpose of the naturalistic/constructivist approach in an investigation was to focus upon the discovery of some elements or insights not yet included in existing theories. But the use of scientific means by naturalistic/constructivist inquirers 'to test hypotheses that have emerged from firmly grounded theory' was not ignored (*Guba and Lincoln*, 1983: 71,72). This indeed was the justification for using the ISA technology since it was both reputable and reliable and depended upon discourse analysis in reaching necessarily tentative conclusions about the identity status of any participant.

3.3.10 Methodological characteristics of the naturalistic/constructivist paradigm

(i) Instrument

While the scientific inquirer 'preferred to develop extensions of himself for purposes of collecting data', his naturalistic/constructivist colleague was 'much more likely to depend upon himself as instrument, perhaps because it is frequently impossible to specify with precision just what is to be assessed'. Human beings as instruments possessed judgement along with the flexibility to use it while scientific 'paper and pencil instruments or physical devices' enjoyed 'standardization, uniformity and...aggregatability' (*Guba and Lincoln*, 1983: 72).

(ii) Timing of the specification of data collection and analysis rules.

While scientific inquirers specified all rules for data collection and analysis in advance, naturalistic/constructivist inquirers were not able to function in this apparently objective fashion. The latter's data accrued 'in the "rawest" possible fashion and must be unitised and categorized after the fact.' Although there was a risk that apparent subjectivity would render data suspect, steps were always taken to ensure that rules for naturalistic/constructivist inquiry were unambiguously stated and

systematically and uniformly applied. These techniques were built on 'emergent insights…loss of rigor (was balanced by) an enormous gain in flexibility' (*Guba and Lincoln*, 1983: 72, 73).

(iii) Design

In naturalistic/constructivist inquiry, design emerged as the investigation proceeded. But some design elements could be specified in advance, albeit incompletely. This ensured that no inordinate constraints were imposed that might interfere with the stance and purpose of the inquiry (*Guba and Lincoln*, 1983: 73).

(iv) Style

Naturalistic/constructivist inquiry depended on selection from naturally occurring events while scientific inquiry's style used intervention. Non-laboratory sciences also used selection as the only way to proceed. The current investigation was neither experimental nor contrived: rather patience and a willingness to search assiduously and diligently were its hallmarks as volunteer respondents uncovered evidence of the impact on them of traumatic loss that in some cases was previously undeclared (*Guba and Lincoln*, 1983: 74).

(v) Setting

Naturalistic/constructivist inquiry took place in 'natural settings' while scientific inquiry used laboratory settings. Unfortunately it was unlikely that laboratory findings would have meaning in any other setting than another laboratory (*Guba and Lincoln,* 1983: 74). Interviews and IDEX software exercises for the current investigation were conducted in that most natural of settings, viz. the homes of volunteer respondents and exceptionally, the investigator's home.

(vi) Treatment

Treatment in scientific inquiry was stable and invariant in order to ascertain reliably the cause-effect relationship, if any.

'But the concept of treatment was foreign to [naturalistic/constructivist inquiry] since it implies some manner of manipulation or intervention' (*Guba and Lincoln*, 1983: 75).

Treatment in naturalistic/constructivist inquiry was therefore expected to be variable.

(vii) Analytic units

All relationships in scientific inquiry were 'expressed as between variables (or systems of variables). But the naturalistic/constructivist mode 'emphasizes the complex patternings that are observed in nature'. Useful metaphors for contrasting these approaches were the tug-of-war and the spider's web. In the former cause and effect are obvious. But when the fly is ensnared in the web, it was difficult to know 'just how the impulse of the fly landing is transferred to the senses of the spider... Only through sensing the pattern of the web can one appreciate what is occurring.' It was doubtful 'whether conventional (i.e. scientific) modes for analysing data...catch these...kaleidoscopic patterns' (*Guba and Lincoln*, 1983: 75).

(viii) Contextual elements

While scientific inquirers sought to control anything that might distract them from their chosen phenomena, naturalists/constructivists welcomed and invited interference 'so that they can better understand real-world events and sense their patterns.' The notion of 'invited interference' was important since the naturalistic/constructivist evaluator was interested in the behaviour of the entity chosen for investigation, not 'in the best of all possible worlds but in the worst'. Constructivists welcomed the mind-stretching opportunity offered by interpretation of 'unanticipated factors' (*Guba and Lincoln*, 1983: 75, 76).

(ix) The investigator as research instrument

The researcher was a trained, qualified, experienced and committed counsellor in private practice. He believed that he possessed the reliable human instrument's requisite skills in observing, analysing, categorizing and careful listening as well as personal qualities as a tolerant, patient, empathetic, humane, honest and open human being (*Guba and Lincoln*, 1983: 139, 140). As interviewer and facilitator for the IDEX software exercise, his professional attributes were fundamental to the successful completion of eight audiotaped interviews and eight IDEX software exercises. He was the principal research instrument performing roles as instrument administrator, data collector, data analyst and data interpreter (*Guba and Lincoln*, 1983: 128). His responsiveness and adaptability and his holistic outlook were key characteristics. In addition he was able to deploy both 'conscious and unconscious levels of awareness and kinds of knowing' that generated several 'knowledge products' including:

(i) conscious insights and apprehensions; and

(ii) unconscious hunches, impressions, feelings, vibrations (in response to nonverbal cues and unobtrusive indicators).

(*Guba and Lincoln*, 1983: 135)

Another desirable quality, 'processual immediacy', enabled the human instrument to respond immediately to presented data by reordering it, changing its direction, generating hypotheses on the spot and testing them with the respondent or in the situation as they were created. Also available were opportunities for clarification and summarization (*Guba and Lincoln*, 1983: 136) and the ability to decide to explore atypical or idiosyncratic responses (*Guba and Lincoln*, 1983: 137, 138):

'Human inquirers... not only are open to the atypical response but encourage and seek it. The ability to encounter such responses and to utilize them for

increased understanding is possible only with human, as opposed to paper-and-pencil instruments' (*Guba and Lincoln*: 1983: 138).

In relation both to human respondents and the researcher, as a human instrument: 'Only human beings, depicting slices of their own lives in their own language, terms and visions can recreate reality' (*Guba and Lincoln*, 1983: 152).

3.3.11 Triangulation

Interview data were 'inherently unreliable as a source of information about human behaviour or experience' (*Dyer*, 1997: 64). Two techniques for corroboration of respondents' interview data were triangulation and cross-examination. The latter was excluded not least because of the voluntary nature of respondents' contributions.

'Triangulation forces the observer to combine multiple data sources, research methods and theoretical schemes in the inspection and analysis of behavioural specimens (*Denzin*, 1970, cited in *Guba and Lincoln*, 1983: 107) **[and] 'depends upon exposing a proposition (...the assertion of an informant...) to possibly countervailing facts or assertions or verifying such propositions with data drawn from other sources or developed using other methodologies'** (*Guba and Lincoln*, 1983: 106, 107).

Identity exploration using IDEXWIN software was an approach to triangulation although participation by respondents was both discretionary and voluntary. Interpretation of the outcomes of identity exploration was a skilled exercise and communication of these results to respondents was necessarily tentative and done with careful and compassionate regard for respondents' welfare. But it was anticipated that some withholding by respondents, at both conscious and unconscious levels, at the interview stage might be counterbalanced and informed by identity exploration data.

A final check, called 'phenomenon recognition', involved 'presenting the (investigator's) "reality" to those who live it, and asking them whether it does, indeed, represent their common and shared experience' (*Guba and Lincoln*, 1983: 186). Although such a check was not included in the present study, it was envisaged that all

respondents would be invited to comment on its findings either individually or at a group discussion following its completion.

3.4 Research Instruments (A)

3.4.1 Interviewing, Observation and Nonverbal Cue Interpretation

Naturalistic/constructivist evaluation used three main kinds of human-to-human measures, viz. interviewing, observation and nonverbal communication. The current investigation focused upon data obtained using audiotaped semi-structured interviews. Attention was paid, on reflection, to observation and nonverbal communication, but neither was as important to the investigation as the audiotaped data. Interviewing was contrasted with ordinary conversation, with the following key differences:

i) INTERVIEW always had an explicitly mentioned purpose: CONVERSATION generally lacked an explicitly mentioned purpose;

ii) INTERVIEW often involved questions being repeated: CONVERSATION involved unspoken rules regarding repetition;

iii) INTERVIEW restricted questioning to the interviewer: in CONVERSATION both parties asked questions;

iv) INTERVIEW enabled the interviewer to express both ignorance and interest: in CONVERSATION both parties were likely to express interest in what the other was saying and/or ignorance of topics that were raised;

v) INTERVIEWING involved all information in respondents' answers, including the respondents' assumptions about what the researcher already knows, to be made explicit; CONVERSATION involved a high level of shared common knowledge;

vi) In INTERVIEWS, answers were always as detailed as possible; in CONVERSATIONS high levels of detail were avoided inter alia out of politeness.

(*Dyer*, 1997: 56-58).

3.4.2 Semi-structured and unstructured interviews

An unstructured interview involved:

'no prepared list of questions...the interviewer decides what questions to ask from moment to moment depending upon the information volunteered by the informant' (*Dyer*, 1997: 59).

The interviewer explained at the outset in general terms what was to be explored and then raised the first theme or topic in the form of an open-ended question.

'When the flow of ideas in answer to that first question comes to an end the interviewer may ask further questions to obtain clarification of some points or may raise a new topic (or theme) and the questioning repeats itself in a chain-like process in which one answer suggests the next question' (*Dyer*, 1997: 59).

But all respondents needed to have their thoughts 'gently guided by questions of some kind' (*Dyer*, 1997: 59). Using a semi-structured format the interviewer worked

'from a number of prepared questions (or themes), while allowing the respondent plenty of opportunity to expand answers (or responses, including silence or emotional release) and pursue individual lines of thought...' (*Dyer*, 1997: 59).

The respondent's motivation was 'the single most important factor in whether the interview is successful'. This was achieved by continuous contact with respondents throughout the investigation, expressing gratitude to individual respondents about the value of their contributions, detailed explanation of the aims and objectives of the research and assurances about confidentiality and anonymity, in relation to any published material (*Dyer*, 1997: 60). The other essential for successful interviewing was the establishment of solid rapport with the respondent. In the current investigation, a very high degree of rapport was sought through the interviewer adopting the role of collaborator, rather than by simply adopting a passive role. Some self-disclosure by the investigator in relation to his own personal interest and commitment to the field of study under investigation was judiciously employed in

order to enable the respondents to identify with the researcher and the research goals (*Dyer*, 1997: 61).

3.4.3 The interview schedule

The pilot study (*O'Keeffe*, 1999) employed a largely structured interview technique and the 'interview schedule' was attached at Appendix 2. For the current investigation is was proposed to collapse the questions into four themes, as follows, in a semi-structured interview approach (Appendix 1):

The first theme examined the circumstances of the suicide, the individual respondent's immediate feelings and how they coped in the immediate aftermath. This was the 'WHAT HAPPENED' theme.

The second theme focused upon the impact on the individual respondent's health and welfare at all levels – physical, emotional, mental/intellectual and spiritual – and the extent and sufficiency of general practitioner and other medical support through the first year after the death. This was the 'HEALTH AND WELLBEING' theme.

The third theme addressed the continuing psychological and emotional impact upon the individual respondent of the suicidal loss. It was conceived from the notion of the 'special scar' that suicidal loss inflicted (Wertheimer, 1991) and Yalom's existential concepts of death, freedom, isolation and meaninglessness, which all must face in their lives. This was explored here, i.e. what 'MEANING' could the respondent attach to the suicidal loss event in all its stark suddenness, fury and finality (*Leick and Davidsen-Neilsen*, 1996: 22).

The fourth theme explored and identified respondents, as 'survivors of suicide' with aftercare needs that extended into an indeterminate future. Counselling support was

discussed explicitly but the theme under exploration was 'AFTERCARE' in all its aspects and manifestations not least self-care following the traumatic hammer blow that the suicidal loss of an intimate relative represented. Respondents had the opportunity during interview to reflect upon what relevance aftercare had for them including any counselling therapies and/or individual approaches to self-care that they had developed.

Each interview took place with compassionate consideration for the respondent's CURRENT QUALITY OF LIFE as she/he understood it and inevitably involved reflection of the changes wrought by the loss event/s.

The benefits of this semi-structured interview technique included removal of the restrictions placed on respondents by the wordiness of set questions and the limitations, including less than useful inflexibility, imposed by the pilot study's format. Respondents would have the opportunity to reflect back to the loss event, other loss events resurrected by the suicide, their current feelings about the suicide's impact on their past and current health, and what meanings, if any, they attached to the event when it happened and in its aftermath as the internalisation process proceeded. Freud observed:

'that in the process of mourning the object (or the person) that is lost is replaced through the grief process by an inner representation of the same object. This process of internalising is one, which those who have worked through grief may be familiar with. The person they have lost in some sense now lives on in them. This internal presence is more than a memory of what the lost person was like, or what they said; it is more like experiencing them in some sense as still part of the present, sometimes with a conscious or unconscious dialogue taking place with them' (*Jacobs*, 1998: 6).

3.5 Research instruments (B)

3.5.1 Data collection instrument: Identity structure analysis (ISA) using IDEXWIN Software

Each volunteer was invited to explore their identity by way of the IDEXWIN software using either computer or instrument printouts. It was explained to each volunteer that participation in the IDEXWIN exercise was discretionary.

3.5.2 Design of identity structure analysis instrument

Bipolar personal constructs and entities were two data necessary for identity structure analysis. The former were characteristics or orientations used by a person to construe (or interpret) her/himself, other people and the social world in general; the latter were individuals and groups of people influential in the person's life. ISA was based upon measurement of 'identity' through the filter of a person's identification with or dissociation from significant others in her/his social world and 'situational selves' (*'me as I am now', 'me as I used to be', 'me as I would like to be'*, and so on). The term 'entity' was therefore given to people, groupings and issues of symbolic meaning to the individual. These entities included various perceptions of the self including ideal self image, viz. *'me as I would like to be'*, current and past self images, viz. *'me as I used to be'* and *'me as I am now'*, and various 'selves for others', viz. *'me as my family sees me'*, *'me as my colleagues see me'* and so on. An individual's ideal self-image, viz. *'me as I would like to be'*, 'provides the basis for designating [a person's] value system' (*Weinreich*, 1988: 10-12).

The investigator used the in-depth interview in a pilot exercise (*O'Keeffe*, 1999) to ascertain a sample range of influential or significant people in the life of a suicide survivor and some events that may have influenced that survivor in important ways (*Weinreich*, 1992: 10). This facilitated the generation of an entity list and a bipolar

personal construct list for use with suicide survivors. An adaptation of these lists was used with the control group that replaced 'suicide' references with equivalent references to 'death' or 'sudden death'.

All respondents including controls were invited to use these personal constructs and social entities to construe their social worlds and various aspects of their self-image using a centre zero scale with nine points. They simply rated the extent to which one or other pole of the bipolar construct applied to a particular entity. The 'zero' point was used when the individual was unable or unwilling to construe that entity with a particular construct.

3.5.3(a) Entities for Respondents

The respondents' list of 19 entities for ISA included five mandatory entities consisting of three 'minimal facets of self' and a minimal set of two significant others (*Weinreich,* 1992 10-11):

first, the ideal (or aspirational) self, e.g. *'me as I would like to be'*, from which for each person, the desired pole of each construct may be determined and her/his aspirational (or role model) identifications may be made;

second, the current self 1 e.g. *'me as I am at home'*, from which a person's empathetic (de facto) identifications with others based in the current self may be estimated;

third, past self 1, e.g. *'me as I was when I left school'*, from which estimates of empathetic (de facto) identifications with others in relation to the person's past self-image may be obtained;

fourth, an admired person, e.g. *'someone I admire'* and fifth, a disliked person, e.g. *'someone I dislike'*, which, respectively, were additional anchoring features of identity that provided checks on the validity of the identity indices computed for each respondent.

An additional current self entity, e.g. current self 2: *'me as I am at work'*, acknowledged the fact that a respondent's identity depended upon the social context of others and institutions.

Two specific past self entities, e.g. past self 2: *'me as I was before I found out about the suicide'* and past self 3: *'me as I was after I found out about the suicide'* facilitated estimates of empathetic (de facto) identifications with others in relation to a respondent's past self image in the context of an intimate's suicide.

Two entities incorporating a metaperspective: metaperspective 1 *'me as my family sees me'* and metaperspective 2: *'me as my contemporaries see me'* facilitated a respondent's perception of the way that some other person/s or group viewed self, viz. 'my family' and 'my contemporaries'.

A further four entities included a range of individuals likely to be influential and significant in the respondent's social world: *'father'*, *'mother'*, *'my closest friend'*, and *'my partner/spouse'*. A further group of entities included four that related to the focal issues of this investigation, viz. the plight of suicide survivors. These *were 'the caring professions'*, *'my minister of religion/spiritual adviser'*, *'a person who has taken her/his own life' and 'a depressed person'*. The final (19th) entity, *'my colleagues in the workplace'*, represented an important social grouping that was

almost invariably strongly influential, positively or negatively, in relation to a respondent's self-esteem vis-à-vis her/his social world (Appendix 3).

3.5.3 (b) Entities for Volunteer Controls

A total of 19 entities for ISA with volunteer controls were similar in all but three cases to entities for volunteer respondents. References to 'suicide' in Past Self 2 and Past Self 3, for in respondents' entities were replaced in controls' entities by references to 'death'. Past Self 2 therefore became *'me as I was before found out about death'* and Past Self 3 became *'me as I was after I found out about death'*. Finally the respondents' entity *'a person who has taken her/his own life'* was replaced by a controls' entity *'a person who died suddenly'*. The reasoning behind this substitution was threefold: first, to ensure that respondents' identities were explored inter alia in the context of their status as suicide survivors; second, to ensure that controls' identities were explored inter alia in the context of their various grief reactions to bereavement, including 'sudden death' experiences; and third, to enable the investigator to analyse the dimensions of suicidal grief in the context of the impact upon respondents' identities of their traumatic experiences (Appendix 4).

3.5.4 (a) Bipolar Personal Constructs for Respondents

A list of 23 bipolar personal constructs for ISA with respondents was prepared. Constructs were designed to:

'incorporate people's value and belief systems, and their "everyday ideologies" [and] include items that allow different people to opt for one or other pole as representing something to which they aspire (*Weinreich,* 1992: 12,13).

This investigation was about suicide. The respondents were volunteer survivors of suicide. Each was aware that the investigation was concerned with postvention

strategies for enhancing suicide survivor welfare. Consequently seven out of 23 constructs included one or more of the words 'grief' or 'suicide' or 'suicides' or 'human mortality' or 'suicidal loss'. Each of the 23 constructs was located within one or more of the following broadly defined categories: personal, social, family, health and suicide. (Note: Summation of entities or percentages exceeded 23 or 100% due to overlapping membership of categories.)

(i) Personal Category:

Seven out of 23, or approximately 30% of constructs addressed respondents' personal issues, as follows:

'can be trusted'/ 'can't be trusted';

'always express/es emotional feelings safely'/ 'never express/es emotional feelings safely';

'continue/s to develop personal values and beliefs'/ 'stick/s rigidly to the values and beliefs of parents /guardians';

'is/are pessimistic about the future'/ 'is/are optimistic about the future';

'I feel encouraged by... ' / 'I feel distressed by... ';

'can often be alone without feeling lonely' / 'cannot be alone for long without starting to feel distressed' ; and

'I loathe... '/ 'I have warm feelings towards... '.

(ii) Social Category

Five out of 23, or approximately 22 % of constructs addressed respondents' social/community issues, as follows:

'feel/s at ease when acting as a member of a group' / 'feel/s uncomfortable when acting as a member of a group';

'withdraw/s from human contact' / 'develop/s good relationships';

'believe/s in the irreplaceable value of each human being' / 'do/es not value human beings very highly;

'do/es not enjoy many social activities and community events' / 'enjoy/s most social activities and community events; and

'believe/s suicide may be anticipated by behaviour' / 'believe/s suicide cannot be predicted by behaviour'.

(iii) Family Category

Five out of 23, or approximately 22 % of constructs addressed respondents' family issues, as follows:

'look/s to be set free from family ties' / 'look/s for security and protection in family';

'rely/ies on family support at times of crisis' / 'do/es not rely on family support at times of crisis';

'believe/s that families eventually get over a suicidal loss' / 'believe/s that families never get over a suicidal loss';

'believe/s that corporal punishment does no harm to children' / 'believe/s corporal punishment is a form of child abuse'; and

'put/s obligations to family first' / 'put/s own ambitions and wishes before obligations to family'.

(iv)Health Category

Five out of 23, or approximately 22 % of constructs addressed respondents' health issues, as follows:

'think/s it is morbid to acknowledge human mortality' / 'think/s it is healthy to acknowledge human mortality';

'always express/es emotional feelings safely' / 'never express/es emotional feelings safely;

'rely/ies mainly on prescribed medication to relieve pain' / 'is/are interested in complementary and alternative therapies';

'believe/s that depression and suicide are not linked' / 'believe/s that depression and suicide are closely linked'; and

'can often be alone without feeling lonely' / 'cannot be alone for long without starting to feel distressed'.

(v) Suicide Category

Six out of 23, or approximately 30 % of constructs addressed respondents' issues in relation to the suicide phenomenon, as follows:

'feel/s that a suicide survivor's grief is like any other' / 'feel/s that a suicide survivor's grief is uniquely painful;

'believe/s that families eventually get over a suicidal loss' / 'believe/s that families never get over a suicidal loss';

'is/are convinced that suicide demands considerable bravery' / 'is/are convinced that suicide is the act of a coward';

'consider/s that most suicides cannot be prevented' / 'consider/s that most suicides could be prevented';

'believe/s suicide may be anticipated by behaviour' / 'believe/s that suicide cannot be predicted by behaviour'; and

'believe/s that depression and suicide are not linked' / 'believe/s that depression and suicide are closely linked' (Appendix 5).

3.5.4 (b) Bipolar Personal Constructs for Volunteer Control Respondents

A list of 20 bipolar personal constructs were prepared for ISA with volunteer controls. All were replications of constructs for volunteer respondents (see par 3.5.4 (a) above)

with the following exceptions: all six respondent constructs containing the words '*suicide*', '*suicides*' and/or '*suicidal*' were excluded. A new controls' construct: '*always express/es emotional feelings in unhealthy ways*' / '*always expresses emotional feelings in healthy ways*' replaced the respondents' construct: '*always express/es emotional feelings safely*' / '*never express/es emotional feelings safely*'. Three new controls' constructs were added to complete the list of 20 controls' constructs, as follows:

'*believe/s that depression is a life-threatening condition*' / '*believe/s that depression is not a life threatening condition*';

'*feel/s that sudden death seldom triggers exceptional grief*' / '*feel/s that sudden death often triggers exceptional grief*'; and

'*believe/s families often get over a loved one's sudden death*' / '*believe/s families seldom get over a loved one's sudden death*'.

Effectively the concept of '*sudden death* ' in the controls' construct list replaced the concept of '*suicide*' in the respondents' construct list: issues addressed in controls' constructs ranged across five broad categories: personal, social, family, health and death (Appendix 6).

3.5.5 Belief and value systems

Analysis of an individual's identity structure using bipolar personal constructs and entities involved ascertaining some dimensions of the individual's values and beliefs system while examining some of the individual's partial identifications with significant others (*Weinreich*, 1988: 2). While such systems may be 'ill thought-through, confused and inconsistent in practice...people within various cultures and sub-cultures often hold to shared everyday ideologies...which are generally not well

articulated' (*Weinreich*, 1992: 9). ISA offered a methodology for exploring the power of one's actual values and beliefs system to condition one's identity.

3.5.6 Identification processes

There were two important identification concepts within ISA, namely role model identification and empathetic identification. Role model identification referred to the degree to which 'one might wish to emulate another when the other is a positive role model (idealistic identification), or dissociate from the other when a negative role model (contra-identification)' (*Weinreich*, 1989a: 52). People aspired to possess 'the attributes of their positive role models, and wish to avoid the characteristics of their negative role models' (*Weinreich*, 1992: 7). Empathetic identification with another referred to 'the degree of perceived similarity between the characteristics, whether good or bad, of that other and oneself.' (*Weinreich*, 1989a: 52). Individuals therefore had *aspirational* identifications that co-existed with *de facto* identifications: 'One aspires to some ideal, represented in one's aspirational identifications with one's positive role models, whilst being of a more mundane existence in the here and now, when one's de facto identifications are more often close to one in shared experiences and characteristics' (*Weinreich*, 1992: 7). Conflicted identifications occurred when one simultaneously saw oneself as similar to another and recognised that other as having characteristics from which one wished to dissociate. Two ISA postulates emerged in relation to identification process dealing with attempted resolution of identification conflicts and emergence of new identifications:

Postulate 1: When one's identifications with others are conflicted, one attempts to resolve the conflicts, thereby reducing re-evaluations of self in relation to the others within the limits of one's currently existing value system.

Postulate 2: When one forms further identifications with newly encountered individuals, one broadens one's value system and establishes a new context for one's

self-definition, thereby initiating a re-appraisal of self and others which is dependent on fundamental changes in one's value system.
(*Weinreich,* 1989a: 53)

3.5.7 Personal constructs and structural pressure

Construal of self was regarded as central to the ISA definition of identity stated above. Personal constructs, cognitive in nature, were used to evaluate the characteristics of self and others. Affective associations were considered in the evaluative connotations of the cognitive constructs in terms both of positive values (the individual's aspirations) and negative values (those from which the individual wished to dissociate). Structural pressure was an ISA index that estimated the extent to which individuals consistently attributed favourable or unfavourable characteristics to particular entities. Three ISA postulates emerged in relation to cognitive affective consistency and structural pressure on constructs:

Postulate 1: When the net structural pressure on one of a person's constructs is high and positive, the evaluative connotations associated with it are stably bound.

Postulate 2: When the net structural pressures on a construct are low, or negative as a result of string negative pressures counteracting positive ones, the evaluative connotations associated with the constructs are conflicted: the construct in question is an area of stress.

Postulate 3: When the net structural pressure on a construct is low as a result of weak positive and negative pressures, the construct in question is without strong evaluative connotations.
(*Weinreich*, 1989a: 55,56)

Application of these postulates allowed an individual's belief and value system to be evaluated. Constructs represented by Postulate 1 were *core evaluative dimensions of identity*. 'These reference the values and beliefs estimated as being central to the respondent's identity, in the sense that the person uses them foremost to judge the merits of self and others. At the extreme (they) could indicate a rigid and perhaps bigoted orientation (and) may be regarded as resistant to change' (*Weinreich,* 1992:

21). Constructs represented by Postulate 2 were *conflicted (inconsistently, or non-evaluative) dimensions of identity*. These 'indicate areas of a respondent's identity...under stress...around which the person's behaviour may be problematic...unpredictable. They may be unstable' and subject to change over time. (*Weinreich,* 1992:21). Constructs represented by Postulate 3 were *consistently unevaluative dimensions of identity* or *dual morality dimensions of identity*. They denoted a tendency to associate with valued others the opposite pole of a construct...to the one desired by the respondent' implying a dual morality in relation to behaviour associated with the construct. (*Weinreich,* 1992: 21).

3.5.8 Identity diffusion, self-evaluation and ego-involvement

Identity diffusion was defined as 'the overall dispersion of, and magnitude of one's identification conflicts with significant others' and was capable of assessment in relation to both current and past self-images (*Weinreich*, 1992: 31). An individual with high identity diffusion might have strongly conflicted identifications dispersed across a number of significant others. Low identity diffusion indicated a person with little identification conflict, 'indicating a defensiveness against identification conflicts', implying a failure to differentiate between 'good' and 'bad' either within the self or others (*Weinreich*, 1992: 36). Self-evaluation was closely linked with one's belief and value system and was defined as 'one's overall assessment in terms of the positive and negative evaluative connotations of the attributes one construes as making up one's current or past self-image, in accordance with one's value system. One's evaluation of another closely paralleled this, in relation to how one assessed the other's attributes, according to one's own value system (*Weinreich,* 1992: 31).

Ego-involvement with oneself - as one aspired to be, or as one was now or as one was in the past – was defined as 'one's overall responsiveness both in quantity and

strength of attributes of one's ideal self-image, or of one's current self-image or of one's past self-image or the future.' Ego-involvement with another involved similar considerations in relation to one's overall responsiveness to the other in terms of the extensiveness of both in quantity and strength of the attributes one construes the other as possessing' (*Weinreich*, 1992: 32).

3.5.9 Identity states

The classification of identity variants was based entirely upon the underlying parameters of self-evaluation and identity diffusion. It was therefore global in its application, ignoring individual characteristics for the individual, such as their various identification and identification conflicts' indices. The classification of nine identity variants was based on Erikson's (1994) eight stage sequence for identity growth and on Marcia's (1966, 1980) four identity statuses – see Table 3.1 below. The most usual identity state was that classified as 'indeterminate', corresponding to moderate identity diffusion and moderate self-evaluation. This identity state was regarded as well adjusted. The term 'indeterminate' was used to direct attention to the underlying detail of the respondent's identity structure reflected in other identity indices. The identity state 'confident' reflecting high self-evaluation and moderate identity diffusion was also regarded as psychologically well adjusted. The remaining seven identity states were regarded as vulnerable as each represented an inappropriate

Table 3.1 - Classification of Identity Variants

Classification of Identity Variants			
	IDENTITY DIFFUSION High (0.41-100)	*Moderate (0.26-0.40)*	*Low (0.00-0.25)*
SELF-EVALUATION High (0.81-1.00)	*Diffuse high self-regard*	*Confident*	*Defensive high self-regard*
Moderate (0.19-0.80)	*Diffusion*	*Indeterminate*	*Defensive*
Low (-1.00-0.18)	*Crisis*	*Negative*	*Defensive negative*

combination of identify diffusion and self-evaluation. Those identity states classified as 'diffused' reflected high and dispersed levels of conflicted identifications with others, were 'diffuse high self regard' – where self-evaluation was also high, 'diffusion' – where self-evaluation was moderate and 'crisis' – where self-evaluation was low. It was suggested that individuals reflecting these states were unable to resolve their identification conflicts and consequently could have difficulty in making definite commitments. The 'negative' identity state, with moderate identity diffusion and low self-evaluation, applied to individuals whose skills deficiency precluded them from acting in accordance with their values and aspirations. The remaining three identity states were classified as 'defensive' (or foreclosed) states with low identity diffusion, indicating a failure to acknowledge ordinary or usual levels of conflicted identifications. They were 'defensive high self-regard' – high self-evaluation, 'defensive' – moderate self-evaluation and 'defensive negative' - low self-evaluation. It was suggested that people reflecting these states made undifferentiated appraisals of their social worlds and found it difficult to adapt to complex relationships and to changed circumstances (*Weinreich,* 1992: 22,23,36; *Irvine*, 1994: 102-109; and *Black*, 2000: 9-21).

3.5.10 Theory building using ISA

It was important to note that ISA was an open-ended metatheoretical framework of concepts concerning the structure, content and processes of identity development. Instead of a 'grand' or 'universal' theory' it should be regarded as a flexible framework built upon careful definition of theoretical concepts relating to aspects of identity and the presentation of theoretical process postulates concerning the development and redevelopment of identity. By applying this framework of concepts and postulates to data assembled by the use of focused identity instruments, investigators might arrive at new theoretical propositions 'about the socio-psychological processes of identity development in the socio-historical and biographical context under investigation' (*Irvine*, 1994: 109)

3.6 Access; Sample Group/Pilot Study; Reliability and Validity

3.6.1 Respondents and controls

Volunteer respondents were identified following a public invitation using letters to selected print media - see Appendix 7 for copies. Eight volunteer respondents, including two volunteer controls, participated. The six respondents were healthy volunteers, both women and men, aged 18 and over, normally resident in their own homes who had lost a close relative by suicide at least one year before being interviewed. Similar criteria applied to the two volunteer controls except in relation to bereavement by suicide. Each control had experienced a non-suicidal bereavement of a loved one at least one year before being interviewed. The researcher excluded from participation anyone currently taking medication prescribed by a medical practitioner for the treatment of depression and/or related conditions. All respondents were invited

to inform their general practitioners of their voluntary participation in this research project.

3.6.2 Sample group/Pilot study

The investigator carried out a pilot study – see para. 3.2 above – which concluded that the hypothesis:

'If an enhanced risk of suicide exists among survivors of bereavement by suicide, then effective prevention strategies, including grief therapy and grief counselling, could moderate that risk and contribute to an enhanced quality of life for survivors'

was largely confirmed although he proposed to amend the phrase 'including grief therapy and grief counselling' to read 'including grief therapy, grief counselling *and mutual befriending by intimate suicide survivors'*. The ISA instruments devised for the present investigation were based upon the discourse with a volunteer suicide survivor that formed the database for the pilot study (*O'Keeffe*, 1999).

3.6.3 Reliability and validity

Three instruments were used in this investigation: the transcript of an audiotaped interview, the ISA instrument and the human instrument, the investigator himself. The only data used in content analysis or that was analysed by the ISA software were actual words used by the respondents and control respondents and actual responses that they wrote on the ISA instruments. The results obtained from each participant were therefore totally based upon data provided only by them. However since the investigator designed the interview structure, participated in the interviews, designed the ISA instruments, supervised their application and carried out all the project's data processing, the reliability of the investigation was dependent upon the trustworthiness of the investigator. If bias or imbalance in the investigation's design or execution was found this was the responsibility only of the investigator. The validity of the investigation rested therefore upon the investigator's objectivity. As he himself was a

double suicide survivor, it was possible that he was influenced by his own suicide survivor status. Perhaps ironically, his survivor status was of crucial importance in obtaining access to the respondents and control respondents.

3.7 Research ethics

3.7.1 Research ethics: Health, safety and comfort of respondents

At the outset it was acknowledged that there was some, albeit negligible, risk to the health of respondents through their participation in the investigation. 'A death by suicide is a terrible tragedy, the loss of a loved one leaves the family deeply shocked and traumatized' (*Daly*, 2000: 4). Consequently it was essential to take all available and reasonable precautions to protect respondents from risks associated with their participation. Some unquantified potential for re-traumatization of respondents existed, for example, when they re-visited their initial suicidal loss experience during the audiotaped interview or while working though the IDEX software (Weinreich and Ewart, 1997).

All respondents were volunteers who had the opportunity to discuss the investigation, its objectives and format with the researcher. But it was surmised that respondents, during their active participation at interview and/or the IDEX software stage, might exhibit mild discomfort if unresolved grief feelings were thereby aroused. The expression of such feelings in a safe, supportive environment was acknowledged to be both therapeutic and healing:

'It will come as no surprise that we feel that the most important way to learn to respond to a suicide is through talking. Keeping silent, hiding your feelings about the suicide, punishing yourself, only perpetuates the grief. Expressing grief and pain, anger and guilt is healthy' (*Lukas and Seiden*, 1990: 144).

The researcher sought to provide such an environment. All respondents were free to withdraw from the audiotaped interview before it commenced and also at any time

during the interview. Before the interview started subjects were so informed and when the interview commenced, a statement reiterating this 'freedom to withdraw at any time without adverse or any inferences being drawn' was repeated during the researcher's introductory remarks on tape. The researcher was available to respondents, by telephone, after the conclusion of the interview/IDEX software session, if short-term advice and/or support were sought. If and when requested, by an individual respondent, the researcher offered relevant help and advice, including counsellor referral information related to longer-term support.

3.7.2 Research ethics: Confidentiality

Some writers took the view that confidentiality in counselling, and by extension in counselling research was 'an absolute principle'. For example, one text designed to help potential clients, published the statement: 'all counselling is totally confidential' (*Einzig* (1989), cited in *Bond*, 1998: 122). An opposing view cited the importance of client autonomy, related to 'the client's values, personal resources and capacity for self-determination' (*Bond*, 1998: 122). In the research context, 'respondent' replaced 'client' but exactly the same considerations applied. Perhaps the common sense position was best summed up as 'the client [or respondent] should know where s/he stands in relation to confidentiality' (*Bond*, 1998: 122).

A major Irish counselling organisation offered the following guidance:

'B.6.1 The IACT Code of confidentiality applies for research purposes' (*Irish Association for Counselling and Therapy (IACT)*, 1998: 6).

Conditional confidentiality was offered to all respondents in the current investigation with three caveats related to:

i) information about or intent to commit serious criminal offence/s including offences against or involving children, terrorism and drug trafficking;

ii) serious intent to self-harm;

iii) information required under sub-poena by any properly constituted court of law (*Bond*, 1999: 8-10).

This was discussed fully with respondents before they commenced any interview/IDEX software work.

3.7.3 Research ethics: Personally identifiable material

A major British counselling organisation offered researchers in counselling the following guidance:

'B7 Research:

B.7.1 The use of personally identifiable material gained from clients or by the observation of counselling should be used only after the client has given consent, usually in writing, and care has been taken to ensure that consent was given freely.

B.7.2 Counsellors conducting research should use their data accurately and restrict their conclusions to those compatible with their methodology' (*British Association for Counselling (BAC)*, 1996: 8).

A major Irish counselling organisation offered researchers precisely the same guidance (*Irish Association for Counselling and Therapy (IACT)*, 1998: 6). Consequently the researcher undertook that all material published in the dissertation associated with this investigation would be anonymised in order to protect respondents' privacy.

3.7.4 Research ethics: Written explanation, consent form and waiver

A written explanation formed the basis for a preliminary discussion between each volunteer respondent and the researcher after which a consent form - sample copy attached at Appendix 8 – was authorised by the signatures of the volunteer respondent, the researcher and a witness, as appropriate.

Each participant completed a waiver - sample copy attached at Appendix 9 - releasing the investigator from any claims by reason of illness or disturbance arising from participation. Each exercise required three quarters of an hour approximately and, where possible, the second exercise was applied immediately after completion of the first exercise, or as soon as possible thereafter. A total time commitment by respondents of around two hours (approximately) was therefore involved. By conveying their written consent, respondents agreed that material obtained through audiotaped interviews/IDEX software could be used for research purposes subject to the caveat concerning 'personally identifiable material'.

3.7.5 Research ethics: Protection for the researcher

By obtaining in advance from respondents full written consent and a waiver, the researcher was protected from legal risks associated with any adverse respondent reaction while actively participating in the research. The researcher accepted moral responsibility for any negative impact on volunteers and made arrangements to help volunteers in this regard - see para. 3.7.1 above for detail.) The researcher was a counsellor in private practice, and an experienced senior counsellor supervised his work. He carried professional indemnity insurance in relation to his counselling activities. He was an associate member of the British Association for Counselling (BAC) and the Irish Association for Counselling and Therapy (IACT) and was an elected member of the latter's Regional Committee for Northern Ireland. He was in personal therapy since September 1997 with a professional trainer and counsellor. This combination of professional and therapeutic resources offered him an adequate level of support for the estimated seven months duration of this investigation.

3.7.6 Research Ethics Committee

The Research Ethics Committee of the University of Ulster approved the study.

3.8 Results

The results obtained by the investigator are presented in the form of eight case studies in the next chapter.

Chapter 4: Results

4.1 Introduction

Results obtained from analysis of eight taped interviews and from interpretation of eight related Identity Structure Analysis (ISA) appraisals are set out below. These data were structured in eight case studies, each of which represented a participant's recorded experience along with her/his response to an ISA instrument. Each case study was regarded as unique and when presenting results, no attempt was made to compare or contrast the individual predicaments of participants.

Each ISA appraisal offered an opportunity to explore the identity of each participant at the date and time that the instrument was completed. Each appraisal was regarded as exploratory. In several of the case studies, there was a time lag - ranging from a few days to several months - between the interview and completion of the instrument. It was not known whether this represented a significant influence upon the results obtained.

However, although it was felt that information emerging from each interview and the corresponding ISA appraisal was likely to be complementary, no assumptions were made in this regard in the presentation of the results.

4.2 Case Study A

4.2.1 Respondent A – personal information

Respondent 'A' was a 46-year-old woman living in Co Antrim with her husband. In October 1977, her 19-year-old sister was found hanged in her study bedroom at an educational establishment in Co Derry/Londonderry. At this time the respondent was

abroad and was therefore unable to attend her late sister's funeral. At an inquest held later police photographs of the death scene and a 'suicide note' left by the deceased were shown to the respondent. Surviving members of the respondent's family of origin were her parents and two brothers, one older than her and the other younger than the deceased.

4.2.2 Respondent A: Transcript analysis

Analysis of transcript 'A' generated 134 issues and emergent themes from which 212 linked concepts were derived. The interview's loose structure employed a framework of five core themes – what happened, health and well being, meaning, aftercare and quality of life.

4.2.3 Respondent A: Concepts (1)

These linked concepts are listed sequentially at Table 4.1 below. They represented the investigator's subjective attempt to illustrate in summary form some aspects of the participant's reported experiences as a suicide survivor: concept referral frequency is stated in parentheses:

Table 4.1 Respondent A: Concepts (1)

PAIN (10) SELF-PROTECTION BY SURVIVOR (2) UNRESOLVED GRIEF (1) DETACHMENT (6) FINAL FAREWELL (12) RECOGNISING RISK (1) FAMILY SECRETS (1) ANGER (1) SADNESS AND GRIEF (2) ISOLATION (7) UNDERSTANDING (4) IDENTITY DISTORTION (3) DISPLACEMENT (4) ANXIETY SYMPTOMS (2) PERFECTIONISM (1) GP ROLE (7) SURVIVOR SUPPORT (36) SENSE OF IDENTITY (5) SURVIVOR CONFUSION (2) SUICIDE

STIGMA (1) ANGER AND RESENTMENT (1) GUILT (3) COMMUNICATION (2) BLOCKED GRIEF (5) DENIAL AS A DEFENCE (1) MEANINGLESSNESS (1) FAMILY THERAPY (13) RESPONDENT'S NEED FOR OPENNESS (3) ONE-TO-ONE WORK (4) SURVIVOR SUICIDE RISK (4) COMMUNITY/SOCIAL PREJUDICE (1) COMMUNITY/SOCIAL RESOURCES (4) UNHEALED HISTORICAL LEGACY (3) DEEP SUICIDE SCAR (2) UNCONDITIONAL SUPPORT (1) HISTORICAL BAGGAGE (1) FAMILY DISINTEGRATION (1) HEALING AVOIDED (1) FAMILY AND FRIENDS' ROLE (4) GOOD HEALING MEMORIES (2) KEEP GOOD MEMORY ALIVE (1)

FAMILY REINTEGRATION (2) FAMILY SECRETS (1) FAMILY SOLIDARITY (1) COMMUNITY/SOCIAL EDUCATION (2) PUBLIC DEBATE (2) UNBEARABLE PAIN (1) HEALING COMPASSION (1) SEPARATION (2) ALTERNATIVES (1) SUICIDE CUL-DE-SAC (1) SAMARITANS ETC (2) DELAYED GRATIFICATION (2) SURVIVAL (1) TALK=UNIVERSAL PANACEA (1) SELF DISCOVERY (3) PERSONAL GROWTH WORK (1) VALUE & BELIEF SYSTEMS (1) TRUE SELF ESTEEM (1) HONESTY (1) INNER KNOWLEDGE (1) INNER CHILD (1) SUICIDE POSTVENTION (1) SUICIDE PREVENTION CENTRES (1) CULTURAL SHIFT (1) ASSESSING SUICIDE RISK (1) CRUSE (1) EXPERT PROFESSIONAL SUPPORT (1) PAYING FOR HELP (1) TRAINING PROGRAMMES (1) SURVIVORS' NETWORK (1) SURVIVORS AS HEALING RESOURCE (1) BUILDING SELF ESTEEM (1) IMMEDIATE INTERVENTION RESOURCE (1) ECONOMIC, SOCIAL & PERSONAL COSTS (1) NET SAVINGS OVERALL OF HEALING GRIEF (1)HUMAN COMPASSION (1) HUMAN COSTS ARGUMENT (1)

NECESSARYBUT NOT SUFFICIENT (1) ADDITIONAL INTERVENTION RESOURCES (1) HOLY GRAIL (1) – *TOTAL # 212*

4.2.4 Respondent A: Concepts (2)

At Table 4.2 below are concepts referred to more than once in the analysis, in descending order:

Table 4.2 Respondent A: Concepts (2)

SURVIVOR SUPPORT (36) FAMILY THERAPY (13) FINAL FAREWELL (12) PAIN (10) ISOLATION (7) GP ROLE (7) DETACHMENT (6) SENSE OF IDENTITY (5) BLOCKED GRIEF (5) UNDERSTANDING (4) DISPLACEMENT (4) ONE-TO-ONE WORK (4) SURVIVOR SUICIDE RISK (4) COMMUNITY/SOCIAL RESOURCES (4) FAMILY AND FRIENDS' ROLE (4) IDENTITY DISTORTION (3) GUILT (3) RESPONDENT'S NEED FOR OPENNESS (3) UNHEALED HISTORICAL LEGACY (3) SELF DISCOVERY (3) DEEP SUICIDE SCAR (2) GOOD HEALING MEMORIES (2) FAMILY REINTEGRATION (2) COMMUNITY/SOCIAL EDUCATION (2) PUBLIC DEBATE (2) SEPARATION (2) SAMARITANS ETC (2) DELAYED GRATIFICATION (2) SADNESS AND GRIEF (2) ANXIETY SYMPTOMS (2) SURVIVOR CONFUSION (2) COMMUNICATION (2) – *TOTAL # 164*

4.2.5 Respondent 'A' – reported experiences

Respondent 'A' contacted the investigator over 22 years after her intimate suicidal loss. It appeared that she had not been facilitated to talk deeply about her loss other than to her husband. The concept 'SURVIVOR SUPPORT (36)' had a referral

frequency almost three times as high as the next highest concept 'FAMILY THERAPY (13)'. The intimate nature of the suicidal loss experience was reflected in two other referrals to 'family', including FAMILY AND FRIENDS' ROLE (4) and FAMILY REINTEGRATION (2). Respondent's inability to attend her sister's funeral was reflected in the high frequency of the concept 'FINAL FAREWELL (12)'. The frequencies of five concepts, viz. 'PAIN (10)', 'ISOLATION (7)', 'DETACHMENT (6)', 'SEPARATION (2)' and 'UNBEARABLE PAIN (1)' reflected her psychological pain of loss and her withdrawal response into that pain in the aftermath of her loss. The absence of effective medical support was reflected in the high referral frequency of 'GP ROLE (7)'. The impact on the respondent's sense of herself was reflected in the combined frequencies of 'SENSE OF IDENTITY (5)' and 'IDENTITY DISTORTION (3)'. Concepts reflecting affective content included 'BLOCKED GRIEF (5)', 'GUILT (3)', 'SADNESS AND GRIEF (2)', 'ANXIETY SYMPTOMS (2)' and 'SURVIVOR CONFUSION (2)'. Concepts containing aspects of coping ability and strategy included 'FAMILY THERAPY (13)', 'UNDERSTANDING (4)', 'ONE-TO-ONE WORK (4)', 'RESPONDENT'S NEED FOR OPENNESS (3)', 'SELF DISCOVERY (3)', 'GOOD HEALING MEMORIES (2)', 'FAMILY REINTEGRATION (2)', 'SAMARITANS ETC (2)', 'CRUSE (1)' and 'COMMUNICATION (2)'.

4.2.6 Respondent 'A' - Identity Structure Analysis

Intimate relatives, i.e. survivors, were affected by the sudden, traumatic loss by suicide of a loved one. All life events affected and altered identity but traumatic life events changed identity significantly. Hence a survivor's identity was inevitably changed as a result of a suicidal loss experience. Recovery was aided by recognition and acknowledgement of such change and its accommodation and integration within

the psyche. Identity structure analysis facilitated exploration of the respondent's identity as represented by value and belief systems, identifications, processes of change in sense of identity and self-evaluation.

4.2.7 Respondent A: Primary analysis

Respondent A's current selves *'me as I am at home'* and *'me as I am at work'* were classified as 'crisis'. Her past selves *'me as I was when I left school'* and *'me as I was before I found out about the suicide'* were classified as 'diffusion'. The respondent's past self *'me as I was after I found out about the suicide'* was classified as 'crisis'. These identity variant classifications (see Table 4.3 below) offered an indication of how the impact of the suicidal loss experience continued to affect her. All of these five classifications were considered to represent vulnerable identities.

Table 4.3 Respondent A – Self Image

SELF IMAGE					
	Ideal Self	Current Self		Past Self	
Ego-Involvement (0.00 to 5.00)	4.53	CS1 CS2	3.55 3.31	PS1 PS2 PS3	3.37 2.62 4.30
Self-Evaluation (-1.00 to +1.00)	1.00	CS1 CS2	0.18 -0.04	PS1 PS2 PS3	0.39 0.35 -0.13
Id. Diffusion (weighte) (0.00 to 1.00)		CS1 CS2	0.46 0.49	PS1 PS2 PS3	0.45 0.45 0.47
	Identity Variant				
Current Self 1	CRISIS				
Current Self 2	CRISIS				
Past Self 1	DIFFUSION				
Past Self 2	DIFFUSION				
Past Self 3	CRISIS				

4.2.8 Respondent A: Impact of suicidal loss in relation to the past self *'me as I was before I found out about the suicide'* and the currently situated selves *'me as I am at home'* and *'me as I am at work'*.

The respondent had very high conflicted identifications with her mother, her father and colleagues at work in her appraisal of her currently situated selves: (CS1 0.58, 0.57, 0.53; CS2 0.62, 0.61, 0.62). The impact of intimate suicidal loss could be traced through how the respondent appraised her identity in terms of those conflicted identifications in her appraisal of herself when she left school (PS1 0.59, 0.55, 0.52) with herself before the suicide (PS2 0.61, 0.48, 0.50) and with herself after the suicide (PS3 0.64, 0.55, 0.55). These conflicted identifications as the respondent appraised her past selves, were most problematic in the period after the suicide and her predicament extended into how she appraised her currently situated selves.

Table 4.4 Respondent A – Conflicts in identification

CONFLICTS IN IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
10	Mother...	0.58	0.62
11	Father...	0.57	0.61
17	My colleagues in th.	0.53	0.62
16	A depressed person..	0.52	0.45
12	My closest friend..)	0.44	0.33
6	A person I dislike.)	0.43	0.58
5	A person I admire..)	0.42	0.36
13	My partner/spouse...	0.35	0.37
19	A person who has ta.	0.29	0.32
15	My minister of reli.	0.16	0.17
14	The caring professi.	0.11	0.10

CONFLICTS IN IDENTIFICATION WITH OTHERS - Past Self
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
10	Mother...	0.59	0.61	0.64
11	Father...	0.55	0.48	0.55
6	A person I dislike.)	0.52	0.44	0.46
17	My colleagues in th.	0.52	0.50	0.55
13	My partner/spouse...	0.45	0.45	0.32
16	A depressed person..	0.45	0.48	0.47
5	A person I admire..)	0.38	0.38	0.38
12	My closest friend..)	0.36	0.46	0.42
19	A person who has ta.	0.30	0.30	0.31
15	My minister of reli.	0.17	0.20	0.16
14	The caring professi.	0.09	0.09	0.10

Her conflicted identification (see Table 4.4 above) with her mother continued throughout her appraisal of her past and currently situated selves (PS1 0.59, PS2 0.61, PS3 0.64, CS1 0.58, CS2 0.62) and was reflected in how she evaluated herself with regard to her mother (-0.21).

4.2.9 Respondent A: Empathetic identifications

Respondent 'A' increasingly empathetically identified (see Table 4.5 below) with her father and with her colleagues in the workplace as she appraised herself from *'after I found out about the suicide'* (PS3 0.64, 0.59) to *'me as I am at work'* (CS2 0.77, 0.73), indicating progress towards acquisition of those qualities they represented in the professional, viz. teaching, context. Her decreasing empathetic identification with her partner/spouse and with her closest friend as she appraised herself from *'before I found out about the suicide'* (PS2 0.52, 0.71) to *'me as I am at home'* (CS1 0.32, 0.64) might reflect her relative isolation in the aftermath of the suicide, as in the discourse:

"I haven't been in touch with any other families... I wouldn't ever talk to people to find out how it affected their members"

Perhaps ironically the respondent increasingly empathetically identified with *'a depressed person'* and *'an admired person'* as she appraised herself from *'before I found out about the suicide'* (PS2 0.67, 0.57) to *'me as I am at home'* (CS1 0.77, 0.68) while her empathetic identifications with these entities decreased only marginally as she appraised herself from *'before I found out about the suicide'* (PS2 0.67, 0.57) to *'after I found out about the suicide'* (PS3 0.64, 0.55). This evidenced the respondent's initial use of denial as a defence that concealed a deeply painful malaise continuing to the present time, as in the discourse:

"...to a certain extent I... didn't really care... I just I didn't actually care that much at the time... sounds callous but I just didn't know what hit me... I just thought 'Oh God'... it was only afterwards... subsequent to that... I kept busy everybody said oh A's getting on great... meanwhile I... got my own life into a bit of a mess... over the years this terrible thing there's been this terrible thing... I sort of... hold it back you'll make up a story... and that that's just pushing it away all the time... and that just builds it up and... makes it worse... you're just building up a bigger and bigger time-bomb for yourself'

Table 4.5 Respondent A: Empathetic Identifications

EMPATHETIC IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
16	A depressed person..	0.77	0.59
5	A person I admire..)	0.68	0.50
11	Father...	0.68	0.77
12	My closest friend..)	0.64	0.36
10	Mother...	0.55	0.64
17	My colleagues in th.	0.55	0.73
19	A person who has ta.	0.50	0.59
6	A person I dislike.)	0.36	0.64
13	My partner/spouse...	0.32	0.36
14	The caring professi.	0.32	0.23
15	My minister of reli.	0.27	0.32

EMPATHETIC IDENTIFICATION WITH OTHERS - Past Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
11	Father...	0.62	0.48	0.64
5	A person I admire..)	0.57	0.57	0.55
10	Mother...	0.57	0.62	0.68
16	A depressed person..	0.57	0.67	0.64
6	A person I dislike.)	0.52	0.38	0.41
13	My partner/spouse...	0.52	0.52	0.27
17	My colleagues in th.	0.52	0.48	0.59
19	A person who has ta.	0.52	0.52	0.55
12	My closest friend..)	0.43	0.71	0.59
15	My minister of reli.	0.33	0.43	0.27
14	The caring professi.	0.19	0.19	0.27

4.2.10 Respondent A: Contra-identifications

Respondent 'A's contra-identifications with her mother (0.61), her colleagues at work (0.52) and her father (0.48) showed her wish to dissociate from these people and corresponded with very high conflicted identifications with these three entities. This was not unconnected with her low evaluation ~~of herself in relation to~~ her mother, as at par 2.5.2 above, exemplified in the discourse:

"...I think my mother was just trying to...I think it's very funny...I shouldn't say this but I don't think she would even communicate with my father...she's kind of opened up to me...which was nice...But that was after twenty nearly twenty years...she's just never talked about it...'

4.2.11 Respondent A: Idealistic identification

The respondent's very high idealistic identification (0.78) with a *'person who has taken her/his own life'* reflected the strength of the attachment she retained to her deceased sister, as reflected in the discourse:

"we were very close... she was my only sister... we shared the same bed when we were growing up... talked about everything".

4.2.12 Respondent A: Structural pressure on constructs

Moderately high structural pressure on the construct *'thinks that it is morbid to acknowledge human mortality'*/ ***'thinks that it is healthy to acknowledge human mortality'*** (53.11) (where the preferred pole is in bold) reflected the respondent's continuing adjustment to the sudden loss of loved one and represented a core evaluative dimension of the respondent's identity. Pressures on five further constructs, viz. *'withdraws from human contact'* / ***'develops good relationships'*** (49.46); ***'continues to develop personal values and beliefs'*** / *'sticks rigidly to the values and beliefs of parents/guardians'* (48.49); *'can't be trusted'* / ***'can be trusted'*** (44.80); ***'relies on family support at times of crisis'*** / *'does not rely on family support at times of crisis'* (42.73); and *'looks the be set free from family ties'* / ***'look for security and protection in family'*** (42.72) represented secondary evaluative dimensions of identity. This respondent continued to place some reliance for support in family life while valuing her personal integrity and independence, evidenced in the discourse:

"... my husband he's fed up listening to me... he listens to me... he didn't know my sister... he would listen a little bit then after a while he doesn't want to listen any more... he would be sympathetic up to a point... you think a death like that... somebody in the family committed suicide... there's still that aura about it... you don't want to give that too much of a public airing... mammy would never really talk much... the fact that I'm sitting talking... '

Low pressures on three constructs: *'considers that most suicides cannot be prevented'* / ***'considers that most suicides could be prevented'*** (10.49); *'feels that a suicide*

survivor's grief is like any other' / ***'feels that a suicide survivor's grief is uniquely painful'*** (-6.02) and ***'believes that families eventually get over a suicidal loss'*** / *believes that families never get over a suicidal loss'* (-8.81) specifically referred to aspects of suicide and were inconsistently evaluative dimensions of identity signifying problematic areas for the respondent. Her inconsistency in appraising her social world in relation to aspects of suicide – prevention, grief and recovery – revealed vulnerable feelings in relation to her own traumatic loss, as reflected in the discourse:

"...it's hard to come to terms...and go on with your life. You can bounce back immediately and then...it's quite raw in me still and it shouldn't be..."

Low pressures on three constructs: *'relies mainly upon prescribed medication to relieve pain'* / ***'is interested in complementary and alternative therapies'*** (8.39); *'believes corporal punishment does no harm to children'* / ***'believes corporal punishment is a form of child abuse'*** (3.60) and ***'puts obligations to family first'*** / *'puts own ambitions and wishes before obligations to family'* (-13.28) similarly represented issues about which the respondent remained uncertain and indecisive.

4.2.13 Respondent A: Summary

This respondent's very high conflicted identifications and modulations in empathetic identifications in how she appraised herself during the period preceding her suicidal loss to date provided an indication of the deep impact upon her identity of suicide trauma. There was evidence of some attempt at resolving her identification conflicts, in particular with her parents. However her identity variant classification 'crisis' in her currently situated selves indicated her continuing sense of vulnerability in her identity. Her very high idealistic identification with her deceased sister suggested continuing unresolved grief although her involvement with her family and her interest

in personal development provided some basis for an effective if basic coping strategy. Evidence of unresolved post-suicide trauma existed in her conflicted dimensions of identity in her belief and value system that contributed to her relatively vulnerable identity state.

4.3 Case Study B

4.3.1 Respondent B – personal information

Respondent B was a woman aged approximately 45 years, living and employed on Co Derry/Londonderry. In October 1996, her 23-year-old son was found dead in his bed at home by his younger brother. At this time, the respondent was staying overnight at her partner's home while some friends of her sons socialised with them in her home. The coroner decided that in view of the particular circumstances of the death an inquest hearing was unnecessary. Surviving members of the respondent's family were her mother – her father died when she was nine years old – two younger siblings, a brother and a sister, and her younger son.

4.3.2 Respondent B: Transcript analysis

Analysis of transcript 'B' generated 114 issues and emergent themes from which 269 linked concepts were derived. The interview's loose structure employed a framework of five core themes – what happened, health and well being, meaning, aftercare and quality of life.

4.3.3 Respondent B: Concepts (1)

These linked concepts are listed sequentially in Table 4.6 below. They represented the investigator's subjective attempt to illustrate in summary form some aspects of the participant's reported experiences as a suicide survivor: concept referral frequency is stated in parentheses:

Table 4.6 Respondent B: Concepts (1)

DEPRESSION (4), FEAR (3), DETACHMENT (6), CHANGES IN BEHAVIOUR, SUICIDE DECISION, SUICIDE PLANNING, SUICIDE ACT (2), SUICIDE PRELUDE, REPRESSED PAIN, PAIN (6), SHOCK AND DENIAL, UNIQUE ANGUISH (2), ANGER (2), FEAR AND RISK, SUICIDE NOTE (3), DISTORTED THINKING (2), UNBEARABLE PAIN (2), BRINGING THE BODY HOME, ACTIVITY, INTERMENT, A CLEAR CUT CASE, SURVIVOR CONFUSION, LACK OF COMPASSION, DEEP GRIEF, SURVIVOR SUPPORT (22), GRIEF PROCESS (3), DISPLACEMENT (2), EXTREME GRIEF REACTION (2), ISOLATION (7), GUILT (2), FAILURE AS A MOTHER, SELF-HATRED, SENSE OF IDENTITY (4), MULTIPLE LOSSES, ENORMITY OF PAIN, BLOCKED GRIEF (3), LOVE, REGRET, COMMUNICATION, HISTORY OF SELF HARM, COUNSELLING SUPPORT, CONCEALED RISK, FALSE COMPARISON, UNIQUE CIRCUMSTANCES, FEAR OF SUICIDE, DENIAL OF SUICIDE, EDUCATION FOR AWARENESS, COMMUNITY/SOCIAL EDUCATION (3), CATHOLIC CONDITIONING, SURVIVOR DEPRESSION, SURVIVOR ISOLATION (2), GRIEF REACTION, SENSE OF UNFAIRNESS, ENFORCED CHANGE, INNER RESPONSE, INSECURITY, LETTING GO (7), SOME CLOSURE, MEANINGLESSNESS (4), MENTAL STATE, COPING ABILITY (6), SECRET PROBLEMS (3), CUL DE SAC, VALUES AND BELIEFS (3), FATHER-

ANCHOR (3), PREDICTABILITY (2), RISK FACTOR, UNHEALTHY SECRECY, SEARCH FOR MEANING (3), SUICIDE GENE (3), UNREALISTIC GUILT (8), TEMPERAMENT, HEREDITY (2), FORGIVENESS (2), EMULATION, FATHER GRIEF, WINNECOT, STUDY (2), COUNSELLING (7), SUICIDE TABOO, LIVING BEREAVEMENT, SELF-FORGIVENESS (5), FLASHBACKS (2), POST-SUICIDE TRAUMA (2), EMULATION FEAR, PERFECTIONISM, ANXIETY (3), SUICIDE TRAUMA, FAMILY THERAPY (5), UNBEARABLE PSYCHOLOGICAL PAIN, SUICIDE IMPULSE, COMPLEXITY, FAMILY OF ORIGIN, PARTNER SUPPORT, IDENTIFICATION (2), HEALING THERAPY (2), MOTHER'S GRIEF (2), UNRESOLVED GRIEF (3), UNFINISHED BUSINESS (3), LONG-TERM PAIN, GRIEF SYMPTOMS, INCOMPLETE GRIEVING (2), CHOICE TO HEAL (3), SELF-FOCUS, SELF-HEALING (2), IDENTITY (2), MISPLACED ALTRUISM, SELF FIRST (2), COMMUNITY/SOCIETY/OTHERS, SELF-KNOWLEDGE (2), SURVIVOR SUICIDE RISK, FINISHING, HEARTLESSNESS, COMPASSION (2), AGNOSTICISM, RE-PARENTING, INNER CHILD, HIGH VULNERABILITY, SELF-COMPASSION, EMOTIONAL PAIN, HEALING THE PAIN, INTEGRATING THE LOSS, LETTING GO AND MOVING ON, EXTERNALISING (3), VOLCANO, POT BOILING OVER, RELEASING FEELINGS, HEALING/FEELING THE LOSS, SINGLE EXPERIENCE, SUFFERED ENOUGH (3), FEAR OF FEELINGS, FEAR OF LETTING IT RIP, BIAS AGAINST COUNSELLING, CHOICE TO CHANGE / HEAL (2), TIME-NECESSARY BUT NOT SUFFICIENT FOR HEALING – *TOTAL # 269.*

4.3.4 Respondent B: Concepts (2)

At Table 4.7 below are concepts referred to more than once in the analysis, in descending order:

Table 4.7 Respondent B: Concepts (2)

SURVIVOR SUPPORT (22), UNREALISTIC GUILT (8), ISOLATION (7), LETTING GO (7), COUNSELLING (7), DETACHMENT (6), PAIN (6), COPING ABILITY (6), SELF-FORGIVENESS (5), FAMILY THERAPY (5), DEPRESSION (4), SENSE OF IDENTITY (4), MEANINGLESSNESS (4), FEAR (3), SUICIDE NOTE (3), GRIEF PROCESS (3), BLOCKED GRIEF (3), COMMUNITY/SOCIAL EDUCATION (3), SECRET PROBLEMS (3), VALUES AND BELIEFS (3), FATHER-ANCHOR (3), SEARCH FOR MEANING (3), SUICIDE GENE (3), ANXIETY (3), UNRESOLVED GRIEF (3), UNFINISHED BUSINESS (3), CHOICE TO HEAL (3), EXTERNALISING (3), SUFFERED ENOUGH (3), SUICIDE ACT (2), UNIQUE ANGUISH (2), ANGER (2), DISTORTED THINKING (2), UNBEARABLE PAIN (2), DISPLACEMENT (2), EXTREME GRIEF REACTION (2), GUILT (2), SURVIVOR ISOLATION (2), PREDICTABILITY (2), HEREDITY (2), FORGIVENESS (2), STUDY (2), FLASHBACKS (2), POST-SUICIDE TRAUMA (2), IDENTIFICATION (2), HEALING THERAPY (2), MOTHER'S GRIEF (2), INCOMPLETE GRIEVING (2), SELF-HEALING (2), IDENTITY (2), SELF FIRST (2), SELF-KNOWLEDGE (2), COMPASSION (2), CHOICE TO CHANGE / HEAL (2). TOTAL # 189

4.3.5 Respondent 'B' – reported experiences

Respondent 'B' contacted the investigator just under three and a half years after her suicidal loss. In the interim she had completed an in-depth study of the suicide

phenomenon. She had sought counselling at the time she commenced her study, several months after her bereavement, but withdrew after two sessions:

"the girl that was to counsel me was actually about the same age as my son that had died... was not a mother... I couldn't just relate to her at all."

Her study focused upon how people cope with bereavement by suicide but she herself was not able to talk deeply about her own loss to a compassionate listener. During the taped interview her feelings were triggered:

"I was battling there earlier on to... not cry too much or get to the point where I wasn't able to speak because I didn't want to ruin the interview but... it was very difficult at the start... I haven't felt like that... for a long time because... I've nobody to bloody talk to about it... that I feel would understand or be interested."

The referral frequency for the related concept 'SURVIVOR SUPPORT (22)' was almost three times as high as the next highest concept 'UNREALISTIC GUILT (8)'. The latter reflected this respondent's continuing inability to release herself totally – 'LETTING GO (7)' - from any responsibility, direct or indirect, for her son's death. This 'stuckness' re-appeared in several related concepts including 'SELF-FORGIVENESS (5)', 'BLOCKED GRIEF (3)', 'UNRESOLVED GRIEF (3)', 'UNFINISHED BUSINESS (3)', 'SURVIVOR ISOLATION (2)', and 'INCOMPLETE GRIEVING (2)'. Her personal feeling of isolation – 'ISOLATION (7)' – emanated from the apparent failure of family members to provide basic support in the months following her loss. Discourse reflecting this aspect included:

"I had a lot of people around me for about two weeks... then... people had to go back to their work... and get on with their own life... I had this terrible sense of isolation, loneliness, fear of death, fear of what it can do, how final it is... It was a long struggle and I feel I had to do it on my own... the family were all there for about the first two weeks... after that I just don't feel I got much support... I think they left me quite... alone far too much'

The strength of this mother's attachment to her deceased son escalated the degree of her desolation. Relevant concepts were 'PAIN (6)', 'UNIQUE ANGUISH (2)',

UNBEARABLE PAIN (2)', 'POST-SUICIDE TRAUMA (2)', 'MOTHER'S GRIEF (2)' and 'ENORMITY OF PAIN'. The following discourse refers:

"I'm very angry at him for wasting his life... you can only be angry for so long... I love him so much I can't stay angry at him for long. I just wish he'd... talked to somebody... me... somebody... I wouldn't say that I loved him any more than... my other son... but... feel a stronger relationship than... my other boy... I don't believe I'll ever come to terms with his death... '

Three core themes 'meaning', 'aftercare' and 'quality of life' were less well addressed in this respondent's interview than the remaining two: 'what happened' and 'health and well-being'. Concepts 'MEANINGLESSNESS (4)' and 'SEARCH FOR MEANING (3)' were relevant here. Finally the respondent's 'COPING ABILITY (6)' had not yet benefited from effective 'COUNSELLING (7)' nor had her wider family considered the potential of 'FAMILY THERAPY (5)'. Her 'VALUES AND BELIEFS (3)' and consequently her 'SENSE OF IDENTITY (4)' were challenged by the past three years and she was much affected by emotions and feelings of 'FEAR (3)', 'ANXIETY (3)', 'ANGER (2)' and 'GUILT (2)'.

4.3.6 Respondent 'B' – Identity structure analysis

As for Respondent 'A', identity structure analysis facilitated exploration of Respondent 'B's identity as represented by value and belief systems, identifications, processes of change in sense of identity and self-evaluation.

4.3.7 Respondent B: Primary analysis

As set out in Table 4.8 below, Respondent B's current selves *'me as I am at home'* and *'me as I am at work'* were classified as 'indeterminate'. Her past selves *'me as I was when I left school'* and *'me as I was before I found out about the suicide'* were classified also as 'indeterminate'. These four identity variant classifications represented relatively well-adjusted identities. But the respondent's past self *'me as I*

was after I found out about the suicide' was classified as 'negative', representing a vulnerable identity. The latter identity variant classification offered an insight into how the impact of her suicidal loss experience affected her

Table 4.8 Respondent B: Self Image

SELF IMAGE					
	Ideal Self	Current Self		Past Self	
Ego-Involvement (0.00 to 5.00)	4.38	CS1 CS2	4.25 4.04	PS1 PS2 PS3	3.29 3.49 5.00
Self-Evaluation (-1.00 to +1.00)	0.99	CS1 CS2	0.43 0.43	PS1 PS2 PS3	0.38 0.52 0.13
Id. Diffusion (weighte) (0.00 to 1.00)		CS1 CS2	0.36 0.38	PS1 PS2 PS3	0.34 0.33 0.37
	Identity Variant				
Current Self 1	INDETERMINATE				
Current Self 2	INDETERMINATE				
Past Self 1	INDETERMINATE				
Past Self 2	INDETERMINATE				
Past Self 3	NEGATIVE				

4.3.8 Respondent B: Impact of suicidal loss in relation to the past self *'me as I was before I found out about the suicide'* and the currently situated selves *'me as I am at home'* and *'me as I am at work'*

The respondent had a very high conflicted identification (see Table 4.9 below) with her mother in her appraisal of her currently situated selves (CS1 0.53; CS2 0.52) and high conflicted identifications with *'a person I dislike'* and *'my partner/spouse'*, in her appraisal of her currently situated selves (CS1 0.43, 0.39; CS2 0.42, 0.42). The impact of suicidal loss could be traced through how the respondent appraised her identity in terms of those three conflicted identifications above, respectively, in her appraisal of herself when she left school (PS1 0.48, 0.41, 0.43), with herself before

the suicide (PS2 0.57, 0.48, 0.39) and with herself after the suicide (PS3 0.57, 0.42, 0.35). The most problematic of these conflicted identifications as the respondent appraised her past selves, both before and after the suicide, was that with her mother. Her predicament extended at only a slightly lower level as she appraised her currently situated selves (PS2 0.57, PS3 0.57, CS1 0.53, CS2 0.52) and was reflected in how she evaluated herself with regard to her mother (-0.29).

Table 4.9 Respondent B: Conflicts in identification

CONFLICTS IN IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
10	Mother...	0.53	0.52
6	A person I dislike.)	0.43	0.42
13	My partner/spouse...	0.39	0.42
16	A depressed person..	0.37	0.41
17	My colleagues in th.	0.37	0.39
19	A person who has ta.	0.33	0.39
12	My closest friend..)	0.31	0.29
14	The caring professi.	0.31	0.31
15	My minister of reli.	0.25	0.23
11	Father...	0.19	0.17
5	A person I admire..)	0.00	0.00

CONFLICTS IN IDENTIFICATION WITH OTHERS - Past Self
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
10	Mother...	0.48	0.57	0.57
13	My partner/spouse...	0.43	0.39	0.35
6	A person I dislike.)	0.41	0.48	0.42
17	My colleagues in th.	0.34	0.37	0.35
19	A person who has ta.	0.32	0.22	0.39
12	My closest friend..)	0.29	0.30	0.28
14	The caring professi.	0.29	0.31	0.30
15	My minister of reli.	0.25	0.27	0.21
16	A depressed person..	0.25	0.18	0.48
11	Father...	0.22	0.23	0.18
5	A person I admire..)	0.00	0.00	0.00

4.3.9 Respondent B: Empathetic identifications

Respondent 'B' increasingly empathetically identified (see Table 4.10 below) with *'a person who has taken her/his own life'* and with *'a depressed person'* as she appraised herself from *'before I found out about the suicide'* (PS2 0.11, 0.06) to *'after I found*

out about the suicide' (PS3 0.36, 0.45) because of her view that her son was depressed when he took his own life, as evidenced in the discourse:

"...looking back now when you look at the stages that people go through in depression and moving towards maybe suicidal tendencies, I could see every one of them in my son – after the fact'

Respondent 'B' also increasingly empathetically identified with her *'minister of religion/spiritual adviser'*, *'an admired person'* and her *'closest friend'* as she appraised herself from *'after I found out about the suicide'* (PS3 0.50, 0.50, 0.59) to *'me as I am at home'* (CS1 0.70, 0.65, 0.74) perhaps acknowledging the support she continued to receive from these individuals, as evidenced in the discourse:

"...somebody sent me a mass card who was a great social support and still would be and I'm very grateful to him".

Table 4.10 Respondent B: Empathetic Identifications

EMPATHETIC IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
12	My closest friend..)	0.74	0.64
14	The caring professi.	0.74	0.73
15	My minister of reli.	0.70	0.59
5	A person I admire..)	0.65	0.68
17	My colleagues in th.	0.61	0.68
6	A person I dislike.)	0.52	0.50
10	Mother...	0.43	0.41
11	Father...	0.39	0.32
13	My partner/spouse...	0.39	0.45
16	A depressed person..	0.26	0.32
19	A person who has ta.	0.26	0.36

EMPATHETIC IDENTIFICATION WITH OTHERS - Past Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
15	My minister of reli.	0.71	0.83	0.50
5	A person I admire..)	0.65	0.72	0.50
12	My closest friend..)	0.65	0.67	0.59
14	The caring professi.	0.65	0.72	0.68
11	Father...	0.53	0.61	0.36
17	My colleagues in th.	0.53	0.61	0.55
6	A person I dislike.)	0.47	0.67	0.50
13	My partner/spouse...	0.47	0.39	0.32
10	Mother...	0.35	0.50	0.50
19	A person who has ta.	0.24	0.11	0.36
16	A depressed person..	0.12	0.06	0.45

Finally this respondent decreasingly empathetically identified with her mother as she appraised herself from *'after I found out about the suicide'* (PS3 0.50) to *'me as I am*

at home' (CS1 0.43), evidencing her increasing alienation from her mother following the loss of her son, as referred to in the discourse:

"...daddy died when I was nine...I was the eldest...mother had to work... hard ...a very strict mother...very demanding...I remember going to my mother and begging her one day for help and she says I don't know what more to do for you...I walked out of that house and I don't remember what happened the rest of the day...I know I wandered about...I was in a pretty bad way...I was really frightened for my sanity'.

4.3.10 Respondent B: Contra-identifications

This respondent's contra-identifications with *'mother'* (0.65), *'a depressed person'* (0.52) and *'a person who has taken her/his own life'* (0.43) illustrated her wish to dissociate from these people. In the case of her mother, it corresponded with her very high conflicted identifications with her mother and her low evaluation of herself in relation to her mother, as at par 4.3.8 above, exemplified in the discourse:

"...my mum...tries to see how far she can push me in relation to how much a priority she is in my life...she seems to wait to she knows I'm under an awful lot of pressure...and then wants something done...or have some crisis which...wasn't a crisis at all...just to see if I'll drop everything and jump'.

4.3.11 Respondent B: Idealistic identifications

The respondent's very high identifications with *'a person I admire'* (0.96), *'the caring professions'* (0.87), *'my closest friend'* (0.83), *'my minister of religion/spiritual adviser'* (0.78) and *'my colleagues in the workplace'* (0.74) showed a range of people whose qualities she aspired to possess in relation to her ideal self *'me as I would like to be'*. It was likely that some of these people shared important aspects of the respondent's beliefs and values, as evidenced in the following discourse extracts.

Re *'the caring professions'*:

"...my dissertation went to quite a few practitioners and professionals...I just don't know how counsellors do it...I just couldn't cope with these people's grief at all'

Re *'my minister of religion/spiritual adviser'*:

"...why would God...let...my son...end his life so abruptly if there wasn't a purpose to it...I spend a lot of time looking at reincarnation now...I wanted to hear what other cultures' views were on an afterlife...I wanted to read anything but this...catholic thing that it was burning in the fires of hell'

Re *'my colleagues in the workplace'*:

"I'm going to do this conference thing tomorrow...if maybe I fluff this...maybe get a card upside down, don't read it right or maybe flick on the screen...I'm really stressed about that...and I...really get cross with myself for that but I still can't help it'.

4.3.12 Respondent B: Structural pressure on constructs

High structural pressure on the constructs *'thinks that it is morbid to acknowledge human mortality'* / ***'thinks that it is healthy to acknowledge human mortality'*** (74.45) (where the preferred pole is in bold), *'withdraws from human contact'* / ***'develops good relationships'*** (71.85), *'can't be trusted'* / ***'can be trusted'*** (69.59), *'does not enjoy many social activities and community events'* / ***'enjoys most social activities and community events'*** (68.73), ***'feels at ease when acting as a member of as group'*** / *'feels uncomfortable when acting as a member of a group'* (66.54) and ***'believes in the irreplaceable value of each human being'*** / *'does not value human beings very highly'* (64.37) represented the respondent's core evaluative dimensions of identity. Having lost her son tragically and suddenly, she valued each human life highly while acknowledging its finite nature. She engaged easily with her fellow humans in social activity and believed that trust was an important human quality, as evidenced in the following discourses:

"You know the worst thing that could ever happen...it happened and I came through that...and I try to look at things and calm myself down and try and put things in perspective about how important they should be in your life...I love to

socialize and...a drink will be part of that but it's always been a socializing thing but...at that stage...I...seriously would have thought about getting drink and sitting in the house and drinking it on my own and that frightened the hell out of me. I never done it...I worry about my other boy obviously...I would have been very overprotective...he was all I'd left...was the way I looked at it...but I'm not now. I've calmed down a lot...made it clear to him that if he's feeling bad and he needs to talk about anything that I'm always there'.

Low pressure on four constructs: ***'relies on family support at times of crisis'*** / *'does not rely on family support at times of crisis'* (19.96); *'relies mainly on prescribed medication to relieve pain'* / ***'is interested in complementary and alternative therapies'*** (4.05); ***'believes that families eventually get over a suicidal loss'*** / *'believes that families never get over a suicidal loss'* (-0.50); *'believes suicide may be anticipated by behaviour'* / ***'believes that suicide cannot be predicted by behaviour'*** (-10.75) represented inconsistently evaluative dimensions of identity, signifying problematic and perhaps unpredictable areas of the respondent's identity. They all referred to scenarios related to the abnormal pain of suicidal loss and the respondent's uncertainty regarding the outworking of her predicament as a suicide survivor, as alluded to in the discourse:

"I know that he's dead and that but I'll never understand it and I'll never get over it. I don't think I will... I'm not able to at the moment...I've got over the stage where I'm expecting him to walk in the door...that went on for a long time... I think just that bereavement by suicide carries its own special circumstances...I think too the fact that I've lost a child makes it all the more painful'.

Very low pressure on the construct: ***'considers that most suicides cannot be prevented'*** / *'considers that most suicides could be prevented'* (-26.35) was categorised as a dual morality evaluative dimension of identity, indicating a possible error in anchoring. Here the respondent's cognitive-affective incompatibilities predominated. She appraised her ideal self *'me as I would like to be'* by opting for the left hand pole, while appraising herself in her current selves CS1 and CS2, her past selves PS1, PS2 and PS3 and in both metaperspectives *'me as my contemporaries see*

me' and *'me as my family sees me'*, respectively, by opting for the right hand pole. Elements of this phenomenon were perhaps alluded to obliquely in the discourse:

"I... feel that blame for my son's death... I feel that I'm to blame in a way that I must have failed him as a mother that he didn't feel that he could come and speak to me as a mother whatever was bothering him... suicide's a very brave thing... goes against all your natural instincts to keep yourself alive... something wrong with their mental processes... my son certainly wasn't thinking straight... if I'm asked to help in any way I'll jump at the chance... either that people think before they commit suicide or... to talk to someone that's been bereaved... '.

4.3.13 Respondent B: Summary

This respondent's very high conflicted identifications and modulations in empathetic identifications in how she appraised herself during the period preceding her suicidal loss to date indicated the extent of the impact upon her identity of suicide trauma. There was evidence that her identification conflict with her mother was deepening as the respondent's identity process proceeded. Her identity variant classification 'indeterminate' in both of her current selves and in her past selves, excluding *'me as I was after I found out about the suicide'*, indicated relatively well-adjusted identities. But her identity variant classification 'negative' for her latter past self pointed to low past self-evaluation in the aftermath of her suicidal loss experience. Her very high idealistic identifications with five entities occupying pivotal positions in the respondent's social world, including an admired person, her closest friend, the caring professions, her spiritual adviser and workplace colleagues, indicated reliance upon an active support framework outwith her family, that balanced alienation from the latter. Evidence of unresolved post-suicide trauma appeared to be focused in her conflicted identifications with her mother. Her conflicted dimensions of identity in her inner schemata contributed to this respondent's moderately vulnerable identity state.

4.4 Case Study C

4.4.1 Respondent C – personal information

Respondent 'C' was a man aged about 42 years, living and employed in Belfast. When the research tasks were completed he was temporarily residing apart from his partner and their children for personal reasons. His father was found dead in a toxic gas-filled room in his family residence in 1965. He was aged 29 years. At the time of his father's death, the respondent was seven years old and he and his younger brother were staying temporarily with an aunt - their remaining siblings were living with other relatives – while both of their parents were hospitalised. Surviving members of the respondent's family were his mother, his younger brother, four younger sisters, one older sister and members of his parent's families.

4.4.2 Respondent C: Transcript analysis

Analysis of transcript 'C' generated 80 issues and emergent themes from which 219 linked concepts were derived. The interview's loose structure employed a framework of five core themes - what happened, health and well being, meaning, aftercare and quality of life.

4.4.3 Respondent C: Concepts (1)

These linked concepts were listed sequentially at Table 4.11 below. They represented the investigator's subjective attempt to illustrate in summary form some aspects of the participant's reported experiences as a suicide survivor: concept referral frequency is stated in parentheses:

Table 4.11 Respondent C: Concepts (1)

DEPRESSION, FAMILY SUPPORT (4), SOCIETY'S LOW VALUATION, CULTURE (2), COPING ABILITY (9), FAMILY BREAKDOWN, MENTAL HEALTH (3), MAN AT RISK, BORN TO REBEL, SCHIZOPHRENIA, FAMILY THERAPY (2), GP ROLE (2), LARGE FAMILY, SERIOUS LOSS, SURVIVOR SUPPORT (14), DETACHMENT (2), GRIEF, REPRESSION, WIDER FAMILY (5), COMPASSION (3), OUTREACH, SEARCHING (4), MEDICAL RECORDS, FAMILY ILLNESS, FATHERHOOD, GENETICS, UNRESOLVED GRIEF (5), FINAL FAREWELL, MAGICAL DISAPPEARANCE, POSSIBLE REAPPEARANCE, CHILDHOOD TRAUMA, FAMILY SECRETS (8), SEPARATION, SEARCHING FOR THE TRUTH, ALIENATION, GUILT, SCAPEGOATING, TABOO/STIGMA (2), SURVIVORS' INNOCENCE, FEAR-BASED SHAME, SHAME, NEED TO KNOW (2), CHALLENGE (2), SEARCH FOR FATHER, DISTORTIONS, WHOLE TRUTH (2), HOLDING BACK, UNFINISHED BUSINESS, FRACTURED FAMILIES, JUSTICE, RESPONSIBILITY, FATHER HIMSELF, IDENTITY (3), GUILT/BLAMING, FORGIVENESS, TRUTH, COMMUNITY ROLE (2), REGRET AND SHAME, PAIN (2), REGRET AND REMORSE, AVOIDANCE, MYSTERY, SHAME AND FEAR, REPETITION, SURVIVOR SUICIDE RISK (2), EMULATION (3), SUICIDE GENE, FUNERAL RITES, CHILDHOOD GRIEF, SUICIDE IDEATION, EMULATION/SCRIPT (3), OTHER OPTIONS, ALCOHOL, ALTERNATIVES, SUICIDE TRAJECTORY, DETAILED RECOLLECTION, FATHER/SON DYNAMIC (4), SENSE OF IDENTITY, ISOLATION, FATHER'S ROLE,

UNACKNOWLEDGED RISK, REPEATER BEHAVIOUR LEARNED, FAMILY STRESS AND ALCOHOL, RE-LEARNING (3), SELF-DISCOVERY (2), SIBLING SUPPORT (2), IDEATION, ALCOHOLISM, ESTRANGEMENT, FAMILY SCRIPTS, PRAGMATISM, LEARNING, OWN IDENTITY=OWN DECISIONS, ABSENCE OF MODEL, INTOXICATED DECISION, RECOVERY=SURVIVAL, RECOVERY PROCESS, SOCIAL/COMMUNITY SUPPORT, FIGHTER, CHILDHOOD TRAUMA, BIG BROTHER ROLE, DEFENCES, SELF-LOVE, NEGATIVE UTILITY, AFTERCARE VACUUM, CURRENT EPIDEMIC, FAMILY HEALTH, MENTAL HEALTH TABOO, ALCOHOLISM/MENTAL DISORDER, ABANDONMENT (2), PSYCHIATRIC RISK-TAKING, MENTAL HEALTH AFTERCARE, CAUSE/METHOD, SURVIVOR AFTERCARE, FAMILY ABANDONED, COMMUNITY CULPABLE, SUICIDES/RUBBISH, SUICIDE/MURDER, EMPATHETIC IDENTIFICATION, SURVIVORS' MUTUAL SUPPORT (3), CRUSE, ASSOCIATION/NETWORK, SURVIVORS' GOODWILL, POSTVENTION, SUICIDE IMPULSE/DECISION, RESOURCES NEEDED, FIREARMS/PARAQUAT etc., REPEATER BEHAVIOUR, WHATEVER WORKS, MUTUAL UNDERSTANDING, SHARED EXPERIENCE, SELF-HELP, SURVIVORS' LIFETIME HEALING, NON-JUDGEMENTAL LISTENING, SURVIVOR TRAINING (2) , MEDIUM NEEDED, RESOURCES, INITIATIVE, DESERVING CAUSE, SELF-FUNDING / LIVES SAVED.

TOTAL # 219

4.4.4 Respondent C: Concepts (2)

Concepts referred to more than once in the analysis, in descending order, are listed at Table 4.12, below.

Table 4.12 Respondent C: Concepts (2)

SURVIVOR SUPPORT (14), COPING ABILITY (9), FAMILY SECRETS (8), WIDER FAMILY (5), UNRESOLVED GRIEF (5), FAMILY SUPPORT (4), SEARCHING (4), FATHER/SON DYNAMIC (4), MENTAL HEALTH (3), COMPASSION (3), IDENTITY (3), EMULATION (3), EMULATION/SCRIPT (3), RE-LEARNING (3), SURVIVORS' MUTUAL SUPPORT (3), CULTURE (2), FAMILY THERAPY (2), DETACHMENT (2), GP ROLE (2), TABOO/STIGMA (2), NEED TO KNOW (2), CHALLENGE (2), WHOLE TRUTH (2), COMMUNITY ROLE (2), PAIN (2), SURVIVOR SUICIDE RISK (2), SELF-DISCOVERY (2), SIBLING SUPPORT (2), ABANDONMENT (2), SURVIVOR TRAINING (2)
TOTAL # 104

4.4.5 Respondent 'C' – reported experiences

Respondent 'C' contacted the investigator 35 years after his suicidal loss at the age of seven years. During those intervening years he grew up, left home, married and supported a growing family. Occasionally personal crises resulted in his leaving his family home and living temporarily apart from them. It was during a recent period of disruption of his family life that he deepened his search ('SEARCHING (4)') for the truth about his father's life and death. This had started when he was 18 years old:

"...as I got older I wanted to know...it wasn't until I was about eighteen, you know, to tell the truth...I always wondered why his father's brothers and sisters never bothered with my mother. I seen other families and relations coming up...but we never had anyone come...especially my father's side...I always claimed this must have something to do with the suicide like...they must be blaming my mother...when they don't visit her...'

The respondent did not identify the exact time that he learned how his father had died. He together with his older sister and his younger brother learned the fact of his death from an aunt was told them on the day after his funeral:

" They took us into aunt A's living room... she had kids herself... older than me... I knew they had been told before us because they were... like an audience... watching... our response... my aunt A just came straight out... just turned round and dead cold ' I have to tell you now your daddy's dead... and he was buried yesterday'... because we were so young there was no big response'.

The respondent's evident 'UNRESOLVED GRIEF (5)' was linked with the 'MAGICAL DISAPPEARANCE' of his father, without any 'FINAL FAREWELL' that attendance at the funeral might have offered:

"... that day... robbed of it... I used the word 'robbed' although it doesn't sound like that. We didn't actually find out anything until he was actually buried... then you didn't believe it... because you never seen a funeral nor nothing'.

The respondent's 'CHILDHOOD TRAUMA' associated with 'FAMILY BREAKDOWN' caused by the hospitalisation of both parents was reinforced by the sudden death of his father. The family's subsequent re-housing extended the respondent's feelings about 'SOCIETY'S LOW VALUATION' of him and his family, not unconnected to the 'TABOO/STIGMA (2)' of death by suicide:

"... as soon as my mother got out of hospital... we went back to... where my father committed suicide... only there about two weeks when we moved... everyone on the street knew what had happened then... major bad thing... to commit suicide... we moved up into... an estate away up on the mountain... only a taxi ride now it was like moving into a wilderness... to get away from it all'.

The urgency of this leaving exemplified the 'FEAR-BASED SHAME' associated with suicide:

"It was... all done so quickly... as if something shameful happened there... a big van pulled up... no cheerio to the neighbours... just straight in and out..."

Married at 16, the respondent's interest in 'SEARCHING FOR THE TRUTH' about his father's fate was stimulated by his wife:

" ...it was because my wife asked me a lot of questions too about it ...kind of sparked it off in my head... because I couldn't answer'

Up to then a response 'I don't know' had been adequate when peers responded to his initial comment 'My father committed suicide' with further questions. His visits with his cousins in his late teens to his uncles and aunts led to close questioning of his father's side of the family about their 'ALIENATION'. This lead to his discovery of a mutilated wedding photograph:

"I found out where everyone lived...we had no photographs of my father...first question 'Why did you never visit us...widowed woman with seven children, your brother's kids, you're our uncle and we never seen you all our lives'...able to ask them questions 'Who found my da? Did he leave a note?'...one main photograph...wedding photo...my mother was...scraped out of it...as soon as I seen that I blamed my mother for what happened to him'

Throughout his married life he had sought information from his mother, her family and from his father's family. But although some facts emerged 'FAMILY SECRETS (8)' predominated:

"...to this day there's things I don't know...maybe because they don't want to hurt us or whatever...'

His father's family appeared to be 'SCAPEGOATING' his mother in relation to his father's death. Over the years since the death 'DISTORTIONS' about what actually happened were almost bound to occur. Recently a coincidental meeting with his former next door neighbour led to clarification 36 years after the event about what exactly happened immediately after his father had died:

"It was the next door neighbour I only met her...about four months ago...I mustn't have seen this woman from I was six...she lived right next door to us...she was the woman that actually smelt the gas and sent for the authorities. I was able to say to her 'Was my dad's brother there because he told me that he broke down the door' and she says no, none of your father's family were there...none of your father's brothers were there. The police put the door in. it was the police that found your father.'

This corrected an earlier version of events supplied by his father's family and satisfied the respondent's 'NEED TO KNOW' the 'WHOLE TRUTH (2)':

" My uncle 'G' told me that he kicked the door in... I think at the time he was trying to comfort me... comfort himself, yeah... why did he tell me his lies... what did he gain... a few friends of both my mother's and my father's who still live there were able to confirm that woman's story. My uncle 'G' was nowhere near the house.'

This respondent confirmed anecdotally that 'SURVIVOR SUICIDE RISK (2)' may be directly related to 'EMULATION (3)' and 'EMULATION/SCRIPT (3)' phenomena:

"... out of the seven of us, three have attempted it... I'm beginning to think myself that when problems:.. become too much for us, we turn to suicide for some reason because my da did... I attempted it... none have been successful like... it could be a cry for help'.

But a more benevolent 'FATHER/SON DYNAMIC (4)' was significant in saving the respondent's life:

"What saved me personally was the thought of my father doing it leaving all the children behind. That stopped me from doing it'.

The respondent's 'INTOXICATED DECISION' not unconnected with 'FAMILY STRESS AND ALCOHOL' linked with incipient 'ALCOHOLISM' which played a large part in his own recent suicide attempt. His 'COPING ABILITY (9)' under stress was severely undermined by excessive use of 'ALCOHOL' leading him over a period of weeks from 'SUICIDE IDEATION' to 'SUICIDE TRAJECTORY', as he reflected:

"I'd split up with my family... the whole family were away... I remember saying to myself: 'This is the way my father got out of it; this is the way I'm going'... I set fire to the house. I lay down on the bed. The bedroom was blazing... choking with the smoke... I was determined I would go through with it... it would be painful but I didn't care. Maybe the drink helped me not to worry about it... when I was lying on the bed... I seen my son – just visually seen him in front of me - and that stopped it '

The respondent reported that two other siblings also self-harmed although it was uncertain whether they attempted suicide. He offered 'SIBLING SUPPORT (2)' at the time. This respondent was **'100% positive. I'll never do it again'** in relation to future suicidal behaviour. But he was certain that 'SURVIVOR SUPPORT (14)' in relation to his mother, his siblings, his father's family, himself and his own family was not available in the past and remained elusive:

"Personally I think the help I should have got should have been years ago... the help my whole family should have got should have been years ago from we were kids... you're bound to have thought about it... it ripped your whole life up... there should have been some kind of counselling for children so young... maybe explain why – where their father went or whatever you know..."

The 'AFTERCARE VACUUM' remained despite the perceived 'CURRENT EPIDEMIC' of suicidal behaviour. There appears little doubt that the respondent's 'IDENTITY (3)' and his 'SENSE OF IDENTITY' were significantly affected by 'ABANDONMENT (2)' in early childhood. He acknowledged that 'SURVIVORS' MUTUAL SUPPORT (3)' implied 'SURVIVOR TRAINING (2)' if an 'INITIATIVE' in support of the 'DESERVING CAUSE' were to attract the 'RESOURCES' that would lead to 'SELF-FUNDING / LIVES SAVED'. He exemplified the need to deploy 'SURVIVORS' GOODWILL' for 'SURVIVORS' LIFETIME HEALING' that might best be undertaken by trained fellow survivors using their invaluable 'SHARED EXPERIENCE' for mutual healing of the special scar left by suicide bereavement. One final thought-provoking extract from this respondent's transcript that linked the concepts 'CAUSE / METHOD' and 'FIREARMS / PARAQUAT etc' concludes this section:

"You know one thing I'm glad and it's probably hard for you with me saying this but I hadn't got a gun with me because it only takes a second to do it when you've got a gun and I think I would've. If I had had a gun I would have shot myself and it would've been over'.

4.4.6 Respondent 'C' – Identity structure analysis

As for Respondents 'A' and 'B', identity structure analysis facilitated exploration of this respondent's identity as represented by value and belief systems, identifications, processes of change in sense of identity and self-evaluation.

4.4.7 Respondent C: Primary analysis

Those states of identity in which a person had *low* identity diffusion were regarded as *defensive* (or *foreclosed*) states (a lack of acknowledgement of ordinary and usual degrees of conflicted identifications): *defensive high self-regard* when self-evaluation was high, *defensive* when self-evaluation was moderate and *defensive negative* when self-evaluation was low. The more usual identity state was that classified as *indeterminate* which corresponded to moderate identity diffusion together with moderate self-evaluation (*Weinreich*, 1992: 23).

As set out in Table 4.13 below, Respondent C's current selves *'me as I am at home'* and *'me as I am at work'* were classified as 'defensive high self-regard'. His past self *'me as I was when I left school'* was also classified as 'defensive high self-regard'. But his past self *'me as I was before I found out about the suicide'* was classified 'indeterminate' and his past self *'me as I was after I found out about the suicide'* was classified as 'defensive'.

All of these classifications were regarded as vulnerable identities of various kinds with the exception of the 'indeterminate' category that was regarded as 'well-adjusted'. In this respondent's case, the latter referred to his construal of himself up to the age of seven years before his father died. It was therefore not surprising if the respondent's construal of his past selves reflected upon this entity (PS2) more

favourably than upon either of the consecutive entities (PS3 and PS1) that followed it. How his father's suicide impacted upon him may be seen in the four vulnerable identity variant classifications that followed this well-adjusted identity variant classification.

Table 4.13 Respondent C: Self Image

SELF IMAGE

	Ideal Self	Current Self		Past Self	
Ego-Involvement (0.00 to 5.00)	4.78	CS1 CS2	5.00 4.83	PS1 PS2 PS3	4.83 2.36 4.28
Self-Evaluation (-1.00 to +1.00)	1.00	CS1 CS2	1.00 0.83	PS1 PS2 PS3	0.83 0.67 0.68
Id. Diffusion (weighte) (0.00 to 1.00)		CS1 CS2	0.20 0.23	PS1 PS2 PS3	0.23 0.27 0.23

Identity Variant

Current Self 1	DEFENSIVE HIGH SELF-REGARD
Current Self 2	DEFENSIVE HIGH SELF-REGARD
Past Self 1	DEFENSIVE HIGH SELF-REGARD
Past Self 2	INDETERMINATE
Past Self 3	DEFENSIVE

4.4.8 Respondent C: Impact of suicidal loss in relation to the past self *'me as I was before I found out about the suicide'* and the currently situated selves *'me as I am at home'* and *'me as I am at work'*.

This respondent had a high conflicted identification (see Table 4.14 below) with his mother in his appraisal of his currently situated selves (CS1 0.43; CS2 0.44) but only moderate conflicted identifications with *'my partner/spouse'*, *'a person I admire'* and *'a person who had taken her/his own life'* in his appraisal of his currently situated selves (CS1 0.29, 0.28, 0.28; CS2 0.27, 0.27, 0.30). High conflicted identification with his mother in the respondent's appraisal of his past selves reached a maximum before his father's suicide (PS2 0.47), lessened in the 8/9 year period before he left

school (PS3 0.41) and then appeared to have stabilised at a slightly higher level from around school-leaving age (PS1 0.44) when, coincidentally the respondent left home and married. Relevant discourse follows:

"...the one main photograph of my father was from my aunt Patricia... in the wedding photo ... it was my mother's face that was scored out of the photo... she says 'Your mother was very hard on your daddy... pushed him a lot to get work... always pushing him out to get work and making him go to work.' I don't think any woman does that... you can't blame my mother really for my father committing suicide even though she did give him a hard life... it was his own decision to do it... he should have been given help by his own relations'

Table 4.14 Respondent C: Conflicts in identification

CONFLICTS IN IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
10	Mother...	0.43	0.44
13	My partner/spouse...	0.29	0.27
5	A person I admire..)	0.28	0.27
19	A person who has ta.	0.28	0.30
12	My closest friend..)	0.20	0.19
11	Father...	0.19	0.21
6	A person I dislike.)	0.18	0.34
16	A depressed person..	0.18	0.15
17	My colleagues in th.	0.18	0.17
14	The caring professi.	##	##
15	My minister of reli.	##	##

CONFLICTS IN IDENTIFICATION WITH OTHERS - Past Self
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
10	Mother...	0.44	0.47	0.41
6	A person I dislike.)	0.34	0.47	0.34
19	A person who has ta.	0.30	0.24	0.32
5	A person I admire..)	0.27	0.29	0.25
13	My partner/spouse...	0.27	0.29	0.25
11	Father...	0.21	0.12	0.18
12	My closest friend..)	0.19	0.18	0.17
17	My colleagues in th.	0.17	0.18	0.15
16	A depressed person..	0.15	0.31	0.27
14	The caring professi.	##	##	##
15	My minister of reli.	##	##	##

4.4.9 Respondent C: Empathetic identifications

Respondent 'C' decreasingly empathetically identified (see Table 4.15 below) with *'my closest friend'*, with *'my partner/spouse'*, with *'a person I admire'*, with *'my colleagues at work'* and with *'my mother'* as he appraised himself from *'before I found out about the suicide'* (PS2 0.82, 0.91, 0.82, 0.82, 0.73) to *'after I found out about the suicide'* (PS3 0.76, 0.71, 0.76, 0.57, 0.57), exemplifying the traumatic impact of his father's sudden death by suicide and its social consequences, as in the discourse:

"...once my father died his whole side of the family died as well...I remember my da taking us to his brothers and us ones playing with his brothers' kids...there was a good bond there but as soon as my father died...you forgot about them...'

However the respondent increasingly empathised with each of these entities as he appraised himself from *'me as I was after I found out about the suicide'* (PS3 0.76, 0.71, 0.76, 0.57, 0.57) to *'me as I was after I left school'* (PS1 0.86, 0.82, 0.86, 0.73, 0.64), evidencing positive aspects in his psychological processes of change and development as he matured into young manhood and independent living, and began to investigate what happened to his father, as in the discourse:

"...when I became eighteen I...wondered why my father's brothers and sisters never bothered with my mother...I was actually married two years before that...I think it was because my wife asked me a lot of questions too about it...'

This development continued in the interim as seen in increasing empathetic identifications with four of the five entities above - the exception was 'my mother' - as the respondent appraised himself from *'me as I was when I left school'* (PS1 0.86, 0.82, 0.86, 0.73) to his currently situated self *'me as I am at home'* (CS1 0.96, 0.91, 0.87, 0.78). The decreasing empathetic identification with *'Mother'* during this period (PS1 0.64: CS1 0.61) evidenced the respondent's current dissociation from her, linked to his continuing search for the truth about his father, as in the discourse:

"...it hurts my ma to talk about it like...she's just telling me the bad things to put me off...she doesn't like me asking...my father's side...but...I want to find

out everything about him... I've decided now not to ask her any more questions because she gets too upset about it... '

Table 4.15 Respondent C: Empathetic identifications

EMPATHETIC IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
12	My closest friend..)	0.96	0.86
13	My partner/spouse...	0.91	0.82
5	A person I admire..)	0.87	0.82
17	My colleagues in th.	0.78	0.73
10	Mother...	0.61	0.64
19	A person who has ta.	0.35	0.41
11	Father...	0.22	0.27
16	A depressed person..	0.13	0.09
6	A person I dislike.)	0.04	0.14
14	The caring professi.	##	##
15	My minister of reli.	##	##

EMPATHETIC IDENTIFICATION WITH OTHERS - Past Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
12	My closest friend..)	0.86	0.82	0.76
5	A person I admire..)	0.82	0.91	0.67
13	My partner/spouse...	0.82	0.91	0.71
17	My colleagues in th.	0.73	0.82	0.57
10	Mother...	0.64	0.73	0.57
19	A person who has ta.	0.41	0.27	0.48
11	Father...	0.27	0.09	0.19
6	A person I dislike.)	0.14	0.27	0.14
16	A depressed person..	0.09	0.36	0.29
14	The caring professi.	##	##	##
15	My minister of reli.	##	##	##

4.4.10 Respondent C: Contra-identifications

This respondent's very high contra-identification with *'a person I dislike'* (0.83) and a moderate contra-identification with *'my mother'* (0.30) illustrated his wish to dissociate from these people. One discourse may be related obliquely to this phenomenon as the respondent pondered the response that he would hope to make if he were confronted with the predicament that faced his father's family 35 years ago:

" I believe he should have got more help and support. He shouldn't have been on his own... to do it... Only out of a mental hospital and left to go back to the house on your own? It doesn't sound right to me... It definitely doesn't... I've said to

them myself... why didn't you support him... definitely if it was my brother I would have been with him."

4.4.11 Respondent C: Idealistic identifications

The respondent's very high idealistic identifications with *'my closest friend'* (0.96), *'my partner/spouse'* (0.91), *'a person I admire'* (0.87) and *'my colleagues in the workplace'* (0.78) reflected a range of people whose qualities he aspired to possess in relation to his ideal self *'me as I would like to be'*, illustrated in the following discourses:

"I'm only learning that now, to start to love myself... I was brought up... all I've done... I've been working from I was about nine... not having a father... losing relations that you could have relied on for help over the years... I've never had anyone... I've always done it all myself."

4.4.12 Respondent C: Structural pressure on constructs

High structural pressure on the constructs *'I loathe'* / ***'I have warm feelings towards'*** (99.96) (where the preferred pole is in bold), *'believes that depression and suicide are not linked'* / ***'believes that suicide and depression are closely linked'*** (96.99), ***'believes in the irreplaceable value of each human life'*** / *'does not value human beings very highly'* (93.45), *'thinks it is morbid to acknowledge human mortality'* / ***'thinks it is healthy to acknowledge human mortality'*** (92.86), *'believes corporal punishment does no harm to children'* / ***'believes corporal punishment is a form of child abuse'*** (90.19) and *'feels that a suicide survivor's grief is like any other'* / ***'feels that a suicide survivor's grief is uniquely painful'*** (90.02) represented the respondent's core evaluative dimensions of identity. He believed that his father's death could have been prevented:

"...he wasn't stable enough to be left on his own...he should have been staying with someone..."

Having survived his own attempted suicide, he was determined never to repeat that behaviour and he believed in supporting his siblings – and anyone else – who was either tempted to self-harm or coping with bereavement by suicide:

"...from I have tried it, I know I'll never ever try it again...I just know it wasn't...a right thing to do...I'm not going to leave my children that way...I'm seeing my sister doing very well...in a rehabilitation centre...I know she's going to make it now too...Definitely people need help to get over it...I would love to help people...it's easier to talk to someone that has suffered'.

4.4.13 Respondent C: Summary

This respondent's high conflicted identification with his mother and modulations in empathetic identifications in how he appraised himself during the period preceding his suicidal loss to date, indicated the extent of the impact upon his identity of suicide trauma. His identification conflict with his mother appeared to have stabilised as the respondent's identity process proceeded. His identity variant classifications, 'defensive self regard', remained vulnerable in each of the entities - PS1, CS1 and CS2 - that followed the entity PS3 (*'me as I was after I found out about the suicide'*) evidencing the respondent's lifelong processing of the consequences of suicide trauma. The respondent's very high idealistic identifications with five entities within his personal and social worlds, including his closest friend, his partner/spouse, an admired person and his colleagues in the workplace showed his involvement with a support framework involving his family and further afield, perhaps reflecting his current temporary residence apart from his family. Finally his continuing search for the truth about his father represented an outworking of a post-suicide trauma that focused to an extent in his conflicted identifications with his mother. His conflicted

dimensions of identity in his belief and value system contributed to this respondent's current moderately vulnerable identity state.

4.5 Case Study D

4.5.1 Respondent D – personal information

Respondent 'D' was a woman aged approximately 45 years, living and employed in Co Down. In September 1994 her older sister, then aged 39 years, was found hanged in the bathroom of a Co Down hospital where she was a patient. At this time the respondent was visiting relatives in Co Antrim and Co Derry/Londonderry. Surviving members of the respondent's family were her parents, her younger sister (domiciled in England), her husband, their three children and her deceased sister's husband and family.

4.5.2 Respondent D: Transcript analysis

Analysis of transcript 'D' generated 92 issues and emergent themes from which 238 linked concepts were derived. The interview's loose structure employed a framework of five core themes – what happened, health and well being, meaning, aftercare and quality of life.

4.5.3 Respondent D: Concepts (1)

These linked concepts are listed sequentially at Table 4. 16 below. They represented the investigator's subjective attempt to illustrate in summary form some aspects of the participant's reported experiences as a suicide survivor: concept referral frequency is stated in parentheses:

Table 4.16 Respondent D: Concepts (1)

IDEALISATION, UNRESOLVED GRIEF (4), PAIN (6), DEPRESSION (6), EXHAUSTION, RATIONALISATION, UNREALISTIC GUILT, HYPERSENSITIVITY, ECHOES (2), CONTRIBUTORY FACTOR I, EXTERNAL EVENT, CONTRIBUTORY FACTOR II, HORMONES, GP ROLE (5), EXTERNAL INFLUENCE, SCHIZOPHRENIA, SUICIDE RISK, PATIENT SUPPORT (6), SELF HELP, UNDERSTANDING (2), SUICIDE TRAJECTORY, TRAUMATIC CHILDBIRTH, FALSE ESTEEM, SELF-EVALUATION, SUPPORT LACKING, SUICIDE IDEATION, HOSPITALISATION, SUICIDE MYTH No 1, FEAR OF SUICIDE, SUICIDE PREVENTION, PROCESS, LACK OF DEFENCE, NEXT-OF-KIN (2), FEAR, MENTAL HEALTH, CATASTROPHIC LOSS, SHOCK AND PAIN AND SERIOUS GRIEF, NIGHTMARE, SUICIDE IMPULSE, ISOLATION, ABANDONMENT (2), FAMILY SUPPORT CRUCIAL, LEGALISM, COMPASSION (4), CLINICAL DEPRESSION, INQUEST, SURVIVORS, PSYCHIATRY, GRIEF REACTION (2), DESOLATION, SURVIVOR SUPPORT (9), ANTICIPATED GRIEF, FAMILY SUPPORT (2), PASTOR/SPIRITUAL ADVISER (2), SUICIDAL FAMILY, FAMILY TRAITS, GENERATIONAL ASPECTS, SUICIDE GENE (2), RC DOGMA, HEARTS OF STONE, SUICIDE TRAUMA, POST-MORTEM, ORGAN DONATION, FUNERAL RITES No 1, SURVIVOR MEDICATION, FUNERAL RITES No 2, IDENTITY (2), SERIOUS GRIEF TRAUMA, SIBLING RIVALRY, FAMILY ORDER, ACCEPTANCE (4), FAMILY THERAPY (4), CRUSE (3), INFORMED SELF-HELP, SHARING GRIEF, SHAME, FAMILY SECRETS, NON-HEALING CRYING, CALLING WEEPING, FINAL FAREWELL, UNACKNOWLEDGED GRIEF, AVOIDED

GRIEF (3), UNRELEASED GRIEF, PATHOLOGICAL GRIEF, DISGUISED GRIEF, ILLUSION AND FALSE FOCUS, GRIEF THERAPY (7), MEDICAL DIAGNOSIS, PSYCHOLOGICAL ASPECTS, SELF-AWARENESS, SACRIFICES, EXHAUSTION, PAIN AND SUFFERING, ALTERNATIVE THERAPY, SURVIVOR'S OWN NEEDS, SELF-FIRST (3), SUFFERED ENOUGH, APATHY, IRRATIONALITY, SELF-SACRIFICE, FALSE ECONOMY, PITY, CONTRA-IDENTIFICATION (2), SELF NEGLECT, MORE SELF NEGLECT, CUL-DE-SAC, SELF-CARE (2), SELF-COMPASSION (2), COMPASSION FOR VICTIM, FORGIVENESS, BLOCKED EMOTIONS, TASK OF DYING WELL, ACKNOWLEDGING MORTALITY, SUICIDE'S PAIN, COMPLETED GRIEF, MODEL, MODE/FACT OF DEATH, ACTUAL GOOD LIFE, ON THE EDGE OF HEALING, NEED FOR THERAPY, KEY TO SUICIDE, LEARNING FROM IT, TRANSMISSION, PROJECTION, THERAPY (2), REALITY TEST, GP TRAINING, GP TRAUMATIZATION, GP VICARIOUS TRAUMATIZATION, COMPOUNDED GRIEF, CHRONIC GRIEF (3), MYSTERY, TRUST, HEALING AND MOVING ON, EMPATHETIC IDENTIFICATION, PAIN INTENSIFICATION, COMPOUNDED GRIEF, SPOUSE/PARTNER, ANGER (2), FAMILY DISPUTES, UNHEALTHY EXPRESSION OF ANGER, UNEXPRESSED ANGER, RESISTANCE, COPING ABILITY (3), MEANINGLESSNESS (2), SEARCHING (2), HEALTHY RESOLUTION, PERSONAL DECISION, ENERGY DEMANDS, HEALTHY EXPRESSION, LEARNING FROM KIDS, SELF-RESPONSIBILITY (2), EXEMPLAR (2), INNER RESPONSE (2), LOVE, SELF-LOVE FIRST, NEW INSIGHTS, PERSONAL DEVELOPMENT, BLOCKED FEELINGS, INITIATIVE NEEDED, RESOURCE IMBALANCE, EMPATHY, FEELING, HEALING AND GROWING. *TOTAL # 238*

4.5.4 RESPONDENT D: CONCEPTS (2)

Concepts referred to more than once in the analysis, in descending order, are listed in Table 4.17 below.

Table 4.17 Respondent D: Concepts (2)

SURVIVOR SUPPORT (9), GRIEF THERAPY (7), PAIN (6), DEPRESSION (6), PATIENT SUPPORT (6), GP ROLE (5), UNRESOLVED GRIEF (4), COMPASSION (4), ACCEPTANCE (4), FAMILY THERAPY (4), CRUSE (3), AVOIDED GRIEF (3), CHRONIC GRIEF (3), SELF-FIRST (3), COPING ABILITY (3), ECHOES (2), CONTRIBUTORY FACTOR I & II, UNDERSTANDING (2), NEXT-OF-KIN (2), ABANDONMENT (2), GRIEF REACTION (2), PASTOR/SPIRITUAL ADVISER (2), SUICIDE GENE (2), FUNERAL RITES Nos 1 & 2, IDENTITY (2), CONTRA-IDENTIFICATION (2), SELF-CARE (2), SELF-COMPASSION (2), THERAPY (2), ANGER (2), MEANINGLESSNESS (2), SEARCHING (2), SELF-RESPONSIBILITY (2), EXEMPLAR (2), INNER RESPONSE (2) *TOTAL # 112*

4.5.5 Respondent D: Reported experiences

The respondent contacted the investigator just over five years after the death of her sister. Following the start of the audiotaped interview, this respondent spoke - with only one brief interruption to answer a telephone call - for almost a half-an-hour (over five pages of transcript) describing in some detail and with considerable emotion what happened to her sister. A significant theme throughout was the respondent's 'UNRESOLVED GRIEF (4)'. Her initial normal and anticipated 'GRIEF REACTION (2)' was compounded, six months after her sister's death, into 'CHRONIC GRIEF (3)' following a second serious loss through miscarriage, twelve weeks into the respondent's first pregnancy in eighteen years of marriage. Unfortunately the respondent neither sought nor was she offered professional

counselling to complement the support of her 'SPOUSE/PARTNER', following this second major trauma:

"I never spoke to anybody...just FG (her husband), you know".

This reluctance to seek help was rationalised by the respondent on the grounds that her children were her priority. She was simply unable to put 'SELF-FIRST (3)' especially where her children's needs were concerned:

"...you always do things for the children but yourself is always the last person that you deal with...you just tend to do things for your kids you know...you're sort of feeling you put yourself on the back burner (about) things that you really need'.

It may however be that this respondent had not yet 'SUFFERED ENOUGH' and was not yet ready to re-think her belief and value system in response to the 'DESOLATION' of her serious losses almost five years before. One incident offered a crucial insight into her predicament, linked to 'CRUSE (3)', the 'GP's ROLE (5)' and possible need for 'GP TRAINING' in relation to general practitioners' contribution to 'SURVIVOR SUPPORT (9)':

"I remember going to the GP one time because I just felt dreadful...it was...a year or so after she died...and she told me to go and phone Cruse...I did and the woman was very good on the end of the phone...very good ways about her and all the rest of it...and she said she would get back to me or that they would get back to me but they never did. So I never contacted them again. So I don't suppose I've had any help really apart from myself...och FG's (her husband) been very good too but FG doesn't talk much'.

She acknowledged that her sense of 'IDENTITY (2)' was altered by suicide trauma:

"I just feel I'm just not...the person I was just died when MN (her sister) died and I'm just a totally different (breaks down and cries)...'

The traumatizing impact upon the respondent of her loss experiences was located in each of three elements: the prelude, the loss events and the consequences. The respondent's 'IDEALISATION' of her sister contributed to the 'SHOCK AND PAIN AND SERIOUS GRIEF' of her 'CATASTROPHIC LOSS':

"MN (her sister) was the most brilliant mother (breaks down and cries)... she was far better than I was... you just couldn't describe how good a mother she was... she was that good to them'

She deeply regretted that she was unable to visit her sister during her 'HOSPITALISATION' due to 'NEXT-OF-KIN (2)' only access rules:

"The hospital didn't allow you to visit her – just... immediate family... she was only in ten days... and she never phoned me... but then the last time I had spoken to her we weren't exactly on the best of terms either because I just couldn't... get through to her.'

The respondent identified her sister's unplanned pregnancy about one year before her death as 'CONTRIBUTORY FACTOR I'. She was attempting three roles as mother/spouse, worker and student during the years immediately preceding the deterioration in her health:

"... she never was that happy nursing and... decided she would like to get out of it... she did this course... a diploma course, which would get you into university... the course was two days a week... but it was during the day... frequently she was coming off night duty from a very busy ward til go to this course... I think that was, to be... quite honest the start of her bother. It was just sheer tiredness"

Sometime after she finished the diploma course, her sister became pregnant. But prior to this she had exhibited symptoms of 'DEPRESSION (6)' that the respondent linked to stress not unconnected to 'CONTRIBUTORY FACTOR II':

"... they moved house... greater travelling expenses and the bigger mortgage... her husband was also facing the prospect of redundancy... that brought a lot of anxiety to the house... "

In the event MN's 'MENTAL HEALTH' stabilised as the pregnancy proceeded but worsened again and she was referred to a consultant gynaecologist.

"The consultant that she went privately to – apart from getting his money at the end of it – couldn't have cared less... she was an emergency section which obviously didn't help... when she was in such an anxious state... she was home... about six days maybe... things really went from bad to worse after that.'

Three months after her 'TRAUMATIC CHILDBIRTH' MN was referred again to the consultant psychiatrist and was hospitalised after she voiced 'SUICIDE IDEATION'. Some time before this the respondent had mentioned suicide to her sister:

"...I remember MN about a year before somebody had killed themselves and I remember saying to...her 'You would never think of doing that?' and she says 'Oh no, no' she says, 'God, I know I'm bad...but I'm not that bad'...so I never gave it another thought."

In the event, the respondent's sister sought contact on the night of her death with nursing and religious personnel attached to the hospital but circumstances conspired to prevent all of the people she approached from reaching her before she acted on the 'SUICIDE IMPULSE':

"...earlier in the evening MN had asked the ward sister could she speak to her...the ward sister was called away to another ward...she'd be back in twenty minutes...she wasn't back...only one other nurse...and an auxiliary...on the ward...the...nurse was assigned to a patient who was...actively suicidal...you can guarantee that the auxiliary...wasn't looking near the other patients at all...MN also phoned the priest...and asked if he could come and see her...he would call up to see her after mass. So nobody could speak to her when she wanted to speak to somebody. And she never phoned me...PQ (her husband) came up...at visiting time and he couldn't find her...nurses...discovered her in the bathroom...she was dead.'

It appeared that this suicidal person, benefiting from a 'MEDICAL DIAGNOSIS' for 'CLINICAL DEPRESSION' and hospitalised for her own safety, became isolated from medical, nursing and religious/spiritual support personnel. In the absence of any 'PATIENT SUPPORT (6)' she took her own life. The consequences of her sister's death were a 'NIGHTMARE' for the respondent. She learned of her sister's death late that evening from a close friend of her sister's husband (PQ), on her return home from visiting relatives:

"...this fellow who was a friend of PQ's...he pushed past me and came in here...and FG (her husband) was in here at the time. The children had just gone down to bed - he put his arm round FG and he put his arm round me and as soon as he put his arm round my shoulder I knew...he just said 'I'm sorry' and here's me 'She's dead' and I just started to scream...the children say all they remember of that night is me screaming."

The respondent's own 'GRIEF REACTION (2)' was complicated by concern for her elderly parents, both of whom were in poor health. This reinforced the respondent's 'PAIN (6)' by the addition of 'ANTICIPATED GRIEF' in relation to her parents and her surviving sister. In the event her mother's reaction was influenced by traditional Roman Catholic beliefs ('RC DOGMA') reflecting absence of 'PITY' or 'COMPASSION FOR VICTIM' and focusing on the assumed culpability of the suicide, without any element of 'UNDERSTANDING (2)' or 'FORGIVENESS':

"...daddy's brother...is a priest...uncle KL...and mammy's GP...met me just round the corner...the three of us went into the house together...mammy and daddy were sitting in the living room...you don't walk in with the GP and a priest...and not knowing something was wrong...uncle KL says 'I'm sorry' he says 'but bad news – MN's dead' and daddy instantly said 'Suicide'. He just knew. And mammy's first words were 'Will she go to hell?'...uncle KL nearly died 'Oh God...no' he said 'don't be so silly'...but that was the old school of thought...you were damned for ever...'

In the period since the death of her sister and the loss of her unborn baby she had not ventilated her grief in a therapeutic way. Her 'CHRONIC GRIEF (3)' caused her to cry frequently:

'...I've...cried about her several times...I don't suppose it bothers me...I cry all the time. Half the time, three quarters of the time I'm crying I think...'

'CHRONIC GRIEF (3)' was difficult to ease even with the benefit of 'GRIEF THERAPY (7)'. The respondent's 'NON-HEALING CRYING' and 'CALLING WEEPING' was indicative of her difficulty with 'ACCEPTANCE (4)' of what had happened which precluded effective 'HEALING AND MOVING ON'. In the absence of 'SELF-COMPASSION (2)', the respondent might not be ready yet to seek 'HEALTHY RESOLUTION'. However she might become more conscious through 'SELF-AWARENESS' of the need to enhance her 'COPING ABILITY (3)' by being aware of 'UNHEALTHY EXPRESSION OF ANGER' related to 'FAMILY DISPUTES' and possibly by 'LEARNING FROM KIDS' in relation to 'HEALTHY

EXPRESSION' of feelings, which contrast with her, at times, 'BLOCKED EMOTIONS' and 'UNEXPRESSED ANGER':

"At times I do feel very isolated, and very alone... I probably thought it wouldn't do me any harm... to talk a bit more about it... PR (her son) is going through a dreadful stage... he just screams and yells... gives you dog's abuse... PR was very ill when he was born... I wonder... has it affected him... I feel that your very best should have him better... because he's our son and we think that much of him'

Her approach to the investigator signalled the possibility that she might at some time seek to understand the 'KEY TO SUICIDE' in what happened within her 'SUICIDAL FAMILY' and whether 'FAMILY TRAITS' and 'GENERATIONAL ASPECTS' were present from which 'NEW INSIGHTS' might emerge, within herself and in her wider family circle through the possibility of 'THERAPY (2)' including 'FAMILY THERAPY (4)'.

4.5.6 Respondent 'D' – Identity structure analysis

As for other respondents, identity structure analysis facilitated exploration of Respondent D's identity as represented by belief and value systems, identifications, processes of change in sense of identity and self-evaluation.

4.5.7 Respondent 'D': Primary analysis

As set out in Table 4.18 below, Respondent D's current selves, *'me as I am at home'* and *'me as I am at work'* were classified as 'indeterminate'. Her past selves *' me as I was when I left school'*, *'me as I was before I found out about the suicide'* and *' me as I was after I found out about the suicide'* were also classified as 'indeterminate'. The classification 'indeterminate' was regarded as 'well-adjusted'. The classification of identity variants was based solely upon the underlying parameters of *identity diffusion*

and *self-evaluation* and was therefore a global one that ignored individual characteristics indicated in detail by the full range of identity indices for the respondent (*Weinreich,* 1992: 36). A closer examination of the underlying parameters generating this classification might be illuminating because in the investigator's albeit subjective view - based upon analysis of the audiotaped interview - this respondent appeared at the date of the interview, to be at some distance from healthy accommodation with her predicament as a suicide survivor. Other factors influencing perceived differences between transcript analysis and ISA outcomes were the investigator's bias and the time elapse between the audiotaped interview and completion of the ISA instrument – in this case four weeks.

Table 4.18 Respondent D: Self Image

SELF IMAGE					
	Ideal Self	Current Self		Past Self	
Ego-Involvement (0.00 to 5.00)	4.84	CS1 CS2	3.65 3.49	PS1 PS2 PS3	3.17 3.02 3.65
Self-Evaluation (-1.00 to +1.00)	1.00	CS1 CS2	0.73 0.76	PS1 PS2 PS3	0.24 0.55 0.42
Id. Diffusion (weighte) (0.00 to 1.00)		CS1 CS2	0.30 0.30	PS1 PS2 PS3	0.35 0.34 0.36
	Identity Variant				
Current Self 1	INDETERMINATE				
Current Self 2	INDETERMINATE				
Past Self 1	INDETERMINATE				
Past Self 2	INDETERMINATE				
Past Self 3	INDETERMINATE				

4.5.8 Respondent D: Impact of suicidal loss in relation to the past self *'me as I was before I found out about the suicide'* and the currently situated selves *'me as I am at home'* and *'me as I am at work'*.

This respondent had a very high conflicted identification (see Table 4.19 below) with her mother in the appraisal of her currently situated selves (CS1 0.51; CS2 0.50). She also had high conflicted identifications with *'a person I dislike'*, *'my closest friend'*, *'a person who has taken her/his own life'*, *'Father'*, *'a depressed person'* and *'my partner/spouse'* in her appraisal of her currently situated selves (CS1 0.47, 0.45, 0.44, 0.43, 0.43, 0.38; CS2 0.48, 0.45, 0.46, 0.42, 0.43, 0.38). Her very high conflicted identification with her mother increased sharply in her appraisal of her past selves, reaching a maximum in her appraisal of PS3 *'me as I was after I found out about the suicide'* (PS1 0.39; PS2 0.49; PS3 0.55). This appeared to be directly linked to her mother's difficult relationship with MN, her first-born child, as evidenced in the discourse:

"Now I had told daddy that MN wasn't well but I hadn't said to mammy because... mammy doesn't like you to tell her your worries or any thing that going to cause bother... she expects everybody else to deal with it but she doesn't want to deal with it... mammy and daddy were sitting in the living room... you don't walk in with the GP and a priest... not knowing something was wrong... uncle KL says '... bad news... MN's dead...' and daddy instantly said 'Suicide'... and mammy's first words were: 'Will she go to hell?'... Those were her first words... her eldest child was dead and those were her first words 'Will she go to hell?'..."

Her high conflicted identifications with *'a person who has taken her/his own life'* and *'a depressed person'* in her appraisals of her currently situated selves reached very high levels in her appraisals of her past selves (PS1 0.57, 0.56; PS2 0.54, 0.54; PS3 0.61, 0.60). These phenomena appeared to be related to the impact on this respondent of post-suicide trauma, as in the following discourse:

"... daddy knew she (MN) wasn't stupid and as I say daddy loved her. Mammy would have constantly criticized her all the time even to her dying day, she would have constantly criticized her. She come into the house and mammy would have been criticizing what she was wearing or what the children were wearing or whatever she was doing... she (MN) was convinced she wasn't a good mother... the psychiatrist asked her... did she ever think of killing herself... MN actually said she had and that alarmed her (the psychiatrist). She was just going

to give her Prozac and just send her home...then she decided 'She's voiced an intent to kill herself...I'd better bring her in...' "

Table 4.19 Respondent D: Conflicts in identification

CONFLICTS IN IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
10	Mother...	0.51	0.50
6	A person I dislike.)	0.47	0.48
12	My closest friend..)	0.45	0.45
19	A person who has ta.	0.44	0.46
11	Father...	0.43	0.42
16	A depressed person..	0.43	0.43
13	My partner/spouse...	0.38	0.38
17	My colleagues in th.	0.20	0.20
14	The caring professi.	0.19	0.19
5	A person I admire..)	0.00	0.00
15	My minister of reli.	0.00	0.00

CONFLICTS IN IDENTIFICATION WITH OTHERS - Past Self
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
6	A person I dislike.)	0.62	0.56	0.41
19	A person who has ta.	0.57	0.54	0.61
16	A depressed person..	0.56	0.54	0.60
12	My closest friend..)	0.44	0.49	0.33
10	Mother...	0.39	0.49	0.55
13	My partner/spouse...	0.35	0.39	0.30
11	Father...	0.33	0.39	0.40
14	The caring professi.	0.16	0.18	0.14
17	My colleagues in th.	0.15	0.19	0.16
5	A person I admire..)	0.00	0.00	0.00
15	My minister of reli.	0.00	0.00	0.00

4.5.9 Respondent D: Empathetic identifications

Respondent 'D' decreasingly empathetically identified inter alia (see Table 4.20 below) with *'my partner/spouse'*, *'the caring professions'*, and *'colleagues at work'* as she appraised herself from *'before I found out about the suicide'* (PS2 0.91, 0.77, 0.86) to *'after I found out about the suicide'* (PS3 0.52, 0.52, 0.65) exemplifying the traumatic impact of her sister's sudden death by suicide, as in the discourses:

Re *'my partner/spouse'*:

"...it was just sheer depression that she had...she got no help for it at all...the day of the inquest...your woman (the psychiatrist) on the stand saying that there was puerperal psychosis...I went over to her and FG said to me 'No...' he said 'this isn't the time'...I said 'FG, I'll never get another chance to speak to this woman...'

Re *'the caring professions':*

"...they (hospital staff) didn't even notice she was missing...PQ came up at visiting time and couldn't find her...they got a little bit alarmed...PQ said he saw these two...nurses absolutely running past him from another ward...one of the nurses had gone in...discovered her in the bathroom, didn't even attempt to take her down...administered oxygen...(that) was certainly going to do any (no) good to her...she was dead'

Re *'colleagues at work'*:

"[maternity ward]...she (MN) went privately during the pregnancy because she didn't feel well...she was let down by everybody...one of the midwives in the hospital actually said to the consultant she didn't feel this girl was...well enough for discharge...he just said '...write a wee note to Dr CD, the psychiatrist' you know just get rid of her basically...s/he couldn't have cared less...you know take her money but to heck really with her...the ward sister was called away...there was only one other nurse...and an auxiliary...[psychiatric ward] the other nurse was assigned to a patient who was supposedly actively suicidal...they didn't have MN on any such assignment at all which they should have had considering that was precisely why she was brought into hospital...'.

Respondent 'D' increasingly empathetically identified with her father, as she appraised herself from *'me as I was before I found out about the suicide'*, to *'me as I was after I found out about the suicide'* and to *'me as I am at home'* (PS2 0.68; PS3 0.74; CS1 0.83). Her relationship with her father appeared to have not only survived the horror of the suicidal loss of their beloved relative but to have become deeper, as evidenced in the discourse:

"I really thought my daddy was going to drop dead in front of me...you know she, MN was the eldest...she was very like daddy...would have been very close to him and daddy loved her...continuous...stress...mammy was going rapidly downhill...mammy's health...worse but not in the life threatening way...daddy's would have been...she would have expected daddy...to have lifted and laid her...he was absolutely exhausted...basically I always take daddy's part and don't take her's...'.

Further the respondent's very high ego-involvement (5.00) with her father was bolstered by a moderately high evaluation (0.61) of herself in relation to her father. This contrasted with high ego-involvement (3.97) with her mother but a low evaluation (0.06) of herself in relation to her mother. Both of these phenomena were reflected in the above discourses.

Table 4.20 Respondent D: Empathetic identifications

EMPATHETIC IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
17	My colleagues in th.	1.00	1.00
5	A person I admire..)	0.96	1.00
13	My partner/spouse...	0.87	0.86
14	The caring professi.	0.87	0.91
11	Father...	0.83	0.82
12	My closest friend..)	0.78	0.77
15	My minister of reli.	0.70	0.73
10	Mother...	0.61	0.59
6	A person I dislike.)	0.39	0.41
19	A person who has ta.	0.30	0.32
16	A depressed person..	0.26	0.27

EMPATHETIC IDENTIFICATION WITH OTHERS - Past Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
12	My closest friend..)	0.73	0.91	0.43
13	My partner/spouse...	0.73	0.91	0.52
6	A person I dislike.)	0.68	0.55	0.30
14	The caring professi.	0.68	0.77	0.52
5	A person I admire..)	0.64	0.86	0.61
17	My colleagues in th.	0.59	0.86	0.65
11	Father...	0.50	0.68	0.74
19	A person who has ta.	0.50	0.45	0.57
15	My minister of reli.	0.45	0.59	0.39
16	A depressed person..	0.45	0.41	0.52
10	Mother...	0.36	0.55	0.70

4.5.10 Respondent D: Contra-identifications

This respondent's high contra-identifications with *'a depressed person'* (0.70), *'a person who has taken her/his own life'* (0.65), *'a person I dislike'* (0.57) and her borderline high contra-identification with her mother (0.43) indicated her wish to

dissociate from these people. This phenomenon related perhaps to the respondent's instinct for self-survival while helping fellow survivors, as in the discourse:

"I think I thought that maybe talking about it to someone would help. I knew I suppose that I had got (breaks down – crying) really no help and sort of thought if me talking about it you know in this research can make any difference to other people then I thought that would be a helpful thing... whatever you get out of this research could maybe point people in a similar situation... in a different direction... more benefit to them in the long run... than six years down the line and they still wouldn't be in the mess that I am... '.

4.5.11 Respondent D: Idealistic identifications

The respondent's very high idealistic identifications with *'a person I admire'* (1.00), *'my colleagues in the workplace'* (0.96), *'the caring professions'* (0.91), *'my partner/spouse'* (0.83), *'Father'* (0.78), *'my closest friend'* (0.74) and *'my minister of religion / spiritual adviser'* (0.70) reflected a range of people whose qualities she aspired to possess in relation to her ideal self *'me as I would like to be'*. They represented positive role models for the respondent. To an extent these phenomena were illustrated in the following discourse about her interest in effective, compassionate helping and support for others:

"... one of the consultants in our place lost his wife... I wrote him a letter... he knew about me and... he wrote back... saying... he felt so much from my letter because he... knew I had experienced such close grief... what he was saying... something from someone who knows... was very nice'.

4.5.12 Respondent D: Structural pressure on constructs

High structural pressures on the constructs ***'believes in the irreplaceable value of each human being'*** / *'does not value human beings very highly'* (93.12) (where the preferred pole is in bold), *'can't be trusted'* / ***'can be trusted'*** (71.45), *'withdraws from human contact'* / ***'develops good relationships'*** (70.01), ***'relies on family support at times of crisis'*** / *'does not rely on family support at times of crisis'* (69.40),

'looks for security and protection in family' / *'looks to be set free from family ties'* (64.52) and *'believes the suicide and depression are not linked'* / ***'believes that suicide and depression are linked'*** (59.04) represented the respondent's core evaluative dimensions of identity. The tragic losses of her sister and her unborn baby reinforced her belief in the value of human beings and human relationships and confirmed her dependence upon her family for support at difficult times, as in the discourse:

"I feel that she (MN) didn't get the enjoyment out of life that she should have got... apart from her family... her husband and her children she adored... FG's been very good too but FG doesn't talk much. He would be a quiet personality... that's what's so awful about miscarriages... people don't know... anything about the baby... there's nothing to see either... just bits of tissue... obviously I talked to FG at the time. And you know he sees me crying frequently... FG's not a person like myself that talks that much... '.

Two constructs: *'relies mainly on prescribed medication to relieve pain'* / ***'is interested in complementary and alternative therapies'*** (0.61) and *'believes corporal punishment does no harm to children'* / ***'believes corporal punishment is a form of child abuse'*** (-17.14) represented inconsistently evaluative dimensions of identity, signifying problematic and perhaps unpredictable areas of the respondent's identity. They referred apparently to the difficulty in relieving the enormous pain of human loss by suicide and/or miscarriage and also to the difficulties the respondent was having with her teenaged child, as in the discourses:

"... before (the suicide)... I could have really enjoyed life... really appreciated life. Now I couldn't care less... I would suffer a fair bit of anaemia... my haemoglobin would tend to be low... off for three months... because it was extremely low... doctor... said 'Your blood is so low... all the symptoms... can be attributed to... low haemoglobin'... took the sleeping tablet... girls in work... saying there's some of those herbal things that work... I haven't got them yet... essential oils supposed to be for relaxation and stuff... I would use a few drops of that... odd times it will help other times it won't help'

and:

"PK's (her son) just going through a dreadful stage at present... giving us a lot of hassle... just gives you dog's abuse... He'll just say the slightest thing comes into his head... won't fuss about what effect his behaviour has on his sisters or anything... I'm probably too intensive and... go on at him... '.

4.5.13 Respondent D: Summary

This respondent's identity variants classified her across relevant entities as 'well-adjusted'. She described herself as being 'in a mess' five years after her suicidal loss and subsequent miscarriage. As intimated above, the reasons for this apparent contrast are unknown but might be due to the investigator's bias and the time elapse between applications of the two instruments. The respondent's affective response throughout the interview contrasted with her apparent calm, perhaps more cognitive demeanour while completing the ISA instrument. Her high conflicted identification with her mother and modulations in empathetic identifications in how she appraised herself during the period preceding her suicidal loss to date, pointed to some degree of post-suicide trauma that was complicated and perhaps reinforced by the distressing impact of her subsequent miscarriage. Her contra-identifications associated with her very high idealistic identifications suggested a need to protect herself and to survive by reaching out to help people like herself. It might be concluded that this respondent was influenced by the two serious loss events to the extent that she believed herself changed by these experiences, as evidenced in the discourses:

Re post-suicide trauma: "... the person I was just died when MN died... I'm just totally different... " and
Re post-miscarriage trauma: "... there's always some that survive but mine didn't and I just felt so angry and I called God everything... I just... you sort of get over it but it never really goes away."

4.6 Case Study E

4.6.1 Respondent E – personal information

Respondent 'E' was a man, aged about 40 years, living and working in Belfast. On 11th June 1998 his younger brother, then aged 37 years, was found hanged in London. The respondent learned of the death on 20th June 1998. At this time he was domiciled in Belfast having been reared in Co Tyrone. Surviving members of the respondent's family included his parents, an unknown number of brothers and sisters, their families and his late brother's partner.

4.6.2 Respondent E: Transcript analysis

Analysis of transcript 'E' generated 56 issues and emergent themes from which 149 linked concepts were derived. The interview's loose structure employed a framework of five core themes – what happened, health and well being, meaning, aftercare and quality of life.

4.6.3 Respondent E: Concepts (1)

These linked concepts were listed sequentially at Table 4. 21 below. They represented the investigator's subjective attempt to illustrate in summary form some aspects of the participant's reported experiences as a suicide survivor: concept referral frequency was stated in parentheses:

Table 4.21 Respondent E: Concepts (1)

SUICIDE TRAJECTORY, HINDSIGHT, ALCOHOLISM, MENTAL DISORDER, INITIAL GRIEF REACTION, SUICIDE MODE, INTENSIFIED GRIEF REACTION, SHOCK, EXPECTATION, GRIEF REACTION, LOSS OF EMOTIONAL CONTROL, TERRIBLE ANGER, NEXT OF KIN ISSUE, ANGER (2), ANGER RE ALCOHOLISM, ANGER RE PARENTS' ROLE, ANGER RE

VICTIM, OUTSIDE SUPPORT, FAITH IN PEOPLE, FAMILY IMPOTENT, FUNERAL RITES (2), SUPPORT FOR FAMILY (2), TRAUMATIZED FAMILY, SUICIDE TRAUMA (3), STIGMA (2), TABOO (2), REINFORCING THE TRAUMA, COMMUNITY ROLE, COPING ABILITY, TALKING THERAPY, COPING STRATEGY, IMPLIES A LISTENER, SURVIVOR SUPPORT (4), EXTERNALISATION (2), FEELING THE FEELINGS, GP ROLE (4), MEDICAL MODEL , SYSTEM FLAW, INITIATIVE RE GP ACTION, PERSONAL COPING STRATEGY, GP & MEDICATION, GP ABSENT, INITIATIVE RE GP ROLE, GP IRRELEVANT, MEDICATION ONLY ROLE (GP), COUNSELLING (2), PSYCHOLOGICAL EFFECT, MODERATE GRIEF REACTION, PHYSICAL HEALTH, CRUSE (7), IDEOSYNCRACY, PERSONAL COPING STYLE, INNER STRENGTH, PERSONAL COPING ABILITY, EARLIER PERSONAL TRAUMA, AWARENESS, SEEKING HELP (3), VISIBILITY, ONE-TO-ONE, GROUP WORK, FRIENDS AND ACQUAINTANCES, TALKING TO EVERYONE, FULL BATTERY OF SUPPORTS, TWELVE STEP FELLOWSHIPS, FELLOW SURVIVOR (2), FEELINGS WORK, EMPATHETIC LISTENING (2), FELLOW SURVIVORS (GROUP), PSTD (POST-SUICIDE TRAUMA DISORDER), MUTUAL SURVIVOR SUPPORT – GROUP, DEPRESSION, OTHER LOSS EXPERIENCES (2), GRIEF PROCESS, SAD (SEASONAL AFFECTIVE DISORDER), GRIEF TRIGGERS, EQUITY OR WHO ASKS GETS, FAMILY SECRETS, MOTHER'S SPECIAL GRIEF, TALKING NECESSARY – NOT SUFFICIENT? SURVIVOR AND PARASUICIDE, EMPATHETIC UNDERSTANDING, CROSS ADDICTIONS, SUICIDE IMPULSE (2), INTERVENTION (2), SUICIDAL ADDICTS, RISK ASSESSMENT, SUICIDE DECISION, RESEARCH ARENA? COUNSELLING GOALS, AMBIGUITY, GROUP COUNSELLING GOALS, EFFECTIVENESS, RESOURCES (2), EQUITY, COST BENEFITS, ICEBERG EFFECT, SOCIAL PRIORITIES, MOTHER'S GRIEF, UNFORGIVEN, TABOO RELATED AVOIDANCE, TABOO RELATED FEAR, IDENTITY SHIFT (3), RECOGNITION OF SUICIDE TRAUMA, SALVAGE FROM THE WRECKAGE, BLESSINGS FROM DISASTER, YOUNG SUICIDE, SUICIDE FAMILIES? A FAMILY AFFAIR? EDUCATION – SHNEIDMAN, AVAILABLE SUPPORT, ACCESSIBLE SUPPORT, INNER CHILD, SPIRITUALITY, PERSPECTIVE, SURVIVORHOOD, ATTITUDE CHANGE, PHOENIX RISING. *TOTAL* #149

4.6.4 Respondent E: Concepts (2)

Concepts referred to more than once in the analysis, in descending order, were listed in Table 4.22 below. (Note: Concepts which appeared to be closely related were grouped together in this table.)

Table 4.22 Respondent E: Concepts (2)

CRUSE (7), [GP & MEDICATION; GP ABSENT; INITIATIVE RE GP ROLE; GP IRRELEVANT; MEDICATION ONLY ROLE (GP)] (5), [COPING ABILITY; COPING STRATEGY; PERSONAL COPING STRATEGY; PERSONAL COPING STYLE; PERSONAL COPING ABILITY] (5), GP ROLE (4), [TERRIBLE ANGER; ANGER RE ALCOHOLISM; ANGER RE PARENTS' ROLE; ANGER RE VICTIM] (4), SURVIVOR SUPPORT (4), [INITIAL GRIEF REACTION; INTENSIFIED GRIEF REACTION; MODERATE GRIEF REACTION, GRIEF REACTION] (4), SUICIDE TRAUMA (3), SEEKING HELP (3), IDENTITY SHIFT (3), [TALKING THERAPY; TALKING TO EVERYONE; TALKING NECESSARY – NOT SUFFICIENT?] (3), ANGER (2), COUNSELLING (2), FUNERAL RITES (2) SUPPORT FOR FAMILY (2), STIGMA (2), TABOO (2), EXTERNALISATION (2), FELLOW SURVIVOR (2), EMPATHETIC LISTENING (2), OTHER LOSS EXPERIENCES (2), SUICIDE IMPULSE (2), INTERVENTION (2), [COUNSELLING GOALS; GROUP COUNSELLING GOALS] (2), RESOURCES (2), [EQUITY OR WHO ASKS GETS, EQUITY] (2), [SUICIDE FAMILIES? A FAMILY AFFAIR?] (2), [RECOGNITION OF SUICIDE TRAUMA, PSTD (POST-SUICIDE TRAUMA DISORDER)] (2), [MOTHER'S SPECIAL GRIEF, MOTHER'S GRIEF] (2), [AVAILABLE SUPPORT; ACCESSIBLE SUPPORT] (2), [SALVAGE FROM THE WRECKAGE, PHOENIX RISING] (2), [FAMILY IMPOTENT, TRAUMATIZED FAMILY] (2), [SOCIAL PRIORITIES, COMMUNITY ROLE] (2), [GRIEF PROCESS; GRIEF TRIGGERS](2) *TOTAL # 91*

4.6.5 Respondent E: Reported experiences

This respondent contacted the investigator a little less than a year and a half after the suicidal loss of his younger brother. He described a 'SUICIDE TRAJECTORY' linked to his brother's 'ALCOHOLISM' and related 'MENTAL DISORDER'. His brother's behaviour had altered in the period leading up to his death in London:

"...he'd gone back drinking after a number of years...he'd been taking drugs and stuff...he had conflict about his sexuality...lot of problems...been in different treatment centres...drinking heavily...seemed to get involved in a cult thing...his behaviour and messages he was sending home...getting more and more bizarre...he just went away off the ropes...he came home six months before he died...he seemed...quite crazy in the way he was going on...very, very angry...'

On learning of his brother's death - over a week after he died – he experienced initial 'SHOCK' which transformed into **'an awful lot of anger'**, a 'TERRIBLE ANGER', directed at his deceased brother and at anyone and anything involved with his brother's death, including his friends in England, his family, his sister-in-law, his parents and alcoholism:

"I just...was very, very angry and I was going out at all the wrong people'.

His ability to live through the initial loss period depended upon the support he felt that he got from friends and neighbours at home, but not from his 'TRAUMATIZED FAMILY', a 'FAMILY IMPOTENT':

"Family was totally shattered so we weren't really in a position to support each other."

The role of medicine and in particular his 'GP's ROLE (4)' was significant in its almost total absence from this respondent's experience. He did not seek nor was he offered any help or support from a medical practitioner:

"I didn't get any help from my doctor. I didn't want any help from my doctor...My doctor in Belfast doesn't really know me...And he wouldn't have known about this."

Nor did he recollect any impact upon his physical health in the period after the death. But he did acknowledge 'SEEKING HELP (3)' in relation to coping with the psychological consequences of the suicide from 'CRUSE (7)':

"I don't think my health was affected... psychologically I wasn't the happiest person but... medically... I was sound... doing everything else that I do... I didn't stop eating or lose sleep... I went to Cruse for support... two days after he died".

This respondent's 'MODERATE GRIEF REACTION' may have been connected with the 'IDIOSYNCRASY' of the 'PERSONAL COPING STYLE' he had developed in the period before his brother's suicide. This included a strong belief in a therapeutic 'COPING STRATEGY' which, he believed, delivered an 'INNER STRENGTH' that was available to him enhancing his 'COPING ABILITY' at times of extreme stress:

"... I... have a belief about... talking about what's going on and feeling my feelings and trying to go through it... in a healthy way without looking for medication and other things... I know the Cruse offices... I persisted until I got one-to-one counselling and... went to a group for relatives of suicide victims but I also... talked a lot to friends... I believe in talking to people... twelve step fellowship support..."

The respondent sought out 'SURVIVOR SUPPORT (4)' but experience had already taught him that, at least in relation to himself, it was beneficial if the 'TALKING THERAPY' was founded on 'EMPATHETIC LISTENING (2)' with a 'FELLOW SURVIVOR (2)':

"... I met a woman going to meetings who lost her sister a couple of years ago and I used to talk to her a lot I found it very helpful to find somebody that's in the same situation... she understood what I was feeling... it was OK to feel how I felt'.

The respondent emphasised strongly his appreciation of the help he had got from Cruse, at both one-to-one and group level. The significant factor for the respondent was being given permission to grieve and freedom to express his pain in whatever appropriate way he wished:

"...freedom to say what I had to say...the woman I did the counselling with...was very good...very professional...allowed me to say what I liked...about my regrets about my brother, about our childhood...all the memories it brought up...and about my anger...and allowing myself to grieve...I felt I had no right to grieve because he had committed suicide...pointed out to me that I didn't hang him...that he did it himself...'

The respondent was equally appreciative of the group counselling offered to him. In particular he was able to raise at group, issues and experiences that he felt unable to mention to anyone else:

"...I was getting...occasional dreams about hangings and very, very black macabre dreams...also the imagery...that was putting my head away...last year was 200 years of the...uprising or whatever it was...posters of nooses...when I saw a noose it was...like a kick in the stomach...really taking me back...ropes were becoming nooses...I'd walk into my flat and I'd look...above the door and I could nearly see him hanging off it...all that imagery...watching a film...suddenly there would be something that would bring it back...I went to this group...found people who knew exactly what I was talking about...that people had the exact same experience...through time that has lessened but at the time it was...hard"

It appeared that several suicide survivors in the group reported similar experiences of disturbing flashbacks giving rise to speculation about the existence of 'SUICIDE TRAUMA (3)' or a version of post-traumatic stress disorder (PTSD) related to bereavement by suicide, viz. PSTD (POST-SUICIDE TRAUMA DISORDER)'.

The respondent's counselling concluded around six or seven months after his brother's death. It appeared that Cruse counselling was limited to addressing the single issue of healing the wounds of suicide bereavement. When unconnected issues - in the respondent's case, relationship and career issues - were introduced by a client, the counsellor identified that suicide bereavement work could safely be concluded for the time being, as it had apparently slipped down the client's agenda. Around the time that he ceased attending Cruse, he was aware of feeling 'DEPRESSION' which might be a 'SAD-SEASONAL AFFECTIVE DISORDER' or related to uncompleted grief work in relation to 'OTHER LOSS EXPERIENCES (2)'.

The respondent's apparent self-focus in his therapeutic work reflected a detachment from his family and a sense of wishing to protect them:

"I don't know about other... I've difficulty talking about other members of my family because I wouldn't want them to read this and think... that I've been talking about them. My mother's still very affected by it."

He believed his mother's grief was exceptional, a 'MOTHER'S SPECIAL GRIEF' on the loss of her son by suicide. Because of his own experience as a parasuicide and now as a survivor, he understood the importance of effective 'INTERVENTION (2)'. He also believed he understood well many of the constituents of his brother's 'SUICIDE TRAJECTORY' that took him, weighed down by 'CROSS ADDICTIONS', to the 'SUICIDE CUL-DE-SAC':

"... I feel I do know why he did it... maybe... arrogant point of view... I've had problems with alcohol and that... went through some very black times and could have done the same thing... couple of years ago... very black times... phoned the Samaritans ... in a bad mess... I feel that... he went to that place and... he went through with it... I have had suicide attempts in my own life... some pretty petty and cries for help... but a number of years ago... very black place... thought I had no alternative but to take my own life... it was a decision I had about putting up a rope... I talked to someone... he suggested 'If you have a rope, get rid of it' and I did. I feel he must have gone to that same place... he was in very active addiction... drugs, alcohol and other things... I think that's what happened to him.'

In relation to aftercare for suicide survivors, the respondent not surprisingly felt that his experience of counselling contributed usefully to meeting his needs and to enhancing his personal healing work. He understood however that the Cruse service for the suicidally bereaved was not well enough known. He knew about it at the relevant time only because he regularly walked past the Cruse offices in Belfast. In addition he was familiar with alternative and complementary therapies. This suggested an 'ICEBERG EFFECT' in relation to bereavement by suicide. Only those traumatized individuals who find their way to Cruse – or into private counselling or other effective support – are likely to obtain life preserving and life enhancing help

and support. But the issue of 'EQUITY' in relation to the use of scarce 'RESOURCES (2)' available to survivors arose if appropriate professional counselling was available only to a fraction of the estimated survivor constituency:

"I think maybe places like this need to put it out more that they're here to help people... and to let people know that they're there'.

The respondent acknowledged the special nature of the survivor's grief and repeated his view that working with 'FELLOW SURVIVORS (2)' appeared to help. But a 'STIGMA (2)' existed that should be acknowledged and addressed.

"... there's a sensitivity needed around suicide... there's a stigma... actually I had a stigma on it myself... I used to feel ashamed that my brother committed suicide... at the church service the priest... seemed to be very shaming... of the family... that we have been judged and... condemned... (but) my grief is as valid as anyone else's whether... what he did was morally right or wrong... he was a very sick boy... my grief is valid... I didn't feel that for a long time because of my... stigma about suicide."

Traditional attitudes to suicide were slow to change and a double 'TABOO' on 'death' and 'suicide' was still influential. The respondent told the investigator that his mother experienced the unconscious cruelty of people motivated perhaps by their irrational fear of suicide:

"My mother says that people never mention his name to her – never speak about him to her'.

He also experienced the impact of the suicide taboo on the behaviour of people who were unable to cope with the feelings that it raised in them. But he was compassionate toward these people:

"A lot of people can't handle death of any description... I think... around suicide... there is a big taboo about it... having said that a year previously this woman I referred to earlier... I wasn't able to approach her when she had her grief... I didn't know what to say and I passed her... I can understand how people felt..."

Finally the respondent acknowledged an 'IDENTITY SHIFT (3)' in his social behaviour in relation to the subject of suicide. He had a considerable personal

knowledge of suicide related to his own life experience, but as a result of his brother's death and his own response to it, such 'SURVIVORHOOD' transformed his contribution to any public discussion of suicide: this was now much more open:

"I can talk to people easily about it because I've been there... I know what the story is... one benefit of the whole experience... if you can call it a benefit... it is hard for people... afraid to upset you or say the wrong thing... so they say nothing... assume you don't want to talk about it... now I do know what it's like so I'm able to talk to people... about my experience... they're not going to turn round and say 'What do you know about it?' I do know about it.'

4.6.6 Respondent E – Identity structure analysis

As for the previous respondents, identity structure analysis facilitated exploration of Respondent E's identity as represented by belief and value systems, identifications, processes of change in sense of identity and self-evaluation.

4.6.7 Respondent E: Primary analysis

As set out in Table 4.23 below, Respondent E's identity variant for his current self, *'me as I am at home'* was classified 'defensive', and appeared to be related to his capacity to resolve identification conflicts with significant others. His identity variant for his past self *'me as I was when I left school'* was classified 'crisis'. This appeared to rest upon the respondent's very low self-evaluation (-0.30) as he appraised himself in that entity. Each of the above classifications was regarded as a vulnerable identity state. The respondent's identity variants for his current self *'me as I am at work'*, and for his past selves *'me as I was before I found out about suicide'* and *'me as I was after I found out about the suicide'* were classified as 'indeterminate'. These

classifications were considered to represent 'well-adjusted' identities and might reflect the respondent's apparent capacity to accommodate the impact of suicide trauma.

Table 4.23 Respondent E: Self Image

	SELF IMAGE				
	Ideal Self	Current Self		Past Self	
Ego-Involvement (0.00 to 5.00)	5.00	CS1 CS2	3.81 2.98	PS1 PS2 PS3	3.63 3.75 3.93
Self-Evaluation (-1.00 to +1.00)	1.00	CS1 CS2	0.73 0.57	PS1 PS2 PS3	-0.30 0.60 0.35
Id. Diffusion (weighte) (0.00 to 1.00)		CS1 CS2	0.24 0.25	PS1 PS2 PS3	0.45 0.26 0.31
	Identity Variant				
Current Self 1	DEFENSIVE				
Current Self 2	INDETERMINATE				
Past Self 1	CRISIS				
Past Self 2	INDETERMINATE				
Past Self 3	INDETERMINATE				

4.6.8 Respondent E: Impact of suicidal loss in relation to the past self *'me as I was before I found out about the suicide'* and the currently situated selves *'me as I am at home'* and *'me as I am at work'*.

This respondent had very high conflicted identifications (see Table 4.24 below) with *'a depressed person'*, *'a person who has taken her/his own life'* and *'Father'*, and a high conflicted identification with *'a person I dislike'*, in his appraisal of his past self *'me as I was when I left school'* (PS1 0.76; 0.72; 0.60; 0.49). He also had very high or high conflicted identifications with all four of the above entities as he appraised himself from *'me before I found out about the suicide'* to *'me after I found out about the suicide'* (PS2 0.40, 0.43, 0.38, 0.45; PS3 0.56, 0.52, 0.45, 0.47). This phenomenon appeared to reflect the impact on the respondent of his suicidal loss, as in the discourse:

"...I was angry with him (his deceased brother)...and with them (his brother's friends)...I was angry with the family. I was angry with my sister-in-law...angry at him for what he did...angry at my parents to stop him and angry at the...alcoholism or whatever killed him...an awful lot of anger, initially"

However the very high conflicted identifications with *'a depressed person'* and *'a person who has taken her/his own life'* declined markedly as the respondent appraised himself from *'me as I was after I found out about the suicide'* to *'me as I am at home'* (PS3 0.56, 0.52; CS1 0.32, 0.35). These decreasing conflicted identifications indicated that these entities were less problematic in terms of the respondent's own identity: his current conception of himself and what he stood for, as evidenced in the discourse:

"It certainly gives you understanding...you feel adequate to talk about it because you've been there yourself...now I do know what it's like..."

Table 4.24 Respondent E: Conflicts in identification

CONFLICTS IN IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
6	A person I dislike.)	0.48	0.44
11	Father...	0.42	0.40
10	Mother...	0.39	0.41
19	A person who has ta.	0.35	0.36
16	A depressed person..	0.32	0.37
17	My colleagues in th.	0.32	0.32
12	My closest friend..)	0.28	0.29
13	My partner/spouse...	0.28	0.29
14	The caring professi.	0.19	0.19
5	A person I admire..)	0.00	0.00
15	My minister of reli.	0.00	0.00

CONFLICTS IN IDENTIFICATION WITH OTHERS - Past Self
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
16	A depressed person..	0.76	0.40	0.56
19	A person who has ta.	0.72	0.43	0.52
11	Father...	0.60	0.38	0.45
6	A person I dislike.)	0.49	0.45	0.47
10	Mother...	0.32	0.40	0.40
17	My colleagues in th.	0.23	0.32	0.28
12	My closest friend..)	0.17	0.28	0.25
13	My partner/spouse...	0.17	0.28	0.25
14	The caring professi.	0.11	0.18	0.16
5	A person I admire..)	0.00	0.00	0.00
15	My minister of reli.	0.00	0.00	0.00

4.6.9 Respondent E: Empathetic identifications

Respondent 'E' decreasingly empathetically identified with (see Table 4.25 below) with *'my closest friend'*, *'my partner/spouse'*, *'the caring professions'*, *'a person I admire'* and *'my minister of religion/spiritual adviser'* as he appraised himself from *'me as I was before I found out about the suicide'* (PS2 0.87, 0.87, 0.78, 0.91, 0.91) to *'me as I was after I found out about the suicide'* (PS3 0.70, 0.70, 0.61, 0.70, 0.70) exemplifying his relative dissociation from these people in the aftermath of the suicide of his brother, for example in the discourses:

Re *'my partner/spouse'*:

"...other situations in my life getting on top of me...a relationship I was in...wasn't very sure whether it was about NP (his deceased brother) or what"

Re *'the caring professions'*:

"I didn't want any help from my doctor...I never went to him anyway...nothing from the medical people. I didn't want any."

Re *'my closest friend'*:

"Some people couldn't handle it at all and backed right off...it's difficult for people"

However the respondent increasingly empathetically identified with all five of the entities mentioned above as he appraised himself from *'me as I was after I found out about the suicide'* (PS3 0.70, 0.70, 0.61, 0.70, 0.70) to *'me as I am at home'* (CS1 0.86, 0.86, 0.86, 0.95, 1.00) evidencing on-going psychological processes of development and change, as in the discourses:

Re *'my closest friend'*:

"I just kept talking about what was going on and how I felt and I kept in touch with my closest friends'

Re: *'my partner/spouse'*
"I got through my university and the relationship I'm - was in I'm still in it and worked through a lot of stuff..."

Re *'the caring professions'*

"They were very good, you know. I really appreciate what they did for me. I'm not here to promote or advertise Cruse but they really helped me a lot, you know..."

Finally the respondent's very high empathetic identification (1.00) with *'my minister of religion/spiritual adviser'* as he appraised himself in his currently situated self *'me as I am at home'* reflected perhaps his own activity in this helping role as he worked with others, for example in 'Twelve Step Fellowship' support groups, as in the discourse:

"I believe in talking to people...I go to twelve step fellowship support...I met a woman going to meetings...very helpful to find someone that's in the same situation."

Table 4.25 Respondent E: Empathetic Identifications

EMPATHETIC IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
15	My minister of reli.	1.00	0.95
5	A person I admire..)	0.95	0.95
12	My closest friend..)	0.86	0.95
13	My partner/spouse...	0.86	0.95
14	The caring professi.	0.86	0.86
17	My colleagues in th.	0.77	0.81
10	Mother...	0.68	0.76
6	A person I dislike.)	0.45	0.38
11	Father...	0.36	0.33
19	A person who has ta.	0.18	0.19
16	A depressed person..	0.14	0.19

EMPATHETIC IDENTIFICATION WITH OTHERS - Past Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
16	A depressed person..	0.79	0.22	0.43
11	Father...	0.74	0.30	0.43
19	A person who has ta.	0.74	0.26	0.39
6	A person I dislike.)	0.47	0.39	0.43
10	Mother...	0.47	0.74	0.74
17	My colleagues in th.	0.42	0.78	0.61
12	My closest friend..)	0.32	0.87	0.70
13	My partner/spouse...	0.32	0.87	0.70
14	The caring professi.	0.32	0.78	0.61
5	A person I admire..)	0.26	0.91	0.70
15	My minister of reli.	0.26	0.91	0.70

4.6.10 Respondent E: Contra-identifications

This respondent's high contra-identifications with *'a depressed person'* (0.74), *'a person who has taken her/his own life'* (0.70), *'a person I dislike'* (0.52) and *'Father'* (0.48) indicated his wish to dissociate from these people. It was possible that he particularly wished to avoid behaviour and / or activities that exemplified qualities that he attributed to them, especially those that he associated with his brother's fate. He acknowledged his difficulties with several addictions but articulated his strategies for coping with these in healthy ways, as in the discourse:

"I have a drug problem myself... so... going looking for medication wasn't really an option... I go to twelve step fellowship support... for addiction and that... if I could find people in that same position was helpful... Cruse was very, very helpful... I did the counselling... once a week... I went to a group once a week... I felt I shouldn't be feeling the way I was feeling because I hadn't seen my brother for a year or two and we'd fallen out previous to this... I was... told it was OK to feel how I felt... I feel I do know why he did it... the only thing I did afterwards was pray to God that I'd never do the same thing myself... I... made a pact that no matter what don't do that".

4.6.11 Respondent E: Idealistic identifications

The respondent's very high idealistic identifications with *'my minister of religion / spiritual adviser'* (0.96), *'a person I admire'* (0.91), *'my closest friend'* (0.83), *'my partner/spouse'* (0.83), *'the caring professions'* (0.83), *'my colleagues in the workplace'* (0.78) and *'Mother'* (0.70) reflected a range of people whose qualities he aspired to possess in relation to his ideal self *'me as I would like to be'*. They represented positive role models for the respondent. The following discourse illustrated aspects of the qualities that he aspired to:

"There needs to be more education... more encouragement for young people to talk about what's going on and a safe place for them to go and talk about how they feel... they don't get that at home... could be done through... schools or... youth clubs... getting people to go in and talk to them... about their experiences... even this experience I've had... you don't need to run away from your depression... let them talk about it rather than putting a rope round your neck... '

4.6.12 Respondent E: Structural pressure on constructs

High structural pressure on the constructs *'can't be trusted'* / ***'can be trusted'*** (84.97) (where the preferred pole is in bold), *'withdraws from human contact'* / ***'develops good relationships'*** (82.56), ***'I feel encouraged by'*** / *'I feel distressed by'* (81.49), *'is pessimistic about the future'* / ***'is optimistic about the future'*** (77.96), *'relies mainly on prescribed medication to relieve pain'* / ***'is interested in complementary and alternative therapies'*** (75.47) and *'considers that most suicides cannot be prevented'* / ***'believes that most suicides could be prevented'*** (74.31) represented the respondent's core evaluative dimensions of identity. He appeared to have responded to the tragic loss of his brother by building a framework of defences rooted in trust, relationship, encouragement, optimism, alternative therapies and suicide prevention. The following discourse evidenced elements of this strategy:

"I talked a lot to friends...I don't know what help is available medically I mean...I didn't stop eating or lose sleep...I go to twelve step fellowship support...I went to Cruse.... I could talk about things...feel the feelings that I felt...the relationship...I'm still in...worked through a lot of stuff...just kept talking...in some form of denial to think that it's all gone...for the most part it wouldn't play a major part in my...mind...or my life...I don't feel so devastated by it now these days...although I can still be angry with him"

Low construct pressures: *'looks to be set free from family ties'* / ***'looks for security and protection in family'*** (14.65), ***'believes that families eventually get over a suicidal loss'*** / *'believes that families never get over a suicidal loss'* (-4.64) and ***'is convinced that suicide demands considerable bravery'*** / *'is convinced that suicide is the act of a coward'* (-5.11) represented inconsistently evaluative dimensions of identity, signifying problematic and perhaps unpredictable areas of the respondent's identity. The latter two referred to difficult and complex aspects of the survivor's recovery following bereavement by suicide while the first related to the balance

between individual freedom and family responsibility and these were alluded to obliquely in the discourse:

Re *complex aspects of suicide*:

"...there's a lot of suicides at the minute...maybe the taboo's been broken a wee bit...maybe you've heightened my awareness...maybe I need to go and think about... suicides and young people'; and

Re *the individual and the family*:

"I've difficulty talking about other members of my family...my mother's still very affected by it...it's worse for a mother...it's shattered her...still is shattering her...Family was totally shattered...everybody was shattered by it.'

4.6.13 Respondent E: Summary

This respondent's identity variants classified him 'defensive' and 'indeterminate' in his currently situated selves and 'crisis' and 'indeterminate' in his past selves. His overall identity state when the instrument was completed veered towards vulnerability, in his current self *'me as I am at home'* although there were indications of positive adjustment in his apparent accommodation to suicidal loss. He exhibited several highly conflicted identifications related to the impact of suicide trauma but decreasing identification conflicts pointed towards some positive development in his current view of himself and in his belief and value system. His contra-identifications evidenced a determination to avoid his brother's fate and to work towards survival in association with fellow survivors. His idealistic identifications reflected those qualities that he needed in order to build appropriate defences. Finally his core evaluative dimensions of identity evidenced a robust survival strategy based inter alia upon trust, relationship and optimism while acknowledging inconsistently evaluative dimensions of identity in relation to the individual and the family and the survivor's

recovery following suicide trauma. Perhaps his current identity state was illustrated in this discourse:

"I have great faith in...talking about things and in feeling feelings...my education wasn't the happiest and I tried to escape it rather than go and try and sort out what was wrong...you don't need to run away from your depression...things will get better and you can sort things out if you hang in there...let them talk about it rather than putting a rope round your neck..."

4.7 Case Study F

4.7.1 Respondent F – personal information

Respondent 'F' was a man, aged in his late fifties, living near Belfast and currently employed in Belfast. On 13th October 1992 his only sibling, a single woman then aged 49 years, was found dead by police at her home in Belfast. She had died approximately two days earlier. At this time the respondent was domiciled in England and he learned about his sister's death following a telephone message from police to his residence. Other than the respondent, only an elderly aunt and a number of cousins survived the deceased.

4.7.2 Respondent F: Transcript analysis

Analysis of transcript 'F' generated 53 issues and emergent themes from which 148 linked concepts were derived. The interview's loose structure employed a framework of five core themes – what happened, health and well being, meaning, aftercare and quality of life.

4.7.3 Respondent F: Concepts (1)

These linked concepts were listed sequentially at Table 4.26 below. They represented the investigator's subjective attempt to illustrate in summary form some aspects of the participant's reported experiences as a suicide survivor: concept referral frequency is stated in parentheses.

Table 4.26 Respondent F: Concepts (1)

SUICIDE PLAN, SELF-NEGLECT, FALSE ESTEEM, BELIEFS AND VALUES, ENDPOINT, NOT CRI-DE-COEUR, PAIN, SUICIDE IDEATION, EXTINGUISHMENT, FATAL SELF-CARING, DEATH MESSAGE, SPECULATION, NOT YET SUICIDE, SHOCK - DENIAL, SUPPORT FOR MOURNER, FRIENDS – COLLEAGUES, IMMEDIATE SUPPORT, COMPOUNDING THE GRIEF (2), SUPPLEMENTARY GRIEF, SUICIDE MODE, SUICIDE GRIEF REACTION, NORMAL GRIEF REACTION, GRIEF VACUUM (2), HARD GOING, VAGUE INFORMATION, LOYALTY TO FRIENDS, PERSONAL VALUES/BELIEFS, LIFE GOES ON, PERSONAL VALUES, TRAUMATIC MEMORY, CARING FOR SURVIVORS, FRIENDS VALUED HIGHLY, RELATIVES' OWN TRAUMA, WORK COLLEAGUES, FUNERAL RITES (2), PHYSICAL HOLDING, FEW FAMILY ATTACHMENTS, GP ROLE, GP IRRELEVANT, SURVIVOR'S CHOICE, MEDICAL SUPPORT, NO FELT NEED FOR MEDICS, LASTING LOSS AWARENESS, AFTERCARE INTEREST, GRIEF PROCESS, EXPRESSION OF EMOTIONS, TRAINING-PRACTICE-WORKSHOP, RELEASING FEELINGS, NO MEDICAL SUPPORT, ALCOHOL NIGHTCAPS, ENERGY, ACTION+FEELINGS, AVAILABLE SUPPORT, SURVIVOR ACTIVITY, GUILT MOTIVATOR, SPECIAL SURVIVOR GRIEF, SPECIAL SCAR, COMPOUNDED GRIEF, NORMAL GRIEF (2), EXCEPTIONAL GRIEF, CAN'T TOUCH SUICIDE, SUICIDE GRIEF, CAN'T TOUCH/FEEL SUICIDE, IMPOSSIBLE EMPATHY, NO MEANING, NO REASONING, NO UNDERSTANDING, EMPTINESS, LACK OF SUBSTANCE, GRIEF TRIGGER, SUICIDE SCAR, SUICIDE VACUUM, UNHEALED WOUND, ABNORMAL GRIEF, NO SCAR, EMOTIONS, SUICIDE LETTER, UNDERSTANDING,

SURVIVOR SUPPORT (2), SUICIDE PREDICTION, VICTIM'S AGENDA, VICTIM'S RATIONALISATION, SUICIDE DECISION, SUICIDE SIGNALS, VICTIM'S CONCEALMENT, ULTIMATE NEGATIVITY, SURVIVOR'S BURDEN, MUTUAL SUPPORT, SURVIVOR'S GRIEF, NO COUNSELLING, FRIENDS' SUPPORT, EFFECTIVE HEALING, SELF+FRIENDS, I DON'T KNOW, HELP FOR OTHERS, FAMILY SUPPORT, FRIENDS/STRANGERS, USEFUL HELPING, CRUSE, RESOURCES, VULNERABILITY, SURVIVOR RISK, WARY OF COUNSELLING, NO INSIGHTS, PTSD, SUICIDE TRAUMA, POST-SUICIDE DISORDER, HUMAN RIGHT TO SUICIDE?, RIGHT TO CHOOSE TO DIE?, SURVIVOR TRAUMA-UNJUST?, RATIONAL SUICIDE, SURVIVOR GUILT EASED, RESPONSIBILITY TO HUMANITY, HUMAN RIGHTS, DEPRESSION DISTORTS, PERMANENT –V- TEMPORARY, RATIONALISATION, VALUES AND BELIEFS (SURVIVOR), VALUES AND BELIEFS (VICTIM), SUICIDE INTERVENTION, 'NECESSARY' SUICIDE, TABOO, TRADITIONAL MORES, GUILT & FEAR, FALSE SELF-ESTEEM, SUICIDE TRAJECTORY (2), QUESTIONABLE EXAMPLE, ULTIMATE REJECTION OF SELF, FIERCE COST IN PAIN, RELIGIOUS MORES, STIGMA & TABOO, CONTRAST GB & NI, IDENTITY ALTERED, SURVIVOR OPTION, SIBLING EXEMPLAR, SIBLING EXAMPLE, SUICIDE DECISION PROCESS, COMPASSION FOR VICTIMS, COMPASSION FOR SURVIVORS, SURVIVOR SELF-COMPASSION, SURVIVOR'S SUICIDE RISK *TOTAL # 148*

4.7.4 Respondent F: Concepts (2)

Concepts referred to more than once in the analysis, in descending order, were listed in Table 4.27 below. (Note: Concepts that appeared to be closely related were grouped together in this table.)

Table 4.27 Respondent F: Concepts (2)

[FRIENDS – COLLEAGUES, LOYALTY TO FRIENDS, FRIENDS VALUED HIGHLY, WORK COLLEAGUES, SELF+FRIENDS, FRIENDS/STRANGERS, FRIENDS' SUPPORT] (7), [GP ROLE, GP IRRELEVANT, MEDICAL SUPPORT, NO FELT NEED FOR MEDICS, NO MEDICAL SUPPORT] (5), [BELIEFS AND VALUES, PERSONAL VALUES/BELIEFS, PERSONAL VALUES, VALUES AND BELIEFS (SURVIVOR), VALUES AND BELIEFS (VICTIM)] (5), [SUPPLEMENTARY GRIEF, SPECIAL SURVIVOR GRIEF, EXCEPTIONAL GRIEF, SUICIDE GRIEF, SURVIVOR'S GRIEF] (5), [SUICIDE PLAN, SUICIDE IDEATION, SUICIDE MODE, SUICIDE DECISION] (4), [HUMAN RIGHT TO SUICIDE? RIGHT TO CHOOSE TO DIE? RATIONAL SUICIDE] (3), [PTSD, SUICIDE TRAUMA, POST-SUICIDE DISORDER] (3), [COMPASSION FOR VICTIMS, COMPASSION FOR SURVIVORS, SURVIVOR SELF-COMPASSION] (3), [VICTIM'S AGENDA, VICTIM'S RATIONALISATION, VICTIM'S CONCEALMENT] (3), COMPOUNDING THE GRIEF (2), GRIEF VACUUM (2), FUNERAL RITES (2), NORMAL GRIEF (2), SURVIVOR SUPPORT (2), SUICIDE TRAJECTORY (2), [FALSE ESTEEM, FALSE SELF-ESTEEM] (2), [SUICIDE GRIEF REACTION, NORMAL GRIEF REACTION] (2), [SELF-NEGLECT, ULTIMATE REJECTION OF SELF] (2), [EXPRESSION OF EMOTIONS, RELEASING FEELINGS] (2), [NO COUNSELLING, WARY OF COUNSELLING] (2), [SURVIVOR RISK, SURVIVOR'S SUICIDE RISK] (2), [CAN'T TOUCH SUICIDE, CAN'T TOUCH/FEEL SUICIDE] (2), [PAIN, FIERCE COST IN PAIN] (2), [TRADITIONAL MORES, RELIGIOUS MORES] (2) *TOTAL # 68*.

4.7.5 Respondent F: Reported experiences

This respondent contacted the investigator just over seven years after the suicidal loss of his younger sister. Her self-killing appeared to have been carried out according to a

detailed 'SUICIDE PLAN' which ensured her death. There was no element of 'CRI-DE-COEUR' in her behaviour: it could have no other 'ENDPOINT' than the 'EXTINGUISHING' of her life:

"...on...Sunday...at some stage...in the afternoon, she sat down and wrote a six-page letter to me as to why and what it was all about...pulled all the plugs out in the flat...also left a little note in the tea caddy...opened the window so that...they wouldn't wreck any window frames...filled two hot water bottles...took an overdose with vast amounts of barbiturates...later on the Sunday evening she would have died...on the Tuesday...she was found dead in bed."

At work in England, the respondent received a message, from his landlady, to contact the police in Belfast about the death of his sister. His initial reaction included 'SHOCK – DENIAL' and involved 'SPECULATION' about what could possibly have happened to her. Her death was 'NOT YET SUICIDE'. He had been speaking to her on the telephone the previous week. A special feature in this respondent's response was the 'IMMEDIATE SUPPORT' of 'WORK COLLEAGUES'. A friend from work phoned the police on the respondent's behalf:

"...some chap from the company...did all the phoning for me...I was ashen...and insecure...only after we got through to the police that they then were able to say it was suicide."

This had the effect of 'COMPOUNDING THE GRIEF' within his 'NORMAL GRIEF REACTION' with a 'SUPPLEMENTARY GRIEF' transforming it into a 'SUICIDE GRIEF REACTION':

"...that fact that it was suicide...was just another thing on top of the fact that she had died...to say it was just one thing more is being very dismissive but it was just incredulity...you just couldn't take anything on board..."

He was unable to get home until Friday and spent three nights in a 'GRIEF VACUUM' knowing his sister had suicided and had left a letter. There was no one in Belfast to act for him, the next-of-kin, and he had to make the funeral arrangements at

a distance. He found this to be 'HARD GOING'. Although his relatives in England were very supportive he relied more on 'FRIENDS' SUPPORT':

"I did a lot of drinking and smoking....for a few days and not much eating...the people in the company...were absolutely marvellous. Anytime that I needed anybody they just opened their arms...I think it's because theatre people are...more upfront about emotions and are more tactile...with the acting fraternity there were tears all round the place...people were in tears for me..."

He found that people he worked with including some that he knew only for a few weeks were:

"...extremely supportive...emotionally and were very supportive in the literal sense of the physical...just the holding...just to feel something to hold on to physically is a great, great help..."

The respondent did not seek 'MEDICAL SUPPORT' around the time of the bereavement. This was his 'SURVIVOR'S CHOICE' but it reflected his peripatetic lifestyle. So a 'GP ROLE' in relation to caring for this respondent as a suicide survivor could be described as 'GP IRRELEVANT' in line with his own wishes and circumstances. Coping with the psychological consequences of suicidal loss he had 'NO FELT NEED FOR MEDICS' relying more upon 'EXPRESSION OF EMOTIONS', physical activity and sleep:

"...for a week or so...I cried myself to sleep...and a vast amount of whiskey...if you've a charge of whiskey you'll sleep...I'd always a hell of a lot of things to do the next day...I didn't know because of commitments to the show when I would get over to Belfast...I organised the funeral...I had to sleep at night to get the energy... because I was the chief mourner...the stage manager...the publicity officer...the front of house manager...I needn't say it helped me through it...there wasn't a great deal of time to sit around..."

There was a slight element of felt guilt in the respondent's 'SURVIVOR ACTIVITY' as his sister's next-of-kin:

"...I wouldn't have wanted anybody else to do it. She was my sister and the least I could do for her having not been around when I should have been retrospectively...I wanted to do it."

This respondent recognised a 'SPECIAL SURVIVOR'S GRIEF' that accompanied his sister's death. There had been several 'normal' family bereavements but his suicidal loss experience caused him to perceive it as fundamentally different in the sense that one 'CAN'T TOUCH SUICIDE':

"...those of us who have been bereaved by suicide, you do have something left...a feeling that nobody else has...several deaths in the family...you don't expect everybody to live forever...people are bereaved and distracted and upset...but you can touch that sort of a death. You can't touch suicide...when somebody commits suicide you know nothing about it at all until you hear about it...all sorts of things have led up to that suicide and nobody knows anything about them...you can't touch it because you don't know what's going on in someone's mind...the reasons why...did they do it..."

This suggested the notion of a 'GRIEF VACUUM' experienced by this survivor in the aftermath of suicide where there was 'NO MEANING', 'NO REASONING' and 'NO UNDERSTANDING'. Within this 'EMPTINESS' there was a lack of substance to aid acceptance and so to trigger a healing 'GRIEF PROCESS'. The 'SUICIDE LETTER' offered this respondent some 'UNDERSTANDING' of his sister's rationale for her action. He was somewhat sceptical about the phenomenon of 'SUICIDE SIGNALS' where a future 'VICTIM'S AGENDA' might enable a close observer to make a 'SUICIDE PREDICTION'. He felt that this was:

"...a hindsight thing...how should you be tuned in to recognise those things – those signs and signals because you're not looking for them."

However on reflection he recalled that he had noted in his diary the last time that he visited his sister, two months before she died, that he had not seen her looking so well. They had:

"enjoyed each other's company for the first time in a long time...again I didn't know that she was being treated for depression...someone told me that afterwards...her doctor told me...I didn't know that...she hadn't told me...all that could well fall into place entirely..."

Hence the 'VICTIM'S CONCEALMENT' of their 'SUICIDE DECISION' leaving survivors to pick up the pieces might represent an act of 'ULTIMATE

NEGATIVITY' about which the victim remained unaware in their 'ULTIMATE REJECTION OF SELF'. In relation to aftercare, this respondent did not avail of counselling support. He relied almost entirely on 'MUTUAL SUPPORT' of 'FRIENDS – COLLEAGUES':

"...not so much counselling but I had...ears to bend in all these friends who were prepared to have their ears bent and are sufficiently upfront with all sorts of emotions...not knowing anybody from scratch, there's no time to hide behind things...therefore in a time of emotional crisis everyone is there for you."

In relation to 'SURVIVOR RISK' the respondent accepted that there might be a link between bereavement induced depression and survivor suicide but he was 'WARY OF COUNSELLING' as a panacea. He admitted that his view might be cynical and in any case he did not know what went on at counselling. Towards the close of the interview, the respondent widened the discussion to include consideration of a 'HUMAN RIGHT TO SUICIDE' defined as being an individual's right to dispose of their own life as they see fit:

"...that person is an individual and that person has their own rights. And if that person decides to end their own life, it is that person's right to do so...that was a great help to me...not pleased because there I was absolving myself from any blame of lack of support for my sister at the time...to see it from the other person's point of view can help...get things into a slightly different perspective".

The respondent acknowledged that such lateral thinking could lift direct responsibility from survivors such that 'SURVIVOR GUILT EASED'. But perhaps such 'RATIONAL SUICIDE' could sometimes be construed as a happy release where the victim believed that it ended unbearable pain. This might be to construe suicide, in an admittedly obscure way, as an expression of optimism that the respondent felt must contain a germ of truth for many victims:

"...the person having got to the stage where it was all too much for them, for whatever set of reasons...what we feel sad about is all the things that led up to it but we shouldn't...be sad for the person who actually did it because for them it was a way out...it wasn't going to get any worse and hopefully it was going to get better."

This argument contained elements of 'RATIONALISATION' because, necessarily the respondent was calling upon his own 'VALUES AND BELIEFS (SURVIVOR)' with which he was intimately familiar as against the 'VALUES AND BELIEFS (VICTIM)' about which he could only make well-informed guesses. The fact was that 'DEPRESSION DISTORTS' thinking processes to a greater or lesser extent and that suicide represented an act that could not be undone. The notion of 'NECESSARY SUICIDE' described the victim's perception of the need for that specific solution to the unendurable psychological pain of their particular life situation. The respondent referred to this when contrasting the response of survivors to the victim's perhaps distorted reality:

"...it's selfish of us to feel...terribly chewed up and upset and distressed about it. Of course we do and of course we should but an awful lot of it is the people who are left behind floundering. We've got to latch on to the fact that ...the person who went didn't see it that way."

The respondent raised the issue of his sister's religious beliefs that would have considered suicide to be morally wrong. He did not at first understand how she could have acted against all the teachings of the...church:

"...but she had seemingly worked it out – that if she confessed to Jesus long time since that she was a sinner, Jesus is there to save confessed sinners...that's how she sorted out...how she could end her own life...as opposed to waiting for the great call..."

He felt that attitudes to suicide in Great Britain contrasted with those in Northern Ireland possibly due to influential 'RELIGIOUS MORES' such that people in Belfast found it difficult to talk about an act that was still considered by many to be a sin and a crime:

"They don't like to talk about it. There's still a great deal of shame attached... I'm here talking to you today because having lived outside Northern Ireland virtually all my adult life...and in the environment we've been speaking about we're a lot more upfront, I'll always be at the head of the queue to air the subject."

He acknowledged that his 'IDENTITY ALTERED' as a consequence of his sister's suicide. In relation to 'SURVIVOR'S SUICIDE RISK' his thinking processes had been changed, not least by his 'SIBLING EXEMPLAR':

"...it's a very brave thing to do for starters...it's something that I could as an outside option take on board where I wouldn't have seven years ago...there's a set of circumstances...suffering a lot of pain...because an example has already been set for me.'

The respondent concluded by appealing for 'COMPASSION FOR VICTIMS' of suicide. He felt that while naturally there was a focus on 'COMPASSION FOR SURVIVORS' and their welfare, not least because of the 'FIERCE COST IN PAIN' they endured, compassion for the victims was also appropriate so as to acknowledge and work to redress the unendurable pain that caused fellow humans to take their own lives.

4.7.6 Respondent 'F' – Identity structure analysis

As for the other five survivor respondents, identity structure analysis facilitated exploration of respondent F's identity as represented by belief and value systems, identifications, processes of change in sense of identity and self-evaluation.

4.7.7 Respondent 'F': Primary analysis

As set out in Table 4.28 below, Respondent F's identity variant for his current selves, *'me as I am at home'* and *'me as I am at work'* were classified as 'indeterminate'. The identity variant for his past self *'me as I was when I left school'* was classified as 'negative'. The identity variants for his past selves *'me as I was before I found out about the suicide'* and *'me as I was after I found out about the suicide'* were classified as 'indeterminate'. The classification 'indeterminate' was regarded as 'well-adjusted'.

This corresponded to moderate identity diffusion combined with moderate self-evaluation. The classification 'negative' was indicative of a vulnerable identity. It corresponded to moderate identity diffusion with low self-evaluation. This respondent's very high self-involvement with *'me as I was after I found out about the suicide'* (PS3 4.30), his very high self-involvement with *'me as I would like to be'* (5.00) and his moderate self-involvement with *'me as I am at home'* (3.33) indicated a higher overall responsiveness in his construal of his past self (PS3) than in his current self (CS1) and evidenced the continuing impact upon his identity of his suicidal loss. The respondent's identity development was adversely affected by his suicidal loss in that, while his ideal self-evaluation was very high (1.00), his self-evaluation after the suicide (PS3 0.63) fell to a lower value in his construal of his current self *'me as I am at home'* (CS1 0.45). This discourse reflected that deep impact:

"I know...there's a set of circumstances...maybe...I'd be...suffering a lot of pain...where's that bottle of aspirin and whiskey...get the will made and do that because the example has already been set for me'

Table 4.28 Respondent F: Self Image

SELF IMAGE

	Ideal Self	Current Self		Past Self	
Ego-Involvement (0.00 to 5.00)	5.00	CS1 CS2	3.33 3.40	PS1 PS2 PS3	2.24 2.76 4.30
Self-Evaluation (-1.00 to +1.00)	1.00	CS1 CS2	0.45 0.49	PS1 PS2 PS3	-0.07 0.37 0.63
Id. Diffusion (weighte) (0.00 to 1.00)		CS1 CS2	0.35 0.35	PS1 PS2 PS3	0.31 0.34 0.36

	Identity Variant
Current Self 1	INDETERMINATE
Current Self 2	INDETERMINATE
Past Self 1	NEGATIVE
Past Self 2	INDETERMINATE
Past Self 3	INDETERMINATE

4.7.8 Respondent F: Impact of suicidal loss in relation to the past self *'me as was before I found out about the suicide'* and the currently situated selves *'me as I am at home'* and *'me as I am at work'*.

This respondent had very high conflicted identifications (see Table 4.29 below) with *'a depressed person'* in his appraisals of his past self *'me as I was after I found out about the suicide'* and of his current self *'me as I am at home'* (PS3 0.51; CS1 0.51). This appeared to be related to the impact of his sister's suicide and the implication that depression may have been a contributory factor, as in the discourse:

"I didn't know that she was being treated for depression that only cropped up – someone told me afterwards. It was her doctor told me. Then I didn't know that – she hadn't told me that at all..."

The respondent also had high conflicted identifications with *'a person who has taken her/his own life'* in his appraisals of his remaining past selves *'me as I was after I left school'* (PS1 0.44) and *'me as I was before I found out about the suicide'* (PS2 0.46) and with his current self *'me as I am at home'* (CS1 0.46). These phenomena were problematic in relation to his own identity both in relation to his conception of himself and what he stood for. The discourse illustrated this:

"...the word 'suicide' is something I try not to use now. I prefer to try and use 'ended their own life' because I think 'suicide' is a very dramatic word...we who are left behind...make it dramatic...because we can't understand it."

The respondent also had quite high conflicted identifications with *'my colleagues in the workplace'* in his appraisals of his past selves (PS1 0.37; PS2 0.38; PS3 0.39) and his current selves (CS1 0.38; CS2 0.39) that were problematic in relation to his identity, as the discourse illustrates:

"...in the situation – the work situation that I'm in, there was enough support around...when you're in the theatre company...you live together...not in the literal sense but it's not like a nine-to-five job where you...go home and be a totally different person that your workmates don't know about.'

Table 4.29 Respondent F: Conflicts in identification

CONFLICTS IN IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
16	A depressed person..	0.51	0.46
19	A person who has ta.	0.43	0.44
10	Mother...	0.38	0.35
17	My colleagues in th.	0.38	0.39
14	The caring professi.	0.37	0.35
6	A person I dislike.)	0.34	0.33
5	A person I admire..)	0.33	0.33
12	My closest friend..)	0.32	0.32
15	My minister of reli.	0.29	0.25
11	Father...	0.12	0.14
13	My partner/spouse...	##	##

CONFLICTS IN IDENTIFICATION WITH OTHERS - Past Self
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
16	A depressed person..	0.44	0.46	0.51
19	A person who has ta.	0.40	0.41	0.42
17	My colleagues in th.	0.37	0.38	0.39
6	A person I dislike.)	0.35	0.34	0.34
5	A person I admire..)	0.31	0.35	0.34
10	Mother...	0.27	0.33	0.40
12	My closest friend..)	0.25	0.30	0.33
14	The caring professi.	0.24	0.33	0.35
15	My minister of reli.	0.21	0.28	0.30
11	Father...	0.16	0.14	0.14
13	My partner/spouse...	##	##	##

4.7.9 Respondent F: Empathetic identifications

Respondent 'F' increasingly empathetically identified with (see Table 4.30 below) *'a person who has taken her/his own life'* and *'the caring professions'* as he appraised himself from *'me as I was before I found out about the suicide'* (PS2 0.64, 0.64) to *'me as I was after I found out about the suicide'* (PS3 0.68, 0.73). This increasing trend continued as he appraised himself in these entities from *'me as I was after I found out about the suicide'* (PS3 0.68, 0.73) to *'me as I am now'* (CS1 0.70, 0.80) indicating identity development throughout the suicidal loss experience, to date, as in the discourse:

"...we've got to remember...that person is an individual and that person has their own rights. And if that person decides to end their own life, it is that person's right to do so."

The respondent decreasingly empathetically identified with a range of entities including *'a person I admire'*, *'my colleagues at working the workplace'*, *'my closest friend'*, *'Mother'* and *'my minister of religion / spiritual adviser'* as he appraised himself from *'me as I was after I found out about the suicide'* (PS3 0.68, 0.59, 0.86, 0.95, 0.68) to *'me as I am now'* (CS1 0.65, 0.55, 0.80, 0.85, 0.65) indicating a tendency to dissociate from these entities as psychological processes of change and development proceeded, as in the discourse:

"I think this is what is so wrong particularly...in Northern Ireland...where...religion ...does genuinely...play more of a part...people still think it is a sin and a crime...that's one of the reasons why I'm here talking to you today..."

Table 4.30 Respondent F: Empathetic identifications

EMPATHETIC IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
10	Mother...	0.85	0.73
12	My closest friend..)	0.80	0.77
14	The caring professi.	0.80	0.73
19	A person who has ta.	0.70	0.73
5	A person I admire..)	0.65	0.64
15	My minister of reli.	0.65	0.50
17	My colleagues in th.	0.55	0.59
16	A depressed person..	0.50	0.41
6	A person I dislike.)	0.45	0.41
11	Father...	0.15	0.23
13	My partner/spouse...	##	##

EMPATHETIC IDENTIFICATION WITH OTHERS - Past Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
19	A person who has ta.	0.62	0.64	0.68
5	A person I admire..)	0.57	0.73	0.68
17	My colleagues in th.	0.52	0.55	0.59
6	A person I dislike.)	0.48	0.45	0.45
12	My closest friend..)	0.48	0.68	0.86
10	Mother...	0.43	0.64	0.95
16	A depressed person..	0.38	0.41	0.50
14	The caring professi.	0.33	0.64	0.73
15	My minister of reli.	0.33	0.59	0.68
11	Father...	0.29	0.23	0.23
13	My partner/spouse...	##	##	##

4.7.10 Respondent F: Contra-identifications

This respondent's high contra-identification with *'a depressed person'* (0.52) indicated a wish to dissociate from this person. He had not known that his late sister was being treated for depression and he was now perhaps more aware of the attributes of the depressed person and the link that is said to exist between depression and suicidal tendencies, as in the discourse:

"...once somebody makes the decision to end their life...they...give the appearance of being...normal...I didn't know she was being treated for depression...she hadn't told me that at all..."

4.7.11 Respondent F: Idealistic identifications

The respondent's very high idealistic identifications with *'a person I admire'* (0.83), *'Mother'* (0.83), *'My closest friend'* (0.83), *'The caring professions'* (0.78), *'My colleagues in the workplace'* (0.74), *A person who has taken her/ his own life'* (0.70), *'My minister of religion / spiritual adviser'* (0.65) and *'a person I dislike'* (0.61) evidenced a number of people whose qualities he aspired to possess in relation to his ideal self *'me as I would like to be'*. They represented positive role models for the respondent as he aspired to possess some of the qualities he attributed to these entities, which appeared to include his late sister, reflecting his consistently high empathetic identifications with *'a person who has taken her / his own life'*. The following discourse illustrated some aspects of these matters:

"...it would never have occurred to me at all...since it has happened I could see myself possibly...I think it's a very brave thing to do for starters...it's something...I could as an outside option take on board where I wouldn't have seven years ago."

4.7.12 Respondent F: Structural pressure on constructs

High structural pressure on the constructs *'thinks that it is morbid to acknowledge human mortality'*/ ***'thinks that it is healthy to acknowledge human mortality'*** (90.08) (where the preferred pole is in bold), ***'is convinced that suicide demands considerable bravery'***/ *'is convinced that suicide is the act of a coward'* (85.69), ***'can often be alone without feeling lonely'*** / *'cannot be alone for long without starting to feel distressed'* (80.16), *'can't be trusted'* / ***'can be trusted'*** (80.33), *'believes that depression and suicide are not linked'* / ***'believes that depression and suicide are closely linked'*** (80.31) and *'withdraws for human contact'* / ***'develops good relationships'*** (76.91) represented this respondent's core evaluative dimensions of identity. In response to the loss of his sister by suicide, he had developed a survival framework comprising realism in relation to human mortality, respect for each individual's choices in life including his own, fortitude in aloneness, trust, compassion for suicide victims and human relationships, as evidenced to an extent in the discourse:

"...you don't expect everybody to live forever...if a person decides to end their life it is that person's right to do so...try and see it from the...other person's point of view...the person who actually ends their life...circumstances maybe if...I knew I'd be...suffering a lot of pain...then...get the will made and do that because the example has already been set for me...woman about forty, two kids, her husband committed suicide...she could only see it from the shit that she perceived into which she had been dumped...she seemed to be totally unable to begin to...feel any compassion for what he had been going through which led him to end his life."

Low construct pressures: ***'puts obligations to family first'*** / *'puts own ambitions and wishes before obligations to family'* (3.85), *'relies mainly on prescribed medicine to relieve pain'* / ***'is interested in complementary and alternative therapies'*** (-8.43) and *'considers that most suicides cannot be prevented'* / ***'considers that most suicides could be prevented'*** (-9.71) represented inconsistently evaluative dimensions of identity, signifying problematic and perhaps unpredictable areas of the respondent's

identity. These constructs related to complications within the respondent's belief and value system in relation to individual choice, family responsibility and the problem of pain, as reflected in the discourse:

"...we shouldn't...be sad for the person who actually did it because for them it was a way out...I was her brother...she was my sister and the least I could do for her having...not been around when I should have been retrospectively...if you keep talking about these things like suicide...and what led up to it...areas which people don't know an awful lot about there's so much still to learn...one has a moral duty to talk about it"

4.7.13 Respondent F: Summary

This respondent's identity variants classified him 'indeterminate' in all but one of his currently situated and past selves. The exception related to the identity variant for the past self *'me as I was when I left school'* which was classified 'negative' and which reflected in his very low evaluation of himself at this time (-0.07). His very high, and high conflicted identifications with *'a depressed person'* and *'a person who has taken her / his own life'*, respectively, and his high contra-identification with *'a depressed person'* pointed towards areas within his belief and value system that remained somewhat problematic. But his idealistic identification inter alia with *'a person who has taken her / his own life'* appeared to point towards compassion for his late sister. His core evaluative dimensions of identity evidenced a flexible survival strategy based upon realism, respect, freedom, trust and compassion for others, especially victims of suicide. His overall identity state when the instrument was completed appeared to lean towards reasonable adjustment, evidencing considerable accommodation to his suicidal loss. Perhaps his identity state, in the context of his suicidal loss, was reflected in this discourse:

"...it is to try to see it from the – other person's point of view from the person who actually ends their life...because we can't touch the thing beforehand, we

then... feel more awful afterwards than we do even if you're watching somebody dying a malingering, painful disease... to see it from the other person's point of view can help or get things into a slightly different perspective."

4.8 Case Study G

4.8.1 Control respondent G – personal information

Control respondent 'G' was a man, aged 29 years, living and working in Belfast. In 1989 a close friend was killed instantly in a road traffic accident in England. Originally from Belfast he had been living and working there. The control respondent had been living and working abroad at the time and learned of the death about a week later. In 1992, the control respondent's grandfather died from cancer. He learned of this death on returning to his home from work at lunchtime on the same day. The control respondent was bereaved by these non-suicidal deaths, the first sudden and accidental, the second natural. The interview and ISA exercise explored the impacts, both short and long term of these events on the control respondent. This was to facilitate, in a general sense, an examination of significant differences between the experiences and consequences for mourners in natural bereavement and those for suicide survivors.

4.8.2 Control respondent G: Transcript analysis

Analysis of transcript 'G' generated 55 issues and emergent themes from which 105 linked concepts were derived. The interview's loose structure employed a framework of five core themes – what happened, health and well being, meaning, aftercare and quality of life.

4.8.3 Control respondent G: Concepts (1)

These linked concepts were listed sequentially at Table 4.31 below. They represented the investigator's subjective attempt to illustrate in summary form some aspects of this participant's reported experiences as a non-suicide mourner: concept referral frequency is stated in parentheses.

Table 4.31 Control respondent G: Concepts (1)

FACTS OF A DEATH, GRIEF REACTION, SHOCK & DENIAL, ACCEPTANCE PROBLEM, ROUGH GRIEF, COPING ABILITY, MATURITY, UNDERSTANDING, REPRESSION, FORGETTING ABOUT IT, UNFINISHED GRIEF (2), MEMORY (2), MEANINGLESSNESS (2), LOSS OF A YOUNG LIFE, REMOTENESS, COMING TO TERMS, FUNERAL RITES (3), FINISHING, NO PAYING RESPECTS, NO FINAL FAREWELL, ACCEPTANCE, DISTANCE, YOUNG HOPES, TEENAGE FRIENDSHIP, SHOCK OF THE LOSS, INNOCENCE, WITHOUT BIAS, TRAGEDY, ABRUPT ENDING, DENIAL, NO JOKE, INVINCIBILITY, FRAGILITY, CLOSE IN AGE, DEATH ALERT, FATAL MESSAGE, REMOTENESS, HENRY'S GRAVE, MEMORIAL, LIFE GOES ON, MEANING, SEARCH, ORDINARY LIFE, LOSS OF LIFE, GRIEF WOUND, NATURAL HEALING, SOME ANGER, REGRET TOO, NO SPIRITUAL BELIEF, MEANING OF LIFE, MEMORY'S ALL, MEN'S GRIEF, FEAR OF DEATH, ATTACHMENT (2), DEGREE OF LOSS, MEN CRYING, EXPRESSION OF EMOTION, NORMAL BEREAVEMENT, TIME TO PREPARE, ANTICIPATION, PAINFUL GRIEF, CARING FOR GRANDA, CONTINUING LOSS, STRONG ATTACHMENT, RECOLLECTION OF LOSS, ANTICIPATION OF LOSS, BAD NEWS GENTLY, NUMBNESS, OPENING TO LOSS, HEALTHY COMMUNAL GRIEF, SYMBOL OF ATTACHMENT, MEMORIES, ATTACHMENT BOND, FINISHING, PATERNITY, CORE OF LIFE, FAMILY COHESION, MUTUAL SUPPORT (2), IMMATURITY, EMOTIONAL ATTACHMENT, NON-JUDGEMENTAL FRIENDSHIP, FOND MEMORIES, SUICIDE TABOO, SUDDEN DEATH TABOO, DEATH CULTURE, BLACK AND MORBID,

CELEBRATION OF LIFE, RELIGION WITHOUT COMPASSION, SELF SUPPORT, SELF-COMPASSION, SPIRITUAL QUADRANT, IMBALANCE, GENETICS, SUICIDE LOSS UNIQUE, SURVIVOR SUPPORT, LIFELONG HEALING, LIFELONG GRIEF, THE OPEN APPROACH. *TOTAL # 105*.

4.8.4 Control respondent G: Concepts (2)

Concepts referred to more than once in the analysis, in descending order, were listed in Table 4.32 below. (Note: Concepts that appeared to be closely related were grouped together in this table.)

Table 4.32 Control respondent G: Concepts (2)

[LOSS OF A YOUNG LIFE, LOSS OF LIFE, DEGREE OF LOSS, CONTINUING LOSS, RECOLLECTION OF LOSS, ANTICIPATION OF LOSS, OPENING TO LOSS] (7), [STRONG ATTACHMENT, SYMBOL OF ATTACHMENT, ATTACHMENT BOND, EMOTIONAL ATTACHMENT] (4), FUNERAL RITES (3), UNFINISHED GRIEF (2), MEMORY (2), MEANINGLESSNESS (2), ATTACHMENT (2), MUTUAL SUPPORT (2), [ACCEPTANCE PROBLEM, ACCEPTANCE] (2), [SHOCK & DENIAL, SHOCK OF THE LOSS] (2), [NO PAYING RESPECTS, NO FINAL FAREWELL] (2), [DISTANCE, REMOTENESS] (2), [MEN'S GRIEF, MEN CRYING] (2). *TOTAL # 34*

4.8.5 Control respondent G: Reported experiences

This control respondent made contact with the investigator eleven years after the sudden, accidental death of a close friend (HJ) and eight years after the natural death of his maternal grandfather. The deceased immigrated to England only a short time before his death. The control respondent learned of his friend's fate in a telephone call to Australia where he was living at the time. He relayed 'THE FACTS OF A

DEATH' and recollected, with hindsight the 'GRIEF REACTION' that was triggered at the time:

"...we're going back ten eleven years...that August that HJ died...I suppose it was difficult...the emotions that were conjured up were...a denial that it had happened."

Only when he received later confirmation did he actually believe that his friend was dead. He found it difficult and experienced an 'ACCEPTANCE PROBLEM'. Far away from home, there was no one with whom he could talk about his feelings of loss, which led to what he recollected as a 'ROUGH GRIEF' experience:

"It was a difficult period...there was no such thing as...any sort of help...it was just a matter of...that's it and you have to live with it...just a matter of forgetting about it...and...getting on with that sense of loss..."

The control respondent contrasted his current 'MATURITY' and 'UNDERSTANDING' with his limited 'COPING ABILITY' in the aftermath of the death that relied upon 'REPRESSION' and 'FORGETTING ABOUT IT'. Thus he seemed to have employed 'REPRESSION' as a psychological defence and even now he acknowledged a remnant of 'UNFINISHED GRIEF' in his 'MEMORY' of HJ and the apparent 'MEANINGLESSNESS' of his fate:

"...on a regular basis I would visit his graveside...and look and wonder why...such a loss of a young life...It's hard...still is hard to explain."

Geography and 'REMOTENESS' made 'COMING TO TERMS' difficult. He was unable to attend the 'FUNERAL RITES' and so there was 'NO PAYING RESPECTS' nor any 'FINAL FAREWELL'. Only when he received letters from home from mutual friends who had attended HJ's funeral did he arrive at full 'ACCEPTANCE':

"It was only then that it hit me that you know he was gone."

The details of HJ's death were that he was knocked down crossing the road one morning in August eleven years ago en route to his work in England. The apparent

'MEANINGLESSNESS' of his premature death dashed his close friend's 'YOUNG HOPES'. He had gone to England to better himself:

"He'd left here because of a sense of hopelessness... he'd gained employment... waiting on his lift to go to work one morning... he crossed the road to go to the shop to get himself - he was 'a tin of Coke and a Mars bar' man... got hit by a juggernaut... he died instantly..."

The strength of the control respondent's 'ATTACHMENT' to his friend appeared to dictate the 'DEGREE OF LOSS' and the consequent level of grief. Apparently they were close as non-fraternal peers, having shared several years of their pre-teen and teenage years in shared activities. The 'SHOCK OF THE LOSS' was all the more intense not least because of the perceived 'INVINCIBILITY' of youth:

"... we were very good friends... we done all the sort of teenage things that teenagers do together... the culture at the time was maybe different... experiment with drink... went to dances... shared a laugh... fifteen sixteen seventeen years of age your whole life in front of you... you don't perceive things like this to happen..."

The impact of HJ's loss caused the control respondent occasionally to reflect upon the circumstance that robbed HJ of his life and his future and to ruminate about what 'MEANING', if any, could be attached to what had happened. He contrasted the creative developments in his own life over the years since the sad fact of the 'ABRUPT ENDING' of his friend's life:

"... I would go up regularly and stand at his grave... as I have been doing since I returned from Australia... I remember standing at his grave and saying 'You're dead a year... you're dead two years...' and then he's dead three years... it's coming up now... it's eleven years... and I also have my own life in mind... how my whole life has changed and progressed since his loss... got myself educated... family, wife, children and all the time HJ wasn't able to do that... I often wonder why, why you know and try to make sense of it all..."

The control respondent acknowledged too the loss of an 'ORDINARY LIFE' of a young man who was also a football supporter, who enjoyed craic, fun and banter. He believed that the 'NATURAL HEALING' of a 'GRIEF WOUND' took place over time:

"...just talking about it...that's...part and parcel of the...natural grieving process...they say time's a great healer...I remember I couldn't at one stage...relate to him...like we used to...all of a sudden you seem to be able to just come to terms with it..."

But he had also experienced feelings of 'SOME ANGER' and 'REGRET TOO' in reaching some accommodation and resolution of his loss:

"...I would actually curse...and...look at him...his grave...his headstone and say 'How did you not see that coming...did you not look up and down **'s sake what happened to you?' you know that sort of thing..."**

The control respondent epitomised the non-believer's approach to death reflecting that he had 'NO SPIRITUAL BELIEF' in relation to what had become of HJ. All that was left of HJ was his memory of him. When HJ died, the control respondent was eighteen years old and he recalled that the cultural norms of the time precluded the overt expression of 'MEN'S GRIEF' related to serious loss:

"...the culture and society...I grew up in...you didn't express your emotions...everything was male orientated...ach sure he's dead...so what we're all going that way...you didn't sit and have a good cry..."

Such macho realism may have been expressed to disguise a 'FEAR OF DEATH'. When his maternal grandfather died three years later his emotional response was more open. He related this inter alia to the degree of affinity he had with the deceased. A different 'DEGREE OF LOSS' existed between the albeit sudden death of a close friend and the natural death of a beloved grandfather. His death from cancer was a 'NORMAL BEREAVEMENT' that allowed for 'ANTICIPATION OF LOSS'. The control respondent was not allowed actively to care for his grandfather as his death approached. The absence of such 'CARING FOR GRANDA' made added to his deep 'PAINFUL GRIEF' and to a sense of 'CONTINUING LOSS' eight years on. The control respondent described his 'STRONG ATTACHMENT' to his grandfather. Following the sudden death of his grandmother when he was about thirteen, he used to visit his grandfather often:

"I used to go up on a Saturday morning... he'd have got the pan on... and stuck the fry on... wrote out a few wee bets on his docket... I'd have gone down to the bookie's for him... had a yarn about football... sat and watched TV... when he went... it was a great loss. Still is."

His memory of that time was of 'ANTICIPATION OF LOSS' related to the nature of his grandfather's serious illness and this sense of loss enveloped his recollection of that time. He described how he learned that his granda had died when his future mother-in-law told him the 'BAD NEWS GENTLY'. A delayed reaction created an initial defensive 'NUMBNESS' that over the period of the next few hours gave way as realisation dawned of the actuality of death. This 'OPENING TO LOSS' developed as he visited his grandfather's house and mingled with other family mourners including his cousins, other grandchildren:

"I remember... looking at him... first thing that came to my mind was 'I'll never eat another fry in this house... I've had my last fry from you..."

This 'SYMBOL OF ATTACHMENT' was no more. That shared activity that was a tangible 'ATTACHMENT BOND' between the grandfather and his grandson would never be enjoyed again. Although he was one of fifty grandchildren – his grandfather had had twelve children – his Saturday routine was known to all of the family. For the control respondent the 'FINISHING' of this activity represented all that he would miss now that his granda was no more:

"... he always gave me a pound for my pay... his whole joke... when he was talking about me... to... aunts and uncles... he used to say he comes here every Saturday... not only does he get a pound but he gets a fry you know... for me that symbolised the love that he had for me and the love that I had for him... looking back it was a friendship as well... it was a friend that you lost... a big loss attached to it."

The influence of 'PATERNITY' in his life motivated the control respondent to reflect now upon his relationship with his father and his hope that his own children would have as sound a relationship with their grandfather as he had with his. The need to maintain 'FAMILY COHESION' caused his aunts and uncles to transform their use

of their father's house as a meeting place into a new routine where they visited each other's houses with the idea of keeping his memory alive by keeping close to each other in 'MUTUAL SUPPORT'. He acknowledged that the loss of his grandfather's spouse coincided with the development of his 'EMOTIONAL ATTACHMENT' to his granda, a person who accepted him and did not judge him. Her loss did not impact upon him to any great extent and he had not fully acknowledged the painful impact on his granda of the sudden loss of his life- partner:

"I was thirteen when it happened... I was a lot younger... she was always my granny... she gave you fish and chips on Friday... I didn't really appreciate the whole death thing at that time... it was hard for him... because... he was actually with her... whenever she took a massive heart attack... she died that night and he was there... I've never really confronted that as a feeling how it was for him you know."

The control respondent's view was that there is a big taboo about death in this culture. He felt too that a sudden death taboo existed that was as pervasive and deleterious in its way as the 'SUICIDE TABOO'. He felt that our whole 'DEATH CULTURE' was less than healthy, with an ambience that was 'BLACK AND MORBID'. He felt that we had much to learn from other cultures that allowed for a 'CELEBRATION OF LIFE' on the occasion of a death:

"... some societies view death as a... passing over... it's a ritual... you actually celebrate death in parts of Greece... it puts a meaning on death... it can also help you confront it."

For himself he did not find comfort, as many of his relatives did, in a close knit family. He paid more attention to the physical, emotional and intellectual than he did to the 'SPIRITUAL QUADRANT'. He resented the fact that death rituals here were dominated by religion, often a 'RELIGION WITHOUT COMPASSION', from which it would be difficult to break away:

"... my source of comfort was from within from myself... my approach... would be to disregard anything religious..."

He felt that 'MEMORY' was all that remained after our demise and that 'GENETICS' explained any other aspects of similarity or identification that we might associate with our antecedents. All that was left for him of his two loved ones and his close friend was limited to that ability that he had to reflect upon what he remembered about them:

"The only thing that's alive for me is my granda's memory and HJ's memory and my grandmother's memory..."

The control respondent knew that this study was concerned with postvention strategies for suicide survivors. He acknowledged the uniqueness of the suicidal loss ('SUICIDE LOSS UNIQUE'), the apparent need for 'SURVIVOR SUPPORT', the potential 'LIFELONG GRIEF' of the survivor that implied the need for 'LIFELONG HEALING':

"...suicide is...the number one taboo...survivors of suicide to be able to confront their feelings...to be given their place...a loss by suicide could be compared with a sudden loss...but more questions...concerned with a suicide...the main one is 'Why?'...why did it happen?...why did I not do something earlier?...could I have done more?...sort of things...associated...with a...suicide...which are unique to a suicide alone...by leaving those questions unanswered...by not confronting them...is more harmful...is doing more harm...those thoughts...are always going to be there...they're always going to come out at some stage'.

4.8.6 Control respondent 'G' – Identity structure analysis

For each of the two control respondents, 'G' and 'H', identity structure analysis facilitated exploration of their identity as represented by belief and value systems, identifications, processes of change of identity and self-evaluation.

4.8.7 Control respondent 'G': Primary analyis

The approximate chronological order of 'past self' entities for this control respondent was assumed to be as follows: PS2 *'me as I was before I found out about death'* viz. before the age of thirteen years; PS3 *'me as I was after I found out about death'* viz. between the ages of thirteen and eighteen years and PS1 *'me as I was when I left school'* viz. at age eighteen years.

As set out in Table 4.33 below, control respondent G's identity variant for his current selves *'me as I am at home'* and *'me as I am at work'* were classified as 'defensive high self regard'. The identity variants for his past selves *'me as I was when I left school'* and *'me as I was before I found out about death'* were classified as 'defensive negative'. The identity variant for the past self *'me as I was after I found out about death'* was classified as 'defensive'. All of these identity variants were designated vulnerable identities of various kinds. The control respondent's very low self-evaluation (PS1 –0.05) at the time he left school perhaps reflected the proximity of HJ's death to that life event. But his identity development was regarded as progressive in view of his high ideal self-evaluation (1.00), his increasingly positive self-evaluation overall from past to present (PS2 0.17; PS3 0.65; PS1 –0.05; CS1 0.84; CS2 0.92), his high ego-involvement with his ideal self (5.00) and his increasing ego-involvement across all entities (PS2 2.10; PS3 3.04; PS1 3.26; CS1 3.99; CS2 4.71).

The following discourse reflected this development in relation to his accommodation to his experience of the death phenomenon:

"I would be... fortunate enough to be able to look at death and to analyse it... because reading anthropology at Queen's... I... remember a module devoted to death and... I've got that knowledge... I... look at our... culture and... our own perceptions of death through the culture of... far-off exotic ones... it puts a meaning on death and... can... help you confront it."

Table 4.33 Control respondent G: Self image

SELF IMAGE					
	Ideal Self	Current Self		Past Self	
Ego-Involvement (0.00 to 5.00)	5.00	CS1 CS2	4.71 3.99	PS1 PS2 PS3	3.26 2.10 3.04
Self-Evaluation (-1.00 to +1.00)	1.00	CS1 CS2	0.92 0.84	PS1 PS2 PS3	-0.05 0.17 0.65
Id. Diffusion (weighte) (0.00 to 1.00)		CS1 CS2	0.15 0.16	PS1 PS2 PS3	0.22 0.23 0.16

	Identity Variant
Current Self 1	DEFENSIVE HIGH SELF-REGARD
Current Self 2	DEFENSIVE HIGH SELF-REGARD
Past Self 1	DEFENSIVE NEGATIVE
Past Self 2	DEFENSIVE NEGATIVE
Past Self 3	DEFENSIVE

4.8.8 Control respondent G: Impact of death in relation to the past self *'me as I was before I found out about death'* and the currently situated selves *'me as I am at home'* and *'me as I am at work'*.

This control respondent had a very highly conflicted identification (see Table 4.34 below) with *' depressed person'* in his appraisal of his past self *'me as I was before I found out about death'* (PS2 0.52) and a high conflicted identification with a *'a depressed person'* in his appraisal of his past selves *'me as I was after I found out about death'* (PS3 0.49), *'me as I was when I left school'* (PS1 0.45) and in his appraisal of his currently situated selves *'me as I am at home'* (CS1 0.45) and *'me as I am at work'* (CS2 0.48). This appeared to relate to his critical view of Northern Ireland's cultural approach to death:

"...it's definitely not healthy our whole perception of death, you know... where everything's black and morbid and it's tearful..."

The control respondent also had high conflicted identifications with *'my colleagues at work'* (PS2 0.43; PS3 0.41; PS1 0.42; CS1 0.40; CS2 0.41) and *'my closest friend'* (PS2 0.41; PS3 0.38; PS1 0.39; CS1 0.39; CS2 0.41) as he appraised himself across all past selves and current selves. These phenomena were problematic in terms of his own identity both in relation to his conception of himself and in relation to his beliefs and values. The discourse about his deceased friend, HJ, reflected this:

"...I would go up regularly and stand at his grave...it's coming up now eleven years...my whole life has changed and progressed since his loss...I often...try to make sense of it all...there's times you try to be too philosophical...I still try to relate to him...without trying to be too philosophical and deep as to why...and how it all happened."

Table 4.34 Control respondent G: Conflicts in identification

CONFLICTS IN IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
11	A depressed person..	0.45	0.48
14	My colleagues in th.	0.40	0.41
8	My closest friend...	0.39	0.41
10	Father...	0.34	0.35
7	A person I dislike.)	0.30	0.31
15	The caring professi.	0.26	0.25
6	A person I admire..)	0.00	0.00
9	Mother...	0.00	0.00
12	My partner/spouse...	0.00	0.00
19	A person who died s)	0.00	0.00
16	My minister of reli.	##	##

CONFLICTS IN IDENTIFICATION WITH OTHERS - Past Self
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
11	A depressed person..	0.45	0.52	0.49
14	My colleagues in th.	0.42	0.43	0.41
8	My closest friend...	0.39	0.41	0.38
10	Father...	0.33	0.34	0.33
7	A person I dislike.)	0.27	0.32	0.32
15	The caring professi.	0.26	0.25	0.24
6	A person I admire..)	0.00	0.00	0.00
9	Mother...	0.00	0.00	0.00
12	My partner/spouse...	0.00	0.00	0.00
19	A person who died s)	0.00	0.00	0.00
16	My minister of reli.	##	##	##

4.8.9 Control respondent G: Empathetic identifications

Control respondent 'G' increasingly empathetically identified (see Table 4.35 below) with *'my partner / spouse', 'a person I admire', 'Mother'* and *'a person who died suddenly'* as he appraised himself from *'me as I was after I left school'* (PS1 0.56, 0.50, 0.56, 0.50) to *'me as I am at home'* (CS1 0.95, 0.85, 0.85, 0.75). These phenomena evidenced identity development throughout his latter two bereavement loss experiences - his close friend and his grandfather – to date, as in the discourse:

"...since the death of HJ I lost my grandfather...that...changed my perception of how I should grieve...when you lose your grandfather...it would be similar to losing your own father...I remember showing a lot of emotion at that time...I didn't care if I cried...it progressed...my own development...a different outlook in life...everything now wasn't the way it was when you were eighteen."

Table 4.35 Control respondent G: Empathetic identifications

EMPATHETIC IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
12	My partner/spouse...	0.95	1.00
6	A person I admire..)	0.85	0.84
9	Mother...	0.85	0.89
8	My closest friend...	0.75	0.84
10	Father...	0.75	0.84
19	A person who died s)	0.75	0.74
14	My colleagues in th.	0.65	0.68
7	A person I dislike.)	0.60	0.63
11	A depressed person..	0.50	0.58
15	The caring professi.	0.45	0.42
16	My minister of reli.	##	##

EMPATHETIC IDENTIFICATION WITH OTHERS - Past Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
8	My closest friend...	0.78	0.83	0.72
10	Father...	0.72	0.75	0.72
14	My colleagues in th.	0.72	0.75	0.67
9	Mother...	0.56	0.58	0.83
12	My partner/spouse...	0.56	0.67	0.94
6	A person I admire..)	0.50	0.67	0.83
7	A person I dislike.)	0.50	0.67	0.67
11	A depressed person..	0.50	0.67	0.61
19	A person who died s)	0.50	0.58	0.67
15	The caring professi.	0.44	0.42	0.39
16	My minister of reli.	##	##	##

4.8.10 Control respondent G: Contra-identifications

This control respondent's moderately high contra-identification with *'a depressed person'* (0.40) indicated a wish to dissociate from this person. He had developed a positive attitude even to the experience of witnessing the death of a loved one from cancer. His dissociation from the qualities he attributed to *' a depressed person'* were perhaps reflected in the following discourse:

"...to...witness a loved one...dying through cancer...it's a terrible experience but in an ironic way...it prepares a family...they prepare themselves for the...death...all the time...they're trying to care for their...loved one...they're also preparing for the finale."

4.8.11 Control respondent G: Idealistic identifications

The control respondent's very high idealistic identifications with *'my partner / spouse'* (1.00), *'mother'* (0.90), *'a person I admire'* (0.85), *'my closest friend'* (0.80), *'father'* (0.80), *' a person who died suddenly'* (0.75) and *' my colleagues in the workplace'* (0.70) evidenced a number of people whose qualities he aspired to possess in relation to his ideal self *'me as I would like to be'*. They represented positive role models for the control respondent, including his deceased close friend, and reflected his consistently high empathetic identifications with him and with several of these entities. This discourse illustrated some of these phenomena:

"...my whole life has changed and progressed since his loss...I've...got a family, wife, children...HJ wasn't able to do that...struck down in the prime of his life...I often wonder why..."

4.8.12 Control respondent G: Structural pressures on constructs

High structural pressures on the constructs *'withdraws from human contact'* / ***'develops good relationships'*** (89.08) (where the preferred pole is in bold), *'I loathe'* / ***'I have warm feelings towards'*** (83.50), ***'is optimistic about the future'*** / *'is*

pessimistic about the future' (82.88), ***'continues to develop own personal values and beliefs'*** / *'sticks rigidly to values and beliefs of parents/guardians'* (78.19), *'does not value human beings very highly'* / ***'believes in the irreplaceable value of each human being'*** (74.99) and ***'can be trusted'*** / *'can't be trusted'* (74.88) represented this control respondent's evaluative dimensions of identity. They referenced values and beliefs that were considered to be central to his identity – he used these to judge the merits of self and others. All of these constructs were positive and developmental and without references to any negative aspect of life. It appeared that the psychological consequences of his bereavement loss experiences did not seriously diminish his sense of identity, as evidenced in the discourse:

"I have a very good relationship with my own father... I... look... at... my own children... and hope that some day they're able to have... as sound a relationship with their granda as what I did with mine."

Low structural pressure on: *'believes corporal punishment does no harm to children'* / ***'believes corporal punishment is a form of child abuse'*** (17.85) represented an inconsistently evaluative dimension of identity signifying a problematic and perhaps unpredictable area of the control respondent's identity. It related to complications within the control respondent's belief and value system in relation to caring for and protecting children, as reflected, obliquely in the discourse:

"... the culture and society I grew up in... you didn't express your emotions... everything was male orientated..."

4.8.13 Control respondent G: Summary

This control respondent's identity variants classified him in each of his past and currently situated selves as belonging to vulnerable identity states of various kinds. But a person's identity variant can be expected to vary over time as her/his biography unfolds. The identity variant for his currently situated self *'me as I am at home'* was

'defensive high self-regard' reflecting a high self-evaluation (0.92) correlated to a low identity diffusion (0.15). This pointed to a failure to acknowledge the usual degrees of conflicted identification that are inevitable in the normal commerce of life. His high conflicted identifications with *'a depressed person'* as he appraised himself from childhood to his present maturity, reflected his high contra-identification (0.40) with that entity. His positive outlook was evidenced in the beliefs and values revealed in through high structural pressures on constructs related to relationship, warm feelings, optimism, personal development, a high value on human life and trust. His high idealistic identifications, especially with his *'partner / spouse'* (1.00), pointed towards a healthy commitment to life and living in a positive family relationship. His overall identity state reflected moderate vulnerabilities, related perhaps to differences between his personal beliefs and values and those that predominate within the society and culture in which he lives and works, as in the discourse:

"I also have my own life in mind you know of how my whole life has changed and progressed since his loss... I've got myself educated and got a family, wife, children... I do tend to look at our own culture and our own perceptions of death through the culture of... far off exotic ones... it puts a meaning on death... and can also help you confront it... I wouldn't say it's healthy no it's definitely not healthy our whole perception of death..."

4.9 Case Study H

4.9.1 Control respondent H – personal information

Control respondent 'H' was a man aged 43 years, living in Co Antrim and employed in Belfast. In 1974 his grandfather collapsed in the street and died and his father died in hospital of heart disease in 1994 following a short illness. In 1997 his mother died after a long illness during which he was the principal carer. The control respondent

was present at or shortly after each death and he was bereaved by each of these non-suicidal deaths of his loved ones. His grandfather's death although sudden and unexpected, was natural while his parents' deaths were both natural and anticipated. The interview and ISA exercise explored the impacts, both short and longer term of these events on the control respondent. This was to facilitate, in a general sense, an examination of significant differences between the experiences and consequences for mourners in natural bereavement and those for suicide survivors.

4.9.2 Control respondent H: Transcript analysis

Analysis of transcript 'H' generated 55 issues and emergent themes from which 131 linked concepts were derived. The interview's loose structure employed a framework of five core themes – what happened, health and well being, meaning, aftercare and quality of life.

4.9.3 Control respondent H: Concepts (1)

These linked concepts were listed sequentially at Table 4.36 below. They represented the investigator's subjective attempt or illustrate in summary form some aspects of this participant's reported experiences as a non-suicide mourner: concept referral frequency is stated in parentheses.

Table 4.36 Control respondent H: Concepts (1)

SUDDEN LOSS, FIRST PAIN, ATTACHMENT, SIGNIFICANCE, FATHERHOOD, SHARED ACTIVITY, EARLY ATTACHMENT, BONDING, SECURITY, SAFETY, CONTENTMENT, MUTUAL ATTACHMENT, EXCLUSIVE ACCESS, BELOVED ONE, DEPTH OF ATTACHMENT, TIME AND MATURITY, COLLEAGUES, FAMILY MEMBERS (2), BALANCING, VALUES AND BELIEFS, LEGACY, EXEMPLAR, MODEL, SERIOUS LOSS,

MEMORY (2), DEATH SCENE, MOTHER, REPRESSION (3), COMMUNITY, SUPPORT, RESPECT, HONESTY, MUTUAL SUPPORT, MOTHER AND SON, FUNERAL RITES (4), VALUE SYSTEMS, CARING FOR MOTHER, EMULATING GRANDA, GRIEF REACTION, RELEASE OF TEARS, ACCEPTANCE, AVOIDED GRIEF, DAUGHTER'S GRIEF, FOCUS UPON LIFE (2), GRIEF FEELINGS, COPING STRATEGY, HEAVY DRINKING, RELIGIOUS VALUES, HUMAN COMPLEXITY, CHARACTER, INHERITED TRAITS, FEARLESSNESS, UNRESOLVED LOSS, UNCONDITIONAL LOVE (2), LIFE'S MYSTERY, DEATH'S MYSTERY, NATURAL DEATH, QUESTIONS, REGRET (2), LIFE PHILOSOPHY, SEXUAL ABUSE, ALCOHOL ABUSE (2), IDENTITY AMBIGUITY, LOSS OF POTENTIAL (2), SECRET SHAME, GUILT, FORGIVENESS, SWAMPED FEELINGS, UNREALISTIC GUILT, SEXUAL VIOLATIONS, TOXIC SHAME, MAJOR LOSS, PAINFUL MEMORY, FATHER'S DEATH, SELF-NEGLECT, ABUSE OF ALCOHOL, COUNSELLING (2), EMOTIONS TRIGGER, SEPARATION, DETACHMENT, PATERNAL ORIGINS, CHANGE SIGNAL, DISPLACEMENT OF FEELINGS, IDENTITY CHANGE, FATHER ANCHOR, MANHOOD, CONSEQUENCES OF LOSS, CARING FOR OTHERS, SUBMERGED GRIEF, RATIONALITY, EMBARRASSMENT, FEELINGS, FAMILY SUPPORT (2), HEALTH RISKS, FEAR OF DEATH, MORTALITY, COMMUNITY SUPPORT, ABSENCE OF SUPPORT, FAMILY DISRUPTION, DEATH CONSEQUENCES, CLERICAL DISRESPECT, RITUAL, LACK OF RESPECT, SURVIVORS OF SUICIDE, COMPLEX GRIEF PROCESS, JOY, SADNESS, RELATIONSHIP CHANGE, LOSS, QUALITY OF LIFE, PERSPECTIVE, WORK, PAIN, CARE, LOVE, EMPATHY, OPTIMISM. *TOTAL # 131*

4.9.4 Control respondent H: Concepts (2)

Concepts referred to more than once in the analysis, in descending order, were listed in Table 4.37 below. (Note: Concepts that appeared to be closely related were grouped together in this table.)

Table 4.37 Control respondent H: Concepts (2)

[SUDDEN LOSS, SERIOUS LOSS, UNRESOLVED LOSS, MAJOR LOSS, CONSEQUENCES OF LOSS, LOSS] (6), [FATHERHOOD, EMULATING GRANDA, FATHER'S DEATH, PATERNAL ORIGINS, FATHER ANCHOR, MANHOOD] (6), [GRIEF REACTION, AVOIDED GRIEF, DAUGHTER'S GRIEF, GRIEF FEELINGS, SUBMERGED GRIEF, COMPLEX GRIEF PROCESS] (6), [DEATH SCENE, DEATH'S MYSTERY, NATURAL DEATH, DEATH CONSEQUENCES, FEAR OF DEATH] (5), [ATTACHMENT, EARLY ATTACHMENT, MUTUAL ATTACHMENT, DEPTH OF ATTACHMENT] (4), FUNERAL RITES (4), [MOTHER, MOTHER AND SON, CARING FOR MOTHER] (3), REPRESSION (3), FAMILY MEMBERS (2), MEMORY (2), FOCUS UPON LIFE (2), UNCONDITIONAL LOVE (2), REGRET (2), ALCOHOL ABUSE (2), LOSS OF POTENTIAL (2), COUNSELLING (2), FAMILY SUPPORT (2), [SEXUAL ABUSE, SEXUAL VIOLATIONS] (2), [HEAVY DRINKING, ABUSE OF ALCOHOL] (2), [IDENTITY AMBIGUITY, IDENTITY CHANGE] (2), [COMMUNITY, COMMUNITY SUPPORT] (2), [SECRET SHAME, TOXIC SHAME] (2), [GUILT, UNREALISTIC GUILT] (2), [FIRST PAIN, PAIN] (2), [LEGACY, INHERITED TRAITS] (2). *TOTAL # 71*

4.9.5 Control respondent H: Reported experiences

This control respondent made contact with the investigator 26 years, six years and three years, respectively, after the deaths of his grandfather, father and mother. The first significant bereavement in the control respondent's life occurred at the age of 18 years when he experienced this 'SUDDEN LOSS' of:

"one of the most important people in my life...at the time the most important man in my life..."

He recalled his 'EARLY ATTACHMENT' to his grandfather that was strengthened by 'SHARED ACTIVITY' facilitated by his retirement from work when his grandson

was only 18 months old. They spent time with each other every day, talking and walking, enjoying each other's company exploring the neighbourhood together:

"...early consciousness of being with 'pap'...walking the country roads...he seemed to have this great gift of making every day an adventure...it was all about nature and fun and...imagination...my father was always working so I didn't see him that much...my grandfather was the...main man in my life. He was the man."

So he experienced 'SECURITY', 'SAFETY' and 'CONTENTMENT' in this 'MUTUAL ATTACHMENT' of older man and young child. He wanted 'EXCLUSIVE ACCESS' to this 'BELOVED ONE' and felt annoyed when on occasion other youngsters joined their cross-town trips and were all treated the same as he was by his grandfather:

"...I wanted to be special to him...I was special to him. But everybody got a three penny bit...He was a great...bloke to be with...as I got older I started to appreciate him more, his life, his political activities...I'd great admiration for him."

He reflected that his grandfather came from a family of ten children of whom only three survived, the remainder dying in infancy and on wartime service. His first wife - the control respondent's maternal grandmother - died tragically when her daughter, the control respondent's MOTHER', was three months old. He married again when she was thirteen years old but lost his second wife following an accidental house fire. She died after surviving for ten days in hospital. He also admired his grandfather for his political activity: he had established and organised a trade union for members of his own trade:

"So he was an interesting man. And he was a man with a great sense of loss himself...a man who had a great sense of tragedy with regard to loss, a great sense of achievement with regard to his working class origins and what he tried to do..."

So he acknowledged the 'LEGACY' of 'VALUES AND BELIEFS' passed on to him by this pragmatic 'EXEMPLAR'. He felt that he could always tell his grandfather

about anything that was troubling him. He could always be himself with this man and did not have to justify himself:

"...he was the only person in my...living existence who didn't judge me...being me was totally enough, more than enough...I didn't have to explain myself...he was the man I wanted to be like...he was the man I could go to with my problems...he never questioned...he was just: 'You're upset. Something's wrong. Let's sort this out.'

The control respondent retained a vivid 'MEMORY' of the death of this 82-year-old man when he collapsed in the street. His mother was notified and left him in the house as she left to see what was wrong. But his could not stay away from his 'BELOVED ONE' and he raced down to road, overtaking his mother and arriving just after his grandfather passed away:

"...I could see him in the distance...lying there with some people round him...his face was turned towards me...and I said 'I'm coming Pap' and 'I'm here'...just as I got there his hand just dropped and he was away...I remember for a split second...'No this can't be'..."

But he remembered an element of displacement when his self-concern was submerged in his anxiety for his mother as she arrived at the 'DEATH SCENE'. The control respondent recalled the events leading up to the 'FUNERAL RITES'. He escorted the remains to the morgue with the 'SUPPORT' of one of his mother's neighbours. He insisted upon 'RESPECT' for his grandfather in retrieving his wallet when initially this was not returned with his belongings. 'MOTHER AND SON' offered 'MUTUAL SUPPORT' to each other while the control respondent recalled making all the funeral arrangements. He remembered the period between the death on a Thursday until the funeral on a Monday that the house was full of people paying their respects to the family:

"So the house was bunged all the time...all these old men calling...al old union men, characters...telling stories...about...the conference in Blackpool...and I knew he'd been a bit of an 'oul carry on'...big with the drink...I had a sense of feeling like – everybody said I take my stature from him...I had a great sense of being like him..."

He remembered that only when he was in the hearse returning from the funeral that he experienced a 'GRIEF REACTION'. He resisted any 'RELEASE OF TEARS' until he got back home:

"...I got into the hearse to come home...I started to feel overwhelmingly hurt that Pap was away...I remember holding in the tears...got into the house...went to my bed and I closed the door...and I was lying there and crying I was that sore until I could cry no more...after that I started to feel a bit better that I'd shifted that emotion..."

'ACCEPTANCE' of his grandfather's death allowed some tears of grief to be released. But he felt that there was some 'AVOIDED GRIEF' since the focus of attention was upon the 'DAUGHTER'S GRIEF' that his mother was expressing. He did not recollect any advice from his grandfather about death and how to cope with it. His grandfather's 'FOCUS UPON LIFE' might have grown out of his major loss experiences meant such that he did not express any deep feelings about his own mortality. It appeared that he may have used 'HEAVY DRINKING' as a 'COPING STRATEGY. But, although he was a socialist, he was tolerant about some 'RELIGIOUS VALUES'. He wanted his daughter to be reared with Christian values and he wanted the same upbringing for his grandson. The impact of this loss upon the control respondent was largely psychological but with elements of spirituality. He no longer experienced his grandfather's 'UNCONDITIONAL LOVE' and he had lost a great support in his life. This first experience of intimate death made him aware for the first time of his own mortality:

"...unconditionally he accepted me...I lost that...that was a great anchor...it brought my own mortality into question...at 18 you think you're invincible...it brought the whole thing of questioning life and death..."

Unanswered questions arose in relation, for example, to his grandfather's 'LIFE PHILOSOPHY' because 'NATURAL DEATH' also led to 'REGRET' about all that might have been explored but which was not. The control respondent had experienced

'SEXUAL VIOLATIONS' in childhood. This led to some 'ALCOHOL ABUSE'. He was not equipped by his father or by his grandfather to cope with 'SEXUAL ABUSE' and he used heavy drinking to escape from the pain of that loss of himself:

"I just remember being very... off the rails at that period before he died until I was about 22... not knowing where I was really... he... accentuated that... he deepened that feeling of identity, of who I was, who I was going to be, without him there, yeah... a milestone on my life, the loss of him"

So he was aware of some 'IDENTITY AMBIGUITY' related to dysfunctional aspects including lack of boundaries and lack of knowledge in his family of origin. He felt 'REGRET' that he was unable to share with his parents, information about what had happened to him in childhood. He felt that his grandfather would not have been able to bear to hear about it but he acknowledged that this demonstrated a combination of 'UNREALISTIC GUILT' and 'TOXIC SHAME'. Hence his 'SWAMPED FEELINGS' in relation to that deep personal loss that was not addressed until some time later in therapy. The loss of his father in 1994 reawakened the control respondent's feelings of grief twenty years after he lost his grandfather. Following a heart attack, his father was listed for a heart bypass operation but died at the age of 73 before he could benefit from that life-extending treatment. The control respondent felt that there might have been medical incompetence, or at least culpable lack of care, which resulted in his father's early death. Once again the control respondent was tasked with organising the funeral and postponed the expression his emotional feelings. Caring for other family members during this period implied an element of 'SELF-NEGLECT' including further 'ABUSE OF ALCOHOL'. But one outcome of this testing period was that the control respondent entered therapy in order to address issues surrounding his relationship with his father:

"It was interesting... that I had my grandfather for the first eighteen years of my life... I was then on my own for a couple of years in the doldrums and then I had

my dad – he and I got to know each other – for the last eighteen years in (his) life.

Thus final 'SEPARATION' and 'DETACHMENT' from the two men who acted in turn as 'FATHER ANCHOR' for the control respondent enabled him to acknowledge his 'PATERNAL ORIGINS'. In a way this acted as 'CHANGE SIGNAL' for him to re-examine his lifestyle and behaviour:

"...it was the signal to do something...through which I was learning a lot of things about myself and...to get the courage to actually face a lot of bad feelings that I had been drinking down since I was a kid."

He reflected that the death of his father was necessary before he could begin to discover himself. He felt that up to then he was not living a full life. There was in this a 'LOSS OF POTENTIAL' together with a sense that he was at risk of losing himself. So he was prepared to do the work that would now be implicit in the 'IDENTITY CHANGE' that he sought. He now had the opportunity to discover his own 'MANHOOD' following the deaths of those 'anchors'. Just after he had commenced that journey of discovery, his mother became seriously ill. He found that he became to an extent a 'surrogate husband' to his mother:

"I became the principal carer...my life went on hold...continued...to see a therapist...containment...processing...further loss of myself...what was coming up was about the loss of myself...as a twelve-year-old...pain that had caused me hurt throughout my life...abusing myself...abusing my own life...and being a principal carer."

This control respondent felt that 'RATIONALITY' had begun to dominate our culture in our emphasis upon internment within a few days of a death, which implied disposal of that which no longer had any value. Emotional needs of mourners were often not properly addressed. 'EMBARRASSMENT' was often present which acted as a block to the expression of natural feelings of empathetic compassion. The control respondent thought that often the family needed to be supported at this time and only the 'COMMUNITY' could provide this:

"...it's not just about the husband and the wife who are left it's the kids or the extended family that are there. It's a family thing...and everybody's affected by it and everybody needs a ear and a shoulder...and the family needs helped out...those in the family who aren't very good at conversing about things emotionally anyhow of an emotional nature. So in an ideal sense...the family need to be able to...need to be helped to talk about it amongst themselves and to talk about it individually if they need to...about their feelings. It doesn't work with bottling it up...cutting off feelings...the cancer, the ulcer or whatever...is going to get you down the line..."

He felt that mortality frightened us into activity to distract it away where the healthy approach was the reverse of this. In his grandfather's time the community, including the churches, played a more significant role in family support at times of crisis and difficulty such as bereavement often represented. Lifestyles had changed and a grief vacuum existed that was often filled in unhealthy ways. People did not pull together as they did in the past and isolation was often the lot of bereaved families. Although supportive interaction between family members was almost essential for healthy healing following bereavement:

"...very often that cannot be. Families are separated by distance...never got on...so many unresolved issues...a death is the one thing that brings up and makes them act very strangely because they don't want to confront the unresolved issues...so they act out and can be very hateful and very cold to one another...family can be a very unsafe place. At a time of death families often do not do it for you."

So 'COMMUNITY SUPPORT' and 'FAMILY SUPPORT' were often more illusory than real. The control respondent believed that normal bereavement has the potential, under extreme circumstances, to resemble closely suicide bereavement. 'FAMILY DISRUPTION' as a consequence of normal bereavement may be not dissimilar to the fate of suicide families which were often quite simply blown asunder by their loss experience and its destructive consequences:

"...mother's death...it was terrible. It's left our family...split, the three of us...very seldom speak to one another...an awful lot of stuff that I have to go and deal with myself...I don't know how the other two dealt with it...the funeral was a horrible time...I couldn't be with them..."

Recognition that a 'COMPLEX GRIEF PROCESS' became operative in the prelude to a bereavement and continued long after the 'FUNERAL RITES' was not adequately recognised even by professional counsellors who may not have engaged sufficiently in their own personal development:

"I have a healthy disrespect for the areas of counselling who say: 'Oh grief, the grieving process: there's six stages. If it's not over in a year there's something wrong, that's pathological grief'... and where all this... comes from is one paperback and very often out of context... the book shouldn't have been published in the first place... clichéd notions ... about what the grief process is... and they simply haven't done their own stuff..."

The control respondent felt that 'QUALITY OF LIFE' was invariably changed by bereavement. Life was always changed by loss and by change itself:

"I can't imagine that life is ever going to be the same. The loss of a loved one always means that life's going to be different... any relationship is change and any change in the relationship is going to make a difference... the path is going to be a different path... to be approached or trod upon in a different way... I'm optimistic enough to think that quality of life can always be attained... that's a visual thing... sometimes you have to change your lenses..."

He felt that by optimism, perspective, personal work, pain, care, love and empathy, quality of life can always be achieved.

4.9.6 Control respondent 'H' – Identity structure analysis

As for control respondent 'G', identity structure analysis facilitated exploration of the identity state of control respondent 'H', as represented by belief and value systems, identifications, processes of change of identity and self-evaluation.

4.9.7 Control respondent 'H': Primary analysis

The control respondent's initial bereavement experience was assumed to have occurred before he left school around the age of 19 years. The chronological order of 'past self' entities was therefore taken to be as follows: (PS2) *'me as I was before I*

found out about death' viz. before the age of 18 years; (PS3) *'me as I was after I found out about death'* viz. around the age of 18 years and (PS1) *'me as I was when I left school'* viz. after the age of 19 years.

As set out in Table 4.38 below, control respondent H's identity variant for his currently situated self *'me as I am at home'* was classified as 'negative' while his currently situated self *'me as I am at work'* was classified 'indeterminate'. The identity variant for his past self (PS2) *'me as I was before I found out about death'* was classified as 'crisis' while the identity variant for his past self (PS3) *'me as I was after I found out about death'* was classified as 'diffusion'. The remaining identity variant for his past self (PS1) *'me as I was when I left school'* was classified as 'crisis'. All of these identity variants were considered to represent vulnerable identities of various kinds with the exception of the 'indeterminate' category for his currently situated self *'me as I am at work'*, which was regarded as 'well-adjusted'. The impact of deleterious life events upon the control respondent's identity was reflected in his low self-evaluation (PS1 0.05) at the time that he left school although this parameter had temporarily reached a moderate level around the time of his grandfather's death (PS3 0.30), as reflected in the discourse:

"I took the death certificate down the next day, registering the death. I remember ringing up the funeral parlour and doing all that arranging... I had a sense of pride in him... also a sense of feeling like him... everybody said I take my stature from him... I had a great sense of being like him... taking on a mantle from him. It was like I wanted to be like him at the time he was dead."

Persistently low self-evaluation affected his identity development over the whole period from (PS2) *'me as I was before I found out about death'* to his currently situated self (CS2) *'me as I am at home'* (PS2 0.01; PS3 0.30; PS1 0.05; CS1 0.18) although there was some development related to his work (CS2 0.33). The relative stability of his high identity diffusion throughout (PS2 0.42; PS3 0.41; PS1 0.42; CS1

0.40; CS2 0.40), representing the overall dispersion and magnitude of his many conflicted identifications, pointed towards problematic aspects in his own identity, as evidenced in the discourse:

"...my mother's death...left our family...split...we very seldom speak to one another...the funeral was a horrible time to the extent where I couldn't be with them...so families don't do it...I needed to find somewhere where I could do it. But...coming from a background where I know how to do that. I'm trained in that...not a cultural leap...to think about going to a good counsellor...yes, I can do that..."

Table 4.38 Control respondent H: Self image

SELF IMAGE					
	Ideal Self	Current Self		Past Self	
Ego-Involvement (0.00 to 5.00)	5.00	CS1 CS2	2.14 2.50	PS1 PS2 PS3	3.00 2.93 2.86
Self-Evaluation (-1.00 to +1.00)	1.00	CS1 CS2	0.18 0.33	PS1 PS2 PS3	0.05 0.01 0.30
Id. Diffusion (weighte) (0.00 to 1.00)		CS1 CS2	0.40 0.40	PS1 PS2 PS3	0.42 0.42 0.41
	Identity Variant				
Current Self 1	NEGATIVE				
Current Self 2	INDETERMINATE				
Past Self 1	CRISIS				
Past Self 2	CRISIS				
Past Self 3	DIFFUSION				

4.9.8 Control respondent H: Impact of death in relation to the past self *'me as I was before I found out about death'* and the currently situated selves *'me as I am now'* and *'me as I am at work'*

This control respondent had very highly conflicted identifications (see Table 4.39 below) with *'me as my family sees me'* in his appraisal of his past selves (PS2 0.58; PS3 0.52; PS1 0.60) and his currently situated selves (CS1 0.53; CS2 0.54). He also

had a very highly conflicted identification (see Table 4.40 below) with *'mother'* in his appraisal of his past selves (PS2 0.60; PS3 0.55; PS1 0.56) and of his currently situated selves (CS1 0.57; CS2 0.53). Further examples of his very highly conflicted identifications were those with *'my partner/spouse'* in his appraisal of his currently situated selves (CS1 0.51; CS2 0.53), with *' a depressed person'* in his appraisal of his past selves (PS2 0.51; PS3 0.51), with *'colleagues at work'* in his appraisal of his past selves (PS3 0.55; PS1 0.51) and with his currently situated self (CS2 0.53). All of these phenomena were regarded as problematic in terms of the control respondent's own identity that is in relation to his conception of himself and what he stood for. In relation to the impact of death upon the control respondent the following discourses are illustrative:

Re *'me as my family sees me'*:

"...I became the principal carer...your own topic of research is different but...akin to a topic...looking at carers and long term carers and...how they deal with their bereavement of the loved ones they look after and the sense of loss during the caring experience...how they deal with the grief and the loss of the loved one and the loss of themselves throughout the process because there's a lot of anger there also with the other members of the family...who got off and got on with their own lives."

Re *'mother'*:

"...when my grandfather died it was all about my mother's loss...I couldn't talk about my loss, when my father went then it all became about her husband, her loss of her husband. And my loss wasn't allowed...then when I was...starting to do some of my own work...starting to be able to say to her: 'Look I've got my own life to lead'...that's when she started to go wrong healthwise...was diagnosed...and I became a principal carer and my life went on hold..."

Table 4.39 Control respondent H: Metaperspectives of self

METAPERSPECTIVES OF SELF

	ENTITY	Ego-invl'mt	Eval'n	Ideal Id.	Contra Id.
4	Me as my contempora.	2.57	0.22	0.70	0.30
13	Me as my family see.	2.64	0.15	0.60	0.40

		Empathetic Id'fn				Ident'fn Conflicts			
4	Me as my contemp.	CS1	0.70	PS1	0.68	CS1	0.46	PS1	0.45
		CS2	0.74	PS2	0.61	CS2	0.47	PS2	0.43
				PS3	0.56			PS3	0.41
13	Me as my family .	CS1	0.70	PS1	0.89	CS1	0.53	PS1	0.60
		CS2	0.74	PS2	0.83	CS2	0.54	PS2	0.58
				PS3	0.67			PS3	0.52

Table 4.40 Control respondent H: Conflicts in identification

CONFLICTS IN IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
9	Mother...	0.57	0.54
12	My partner/spouse...	0.51	0.53
11	A depressed person..	0.46	0.35
7	A person I dislike.)	0.42	0.40
14	My colleagues in th.	0.42	0.53
8	My closest friend...	0.40	0.41
15	The caring professi.	0.37	0.46
10	Father...	0.35	0.36
16	My minister of reli.	0.32	0.34
19	A person who died s)	0.27	0.33
6	A person I admire..)	0.00	0.00

CONFLICTS IN IDENTIFICATION WITH OTHERS - Past Self
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
9	Mother...	0.56	0.60	0.55
14	My colleagues in th.	0.51	0.47	0.55
11	A depressed person..	0.47	0.51	0.51
12	My partner/spouse...	0.47	0.50	0.54
7	A person I dislike.)	0.46	0.33	0.37
8	My closest friend...	0.43	0.47	0.46
15	The caring professi.	0.41	0.35	0.35
10	Father...	0.40	0.41	0.39
19	A person who died s)	0.32	0.34	0.32
16	My minister of reli.	0.31	0.33	0.32
6	A person I admire..)	0.00	0.00	0.00

4.9.9 Control respondent H: Empathetic identifications

Control respondent 'H' increasingly empathetically identified (see Table 4.41) with *'my partner / spouse'* and with *'a person I admire'* as he appraised himself from *'me as I was when I left school'* (PS1 0.63, 0.42) to *'me as I am at home'* (CS1 0.75, 0.55) and to *'me as I am at work'* (CS2 0.79, 0.68) evidencing ongoing psychological processes of change and development reflected indirectly in the discourse:

"...he was nearly 82...he'd never actually told me what he believed in...I wondered how he'd gone to the other side in his mind...there's a lot of stuff you don't know about someone you love, admire and talk to so much...regret about not having had more conversations about that...had you the opportunity of doing those things over again there would have been subjects broached that weren't, yeah"

However the control respondent decreasingly empathetically identified with *'my closest friend', 'Father', 'a person who has died suddenly'* and *'colleagues in the workplace'* as he appraised himself from *'me as I was when I left school'* (PS1 0.74, 0.63, 0.68, 0.58) to *'me as I am at home'* (CS1 0.65, 0.50, 0.50, 0.40). Some dissociation from these entities by the control respondent was implicit in these results. But any alienation between the control respondent and *'a person who died suddenly'* was relieved somewhat when he appraised himself from *'me as I was when I left school'* (PS1 0.68) to *'me as I am at work'* (CS2 0.74). This may have been linked with the control respondent's developing professional interest in healing therapies, including grief therapy, evidenced in the discourse:

"I suffered from the notion as part of my counselling training from hearing clichés from people...I suffered from this notion of pathological grief when this sort of thing started to kick in: 'Am I grieving pathologically? Is there something wrong with me?' until I went into it at a deeper level myself. This is not pathological grief. There's more to it...and there's a great deal of work that needs to be done...a lot of therapists are themselves blind to that..."

Table 4.41 Control respondent H: Empathetic identifications

EMPATHETIC IDENTIFICATION WITH OTHERS - Current Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	CS1	CS2
12	My partner/spouse...	0.75	0.79
8	My closest friend...	0.65	0.68
9	Mother...	0.65	0.58
6	A person I admire..)	0.55	0.68
10	Father...	0.50	0.53
16	My minister of reli.	0.50	0.58
19	A person who died s)	0.50	0.74
14	My colleagues in th.	0.40	0.63
7	A person I dislike.)	0.35	0.32
11	A depressed person..	0.35	0.21
15	The caring professi.	0.30	0.47

EMPATHETIC IDENTIFICATION WITH OTHERS - Past Self/Identity State
Indices range from 0.00 to 1.00

	ENTITY	PS1	PS2	PS3
8	My closest friend...	0.74	0.89	0.83
19	A person who died s)	0.68	0.78	0.67
9	Mother...	0.63	0.72	0.61
10	Father...	0.63	0.67	0.61
12	My partner/spouse...	0.63	0.72	0.83
14	My colleagues in th.	0.58	0.50	0.67
16	My minister of reli.	0.47	0.56	0.50
6	A person I admire..)	0.42	0.50	0.56
7	A person I dislike.)	0.42	0.22	0.28
11	A depressed person..	0.37	0.44	0.44
15	The caring professi.	0.37	0.28	0.28

4.9.10 Control respondent H: Contra-identifications

This control respondent's high contra-identifications with *'a depressed person'* (0.60), *'Mother'* (0.50), *'a person I dislike'* (0.50), *'my colleagues at work'* (0.45) and *'the caring professions'* (0.45) indicated a wish to dissociate from these people and/or institutions. They represented the extent of the control respondent's desire to dissociate from certain qualities that he attributed to these entities and reflected his very highly conflicted identifications, particularly with *'Mother'*. Also in relation to *'the caring professions'* for example, his dissatisfaction regarding the quality of treatment his father received from some medical personnel was palpable:

"...about March 1992...he actually had the heart attack in the hospital...in the Intensive Care Unit in the Royal...we weren't told for...two years how serious and how much damage was done by that heart attack...in January 1994...check-

up... 'They're recommending a triple bypass'... started to unfold that the triple bypass would occur in May... in Birmingham... something wrong... waiting list closed because... private patients paying from the South and the surgeons were doing it for the money... beginning of May... bad weekend... Wednesday... taking my father to hospital... so much damage done they couldn't do a triple bypass... he rallied on the Sunday... I went back to work (but) he passed away the next day..."

4.9.11 Control respondent H: Idealistic identifications

The control respondent's very high idealistic identifications with *'a person I admire'* (0.85), *' person who died suddenly'* (0.80), *'my closest friend'* (0.75), *'Father'* (0.70), *'my minister of religion / spiritual adviser'* (0.70) and *'my partner / spouse'* (0.65) suggested a number of people whose qualities he aspired to possess in relation to his ideal self *'me as I would like to be'*. They represented positive role models and included both of the men who strongly influenced his development, as in the discourse:

"... big man, walking stick, pipe... he'd a lot of respect for things Christian but... my father was a small man... good at football and very good with his hands... very prim and proper... grandfather was a big man... hopeless with his hands... far from prim and proper... similar in that they both found their voice, one through socialism, the other through Christianity... both... when they... believed... strongly enough they were fearless about standing up on a platform... and preaching what they believed in... they shared that strength of character."

4.9.12 Control respondent H: Structural pressures on constructs

High structural pressures on the constructs *'does not value human beings very highly'* / ***'believes in the irreplaceable value of each human being'*** (100.00) (where the preferred pole is bold), ***'is interested in complementary / alternative therapies'*** / *'relies mainly upon prescribed medicine to relieve pain'* (77.14), *'feels that sudden death seldom triggers exceptional grief'* / ***'feels that sudden death often triggers exceptional grief'*** (73.16), ***'can often be alone without feeling lonely'*** / *'cannot be*

alone for long without feeling distressed' (65.11), ***'is optimistic about the future'*** / *'is pessimistic about the future'* (61.09) and ***'continues to develop own personal values and beliefs'*** / *'sticks rigidly to values and beliefs of parents/guardians'* (60.83) represented this control respondent's evaluative dimensions of identity. They referenced values and beliefs that were considered central to his identity and which he used to assess the merits of self and others. Excluding the construct referring to sudden death and exceptional grief, all could be considered positive and developmental representing personal qualities including commitment to personal development, optimism, inner strength and composure, interest in non-drugs based therapy and above all, a strong conviction concerning the unique value of each human. However his experiences of bereavement continued to influence his identity development. This discourse reflected some of these aspects:

"So it was interesting when I stood at the grave where they're both buried and rest the two men in my life as it were... it was a start... it was a signal through which I was learning a lot of things about myself... through which I was starting to get the courage to actually face a lot of the bad feelings... the emotional side... fear of knowing I wasn't living a complete life..."

Low structural pressures on: ***'feels at ease as a member of a group'*** / *'feels uncomfortable as a member of a group'* (9.75), ***'relies on family support at times of crisis'*** / *'does not rely on family support at times of crisis'* (4.32), ***'believes that depression is a life- threatening condition'*** / *'believes that depression is not a life-threatening condition'* (-0.14), ***'looks to be set free from family ties'*** / *'looks to family for security and protection'* (-4.80) and ***'always expresses emotional feelings in healthy ways'*** / *'always expresses emotional feelings in unhealthy ways'* (-17.33) represented inconsistently evaluative dimensions of identity signifying areas of the control respondent's identity that might be under stress and around which his behaviour might be problematic and perhaps unpredictable. These areas included

group activities, family relationships, lethality of depression and expression of emotions, as illustrated in the discourse:

"I don't find it depressing. I find it sad....your... topic of research is different but very akin to a topic I'm interested in... sad but fascinating and interesting... looking at... long term carers and the loss... of loved ones and the sense of loss of themselves during the caring experience... they... deal with the grief... while other members very often managed to get off perfectly well in our family... to me ... all part of a grief thing..."

4.9.13 Control respondent H: Summary

This control respondent's identity variants classified him in his past selves and in his currently situated self *'me as I am at home'* as belonging to vulnerable identity states of various kinds. His very high conflicted identifications with *'my partner / spouse'*, *'mother'* and with *'me as my family sees me'* and his contra-identification with *'mother'* may have contributed to his current vulnerable identity state. The identity variant for his currently situated self *'me as I am at work'* was classified 'indeterminate', representing a well-adjusted identity. But work-related issues appeared to impede further identity development as evidenced in moderate ego-involvement (2.50), relatively low self-evaluation (0.33) as he appraised himself currently in *'me as I am at work'* and a high contra-identification (0.45) with *'my colleagues in the workplace'*. His very high idealistic identifications, with *'person who died suddenly'* (0.80), assumed to be his beloved grandfather, and with *'father'* (0.70) was reinforced by high structural pressure on the construct ***'continues to develop own personal values and beliefs'*** / *'sticks rigidly to values and beliefs of parents / guardians'* (60.83) evidencing both a desire to emulate the attributes and qualities of these men but also to find his own way, as in the discourse:

"The loss of a loved one always means that life's going to be different. You know any change – any – any relationship is change and any change in the relationship is going to make a difference. So I think you have to accept that – that the path is

going to be a different path that's going to be approached and trod upon in a different way and go in a different direction."

4.10 Summary

4.10.1 Limitations

It was noted at conclusion of fieldwork and as writing up of results proceeded, the investigator's insights in relation to analysis of transcripts, summarising reported experiences and analysis of ISA findings, deepened and developed such that results narrative length increased, as did incorporation of discourse extracts. It was possible that application to earlier case studies of lessons learned by the investigator during later case studies could have developed the content of the earlier work. However it was not practicable for the investigator comprehensively to review narratives for all of the earlier work with this in mind in view of time limitations. It was intended to address any evident shortcomings in the discussion and presentation of findings in the next chapter.

4.10.2 Discussion and findings

In this chapter case study results data obtained from interview transcripts and from ISA instrument applications were presented in summary form following analysis. A synopsis of each transcript and a statement of each set of ISA findings were supported by extracts from the relevant discourse but no attempt was made either to discuss outcomes or to interpret findings in relation to the investigation's objectives. In the next chapter, each case study was examined for evidence of identity processes connected to bereavement experience. Findings related either to suicide survivors or to non-suicide mourners were summarised and contrasts in identity process as between survivors and mourners were highlighted. Finally some conclusions were drawn in relation to postvention strategies for suicide survivors.

Chapter 5: Discussion and conclusions

5.1 Introduction

This investigation was concerned with the predicament of suicide survivors in view of the ongoing debate about whether, as an identifiable group, they were liable to an enhanced risk of suicidal behaviour (*Stengel,* 1977; *Faberow,* 1991, 1996; *Brent,* 1996). It looked at suicidal loss as an example of a life-changing event for survivors and sought to ascertain through the window of survivors' experiences, its impact on their identities and their coping response in its aftermath. Crucially it sought to investigate the external support mechanisms required, if any, to complement individual survivors' personal adaptive resources. The methodology used transcript content analysis and identity structure analysis (ISA) with a self-selecting group of six suicide survivors. The same methodology, with an appropriately tailored ISA instrument to reflect their status, was applied to two non-suicide mourners acting as controls. The case studies presented in Chapter 4 were idiosyncratic and exemplified the survivorship experience, allowing each participant freely to report their ongoing predicament and its impact upon their identity process.

5.2 Case Study A – Findings

5.2.1 Respondent A: Transcript discussion

In the transcript this respondent alluded often to survivor support, family therapy and one-to-one work indicating an unmet need for external support resources. Intense psychological disturbance was reflected in her allusions to pain, isolation and unbearable pain. It was plain that her predicament was linked with blocked grief

deep suicide scar and an unhealed historical legacy extending back over the 22 years since her sister's suicide. Non-participation in her sister's obsequies restricted her opportunity then for 'final farewell' and she remained emotionally affected by guilt, sadness and grief, anxiety symptoms and survivor confusion (*Leick and Davidsen-Nielsen*, 1996: 61, 133). Continuing isolation from family members appeared to preclude family reintegration without an external stimulus. She also alluded to her sense of identity and to identity distortion consequent upon her loss experience.

5.2.2 Respondent A: Identity process discussion

All five identity variant classifications - see Table 4.3 above - for this respondent represented vulnerable identities that could be traced back to her suicide experience. Her identity variants for both currently situated selves and for her past self *'me as I was after the suicide'*, are classified 'crisis' confirming low self-evaluation and inability to resolve her identification conflicts. These very high conflicted identifications, especially with *'mother'*, existed across her past self entities and into her currently situated selves: this was reflected in her very low evaluation of herself with regard to her mother (-0.21). Her empathetic identifications in relation to *'my colleagues at work'* reflected dependence upon her teaching activities to balance the isolation that she exhibited in her modulated empathetic identifications with *'my partner/spouse'*. Further modulated empathetic identifications in relation to *'a depressed person'* demonstrated her continuing use of inappropriate coping methods, including denial, in relation to suicidal loss. Her contra-identifications with *'mother'*, *'her colleagues at work'* and *'father'* were associated with very high conflicted identifications with these entities and with a sequence of very low evaluations of herself in relation to *'father'* (0.05), *'my colleagues in the workplace'* (0.02), *'me as I*

am at work' (-0.04), *'me as I was after I found out about the suicide'* (-0.13) and *'mother'* (-0.21). These were balanced only by her very high idealistic identification (0.78) with her dead sister, *'a person who has taken her/his own life'*. However structural pressures on three suicide related constructs were inconsistently evaluative dimensions of identity signifying problematic areas for the respondent. These phenomena point to a strong negative impact on her identity development of her suicide experience (*Shneidman* (1984), cited in *Stillion and McDowell*, 1996: 232).

5.2.3 Respondent A: Conclusions

Many of this respondent's difficulties in her personal and family life could be traced to her suicidal loss. Although there was no evidence of suicide ideation, some disturbing indicators - very low self-evaluation, idealistic identification with her dead sister, isolation and inadequate external support – suggested individual and family therapy (*Bradshaw*, 1995: 55-80). It was hoped that the respondent's approach to the investigator was a positive sign in this direction.

5.3 Case Study B - Findings

5.3.1 Respondent B: Transcript discussion

This respondent alluded frequently to survivor support, counselling, family therapy and healing therapy reflecting her own brief but unsatisfactory therapy experience and acknowledging the utility of appropriate therapy for other survivors, if not for herself. She harboured unrealistic guilt about her son's suicide and was resistant to letting go and moving on. She continued to feel enormous pain and alluded often to her unique anguish, abnormal pain and to post-suicide trauma. She believed her grief as a mother

whose son suicided was thereby more intense, than for example, the grief of sibling suicide. She felt that her values and beliefs and her sense of identity were challenged by her loss and healing experiences over the last three years. She believed that the pain of the loss of her son was an effective defence against her own suicide, lest she re-visit that agony on her own family. She was interested in supporting suicide survivors in any way that she could and that was why she made contact with the investigator.

5.3.2 Respondent B: Identity process discussion

The identity variant classification - see Table 4.8 above – for this respondent's past self *'me as I was after I found out about the suicide'* was classified 'negative', representing a vulnerable identity state of moderate identity diffusion and low self-evaluation. This was found in individuals who 'perceive themselves as lacking in the skills to act in accordance with their values and experiences' (*Irvine*, 1994: 108). But her remaining identity variants, for her other past selves, *'me as I was when I left school'* and *'me as I was before the suicide'*, and for both her currently situated selves were classified 'indeterminate' or well adjusted. Something had happened to restore her self-evaluation to the moderate levels of her current selves. This was perhaps related to her very high idealistic identifications, including *'my colleagues in the workplace'* (0.74) and her recent achievement and recognition at work. Her very high conflicted identification with *'mother'* in her currently situated selves was reflected both in her contra-identification with *'mother'* (0.65), in her decreasing empathetic identification with *'mother'* as she appraised herself from the suicide event to the her current self (PS3 0.50; CS1 0.43; CS2 0.41) and in her very low self-evaluation in relation to *'mother'* (-0.29) with whom she remained very highly ego-involved (4.73).

Structural pressures on four constructs represented inconsistently evaluative dimensions of identity and pressure on one construct represented a dual morality evaluative dimension of identity. All constructs referred to aspects of healing and recovery after a suicidal loss and evidenced continuing uncertainty within her identity process.

5.3.3 Respondent B: Conclusions

This respondent's identity process was adversely affected by the tragic loss of her son but three years on, by incredible fortitude and focused self-healing effort she now had a highly developed knowledge and a deep awareness of the suicide phenomenon, its risk factors and postvention strategies in relation to herself and others. She had transformed the crisis of her son's suicide from an underlying threat of self-harm into a positive, life-enhancing opportunity through personal, academic and employment achievement. Her progressive identity development was temporarily stalled by her suicidal loss but her personal healing and growth appeared to have been restored despite her continuing alienation from her mother and distancing from her family particularly since her suicidal loss. But she continued to use 'calling' weeping (*Bowlby*, 1969, 1973, 1980) and may not yet have been able to engage in the deeper 'letting go' weeping that would signal that she was 'finally willing to let go of what one has lost' (*Leick and Davidsen-Neilsen*, 1996: 12).

5.4 Case study C - Findings

5.4.1 Respondent C: Transcript discussion

Respondent C alluded often to survivor support, family support, family therapy and sibling support. As a seven-year-old survivor, now reflecting back on his

survivorship, he had availed only of inner resources in coping with suicidal loss due to lack of external resources. He and two of his siblings attempted suicide: in his own case he was fortunate to survive. Children of parents who suicide were at risk of pathological grief (*Leick and Davidsen-Nielsen*, 1996: 71) but his own self-harm was in line with an elevated risk for suicidal behaviour in suicide survivors (*Brent*, 1996:1), and was triggered by an emulation process linked to 'the example set by the suicide of their loved one' (*Faberow*, 1996: 1). The abandonment process that contributed to his father's suicide in 1965 mirrored his intoxicated isolation as a factor in his own suicide attempt. On the other hand he was determined not to subject his own children to the trauma of parental loss that he suffered and believed that this was now a robust defence. As a suicide survivor, his life was indeed 'forever changed' (*Shneidman* (1984), cited in *Stillion and McDowell*, 1996: 232). Only now, 35 years on and bearing the additional burden of a parasuicide experience, this respondent was actively working on reconstructing his identity. He offered the investigator any help that he could to help other suicide survivors.

5.4.2 Respondent C: Identity process discussion

This respondent's identity was fundamentally changed by his suicidal loss. His identity state moved from an 'indeterminate' identity variant classification - see Table 4.13 above - before his father's suicide when he was seven years old, to a 'defensive' identity variant classification. This signalled a foreclosed identity state in which people were inclined to 'make undifferentiated appraisals of their social worlds, so are likely to have difficulties in responding to complex relationships and to changed circumstances' (*Irvine*, 1994:108). His identity development up to leaving school and marrying at the age of 16 years, progressed until he reached an identity variant state of

'defensive high self-regard', reflecting enhanced self-evaluation as he established his new family and began his search for his long-dead father. Modulations in empathetic identifications reflected the traumatic impact of the suicide as well as some dissociation from *'mother'* that permitted him a high idealistic identification with her (0.61). Very high structural pressures on constructs about the unique pain of suicidal loss, the inestimable value of human life and warmth in human relationships reflected a progressive identity process in the context of his father's suicidal loss and his own and sibling parasuicide events that were key identity deconstructing experiences.

5.4.3 Respondent C: Conclusions

The lifelong identity impact of suicide trauma was evidenced in this respondent's reported experiences. His father's suicide and his own parasuicide fitted Freud's view that suicidal tendencies 'originated in experiences of loss or rejection involving a significant person' where 'the process of identification' transformed anger directed against the rejecting person into self-harm (*Freud* (1917), cited in *Balance and Leenaars,* 1991: 142,143). Current identity development was strongly bonded to a support framework, including counselling, structured around people with whom he evidenced very high idealistic identifications. His current identity state remained vulnerable but there were indications of identity reconstruction as he redefined a belief and value system containing life preserving and life enhancing goals.

5.5 Case Study D - Findings

5.5.1 Respondent D: Transcript discussion

This respondent's predicament exemplified aspects of chronic grief related to her reluctance to accept her sister's death five years before and so to begin to move

towards an as yet avoided final farewell in her grief process. Her suicidal loss was a pivotal event such that it 'still fills (her) life...everything that (she) recounts is shadowed by the loss' (*Leick and Davidsen-Nielsen,* 1996: 83). Administrative incompetence of Cruse personnel and of her own general practitioner in failing to meet her counselling needs, echoed her attachment difficulties with her parents and reinforced her sense of abandonment. An inadequate attachment process (*Bowlby,* 1969, 1973, 1980) pointed towards 'problems in living through the emotions of grief in a healing way' (*Leick and Davidsen-Nielsen*, 1996: 9). She idealized her dead sister in an attempt to relieve her 'pain of loss and feeling of void...to re-instate the dead one...in recalling all the good qualities of the departed' (*Saltzberger-Wittenberg,* 1999: 96). The 'nightmare' experience of a hospital suicide compounded the respondent's grief. More that 5% of suicides occurred in US hospitals although clinicians 'should recognise severe anxiety...in a depressed patient, and it should be treated quickly...it could be lifesaving' (*Fawcett*, 1999: 3). She believed that talking about her grief would help her, confirming that 'the most important way to learn to respond to a suicide is through talking' (*Lukas and Seiden,* 1990: 144). Her miscarriage six months after her sister's death was a serious complicating factor in her response to her sister's death. She felt that the person she was 'just died' when her sister died: that she was now 'totally different' and that her post-miscarriage trauma 'never really goes away'. Her coping ability was remarkable given the heavy burdens of home management, child rearing and employment, in view of the low priority that she appeared to give to self-care. Her approach to the investigator might have announced her intention, as a 'caretaker' of family and patients at work, to address her own displaced needs before these became more immediate and urgent through potentially serious physical health symptoms.

5.5.2 Respondent D: Identity process discussion

This respondent's five identity variant classifications – see Table 4. 18 above - were 'indeterminate' indicating a well-adjusted identity state. The underlying parameters offered insights into this – at face value – surprising outcome. Her very high conflicted identification with *'mother'* (0.55) coincided with the loss of her sister with whom she had an even higher conflicted identification (0.60) as she appraised herself in her past self *'me as I was after I found out about the suicide'*. These indices were reinforced by low and very low evaluations of herself, respectively, in relation to *'mother'* (0.06), *'a person who has taken her/his own life' (-0.41)* and *'a depressed person'* (-0.45) . In her contra-identifications she also dissociated very strongly from *'a person who has taken her/his own life'* (0.65) and from *' a depressed person'* (0.70). It was as if she was detaching herself from the illness – depression – linked with her sister's death. Her deepening relationship with her father, who loved her sister, was evidenced in her modulated empathetic identifications with *'father'*, associated with very high ego-involvement with him (5.00), a high evaluation of herself (0.61) in relation to him, and a very high idealistic identification (0.78) with him. It appeared that she was withdrawing 'psychological energy from the person (she) has lost' in order 'to be able to re-invest (her) emotional energy…in new ways' in her relationship with her father (*Leick and Davidsen-Nielsen*, 1996: 59). So this key element of the grief process was evidently moving forward. Her belief and value system including a personal survival strategy represented in high structural pressures on constructs, developed positively in response to her double loss experiences. This was evidenced by the very high valuation she placed on human life, her involvement in family relationships and her reinforced awareness of links between depression and

suicide where those like her sister 'suffering from depression tend to be at elevated risk...in the early stages of a disorder...and the incidence of suicide decreases with time' (*Hawton* (1987), cited in *O'Connor and Sheehy*, 2000: 33). But low structural pressure on the 'corporal punishment construct' represented an inconsistently evaluative dimension of identity: she was uncertain and perhaps unpredictable in relation to her child rearing strategies. Her identity was changed by her double loss but a range of indices, including high evaluations of her ideal self (1.00), her work colleagues (0.71), her partner (0.59) and her currently situated selves (CS10.73; CS2: 0.76) confirmed that she was able in the period since to reconstruct some of those damaged constituents by positive development within her personal and social worlds.

5.5.3 Respondent D: Conclusions

The process of reconstructing an identity radically altered by multiple traumatic loss was exemplified by this respondent. This did not mean that she was restored to what she had been. Rather as she expressed it 'I'm just totally different'. Her coping strategy was to dissociate from whatever she felt harmed her sister – unrealistic goals, dis-stress, depression – while reinvesting emotional energies in her partner, her children and her father while developing compassion for her mother. She was devoted to her children and to her partner but she hinted that she might consider self-care in the interest of all those 'others' that she cared for. Her voluntary participation in this investigation and her hope that its outcome might help alleviate the enormous pain of survivors was a positive indicator of her own progressive identity development in relation to her traumatic experiences.

5.6 Case Study E - Findings

5.6.1 Respondent E: Transcript discussion

This respondent represented a survivor who was able to respond very quickly to his serious loss event by arranging counselling support from Cruse. More relevant was his familiarity with 'the talking therapies'. He admitted that he had already survived a dangerous suicide ideation of the type that his brother may have acted out. In his recovery from multiple addictions, he participated in 'twelve step' fellowships. His suicide grief reaction was unconsciously transformed by the influence of a belief and value system incorporating a heightened awareness of healing skills and practices appropriate for successful, healthy adaptation to enforced change. There was evidence that while '...change...itself...is a stressor...rapidly accumulating change...of a negative nature...enhances the anxiety and depression that frequently accompany suicide attempts' (*Holmes and Rahe* (1967), cited in *Stillion and McDowell*, 1996: 32). He alluded often to the irrelevance of his GP in his recovery, Cruse, coping skills and strategies and the emotional turmoil of his suicide grief reaction. His dual status as parasuicide and survivor reinforced the identity shift necessary to persevere until one-to-one and group counselling was arranged for him by Cruse. Because of resource shortfalls, gatekeepers at Cruse were powerful barriers to those survivors who lacked the necessary persistence and courage to achieve client status. Although devastated by his brother's death, he found at Cruse a forum for expressing his guilt, anger, helplessness and fear, depression and loss. 'Men have a harder time expressing their feelings...a lot more pain stays inside them...an inability to talk about the suicide...is a dangerous thing' (*Lukas and Seiden*, 1990: 139, 141). The suicide experience revealed the prejudice rooted in fear that had caused him to stigmatise survivors that he had encountered before his brother's death. This was understandable

since 'criminalisation and stigmatisation of suicide can be traced to the sixth century AD and was largely unchallenged' (*O'Connor and Sheehy*, 2000: 9) until recent years. This respondent believed that his post-suicidal loss healing and growth was the sole 'benefit' of his tragic experience: he offered to help other survivors in any way that he could.

5.6.2 Respondent E: Identity process discussion

The identity variants – see Table 4. 23 above – for this respondent were classified 'indeterminate' for his past selves *'me as I was before I found out about the suicide'* and *'me as I was after I found out about the suicide'* and for his current self *'me as I am at work'*. But his self-evaluation plummeted as he appraised himself before (0.60) and after (0.35) he learned about his brother's suicide. His identity variant for his current self *'me as I am at home'* was classified as 'defensive' reflecting the impact on him of his changed circumstances two years after the suicide. His ability to resolve his conflicted identifications remained limited in both of his currently situated selves (CS1 0.24; CS2 0.25) although his identity variant for CS2 *'me as I am at work'* was classified 'indeterminate'. Decreasing conflicted identifications with *'a depressed person'* and *'a person who has taken her/his own life'* as he appraised himself from after the suicide to date, together with high contra-identifications with both entities exemplified identity process so as to avoid the behaviour that he associated with his brother's demise. His idealistic identifications reinforced his aspirations in relation to qualities of caring, pastoral counselling and academic competence. His values and beliefs evidenced by structural pressures on constructs revealed an identity shift towards self-protecting behaviours that acknowledged the continuing impact of his brother's suicidal loss on his identity.

5.6.3 Respondent E: Conclusions

This respondent's identity reconstruction was strongly influenced by developing awareness of his need to self-care. This preceded the suicidal loss event so that he was quickly able to call in support a range of helping therapies based upon open dialogue and honest emotional expression. His past experiences in recovery along with mutual survivors of addiction trauma were of considerable advantage to him in coping with identity changes imposed by his brother's death. His current identity state remained moderately vulnerable but his personal aftercare strategy mirrored five strategies – communication, coping, destigmatisation of stressors, destigmatisation of depression and suicide risk factors (including alcoholism and other addiction disorders) and awareness of survivor support services – advocated by acknowledged suicidology authorities (*O'Connor and Sheehy*, 2000: 120, 121).

5.7 Case Study F - Findings

5.7.1 Respondent F: Transcript discussion

The validity and effectiveness of contact with professional friends and colleagues in immediate and follow-up support to a survivor was exemplified in this case study. Police informed the respondent by telephone call of his sister's death at home in Belfast by suicide. Professional theatre colleagues provided immediate personal support where he worked in England. He placed enormous value on their spontaneous compassion for him. This enabled him to release safely the volcano of emotions within his grief reaction. His coping strategy throughout was heavily dependent on external support from these colleagues who as actors found no difficulty in accepting

his emotional response. Being held physically by his colleagues was, he said 'a great, great help'. In his grief, it provided for the respondent's 'need for bodily closeness and warmth (and gave) a sense of acceptance and sympathy, enabling (him) to get closer to the "letting go" kind of weeping' (*Leick and Davidsen-Nielsen*, 1996: 47, 94). He did not avail of medical support, bereavement counselling or medication and high alcohol consumption in the immediate aftermath tapered off. He came to some understanding of what his sister believed about her own suicide, what it meant for her, and advocated 'freedom to choose'. He accepted that only she could make the judgement 'whether life is or is not worth living' (*Camus,* 1985: 11). He believed that presumptions about any coincidence in belief and value systems of suicide victim and survivor were suspect: only his sister knew why she ended her life. She left a six page 'suicide note' for the respondent but he reflected Shneidman's belief that suicide victims died as they lived in relation to how they 'previously reacted in periods of threat, stress, failure, challenge, shock and loss' (*Shneidman*, 1994: 201). This respondent drew a key distinction between normal and suicide bereavement when he said 'You can't touch suicide'. Resolution of the impact of his sister's suicide appeared to have been by way of compassionate respect for her decision. He did not appear to harbour resentment for her: rather he felt much compassion for her - perhaps more than he did for survivors. He described circumstances, related to unbearable pain and advanced years, where emulation of his sister would be an option for him: 'the old have always been the most self-destructive of any age group' (*Stillion and McDowell*, 1996: 289). His suicidal loss had changed him. He recognised his sister's unendurable pain and as a survivor he was interested in being involved in suicide prevention work.

5.7.2 Respondent F: Identity process discussion

Identity variants – see Table 4.28 above – for this respondent were classified 'indeterminate' for his currently situated selves and for his past selves other than *'me as I was when I left school'* which was 'negative'. It appeared that he had successfully resolved at least some of the issues around his suicidal loss. Yet his conflicted identifications with *'a depressed person'* and with *'a person who has taken her/his own life'* remained very high or high, as he appraised himself from his past selves to his current selves (PS3 0.51, 0.42; CS1 0.51, 0.43) evidencing continuing problems in resolving issues around his sister's suicide. Increasing modulations in empathetic identifications with *'a person who has taken her/his own life'* evidenced minimal identity development to date (PS3 0.68; CS1 0.70) but was associated with very high idealistic identification with that entity (0.70) and illustrated his strong compassion for his sister. His contra-identification with *'a depressed person'* (0.52) was indicative of his concerns about the linkages between depression and suicidal behaviour. High structural pressures on constructs highlighted beliefs and values that the suicide impacted on, including respect for individual choice, self-sufficiency and compassion for suicide victims. Inconsistently evaluative dimensions of identity reflected problematic areas of his identity including suicide prevention and some guilt about his inability to support his sister in her predicament. His overall identity state revealed considerable accommodation to his sister's loss.

5.7.3 Respondent F: Conclusions

This respondent's identity changes originated through the ability and willingness of his professional colleagues to mirror his anguish on hearing about the suicide. This enabled him immediately to externalise the full range of grief feelings it evoked. Their practical support freed him to accept the reality of his predicament and energised him

through the immediate aftermath. He appeared to be able to return to his friends afterwards and to rely on them for as long as was necessary. A fundamental identity shift directly related to the suicide was represented when he acknowledged the risk of emulation: 'Middle aged and older adults who lack support systems that develop from intimate relationships with others are a group at high risk for suicide' (*Stillion and McDowell,* 1996: 98). But by combining the intimate support of his friends with inner resilience and developing self-knowledge, this survivor was fairly well defended against suicide in the foreseeable future: 'The greatest loss in suicide is the loss of the self…Our greatest fealty and loyalty is to ourselves' (*Shneidman,* 1994:238).

5.8 Case Study G - Findings

5.8.1 Control Respondent G: Transcript discussion

This interview was with the first of two control respondents whose losses were by non-suicidal bereavement. There were no complications in any of the three bereavements that he described: indeed the death of his grandmother was fully resolved. During interview he focused on: the sudden death of his school pal and the natural death of his grandfather. He continued to visit the grave of his school pal: it was located close to that of his grandfather. Some delay in making a 'final farewell' to his pal – 'One has to say goodbye in order later to be able to say hello' (*Leick and Davidsen-Nielsen,* 1996: 39) - was geographically determined and was presumably completed on his return to Belfast from Australia. This control respondent had excellent recall of the precise circumstances of both losses. During visits to the grave he externalised his anger about the loss of his pal but he was rooted in the reality of completed grief through natural healing. He acknowledged the strength and security of his attachment (*Bowlby,* 1969, 1973, 1980) to his grandfather that explained 'the

strong emotional reaction...when those bonds are threatened or broken' (*Worden*, 1983: 7). This explained the differences in the intensity of his grief reactions: '...it is the loss of someone close to us that triggers off the deepest grief' (*Leick and Davidsen-Nielsen*, 1996: 8) – exemplified in the openly tearful response that was missing in relation to his pal's death. His mourning was largely completed when he was able to think about both of the deceased perhaps with a sense of sadness but without the wrenching quality it previously had, without intense crying and tightness in the chest. He was able to reinvest in life and in the living (*Worden*, 1983: 16). The control respondent was betrothed at the time that his grandfather died and was now, eight years later, a contented and fulfilled husband and father.

5.8.2 Control respondent G: Identity process discussion

The control respondent's identity variants – see Table 4.33 – were classified as vulnerable identities of various kinds within a foreclosed identity state. Identity development from school leaving was evidenced by increasing self-evaluation and increasing ego-involvement across all entities, from past to current. But vulnerability was present in his undifferentiated appraisal of his social world (*Irvine*, 1994: 108) as evidenced by the consistency of his defensiveness against conflicted identifications. High conflicted identifications were located within his critical view of the Northern Ireland's 'black and morbid' attitude to death while he maintained an agnostic and perhaps neutral attitude disconnected from religious or spiritual mores. Very high idealistic identifications and modulations in empathetic identifications with *'my partner/spouse'*, *'a person I admire'*, *'mother'* and *'a person who died suddenly'* as he experienced the two deaths and established his own family unit evidenced positive identity development. High structural pressures on constructs revealed a belief and

value system related to family life, warmth in human relationships, optimism and a high value on human life. As a parent, reared in an abnormally 'macho' society, his only unpredictable area of his identity appeared to relate to the role of corporal punishment in child rearing, which represented an inconsistently evaluative dimension of identity.

5.8.3 Control respondent G: Conclusions

This control respondent's identity development progressed through his bereavements. But his foreclosed identity state indicated that he might have problems in responding to complex relationships and to changed circumstances (*Irvine*, 1994: 108). He had resolved issues around the deaths of his pal and his grandfather and his self-evaluation was very high. But his identity diffusion perhaps indicated that he had not yet arrived at the stage of 'identity achievement' where 'the individual is considered to have experienced a crisis but to have resolved it on his or her own terms and now to be firmly committed to an occupation, an ideology and social roles (*Marcia* (1966), cited in *Coleman and Hendry*, 1993: 63,64).

5.9 Case Study H – Findings

5.9.1 Control Respondent H: Transcript discussion

A significant aspect emerging from this interview transcript was the existence of childhood trauma hidden under 'toxic shame' (*Bradshaw*, 1995: 29) for over 20 years. Three normal bereavements provided material structured around the core themes – what happened, health and well being, meaning, aftercare and quality of life. Yet sexual abuse and sexual violations at twelve years of age represented an unhealed loss that he was unable to grieve until the deaths of his two 'anchors' – his grandfather and

his father. This 'avoided grief' (*Leick and Davidsen-Nielsen*, 1996: 27) was 'contained' in therapy (*Salzberger-Wittenberg*, 1999: 143, 144) during his mother's illness having been 'repressed' (*Corey*, 1996: 95) from childhood until he entered therapy following his father's death. Major linked concepts alluded to by this control respondent were loss, aspects of manhood and fatherhood, grief, death and attachment. His use of and developing dependency on alcohol prior to his grandfather's death may have been linked to depression resulting from sexual abuse (*Berry*, 1998: 9). Therapeutic support was important to this control respondent's identity development following his father's death. But only after his mother's death was he able to address the 'unfinished business' of his childhood abuse. In the three years since his mother's death progressive identity development was evident.

5.9.2 Control respondent H: Identity process discussion

This control respondent's identity variants – see Table 4.38 – were classified as vulnerable identities of various kinds except that relating to his currently situated self *'me as I am at work'* which was classified 'indeterminate', a well-adjusted identity state. The variant for his currently situated self *'me as I am at home'* was 'negative'. He was not yet able to achieve the values and aspirations he had for his life with his partner. The identity variant for his past self *'me as I was before I found out about death'* was 'crisis', reflecting very low self-evaluation (0.01) due to post-abuse trauma (*Briere*, 1992: 27) and an inability to resolve his dispersed identification conflicts or to form clear-cut commitments (*Irvine*, 1994: 108). The identity variant for his past self *'me as I was when I left school'* was 'crisis' reflecting very low self-evaluation (0.05) related to childhood abuse and the loss of his grandfather. The identity variant 'diffusion' was the classification for his past self *'me as I was after I*

found out about death' and was linked to heavy drinking as he remained 'in the doldrums' following his grandfather's death when 'there is no indication that he...is actively trying to make a commitment' (*Marcia*, 1966, cited in *Coleman and Hendry*, 1993: 63). Very high and unresolved identification conflicts with *'mother'* and *'my partner/spouse'*, very high contra-identifications with the former and modulations in his empathetic identifications with the latter evidenced separation issues linked to his 'principal carer' role following his father's death. His very high idealistic identifications with *'a person who has died suddenly'* and *'father'* pointed to these strong positive role models, while modulations in his empathetic identification with the former, as he appraised himself from school-leaving to *'me as I am at work'* reflected his professional involvement in healing therapies. His high structural pressures on constructs demonstrated his belief and value system that acknowledged the traumatic effects of sudden death but was committed to progressive, personal development based upon optimism, inner strength and composure. But problematic and perhaps unpredictable areas of his identity included family relationships and fears about the potential lethality of depression.

5.9.3 Control respondent H: Conclusions

Identity development was strongly influenced by this control respondent's multiple traumatic losses including childhood sexual abuse and his three bereavements. The most recent death of his mother was prefaced by further losses associated with his caring role and family alienation followed it. Therapeutic support and his developing professional interest in healing therapies, allied to his personal relationships have combined to offer a defensive framework while he continued to heal his grief wounds. He was developing a new identity as a 'wounded healer' making 'it possible to

combined to offer a defensive framework while he continued to heal his grief wounds. He was developing a new identity as a 'wounded healer' making 'it possible to transform the pain of negative life experiences into a resource for helping others' (*McLeod*, 1998: 355).

5.10 Comparisons and Contrasts

The impact on identity process of the experiences of each group was ascertained by examining the overall findings for survivors – the target group – and for non-suicide mourners – the control group. It was important to note, in relation to this investigation, that the only common identity shaping experience of target group members was the suicidal loss of a loved one. Similarly control group members shared only the fact that they experienced non-suicidal bereavement. The only bond connecting the eight volunteers was their participation in the investigation.

5.10.1 Global analysis – identity variants

Global descriptions of participants' identity states were given in terms of identity variant classifications (*Weinreich*, 1992: 23). An overview of what emerged in relation to the impact of bereavement on identity process was obtained by comparing identity variants within the target group and between the two groups, as far as this was practicable (Tables 5.1 and 5.2).

For the target group, five survivors (n = 5) demonstrated vulnerable identities as they appraised both current and past selves. Three survivors (n = 3) demonstrated vulnerable identities as they appraised themselves in their currently situated selves. Three survivors (n = 3) demonstrated vulnerable identities as they appraised the past

self *'me as I was after I found out about the suicide'*. One survivor (n = 1) demonstrated vulnerable identities across all the situated selves under examination.

Table 5.1 Identity variants - target group

Table 5.1: Target Group – Identity Variants					
	Current Self 1	Current Self 2	Past Self 1	Past Self 2	Past Self 3
Respondent A	CRISIS	CRISIS	DIFFUSION	DIFFUSION	CRISIS
Respondent B	INDETERMINATE	INDETERMINATE	INDETERMINATE	INDETERMINATE	NEGATIVE
Respondent C	DEFENSIVE HIGH SELF-REGARD	DEFENSIVE HIGH SELF-REGARD	DEFENSIVE HIGH SELF-REGARD	INDETERMINATE	DEFENSIVE
Respondent D	INDETERMINATE	INDETERMINATE	INDETERMINATE	INDETERMINATE	INDETERMINATE
Respondent E	DEFENSIVE	INDETERMINATE	CRISIS	INDETERMINATE	INDETERMINATE
Respondent F	INDETERMINATE	INDETERMINATE	NEGATIVE	INDETERMINATE	INDETERMINATE

In the control group, both non-suicide mourners (n = 2) demonstrated vulnerable identities as they appraised both current and past selves while one non-suicide mourner (n = 1) demonstrated vulnerable identities across all situated selves. It transpired that he had suffered multiple trauma in childhood that he was unable to begin to resolve until his late thirties. Both non-suicide mourners demonstrated vulnerable identities as they appraised the past self *'me as I was after I found out about death'*.

Table 5.2 Identity Variants - Control Group

Table 5.2: Control Group – Identity Variants					
	Current Self 1	Current Self 2	Past Self 3	Past Self 4	Past Self 5
Control Respondent G	DEFENSIVE HIGH SELF-REGARD	DEFENSIVE HIGH SELF-REGARD	DEFENSIVE NEGATIVE	DEFENSIVE NEGATIVE	DEFENSIVE
Control Respondent H	NEGATIVE	INDETERMINATE	CRISIS	CRISIS	DIFFUSION

Disrupted identities were to be anticipated in individuals making up both target and control groups in view of their common experiences of serious loss (*Jacobs*, 1998: 4).

In order to explore further the differences between individual survivors in the target group and between these survivors and mourners in the control group it was necessary to go beyond global identity variants, which were used as a first stage in identity analysis, and to explore some underlying parameters.

5.11 Conflicted identifications and empathetic identifications

5.11.1 Conflicted identifications

Conflicted identifications represented a combination of empathetic identification and contra- identification. It was decided to compare the level of identification conflicts in relation to their currently situated selves that survivors had with *'a person who has taken her/his own life'*, against the level of identification conflicts that non-suicide mourners had with *'a person who died suddenly'*.

Five survivors (n = 5) and both non-suicide mourners (n = 2) had high identification conflicts with *'a depressed person'*. But four survivors (n = 4) had high identification conflicts with *'a person who has taken her/his own life'*, while neither non-suicide mourner (n = 0) had high identification conflicts with *'a person who died suddenly'*. All six survivors (n = 6) had high identification conflicts with *'mother'* compared with one only of the non-suicide mourners (n = 1) (Tables 5.3 and 5.4). It appeared that survivors' identity development continued to be involved with their deceased without regard to the chronology of the loss itself. Survivors were resolving issues about suicide events occurring between 1965 to 1998 or up to 35 years ago. They feared the potential lethality of depression and wanted to dissociate from that. The findings in relation to involvement with *'mother'* reflected the pivotal role that five of the six survivors' mothers played in the prelude to the suicide and in its aftermath.

'The internalisation of parental hostility and malice through the defence of identifying with the aggressor is a primary causative factor in suicide' (*Firestone,* 1997: 282) In relation to the control group finding, control respondent H's relationship with his deceased mother continued to be a fundamental influence on his identity process. Empathetic identifications further illuminated these findings.

Table 5.3 Conflicted identifications – target group

Table 5.3: Target Group – Conflicted Identifications			
	A Person who has taken her/his own life	Depressed Person	Mother
Respondent A		✓	✓
Respondent B	✓	✓	✓
Respondent C			✓
Respondent D	✓	✓	✓
Respondent E	✓	✓	✓
Respondent F	✓	✓	✓

Table 5.4 Conflicted identifications – control group

Table 5.4: Control Group – Conflicted Identifications			
	A Person who died suddenly	Depressed Person	Mother
Control Respondent G		✓	
Control Respondent H		✓	✓

5.11.2 Empathetic identifications

Modulated empathetic identifications as participants appraised the deceased, family members and significant others pointed up identity development since the loss event. All participants experienced modulations (Table 5.5) evidencing identity processes directly related to bereavement. The most frequent of fifteen modulations (n = 15) detected for the target group were those related to appraisals between *'me as I was before I found out about the suicide'* and *'me as I was after I found out about the suicide'* (n = 6) reflected responses in the aftermath of suicidal loss. For example, Respondent A decreasingly empathetically with *'a depressed person'* and *'an admired person'* evidencing her use of denial as a coping tactic while Respondent B

increasingly empathetically identified with the deceased and with *'a depressed person'*, responding to the lethality of her dead son's depression. Respondent F increasingly empathetically identified with the deceased, feeling compassion for his dead sister. Respondents C, D and E decreasingly empathetically identified with significant others, including *'my partner/spouse'*, demonstrating post-suicide dissociation. Faberow (1991) reported research on the influence of kinship in suicide reaction that concluded that parent survivors worried less about their own suicide than sibling survivors, the 'forgotten mourners' (*Morse*, 1984) and overall, siblings experienced more 'difficulties' in their bereavement course (*Faberow* (1991), cited in *Leenaars*, 1991: 266). In relation to children's reactions to suicides of parents, Pfeffer (1981) noted 'denial, distortion and lack of open discussion' leading to psychological problems for survivors (*Faberow* (1991), cited in *Leenaars*, 1991: 268).

There were three modulations (n = 3) for survivors in relation to appraisals between *'me as I was after the suicide'* and *'me as I am at home'*. Respondent B increasingly empathetically identified with *'my minister of religion/spiritual adviser'* who supported her in the aftermath of her son's suicide, while Respondent E increasingly empathetically identified with significant others, including *'my partner/spouse'* evidencing change and recovery through counselling support. In contrast, Respondent F decreasingly empathetically identified with significant others, including *'mother'* and *'my minister of religion/spiritual adviser'*, distancing himself from what he perceived as traditional attitudes to suicide in Northern Ireland, which included elements of crime, sin, stigma and taboo (*Shneidman*, 1994: 31).

There were three modulations (n = 3) in relation to appraisals between *'me as I was before I found out about the suicide'* and *'me as I am at home'*. Respondents A,

coping with sibling loss, increasingly empathetically identified with *'a depressed person'* and *'an admired person'* as she continued to suffer post-suicide symptoms 'of prolonged and intensive grief, unresolved coping and more problematic bereavement' (*Morse* (1884) cited in *Leenaars*, 1991: 268). This was reinforced by her decreasing empathetic identification with *'my partner/spouse'* and *'my closest friend'* exemplifying some isolation in survivorhood. Unfortunately she might incur an elevated risk of self-harm as 'social isolation is seen as the first stage leading to suicidal feelings and a possible suicide attempt' (*Jacobs* (1971) and *Teicher* (1970), cited in *O'Connor and Sheehy*, 2000: 48). Meanwhile Respondent D's developing relationship with her father, in the aftermath of sibling suicide was demonstrated in her increasing empathetic identification with *'father'*.

Modulations by the control group (n = 4) evidenced aspects of recovery for both non-suicide mourners in relation to appraisals between *'me as I was when I left school'* and *'me as I am at home'*. Control respondent G's increasing empathetic identifications with *'my partner/spouse'* and *'an admired person'* pointed up a 'turning point' as he benefited from the release of 'deep weeping' for his loss (*Leick and Davidsen-Nielsen,* 1996: 6, 46). Respondent H's decreasing empathetic identifications with significant others, including his two paternal models, signalled dissociation perhaps from dependent past behaviour patterns while increasing empathetic identifications, with *'partner/spouse'* and *'admired person'* and with *'a person who has died suddenly'* as he appraised himself from the past into *'me as I am at work'* illustrated a drive towards his new identity as a professional therapist.

The contrast between the target group and the control group evidenced by their respective empathetic identifications was consistent with Faberow's (1996) more

recent view that 'surviving a loss to suicide is more difficult, more complicated and more intense...survivors may be left with persistent, troubling concerns' (*Faberow*, 1996: 1).

Table 5.5 Empathetic identifications – Modulations as a consequence of bereavement

Table 5.5: Empathetic identifications – Modulations as a consequence of bereavement								
	Respondent A	Respondent B	Respondent C	Respondent D	Respondent E	Respondent F	Control Respondent G	Control Respondent H
PS1/CS1			Increasing				Increasing	Decreasing
PS1/CS2								Increasing (2)
PS2/PS3	Decreasing	Increasing	Decreasing	Decreasing	Decreasing	Increasing		
PS2/CS1	Increasing Decreasing			Increasing				
PS3/PS1			Increasing					
PS3/CS1		Increasing			Increasing	Decreasing		
PS3/CS2	Increasing							

Key:
'Decreasing' refers to entities where modulations in empathetic identification decreased from the first to the second entity.

'Increasing' refers to entities where modulations in empathetic identification increased from the first to the second entity

PS1 'me as I was when I left school'
PS2 'me as I was before I found out about the suicide'
PS2 'me as I was before I found out about death' (Control entity)
PS3 'me as I was after I found out about the suicide'
PS2 'me as I was after I found out about death' (Control entity)
CS1 'me as I am at home'
CS2 'me as I am at work'

5.12 Core and Conflicted Dimensions of Identity

5.12.1 Core evaluative dimensions of identity

The extent to which people consistently attribute favourable and unfavourable characteristics to those they approve or disapprove of, respectively, was assessed by the ISA index of structural pressure on particular constructs (*Weinreich*, 1992: 4). Very high net structural pressures were considered to dominate the individual's evaluation of others to the limits of rigidity and bigotry and were regarded as very

dominant core evaluative dimensions of identity when individuals used them to assess the merits of others (*Weinreich*, 1992: 5). Typically, a core evaluative dimension of identity was highly evaluative, judgemental and resistant to change representing a strong aspiration within the individual's belief and value system (*Black*, 2000: 107).

Seven constructs (n = 7), for the target group and three constructs (n = 3) for the control group represented commonly held aspirations of participants in their construal of themselves in their social world while appraising their identity structure in this investigation (Tables 5.6 and 5.7).

Table 5.6 Target Group - Core evaluative dimensions of identity

Core Evaluative Dimensions of Identity – Target Group				
Construct List		Incidence of High Structural Pressure within Target Group on constructs	Preferred polarity	
+	–		+	-
13. ... can be trusted	... can't be trusted	83%	5	0
5. ... develops good relationships	... withdraws from human contact	83%	5	0
6. ... thinks it is healthy to acknowledge human mortality	... thinks it is morbid to acknowledge human mortality	67%	4	0
7. ... believes in the irreplaceable value of each human being	... does not value human beings very highly	50%	3	0
23. ... believes that suicide and depression are closely linked...	... believes that suicide and depression are not linked	50%	3	0
5. ... relies on family support at times of crisis	... does not rely in family support at times of crisis	33%	2	0
4. ... looks for security and protection in family	... looks to be set free from family ties	33%	2	0

Key: personal construct social construct health construct suicide construct family construct

NB Construct No 23 belongs to both 'health' and 'suicide' construct categories

Table 5.7 Control Group - Core evaluative dimensions of identity

Core Evaluative Dimensions of Identity – Control Group				
Construct List		Incidence of High Structural Pressure within Control Group on constructs	Preferred polarity	
+	–		+ / -	
5. …is optimistic about the future	…is pessimistic about the future	100%	2	0
7. …believes in the irreplaceable value of each human being	…does not value human beings very highly	100%	2	0
16. …continues to develop own personal values and beliefs	…sticks rigidly to values and beliefs of parents/guardians	100%	2	0

Key: ○ personal construct ▭ social construct

Five survivors (n = 5) reflected common aspirations to personal and social values implicit in self-trust (Construct No 13) and development of good relationships (Construct No 3). Sibling survivors experienced more problems including anger, stigma, concern about their own suicide, panic attacks and experienced less 'forgetting' that their loved one was dead and more incidences of 'seeing' their deceased family member after the death (*Faberow*, 1991: 266). Survivors' aspirations were contrary to expectations since 'suicide affects the readiness of the survivor to trust – fears of abandonment may provoke hesitancy toward commitment to any subsequent relationship' (*Faberow,* 1996: 1). Four survivors (n = 4) asserted that acknowledgement of human mortality (Construct No 6) was a core dimension of their identity. Suicide of a loved one demonstrated the frailty of life and the finality of death. This core evaluative dimension had 'the merit of taking somewhat more into account the true state of affairs' (*Freud* (1915), cited in *Becker*, 1997: 11). Three survivors (n = 3) confirmed their belief that suicide and depression were closely

linked (Construct No 23) and their belief in the irreplaceable value of each human being (Construct No 7). Yet 'hopelessness', a key predisposing variable in depression, was a better predictor of suicide: "...(the 'hopeless' depressed) go on to take their own lives and...(the 'hopeful' depressed) do not' (*O'Connor and Sheehy*, 2000: 33). Two sibling suicide survivor respondents – A and D – sought (Construct No 4) and relied upon (Construct No 5) family support although Respondent A's structural pressures (42.72, 43.73) were 'secondary' evaluative dimensions while Respondent D's structural pressures (64.52, 69.40) were 'core' evaluative dimensions of identity. In relation to family support a recent study on depression found that 'the only psychosocial variable significantly related to suicide in the short term was not having a child under eighteen at home' (*Fawcett*, 1996: 1). Both respondents' aspirations also reflected the constructs relating to trust and relationship, discussed above.

Control group members shared three core dimensions of identity detected by high structural pressures. These related to a feeling of optimism about the future (Control Construct No 5), a strong belief in the irreplaceable value of each human being (Control Construct No 7) and an interest in personal development (Control Construct 16).

The only aspiration common to both control group members and to more than one target group member related to the value of human life but control group members, as individuals, placed a high value on trust, relationships, warm feelings, personal development, alternative/complementary therapies and optimism and shared these with at least one target group member.

5.12.2 Conflicted dimensions of identity

When structural pressures were very low or negative, the construct in question was subject to cognitive-affective inconsistency. Accordingly the construct encompassed a highly conflicted area of judgement of self and others (*Weinreich*, 1992: 5). Five constructs (n = 5), for the target group and nil constructs (n = 0) for the control group represented commonly held areas of uncertainty and unpredictability for participants in their construal of themselves in their social world while appraising their identity structure in this investigation (Table 5.8).

Four survivors (n = 4) reflected uncertainty and unpredictability in relation to complementary/alternative therapies (Construct No 22). Three survivors (n = 3) reflected uncertainty and unpredictability in relation to recovery from suicidal loss (Construct No 9) and two survivors (n = 2) were ambivalent in relation to suicide prevention (Construct No 14). Two survivors (n = 2) reflected uncertainty and unpredictability in relation, respectively, to the use of corporal punishment (Construct No 10) and one (n = 1) survivor reflected uncertainty in relation to family support (Construct No 4).

Table 5.8 Target group - conflicted evaluative dimensions of identity

Conflicted Evaluative Dimensions of Identity – Target Group				
Construct List		Incidence of Low Structural Pressure within Control Group on constructs	Preferred polarity	
+	–		+ /	-
22. „...is interested in complimentary and alternative therapies	...relies mainly on prescribed medication to relieve pain	67%	4	0
9. ...believes that families eventually get over a suicidal loss	...believes that families never get over a suicidal loss	50%	3	0
14. ...considers that most suicides could be prevented	...considers that most suicides cannot be prevented	33%	2	0
10. ...believes corporal punishment is a form of child abuse	...believes corporal punishment does no harm to children	33%	2	0
4. ...looks for security and protection in family	...looks to be set free from family ties	17%	1	0

Key: personal construct social construct health construct suicide construct family construct

NB. Construct No.23 belongs to both 'health' and 'suicide' categories.

Three constructs relating to family support (construct No 5 / control construct No 8), group participation (construct No 4 / control construct No 17) and corporal punishment (construct No 10 / control construct No 2) represented areas of uncertainty and unpredictability common to at least one member of each group.

In relation to the healing of individual survivors' 'psychological trauma' (*Lukas and Seiden*, 1990: 27) the question 'Why?' remained unanswered despite public inquests, suicide notes (*Leenaars*, 1991: 127), psychological autopsies, interviews with parasuicides and high-risk groups (*O'Connor and Sheehy*, 2000: 24). It was not unexpected therefore that construct No 9 *'believes that families eventually get over a suicidal loss'* / *' believes that families never get over a suicidal loss'* strongly challenged survivors. Yet, in relation to suicide prevention and postvention, survivors represented an invaluable resource in relation to self-help and in reaching out to other survivors but a 'stigma as it applies to the survivor' appeared to preclude their involvement in 'a committed, concerted effort to "postvene"' (*Lukas and Seiden*, 1990: 209).

5.13 Suicide Survivors: Attributes, relationships and grief

This investigation explored survivor postvention strategies by examining reported experiences of a self-selected sample group – the target group. Although the study focused on the mode of their loved one's death, family systems or 'kinship networks for at least three generations' (*Bradshaw*, 1995: 57) in which each survivor was reared, including the influence of their 'sibling position' (*Toman* (1994), cited in *Bradshaw* 1995: 65) and other family characteristics provided the context for a self-destructive dynamic that culminated in suicide. Table 5.9 summarised some survivors' characteristics, attributes and relationships connected directly or indirectly

to their suicide loss. Where the psychological autopsy (*O'Connor and Sheehy*, 2000: 26,27) was literally 'post mortem' (*Ehrlich,* 1999: 182) use of family systems theory (*Bowen* (1985), cited in *Bradshaw*, 1995: 58) and the more recent theory of causative formation (*Sheldrake* (1989), cited in Bradshaw: 78) in family therapy could offer survivor families self-protecting, life-extending insights.

Table 5.9 Target group - Characteristics, attributes and other descriptors

Target group - Characteristics, attributes and other descriptors							
Respondents	**A**	**B**	**C**	**D**	**E**	**F**	**Totals**
Sex (M/F)	F	F	M	F	M	M	
Attempted Suicide			✓		✓		
Suicidal thoughts but no acting out					✓	✓	
Self-harming behaviour	✓		✓		✓		
Counselling support		✓			✓		
Other effective support		✓			✓	✓	
Sought, but unable to find help				✓			
Found GP helpful and supportive				✓			
Did not seek help	✓		✓			✓	
Talked openly to non-judgemental listener					✓		
Had never spoken openly about loss	✓	✓	✓	✓		✓	
Survivor's relationship with deceased	Sister	Son	Father	Sister	Brother	Sister	
Age of deceased at death	19	23	29	39	37	49	
Age of survivor at death of deceased	23	41	7	38	38	53	
Years lost by deceased in terms of normal life expectancy *	52.9	44.6	27.8	32.9	30.5	22.9	211.6
Years of survivors' grief in terms of normal life expectancy *	48.9	30.9	60.5	33.9	29.5	14.5	218.2

* based on data in Caselli, G. (1994) *Long-term trends in European mortality.* London: HMSO.

5.14 Propositions emerging from discussion

Survivors were at different stages in their identity process but all were strongly impacted upon by their only common identity forming experience – their loss by suicide. Different modes of self-killing – by hanging, by self-poisoning, by gassing - of, and varying degrees of kinship – sibling, parent or child – with the deceased differentiated the overall impact upon each survivor but no assessment or comparison of their internal angst was possible. The key 'grief' variable was the degree of attachment.

Proposition No 1: Survivors' pain and anguish was not directly related to the specific killing method.

Proposition No 2: Degrees of attachment were stronger indicators of the intensity and persistence of survivors' grief than degrees of kinship.

Although four survivors were in sibling relationships with their loved one, only one, Respondent D demonstrated a well-adjusted state in all her situated selves. Yet her 'unfinished business' with her deceased sister was evident in its continuing impact upon her sense of herself, as reported by her.

Proposition No 3: All identity variant states were indicators along a vulnerability spectrum. The 'well-adjusted' identity state showed only that a survivor's internal and external coping strategies were balanced when the ISA instrument was applied.

Two male survivors attempted suicide and two male survivors acknowledged suicidal thoughts. Respondent C's attempt emulated his father's suicide while Respondent E made suicide attempts before his brother's completed suicide. Respondents E and F also had suicidal thoughts. Respondent E coped using a range of learned strategies while Respondent F admitted that he could emulate his sister at a future time. Respondents A and B were defended against suicide ideation by a sense of

responsibility towards their own family survivors but the former was concerned that her brother might emulate their sister while Respondent C's siblings were also parasuicides.

Proposition No 4: Dysfunctional families were often breeding grounds for suicidal behaviour both ideation and acting out. A completed suicide pointed to the existence of past or current suicidal ideation in surviving family members.

All but one - Case Study B - of the suicides was considered by a formal inquest hearing. Such events have a minimal and indeterminate role and only in a general sense in relation either to healing the grief of survivors or in suicide postvention. None of the survivors reported that the suicide was the subject of a formal psychological autopsy involving a dedicated 'suicide team'. Responsibility for the health of individuals comprising the survivor family remained with general practitioners. But survivors reported minimal involvement by their family doctors after the suicide. It was suggested that doctors of patients who suicide could be at risk of secondary traumatization.

Proposition No 5: Public inquests addressed legal imperatives. But survivors' needs for an answer to the 'Why?' question were not the responsibility of the legal system. The resulting silence often intensified the chronicity of survivors' grief. Acknowledgement was needed of this lacuna by compassionate coroners and in due course by the legislature.

Proposition No 6: Consideration was needed of public provision of a preliminary psychological examination of the living family systems [based upon psychological autopsy of the suicide deceased] from which each suicide emerged, as a contribution to survivor postvention. Removal of the double stigma and double taboo – death and suicide - that presented a barrier to this development needed determined educational efforts across the community.

Proposition No 7: All general practitioners required specialist training in the health needs of survivors.

Proposition No 8: Assessment and provision of individual, family and group therapy to the survivor family, using public or private counselling resources as appropriate, was a vital postvention activity that traumatized practitioners may not be able to address.

Proposition No 9: The general practitioner of a patient who suicided required the option of availing of the support of a deputised colleague to care for the survivors of her/his patient for up to one year.

Only one survivor secured effective counselling (Respondent E) and none of the others had spoken openly, viz. at group therapy or to a non-judgemental listener prior to their participation in this study. One survivor (Respondent B) secured short but ineffective counselling support. One survivor (Respondent D) sought support from Cruse but did not obtain help. Three survivors (Respondents A, C and F) did not seek help outside their immediate family. Two survivors, Respondents E and F obtained effective ongoing support from 'twelve step fellowships' and work colleagues/close friends.

Proposition No 10: Cruse's pivotal position in the provision of voluntary counselling for suicide survivors placed an important responsibility on their volunteer administrative staff. Cruse may defeat their mission by adding to survivors' pain if undertakings given to ALL survivors who contact them are not fulfilled.

Proposition No 11: Employer-provided counselling services may fail to meet their objectives if an effective referral policy was not in place to meet survivors' needs that are outside the organisation's immediate resources.

All survivors experienced depression in varying degrees as a consequence of their grief experience. Some sought the immediate if illusory relief of mood changing substances. Three survivors reported engaging in self-harming behaviours, including inappropriate use of alcohol and other drugs of dependency. There may be no general relationship between survivorhood and self-harming behaviours but the psychological pain of unresolved or unfinished grief may provide a bridging motivation.

Proposition No 12: Survivorhood was a readily identifiable pre-disposing factor for depression.

Proposition No 13: Suicide's black reputation stimulated a withdrawal reflex based upon fear that prevented proactive behaviour by support mechanisms in the family and community usually triggered by normal bereavement. Inability to anticipate suicide conspired with shock, silence, stigma and taboo to render those mechanisms impotent.

Survivor recovery and resolution was complicated by many factors some of which were explored in this study. If survivorhood trauma were a lifelong identity-determining factor (this study did not investigate that hypothesis) simple calculations based upon data on changes in life expectancy demonstrated that survivors could anticipate a total of 211.2 years of trauma-related psychological pain. Participants had already grieved for a high of 35 years (Respondent C) to a low of 2 years (Respondent E) or a total for the six survivors of almost 80 years. Based on the same source suicide deceased lost the potential for a total 218.6 years of life.

Proposition No 13: The human cost of suicidal loss was acknowledged to be incalculable.

Proposition No 14: Life expectancy data inferred that 'lost time' for suicide deceased was assessable. But financial estimates of the costs of suicide to society were not generally known.

Proposition No 15: A methodology for exploring two hypotheses: 'Survivorship trauma is a lifelong identity-determining factor' and 'An enhanced risk of suicide exists among survivors that can be related directly or indirectly to survivorship' potentially existed in Identity Structure Analysis (ISA).

Proposition No 16: An exploration of suicide survivor identity using ISA within a longitudinal study offered the tantalising prospect of breaking out from the many, negative influences of suicide myths whose origins were lost in antiquity, into a more informed, more positive and more compassionate perspective on an issue that has challenged humanity at all times and in all cultures.

Proposition No 17: It was arguable that there was a massive imbalance between public investment in suicide prevention and postvention, and the costs to society of suicidal loss.

Proposition No 18: A recent study into the costs to Northern Ireland of the 'Troubles' provided major input to policy in recent years. A similar enquiry into the costs of suicide was seldom aired publicly possibly because inter alia of factors listed in Proposition No 13 above, viz. shock, silence, stigma and taboo.

It was arguable that there were differentiated identity responses to bereavement as between the target group of survivors and the control group of non-suicide mourners. Outcomes from application of each of the instruments, viz.content analysis and identity structure analysis illustrated this. Across a majority of ISA indices, survivors exhibited vulnerable identity states, conflicted identifications, empathetic identifications, contra-identifications, idealistic identifications and both core and conflicted dimensions of identity that appeared to relate frequently and consistently to the key issue for each survivor, viz. the experience of suicidal loss of their loved one. A majority of similar ISA indices for non-suicide mourners did not relate as frequently or as consistently back to the single issue of their bereavement experiences. Ideally, participation by equal numbers of survivor and non-suicide mourners may or may not have reinforced these results. In the present study, the most important differentiating factor between the groups was the mode of death of the deceased.

Proposition No 19: Identity differentiation related to bereavement was shown to be significantly related to the mode of death of the loved one.

Proposition No 20: Factors such as age, chronology of the bereavement, availability of and access to personal, family, medical and counselling support did not affect the impact of mode of death on the identity development of either survivors or non-suicide mourners.

Content analysis was a qualitative methodology that permitted the investigator as a research instrument to respond idiosyncratically to the challenges of research strategy and design, outcomes of fieldwork, data processing and content analysis. Consistency in instrument design and application, e.g. use of an interview schedule, investigator's

presence when the ISA instrument was applied and ensuring that each respondent's well being was attended to throughout the study, including progress feedback to participants, was allied to investigator transparency in relation to his own status as a survivor. Consequently the investigator derived the above propositions with discipline and rigour but also with as much compassion as he could muster in view of the nature of the study, the feelings of the participants and his own vulnerability as a wounded healer. Conclusions and recommendations in the next paragraph concluded the study.

5.15 Conclusions and recommendations

5.15.1 Conclusions

Three objectives and nine related activities (see pages 2/3 above) were established at the outset of the study as a path towards achieving the study's aim. All of the activities were carried out. Findings emerging from the study in relation to these objectives were set out below:

Re Objective No 1 – examination of survivor suicide risk

Survivors were found to be at greater risk of suicide than non-suicide mourners. Four survivors engaged in one or more activities that pre-disposed towards future completed suicide – self-harm, suicide ideation or attempted suicide – while one of the control group engaged in a self-harm activity related to childhood trauma.

Re Objective No 2 – survivor counselling and loss integration

One survivor secured effective one-to-one and group counselling. ISA findings inferred that he achieved some loss integration and confirmed that his identity process

was designed so that he would avoid his dead brother's fate. Although it was not possible to isolate effective counselling as a significant factor that secured loss integration and a positive prognosis, there may be a causative relationship of some kind between the combination of self-help activities and his access to tailored counselling, and his identity development. Again it was not possible to infer a causative relationship between lack of effective counselling in relation the remaining five survivors and their identity development.

Re Objective No 3 – survivors as a therapeutic resource

All of the survivors expressed an interest in the outcome of this study in relation to the well being of other survivors. Active participation by survivors in therapeutic programmes for survivors was conditional upon the level of resolution of their own loss trauma and provision of any necessary training and organisation. It seemed that the goodwill of these wounded, recovering individuals was an invaluable basis upon which to consider therapeutic programmes at some future time.

The study's aim and purpose (see page 2 above) was achieved by examination of the three propositions within the objectives.

5.15.2 Recommendation

Twenty propositions (see par 5.14 above) emerged from discussion of the transcript and identity process analyses. It was recommended that many of these propositions were worthy of further study and research.

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APPENDIX – 1

Schedule of themes used by the investigator in interviews

1 What happened

2 Health and well-being

3 Meaning

4 Aftercare

Note: The context was the quality of life of each participant.

APPENDIX – 2

Interview schedule used in pilot study

Research Methods (CMM 804J1) interview structure

I want to thank you (name of interviewee) for agreeing to talk on tape about the support you received and how you coped with your loss at the time of the death and in the period afterwards.

CIRCUMSTANCES

1 Perhaps I could begin by asking you to tell me when your (relative) died and what the circumstances of the death were.

IMMEDIATE FEELINGS

2 How did you feel at the time you heard about the death?

COPING

3 How did you to cope with these feelings – did close relatives and friends offer you support?

MEDICAL SUPPORT (1)

4 What help and support in coping with your distress did you get from your general practitioner – I mean did you contact your doctor's surgery? Did your doctor call to see you?

MEDICAL SUPPORT (2)

5 Looking back to that sad time, was the right medical help and support available to help to you to cope with what happened? Was it sufficient?

HEALTH

6 Has your own health been adversely affected since the death? I mean did you need medical help to cope for example with feelings of sadness, anger or depression?

SPECIAL SCAR

7 The loss by suicide of a close relative is said to leaves a 'special scar' in those who survive the loss. Do you recognise such a 'scar' in yourself or members of your family?

SEARCH FOR MEANING

8 Wertheimer (whose sister committed suicide) said that 'survivors only achieve understanding with hindsight'. Do you understand why your relative chose to do what she did?

COUNSELLING SUPPORT

9 People bereaved by the suicide of a close family member are sometimes called 'survivors of suicide'. As a survivor of suicide, did you seek counselling support to help you to come to terms with your loss? Can you tell me something about this?

AFTERCARE SERVICES

10 This research study is about the nature, availability and delivery of aftercare to survivors of suicide. In the light of your own experience, what additional services and resources might be made available to survivors?

FINALLY

One approach to helping people who have suicidal urges is to encourage them to speak their thoughts and to express any emotions and feelings that may emerge to a compassionate counsellor. How do you think that survivors of suicide, particularly young people, might be helped to resolve their fears for themselves so as to achieve their full potential as human beings?

APPENDIX – 3

Target Group Entity List

ENTITY LIST - Instrument : MSc Study

1	* IDEAL SELF	Me as I would like to be...
2	* CURRENT SELF 1	Me as I am at home...
3	CURRENT SELF 2	Me as I am at work...
4	* PAST SELF 1	Me as I was when I left school...
5	* ADMIRED PERSON	A person I admire... (nominate)
6	* DISLIKED PERSON	A person I dislike... (nominate)
7	PAST SELF 2	Me as I was before I found out about the suicide...
8	PAST SELF 3	Me as I was after I found out about the suicide...
9	METAPERSPECTIVE 1	Me as my family sees me...
10		Mother...
11		Father...
12		My closest friend... (nominate)
13		My partner/spouse...
14		The caring professions...
15		My minister of religion/spiritual adviser...
16		A depressed person...
17		My colleagues in the workplace...
18	METAPERSPECTIVE 2	Me as my contemporaries see me...
19		A person who has taken her/his own life...

APPENDIX – 4

Control Group Entity List

ENTITY LIST - Instrument : MSc Study - Controls

1	*	IDEAL SELF	Me as I would like to be...
2	*	CURRENT SELF 1	Me as I am at home...
3		CURRENT SELF 2	Me as I am at work...
4		METAPERSPECTIVE 1	Me as my contemporaries see me...
5	*	PAST SELF 1	Me as I was when I left school...
6	*	ADMIRED PERSON	A person I admire...(nominate)
7	*	DISLIKED PERSON	A person I dislike...(nominate)
8			My closest friend...
9			Mother...
10			Father...
11			A depressed person...
12			My partner/spouse...
13		METAPERSPECTIVE 2	Me as my family sees me...
14			My colleagues in the workplace...
15			The caring professions...
16			My minister of religion/spiritual adviser...
17		PAST SELF 2	Me as I was before I found out about death...
18		PAST SELF 3	Me as I was after I found out about death...
19			A person who died suddenly...(nominate)

APPENDIX – 5

Target Group Construct List

CONSTRUCT LIST - Instrument :
MSc Study

1	...feel/s that a suicide survivor's grief is like any other	...feel/s that a suicide survivor's grief is uniquely painful
2	...feel/s at ease when acting as a member of a group	...feel/s uncomfortable when acting as a member of a group
3	...withdraw/s from human contact	...develop/s good relationship
4	...look/s to be set free from family ties	...look/s for security and protection in family
5	...rely/ies on family support at times of crisis	...do/es not rely on family support at times of crisis
6	...think/s that it is morbid to acknowledge human mortality	...think/s that it is healthy to acknowledge human mortality
7	...believe/s in the irreplaceable value of each human being	...do/es not value human being very highly
8	I loathe...	I have warm feelings towards..
9	...believe/s that families eventually get over a suicidal loss	...believe/s that families never get over a suicidal loss
10	...believe/s corporal punishment does no harm to children	...believe/s corporal punishment is a form of child abuse
11	...put/s obligations to family first	...put/s own ambitions and wishes before obligations to family
12	...is/are convinced that suicide demands considerable bravery	...is/are convinced that suicide is the act of a coward
13	...can't be trusted	...can be trusted
14	...consider/s that most suicides cannot be prevented	...consider/s that most suicides could be prevented
15	...always express/es emotional feelings safely	...never express/es emotional feelings safely
16	...continue/s to develop personal values and beliefs	...stick/s rigidly to the values and beliefs of parents/guardians
0		

CONSTRUCT LIST - Instrument :
MSc Study

17	I feel encouraged by...	I feel distressed by...
18	...is/are pessimistic about the future	...is/are optimistic about the future
19	...do/es not enjoy many social activities and community events	...enjoy/s most social activities and community event
20	...believe/s suicide may be anticipated by behaviour	...believe/s that suicide cannot be predicted by behaviour
21	...can often be alone without feeling lonely	...cannot be alone for long without starting to feel distressed
22	...rely/ies mainly on prescribed medication to relieve pain	...is/are interested in complementary and alternative therapies
23	...believe/s that depression and suicide are not linked	...believe/s that depression and suicide are closely linked

APPENDIX – 6

Control Group Construct List

CONSTRUCT LIST - Instrument :
MSc Study - Controls

1	...think/s it is morbid to acknowledge human mortality	...think/s it is healthy to acknowledge human mortality
2	...believe/s corporal punishment does no harm to children	...believe/s corporal punishment is a form of child abuse
3	I feel distressed by...	I feel encouraged by...
4	...can be trusted	...can't be trusted
5	...is/are optimistic about the future	...is/are pessimistic about th future
6	...is/are interested in complementary / alternative therapies.	...rely/ies mainly on prescribed medication to relieve pain
7	...do/es not value human beings very highly	...believe/s in the irreplaceable value of each human being
8	...rely/ies on family support at times of crisis	...do/es not rely on family support at times of crisis
9	I loathe...	I have warm feelings towards..
10	...feel/s at ease as a member of a group	...feel/s uncomfortable as a member of a group
11	...can often be alone without feeling lonely	...cannot be alone for long without starting to feel distressed
12	...enjoy/s most social activities and community events	...do/es not enjoy most social activities and community event:
13	...always express/es emotional feelings in unhealthy ways	...always express/es emotional feelings in healthy ways
14	...put/s obligations to family first	...put/s own ambitions and wishes before obligations to family
15	...withdraw/s from human contact	...develop/s good relationship:
16	...continue/s to develop own personal values and beliefs	...stick/s rigidly to values and beliefs of parents/guardians

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CONSTRUCT LIST - Instrument :
MSc Study - Controls

17	...look/s to be set free from family ties	...look/s to family for security and protection
18	...believe/s that depression is a life-threatening condition	...believe/s that depression i not a life-threatening condition
19	...feel/s that sudden death seldom triggers exceptional grief	...feel/s that sudden death often triggers exceptional grief
20	...believe/s families often get over a loved one's sudden death	...believe/s families seldom get over a loved one's sudden death

APPENDIX – 7

Copy letters to the media

Letter e-mailed to n.doran@irishnews.com today

The Editor
'Irish News'
Donegall Street
Belfast
BT1 2GE

Mon 8 November 1999

AFTERCARE FOR PEOPLE BEREAVED BY SUICIDE

I am a postgraduate research student at the University of Ulster at Jordanstown. My area of study is the nature, availability and delivery of aftercare, including grief therapy and grief counselling, for people bereaved by the suicide of a close family member. Such bereaved individuals are sometimes referred to as 'survivors of bereavement by suicide'. According to the poet John Donne: 'Any man's death diminishes me because I am involved in mankind'. But it is suggested that those bereaved by suicide may require compassionate help of a particular kind in order to heal and recover from a loss that often leaves a 'special scar'. I would wish to meet and talk, in strict confidence, with individuals, about what support they received and how they coped with their loss at the time of the death and in the period afterwards.

I undertake to respond to everyone who contacts me by telephone (on **028 9065 2296**) or by letter at **4 Ardgreenan Place Belmont Church Road Belfast BT4 3FY.**

Yours sincerely

Phil O'Keeffe T Cert BSc (Econ) DMS MSc

Letter e-mailed to lettersed@irish-times.ie today

The Editor
'Irish Times'
10-15 D'Olier Street
Dublin 2
Republic of Ireland

Sat 13 November 1999

AFTERCARE FOR PEOPLE BEREAVED BY SUICIDE

I am a postgraduate research student at the University of Ulster at Jordanstown. My area of study is the nature, availability and delivery of aftercare, including grief therapy and grief counselling, for people bereaved by the suicide of a close family member. Such bereaved individuals are sometimes referred to as 'survivors of bereavement by suicide'. According to the poet John Donne: 'Any man's death diminishes me because I am involved in mankind'. But it is suggested that those bereaved by suicide may require compassionate help of a particular kind in order to heal and recover from a loss that often leaves a 'special scar'. I would wish to meet and talk, in strict confidence, with individuals, about what support they received and how they coped with their loss at the time of the death and in the period afterwards.

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Yours sincerely

Phil O'Keeffe T Cert BSc (Econ) DMS MSc

Letter e-mailed to edmund.curran@belfasttelegraph.co.uk today

The Editor
'Belfast Telegraph'
124-144 Royal Avenue
Belfast
BT1 1EB

Sat 13 November 1999

AFTERCARE FOR PEOPLE BEREAVED BY SUICIDE

I am a postgraduate research student at the University of Ulster at Jordanstown. My area of study is the nature, availability and delivery of aftercare, including grief therapy and grief counselling, for people bereaved by the suicide of a close family member. Such bereaved individuals are sometimes referred to as 'survivors of bereavement by suicide'. According to the poet John Donne: 'Any man's death diminishes me because I am involved in mankind'. But it is suggested that those bereaved by suicide may require compassionate help of a particular kind in order to heal and recover from a loss that often leaves a 'special scar'. I would wish to meet and talk, in strict confidence, with individuals, about what support they received and how they coped with their loss at the time of the death and in the period afterwards.

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Yours sincerely

Phil O'Keeffe T Cert BSc (Econ) DMS MSc

APPENDIX – 8

Copy of consent form

CONSENT FORM FOR PARTICIPATION IN RESEARCH PROJECTS AND CLINICAL TRIALS

PART ONE

TITLE OF PROJECT: SUICIDOLOGY, COUNSELLING AND IDENTITY EXPLORATION: AN INVESTIGATION INTO POSTVENTION STRATEGIES FOR SUICIDE SURVIVORS

OUTLINE EXPLANATION:

Survivors of suicide are people like you: intimate relatives of individuals who have died in this way. Bereavement by suicide can have a traumatic impact upon the lives of suicide survivors. Your life may have been considerably changed by that tragic and terrible event.

This project investigates the relevance and usefulness of counselling for helping survivors in coping and recovery after such a loss. You may have been affected in several major ways.

For example your identity or 'sense of who you are' may have been challenged or changed in subtle ways that may or may not be apparent to you or other close family members.

Your quality of life may also have been adversely and apparently irrevocably affected in various ways. This may depend upon your personal relationship with the deceased and your ability successfully to cope with, recover from and integrate your traumatic loss.

By interviewing you and a number of other volunteer survivors on audiotape it is hoped to explore:

(i) What was your individual experience of loss?

(ii) How did you cope with this particular bereavement - what effective support was available from family and friends, general practitioner or other medically qualified personnel? Did you obtain any help from bereavement support agencies including any organisations dedicated to the support of survivors of suicide?

(iii) What impact did your loss experience have upon your sense of identity and your quality of life? and

(iv) What additional support do you consider that people like yourself and other survivors of suicide would find useful? What can you do to support yourself from within by personal development? What was available from outside sources to enable you to maintain your recovery and to enable you to enjoy the rest of your natural life and to achieve your full potential as a human being?

This project will use several research methods including audiotaped interviews, discourse analysis, and evaluation and may use identity structure analysis. It may also attempt to develop simple parameters to enable survivors like you to self-assess your present and anticipated quality of life.

It is hoped that this project will contribute to the development of new insights into your needs and the needs of other suicide survivors. The study will focus upon two specific areas. These are:

(i) Healing what has been called 'the special scar' of suicidal loss; and

(ii) Achievement by survivors of their full potential as human beings.

CONSENT FORM FOR PARTICIPATION IN RESEARCH PROJECTS AND CLINICAL TRIALS

PART TWO

TITLE OF PROJECT: SUICIDOLOGY, COUNSELLING AND IDENTITY EXPLORATION: AN INVESTIGATION INTO POSTVENTION STRATEGIES FOR SUICIDE SURVIVORS

I (Name) .....

of (address) .....

.....

hereby consent to take part in the investigation outlined above, the nature and purpose of which have been explained to me. Any questions I wished to ask have been answered to my satisfaction.

I understand that I may withdraw from the investigation at any stage without necessarily giving a reason for doing so and that no adverse inferences or consequences whatsoever will result.

I acknowledge that I have been invited by the applicant investigator to inform my general practitioner of my voluntary participation in this investigation/research project.

I understand that my contribution to this investigation/research project will be treated as confidential, subject to any exceptions that have been explained to me.

I understand that all material used in any related dissertation will be rendered anonymous in order to protect my privacy and the privacy of other respondents and participants and that no personally identifiable material will be used. I consent to the use in this investigation/research project of material obtained through audiotaped interviews and identity structure analysis.

Signed (Volunteer) ..... Date .....

(Investigator).....PHILIP O'KEEFFE Date .....

(Witness, where appropriate) ..... Date .....

APPENDIX – 9

Copy of waiver

WAIVER

Please read, sign and date below.

I understand my participation in this:
(e.g. counselling session, research interview, counselling workshop, seminar or other activity, etc.)

is voluntary. It may involve me in emotional distress. I agree to accept such risks and assume the responsibility for the effects thereof. I release (names of individuals:

from all claims made by me or on behalf of me by reason of any illness or disturbance arising from participation.

SIGNED DATE

WAIVER

Please read, sign and date below.

I understand my participation in this:
(counselling session, research interview, counselling workshop, seminar or other activity, etc.)

is voluntary. It may involve me in emotional distress. I agree to accept such risks and assume the responsibility for the effects thereof. I release (names of individuals:

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SIGNED DATE