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**THE EXPERIENCES OF NEW ZEALANDERS  
BEREAVED BY SUICIDE**

*A thesis presented in partial  
fulfilment of the requirements  
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of Master of Arts  
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## ABSTRACT

Bereavement by suicide is a relatively untapped facet of suicidology in New Zealand. The current study used a qualitative approach to investigate the experiences of New Zealanders bereaved by suicide. It was intended that such an approach would provide rich and detailed information. Audiotaped interviews were conducted with eight New Zealand suicide survivors. Grounded theory was used to analyse the transcribed data and to construct a theory of the experiences of New Zealanders bereaved by suicide. Grief responses which parallel those documented in suicide bereavement literature were identified and a host of Intensifying and Alleviating Factors were involved in compounding or lessening participants' grief. These findings are discussed in terms of the aims of the study. Limitations of the study are acknowledged and suggestions for further research are presented.

For Joanna

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Clinical diagnoses are important...but they do not help the patient. The crucial thing is the story. For it alone shows the human background and the human suffering...

(Jung, 1961/1989, p.124)

PART ONE:

**Introduction**

## CHAPTER ONE:

### LITERATURE REVIEW

#### INTRODUCTION

There can be no doubt that suicide is a subject of intense fascination for researchers. Almost every conceivable aspect of this tragic phenomenon appears to have been the focus of international research scrutiny. New Zealand suicidology research has focused on: risk factors (Beautrais, Joyce, & Mulder, 1996a, 1996b); epidemiological factors (Deavoll, Mulder, Beautrais, & Joyce, 1993; Pritchard, 1992; Skegg, Cox, & Broughton, 1995); youth suicide (Disley & Coggan, 1996; MacDonald, 1996); life events of attempters (Fergusson & Lynskey, 1995); prevention strategies (Beautrais, 1995); relationship to mental health (Beautrais, Joyce, Mulder, Fergusson et al., 1996); situational influences such as the prison setting (Cox & Skegg, 1993); and contagion effects or clustering (Gould, Petrie, Kleinman, & Wallenstein, 1994; Hazell, 1993).

One area of suicidology which has emerged as increasingly important for researchers to study, but which has been relatively neglected, is the experience of family members and friends bereaved by the self chosen and self inflicted death someone close to them. Less than 1.5% of all the suicide research literature deals with the aftermath of suicide (Dunne-Maxim, 1986). McIntosh (1993) points out that "until recently, survivors have largely been ignored within the field of suicidology" (p. 146). Barrett and Scott (1990) believe "until recently the focus of attention has been upon the person who engages in suicidal behavior, with little attention directed toward the experience of those whose lives continue in the aftermath of someone else's suicide" (p.1). The dearth of literature is obvious in New Zealand where, at the time of writing, there appeared to be only one study which investigated the effects of a suicidal death on the family and friends of the suicide victim (Booth, 1994, unpublished Master's Thesis).

Outside of the New Zealand, the last ten years have seen a steady increase in international research studies on suicide bereavement (McIntosh, 1996). Appropriately, the increasing attention being afforded people bereaved by suicide parallels the recognition that as suicides continue to occur, the number of people gaining survivorship status is growing. Shneidman (1969) proposed that for each suicide, there are six survivors and Lukas and Seiden (1987) put the number at between 7 and 10. In the United States, more than 30,000 people take their own life each year (Kaplan, Sadock, & Grebb, 1994) leaving between 180,000 and 300,000 new survivors annually.

What happens to these and other suicide survivors? The review which follows, will familiarise the reader with research findings on suicide survivorship. It is intended that the reader will be able to situate the topic of suicide grief within the broader contexts of normal grief, pathological grief, and grief following unnatural death. Hence, a brief discussion of the aforementioned aspects of grief is presented prior to focusing on grief instigated by suicide.

A discussion of research findings on the nature of suicide bereavement constitutes the bulk of the review and is divided into two sections. Initially, specific grief reactions and experiences which have been associated with suicide bereavement by researchers, clinicians, and survivors themselves, are reported and the nature of each is examined. Subsequently, control group studies which compare grief reactions following suicide and other types of deaths, particularly other sudden deaths, are considered.

Two current trends in the research on suicide survivorship constitute the subsequent two sections of the review. The topic of the kinship relation between suicide victims and survivors is introduced. The area of postvention or assistance for those bereaved by suicide is also considered.

Finally, the current study is introduced. Several issues are raised which explain and justify the place of the current study within the extant literature.

## THE LITERATURE

### The Nature of Bereavement and Grief

Before examining the research findings on the nature of grief in those bereaved by suicide, it is helpful to know something of the nature of bereavement and grief, in general. While it is recognised that grief may follow many types of loss (Gentry, Kennedy, Paul, & Hill, 1995; Parkes, 1986), in the current discussion, grief refers to the reaction that occurs following bereavement. An important point to note is that grief and bereavement are not the same phenomenon. Bereavement involves the loss of a significant other through death (Reed, 1993). Grief, on the other hand, incorporates a wide variety of thoughts and emotions which are associated with bereavement (Hauser, 1987).

Grief following bereavement is a normal reaction (Bultema, 1994) which affects almost everyone occasionally. "Grief, after all, is a normal response to a stress which, while rare in the life of each of us, will be experienced by most sooner or later..." (Parkes, 1986, p. 24). Van Dongen (1988) views grief as necessary for effective human functioning and points out that it can be demonstrated either through overt responses or covert psychosomatic manifestations.

Somatic, intrapsychic, and behavioural symptoms have been associated with individual grief reactions (Moos, 1995). Somatic symptoms include tightness in the throat, shortness of breath, disturbed sleep patterns, loss of energy and changes in appetite. Behavioural symptoms involve crying, withdrawal or over dependence, loss of interest, restlessness and hostile outbursts. The intrapsychic or emotional symptoms include numbness, disorientation, sadness, depression, anger, fear, anxiety, and guilt.

The majority of the research on bereavement and resulting grief is devoted to the experiences of individuals (Kissane et al., 1996b; Moos, 1995). A variety of models incorporating stages or tasks of individual grief are presented in the bereavement literature (Bailey, 1988; Parkes, 1972; Worden, 1982). One such model is briefly considered here.

Bailey (1988) proposed a six stage model of recovery after bereavement. This model of grief recovery is discussed extensively by Curry and Stone (1992). **Loss** is characterised by shock, denial and confusion. **Protest** often involves feelings of abandonment, anger or rage. The anger and rage may be directed at oneself, the victim, or others. Curry and Stone believe **searching** involves the bereaved trying to live their lives as they used to be. Behaviour in this stage may include talking about the deceased, or engaging in activities which they used to share with the deceased. The stage of **despair** can be seen when “the anguish of the grief and the depression from the loss surface in full force” (p.184). Accordingly, Curry and Stone report this stage as often being the most painful for those who are grieving and they indicate that bereaved individuals may demonstrate signs of clinical depression. In **reorganisation**, the bereaved individual begins to enjoy life if only in brief periods. It is here that energy returns and the person is able to go on with their life without the deceased. Finally, in **reinvestment**, the bereaved is able to engage in other significant relationships. Curry and Stone point out that in this stage the deceased is still remembered, but the bereaved is able to take risks and to love again.

In spite of quantitative (number of stages) and qualitative differences (such as the presence or absence of particular stages), many theories of grief contain similar components to Bailey’s (1988) model. Sapsford (1995) points out that “traditional theories of grief begin with the “acceptance of the death” stage and end with a final stage of “resolution”...” (p. 256). Commonalities amongst theories may be seen as indicating some agreement about what is involved in individual grief reactions. The fact that similar components have been found over time adds credence to the idea that the models contain universal aspects of individuals’ grief responses. A final point to be considered about traditional theories of grief is that they incorporate factors involved in recovery from grief. One of the aims of the current study is to focus upon both the nature of emotional reactions to death by suicide and the factors involved in recovering from bereavement by suicide.

A current trend in the grief literature is toward investigating the effect of bereavement on the family unit rather than on the individual (Gentry et al., 1995; Moos, 1995; Nelson & Frantz, 1996). Recent research findings suggest that some families may be at greater risk for problematic grief (Kissane et al., 1996a, 1996b). In particular, Kissane et al. (1996a) found that family cohesiveness is linked with coping ability while unresolved conflict and lack of expressiveness are associated with more problematic responses to grief.

### **Pathological or Abnormal Grief**

While grief in most instances is a healthy response to a major stress, there are many who suffer abnormal grief responses (Ness & Pfeffer, 1990). Kaplan et al. (1994) report that pathological grief can take several different forms. These include delaying, inhibiting or denying grief, or, at the other extreme, suffering a particularly intense and/or prolonged grief reaction. In a prolonged, intense grief reaction, the bereaved person may suffer from suicidal thoughts and exhibit psychotic symptoms (Kaplan et al.). Other severe reactions may include a preoccupation with the deceased, continuing depression, and chronic illness behaviour (Ness & Pfeffer, 1990).

### **Unnatural Death and Relationship with the Victim**

A factor thought to make the bereaved more vulnerable to pathological grief reactions is the unnaturalness of the death (Hauser, 1987). Where bereavement is sudden, unexpected, violent or traumatic, it is viewed as more likely to result in a problematic grief response which includes psychological problems and physical illness (Hauser, 1987; Reed, 1993). Specific grief reactions are also thought to be more severe. For example, one study (Weinberg, 1994) found blame of self, others and victim was greater in the case of unnatural deaths including accident, murder and suicide.

Rynearson (1986), in an intriguing article, calls for those who have been bereaved by an unnatural death such as murder, accident or suicide, to be studied as a separate research population. He believes survivors of unnatural death undergo a different grief experience compared with those bereaved by natural death. While many would view the

components of the reaction to the unnatural death as indicative of pathological grief, he believes that given the fact of the unnatural death, certain traditionally abnormal grief responses may, in fact, be normal.

Finally, and briefly, one other factor which has been implicated in severe grief reactions is the relationship between the bereaved and the deceased. In general it is thought that where a close relationship exists, the grief of the bereaved person is likely to be more severe (Parkes, 1986).

Given the fact that unnaturalness of the death and close relationships have been implicated in severe and prolonged grief reactions, it might be concluded that suicide bereavement leaves a close relation or friend vulnerable to a particularly painful grief experience. The following discussion focuses upon the nature of suicide bereavement. Initially, it examines specific grief reactions found to be associated with suicide bereavement. Subsequently, it scrutinises evidence for the suggestion that suicide is more painful than other types of deaths including other sudden and unnatural deaths.

### **The Nature of Suicide Bereavement**

A veritable host of reactions following the suicide of a loved one are reported in the literature. Shock, numbness, denial, relief, guilt, anger/blame, fears, shame, stigma, searching for an explanation, rejection, physical health problems, sadness, depression, suicidal ideation and reactions indicating recovery have been variously identified by researchers and clinicians (Barrett & Scott, 1989; Calhoun, Selby, & Selby, 1982; Clark & Goldney, 1995; Dane, 1991; Demi & Howell, 1991; Eddy, 1986; Farberow, 1994; Gyulay, 1989; McIntosh & Wroblewski, 1988; McQuaide, 1995; Ojanlatva, Hammer, & Mohr, 1987; Pfeffer et al., 1997; Smith, Mitchell, Bruno, & Constantino, 1995; Van Dongen, 1990; Wertheimer, 1991). Each of these reactions has also been reported as occurring following deaths of other types. The intention here is to highlight qualitative components found in suicide bereavement reactions which may be specific to suicide.

Grief following suicide is initially characterised by feelings of **shock and disbelief** (Constantino, Sutton, & Rohay, 1997). The days after the suicidal death may pass by in

a haze as survivors try to take in the enormity of the suicide, and make funeral arrangements. Gyulay (1989) perceives shock as a frozen emotional state which protects "...against thawing the chilling reality of the death" (p. 113).

In some cases, disbelief may turn into longer term **denial** (Wertheimer, 1991) and it may take months, even years, for the bereaved to accept the reality of the suicide (Gyulay, 1989). In some cases survivors may never face the truth.

It is important to note that denial may ensue not only as a result of the death itself, but also as a result of the cause of the death. Participants in Clark and Goldney's (1995) study were upset when the coroner's verdict confirmed suicide as the cause of death. They had wanted to believe that accident or physical illness were responsible for the deaths. Hauser (1987) believes that by denying the death was a suicide, the bereaved is engaging in an attempt to deal with intense guilt.

Although the commonness of **relief** in survivor responses to suicide is debatable, this is an emotional reaction which is familiar to many of those investigating the aftermath of suicide. Ojanlatva et al. (1987) describe relief as a prominent response following suicidal deaths while Lukas and Seiden (1987) point out that for a small group of survivors relief that "it's over" is apparent. In particular, it seems that relief is more likely to ensue when the victim has had a history of mental health problems.

Where relief is identified in the literature, discussion of guilt is not far behind. Gyulay (1989) points out that because feelings of relief may not be acceptable to survivors, any relief usually brings guilt. Rudestam and Agnelli (1987) state "a rich source of potential guilt is the relief often felt by suicide survivors when the suicide victim was a disruptive force in the family, as is often the case" (p. 211). Another possible reason for feelings of guilt is simply that the bereaved is a survivor while the victim is not (Kaltreider, 1990; Lukas & Seiden, 1987). According to Gyulay (1989), in order to counter feelings of guilt, the survivor needs to realise that relief is a desire, not for the death of the victim, but for health and wholeness for all concerned.

**Anger** at, and **blame** of, the victim and others have been repeatedly reported as powerful emotional reactions following suicide. Demi and Howell (1991) reported anger as the strongest and most consistent theme in their grounded theory study of experiences of parents and siblings bereaved by suicide and Ojanlatva et al. (1987) consider anger to be the most enduring emotional response following a suicide. The anger experienced by survivors may be directed towards themselves, the victim, the mental health system, health professionals, God, and the world at large (Gyulay, 1989; Van Dongen, 1990). Additionally, other family members may be the recipients of a bereaved individual's anger and blame (Demi & Howell, 1991). Anger directed at others may assist the survivor to deny their own role in the suicide and help them to create a meaning for the occurrence of the suicide (Ojanlatva et al., 1987).

Most anger following a suicide, appears to be directed at the deceased (Demi & Howell, 1991; McIntosh & Wroblewski, 1988). The bereaved person may express their anger with the deceased for leaving them in that way (Smith et al., 1995). Gyulay (1989) points out that anger towards a suicide victim may occur in four cycles. For example, the bereaved person may feel anger early in the grief response. This anger then abates quickly often due to feelings of guilt. It returns later in the grief experience. A second cycle may involve feelings of anger toward the deceased which persist for several years without abating. Thirdly, anger at the victim may occur years following the suicide. Finally, the bereaved may replace anger at the victim with feelings of anger towards themselves and others and hence, refuse to admit feeling angry with the deceased. Clark and Goldney (1995) observed that that some bereaved individuals in their support group refused to admit their anger at the deceased. However, when one member admitted to feelings of anger toward the deceased, permission was given to others to admit similar feelings.

**Guilt** is a prominent emotional reaction amongst those bereaved by suicide (Hatton & Valente, 1981; McIntosh & Wroblewski, 1988). Seguin, Lesage, and Kiely (1995b) define guilt as "a feeling of self-reproach from believing that one has done something wrong..." (p. 489). In the case of suicide, guilt may result for a number of reasons. It may be the outcome in cases where the deceased was skilled at creating guilt amongst

family members and where feelings of anger towards the deceased are suppressed (Van Dongen, 1988). Barrett and Scott (1989) indicate that survivor guilt may result both when the survivor rues things that they said and did and when they rue things that they did not say and do prior to the suicide. In a case report of her therapy for the parental survivors of their son's suicide, McQuaide (1995) provides a clear example of survivors' beliefs that something they did or did not do would have saved the victim.

“In this guilty state they were reviewing Peter's childhood, second guessing everything they could have done differently, analyzing, criticizing and regretting all that they could remember about the times that they were together. They both assumed that the answer to why Peter chose death over life was because of something they did or didn't do” (p. 418).

Possibly controversially, Gyulay (1989) claims that some guilt may be justified. This is especially true, she maintains, where there has been family dysfunction and where the deceased child has been a scapegoat in the family. Gyulay further explains that the nature of death is such that there is no chance of clarifying with the deceased whether the guilt is irrational or justified.

Although guilt is a conspicuous and common response after a suicide, Wertheimer (1991) points out that it is not universal in grief reactions following suicide. McIntosh and Wroblewski (1988) found that 85.1% of their 141 suicide survivors acknowledged feelings of guilt. Hence, 14.9% of the subject sample did not report guilt as an emotional response.

While anger, blame and guilt are commonly associated with suicide bereavement, a generally lesser known grief response to a suicidal death is that of **fear** instigated in the survivor by the suicide. Qualitative reports and case studies, in particular, indicate that a number of different fears have been repeatedly identified in survivors of suicide. Wertheimer (1991) discusses her respondents fears that coroners' inquests would provide horrific and distressing information. McQuaide (1995) reports her clients' fears that they would never recover from the death of their son. From a different perspective,

Brownstein (1992) surveyed therapists who had a client suicide. He found that the majority of respondents exhibited justified fears about the response of the family.

Perhaps the most common and well documented survivor fear is that of concerns about issues of mental illness, suicide and the contagiousness of suicide (Smith et al., 1995). Demi and Howell (1991) reported their participants' fears of a genetic component to mental health problems which may lead to them suiciding themselves. Clark and Goldney (1995) documented similar fears acknowledged in their support group. "A particular fear was that those left behind were condemned to follow the same fate as their loved one, in the belief that suicide itself was familial" (p. 29). Fears about the likelihood of a further suicide extend to other family members also. Hatton and Valente (1981) discussed the role of their support group in assisting suicide bereaved parents who were previously "immobilized by fear" (p. 149) to deal with their fears that their second son would also take his own life.

Although **shame and stigmatisation** have often been discussed interchangeably in the literature on suicide bereavement (Demi & Howell, 1991; Clark & Goldney, 1995; McIntosh & Wroblewski, 1988; Wertheimer, 1991), the two concepts are viewed by the present author as distinct and, hence, are discussed separately in the current discussion.

In defining the components of their Grief Experiences Questionnaire (GEQ), Barrett and Scott (1989) discuss **shame** as the bereaved person's embarrassment regarding the cause, nature, or circumstances of the suicide. Wertheimer (1991) points out that shame, while not necessarily universal, has been found to be a common and often, intense, component of the aftermath of suicide. In their study, Seguin et al. (1995b) reported that shame appeared to be both "unique and central to the experience of suicide bereavement..." (p.495). Gyulay (1989) emphasises that shame may lead to silence within the family and, in turn, silence leads to problems with grief recovery. Lying about the death to others, isolation and withdrawal from others are common components of a shame reaction.

Solomon (1983) defined **stigma** as a mark of disgrace which potentially detracts from a person's reputation or character. That definition is extended by Barrett and Scott

(1989) who suggest that in the case of a suicide, stigma has a negative impact upon the survivor permanently marking him/her as different from survivors of other types of deaths. While the survivor himself may feel no shame, he may perceive others as viewing the suicide as shameful. Specifically, survivors may tend to believe that others view them as responsible for the suicide.

According to Colt (1987), "no subject has been more stained by stigma than suicide" (p.4). Colt points out that, traditionally, suicide was outlawed in most countries and in the Catholic Church, in particular, suicide was viewed as a sin for which a person would go to hell. In medieval France and England survivors were often punished for a family member's suicide. Colt further suggests that the social stigma surrounding suicide results from its traditional illegality and moral 'wrongness'.

Barrett and Scott (1989) implicate gossip, negative attitudes, suggestion of family discord and mental illness, overt blame, and social avoidance on the part of others in survivor feelings of stigmatisation. The stigma experienced by survivors may last for a period of many years (Lukas & Seiden, 1987) and is linked with feelings of rejection (Watson & Lee, 1993). Dane (1991) states "the social stigma attached to suicide frequently results in a lack of social and emotional support for the survivors, which further jeopardizes survivors' successful grief resolution" (p. 39). In a novel approach to survivorship research, Calhoun, Selby, and Steelman (1989) asked funeral directors about their impressions of how others react to the surviving family. Most funeral directors indicated others felt uncomfortable when dealing with the family and that expression of sympathy is difficult after a suicidal death. Interestingly, the funeral directors also perceived that others may feel more compassion for those bereaved by suicide than those bereaved by other types of death.

There are those who believe that stigma is only experienced by a minority of suicide survivors. Solomon (1983) found that only 28 out of 90 (31%) suicide survivor participants in his study felt stigmatised. Van Dongen (1993) reported that only a few survivors in her study discussed feeling stigmatised following the suicidal death of their family member. Where feelings of stigmatisation were acknowledged, the experiences were subtle and apparent in what people did not do or say rather than in open rejection.

For example, some of Van Dongen's participants' perceived their friends as avoiding them.

Asking "why?" is a well documented feature of survivors' responses to a suicidal death. Stevenson (1995), in a personal account of the experience of losing his son to suicide, states "I was hunting for clues as to why? [sic] Why? Why? It went on and on ... it never stopped" (p.79). Hauser (1987) states that this relentless pursuit is typical of survivors.

In a grounded theory study of the experiences of survivors of suicide victims, Van Dongen (1990) found that survivors engage in agonising questioning not only about why the suicide occurred but also about issues concerning "the current and continuing impact of the death on their own lives and the lives of other family members" (p.228). The theme of agonising questioning persisted throughout survivors' experiences of being bereaved by suicide. In contrast, however, Demi & Howell (1991), in another grounded theory study, found that although questioning occurred, it tended to diminish over time. The difference between the findings of the two studies may be due to the fact that each study considered participants' experiences at different times following the suicides. The longer time since the suicide appears to be associated with less questioning .

**Rejection** discussed here comprises feelings of being rejected by the deceased. Feelings of being rejected by others are incorporated in the previous discussion of stigma. Hauser (1987) states "in every suicide there is a component of rejection" (p. 65) and Barrett and Scott (1989) point out that it is common for suicide survivors to experience feelings of rejection at the hands of the deceased. In their suicide survivor group, Clark and Goldney (1995) identified feelings of rejection as a common response amongst participants. Some participants in their study viewed the suicide as a malicious act or a way in which the victim had tried to 'get even' with them and they further believed that this was a burden unique to grief after a suicide.

**Physical health problems** are known to increase following a death of any nature (Barrett & Scott, 1989). A number of authors assert that suicide is no exception (Rudestam, 1977; Sapsford, 1995; Van Dongen, 1990, 1991a, 1991b; Wertheimer,

1991). Van Dongen (1990) found that all 35 participants reported physical changes including gastrointestinal disturbances, fatigue, chest discomfort, and sleep disturbances. Some participants also reported exacerbation of existing complaints. Wertheimer (1991) reported that a number of participants suffered chest pain which she suggested may be symptomatic of a broken heart.

**Sadness** in a suicide bereaved individual is a grief reaction anyone might expect. Indeed, those examining suicide bereavement report that feelings and behavioural expressions of sadness are common. Demi and Howell (1991) found that sadness which abated over time was reported by most of their participants. Participants in Van Dongen's (1991a, 1991b) study reported continuous sobbing and crying in the initial days after the suicide.

**Depression** of clinical severity has also been reported in the literature. Brent, Perper et al. (1993) found that clinically significant symptoms of depression resulted in both the siblings and mothers of suicide victims. At a three year follow-up, Brent, Moritz, Bridge, Perper, and Canobbio (1996) reported that siblings demonstrated less depressive symptomatology although mothers still maintained higher levels of depression.

Much attention has understandably been focused on **suicidal ideation** in suicide bereaved individuals. Dunne-Maxim (1986) states that there is a three times higher risk for completed suicide in those who survive suicide than in the general population. Lukas and Seiden (1987) point out that suicide support groups discuss suicidal ideation as a normal response on the part of suicide survivors. Particular concern focuses on adolescents and peers of youth suicide victims (Hazell, 1993; Mauk, Gibson, & Rodgers, 1994).

That suicide can indeed follow in the wake of other suicides is tragically apparent in Sapsford's (1995) study. Sapsford reported the disturbing fact that one of her suicide survivor participants (Connie) suicided two years after the completion of the study. Even more upsetting is the fact that Connie was the third sibling in her family to suicide.

### Coping Factors

One facet of suicide bereavement which does not appear to have been the focus of a great deal of attention afforded suicide survivors is that of factors which are involved in coping with grief. (An exception is the increasing focus on support groups, a discussion of which is found on p. 22). A possible reason for this relative lack of information is that many suicide bereavement studies are carried out within the first year following the deaths (Sapsford, 1995), and hence, provide information on intense grief reactions rather than coping factors which become more apparent later in survivors' experiences. Studies which do provide information on the nature of coping strategies and factors involved in recovery appear to be mostly qualitative in nature, and often rely on information from suicide support groups. Some of the findings of such studies are outlined here.

Clark and Goldney (1995) describe 'finding the positive' as an important factor in dealing with grief. They reported that in their support group, recognition that it was the victim's wish to die and that the victim is now 'at peace', were components associated with coping. Other writers also discuss the importance of taking the positive from such a traumatic experience. In a letter to the British Medical Journal, Roques (1996) emphasises the importance of focusing on the positive aspects of his brother's suicide. Roques states that for his brother, "...his death was surely positive for him at the time. Finally his torment and suffering were allowed to end" (p. 191). Further, Roques underlines the importance of focusing on his brother's rich life rather than on his death. He sees the strength of his family and his own less complacent view of life as positive elements which emerged from the experience of his brother's suicide. Finally, he stresses that positive aspects continued to appear from the bitter experience.

Clark and Goldney (1995) also reported that participants were able to 'rebuild' themselves and create new lives. Rebuilding of oneself was associated with increased self confidence, and self esteem and gaining control over one's own life. Creating a new life involved "...rebuilding social relationships, relocating homes, and learning new skills, including roles previously carries out by the deceased" (p. 31).

In their discussion of healing the pain after a suicide, Demi and Howell (1991), identify 'expressing', 'sharing', and 'obtaining therapy' as factors which assisted their bereaved participants to deal with grief. Expression of feelings included visiting the deceased's grave and talking, crying, cursing, writing, and punching pillows. Sharing involved discussing feelings with empathetic others especially those who had undergone similar loss. Obtaining therapy often occurred several years following the suicide and was sometimes precipitated by some other kind of personal trauma.

Range, Walston, and Pollard (1992) investigated comments which may be helpful to those bereaved by suicide. Findings indicated that comments to the effect that others were willing to assist or listen were helpful. "Time heals" and "get on with life" comments were particularly helpful after a suicide. Comments to the effect that the deceased was no longer suffering and expressions of sympathy about feeling out of control were relatively unhelpful to suicide survivors.

Sapsford (1995), offers an interesting perspective on recovery from grief after a suicide. Her grounded theory study of the experiences of four women bereaved by suicide led her to suggest that 'recovery' is a misnomer. Rather, she proposes that 'integration' of grief occurs following a suicide. She conceptualises women survivors as learning to incorporate grief into their lives rather than recovering from it.

### **Control Group Studies**

A steadily growing body of literature on suicide survivorship is that of control group studies. These investigate whether suicide survivorship differs from other forms of bereavement. In particular, the suggestion that suicidal deaths precede qualitatively and quantitatively different grief reactions from sudden or unnatural deaths (Reed & Greenwald, 1991; Rudestam, 1977; Silverman, Range, & Overholser, 1994) has been the focus of increasing research attention. The following discussion presents evidence pertinent to suggestions that grief is worse for suicide survivors than those bereaved in other ways.

Some researchers support the view that grief reactions of suicide survivors are more difficult and/or more prolonged than those of people bereaved by other forms of death. For example, Silverman et al. (1994) compared college students bereaved by suicide, homicide, accidental death, natural anticipated deaths, and natural unanticipated deaths. Overall, they found that “bereavement from suicide was associated with more intense grief reactions than the other four groups” (p. 41).

Specific grief responses have been identified as worse in the case of suicide than other sudden deaths. For example, Barrett and Scott (1990) found that suicide survivors experienced greater rejection than survivors of deaths by other causes including sudden death. Sheskin and Wallace (1976) supported ‘searching for explanation’ as being more intense after a suicide and Reed and Greenwald (1991) reported that suicide survivors experienced significantly more feelings of guilt, shame, and rejection than accidental death survivors. It is worth noting, however, that in all three studies, similarities between accidental death and suicide survivors’ grief reactions were also reported. Of further note is the fact that McIntosh (1993) points out methodological limitations in the studies of Barrett and Scott (1990) and Reed and Greenwald (1991). These include small or select sample groups (respectively) and a lack of non bereaved control groups in both studies.

One grief experience which has repeatedly been found in control group studies to be worse for suicide survivors compared to those bereaved in other ways is that of social stigma. Calhoun, Selby, and Abernathy (1984) investigated the reactions of people who knew others bereaved by suicide, accident, and natural causes. They concluded that suicide was viewed “as a more difficult type of death with which to cope” (p. 255) and “...interactions with survivors of suicidal death are seen as somewhat more stressful” (p. 255). Interestingly, the same study also found that familiarity with the surviving family may be a mitigating factor in a person’s tendency to see the family negatively. A further study (Calhoun, Abernathy, & Selby, 1986) similarly reported that interactions with suicide survivors were perceived as more difficult and constraining than interactions with those bereaved by accident or natural causes. Although their quantitative analysis found that suicide survivors were no more likely than those bereaved by accident or

natural causes to be perceived as negative, Allen, Calhoun, Cann, and Tedeschi (1993) did identify qualitative differences between the groups.

In contrast to the studies cited above there are many which report finding little or no difference between suicide survivors and other types of survivors. Demi and Miles (1988) compared parents who were bereaved by suicide or accidental or chronic illness deaths. They found that suicide bereaved parents and non-suicide bereaved parents were at similar risk for emotional distress and physical health problems. The findings of Demi and Miles' study supported an earlier study by Demi (1984) in which grief reactions of spouses of suicide and accidental death victims were compared. Demi concluded that, overall, the suicide survivors were at no greater risk than the non-suicide survivors for an unsatisfactory bereavement outcome. In a study of widows bereaved through accident and suicide, McNiel, Hatcher, and Reubin (1988) discovered no significant differences on measures of family functioning, life stress and psychiatric symptoms.

One factor which may carry considerable weight in allowing researchers to distinguish suicide bereavement from other forms of bereavement is the course of time. In a retrospective study, Kovarsky (1989) compared the grief reactions of parents bereaved of a child through suicide and accidental death. She reported that accidental death parents demonstrated more grief immediately after the deaths but that the grief of suicide bereaved parents remained the same or intensified over time.

A longitudinal investigation compared elderly widows bereaved by suicide with elderly widows bereaved by natural death and non-bereaved controls (Farberow, Gallagher, Gilewski, & Thompson, 1987; Farberow, Gallagher-Thompson, Gilewski, & Thompson, 1992a, 1992b). The authors reported widows' grief reactions at four different times (2 months, 6 months, 12 months and 2.5 years) after the deaths. The results showed few differences between the suicide survivors and the natural death survivors at two months and six months. However, at the 12 month time, suicide survivors indicated more depression and mental health problems than natural death survivors. Although most differences between the bereaved groups had disappeared at 2.5 years, the suicide survivors still rated their mental health as poorer than non bereaved controls. Natural death survivors did not. In another study, Seguin et al. (1995b) interviewed parents of

suicide and car accident victims at six months and nine months after the deaths. They found that suicide bereavement was associated with greater parental depression than accidental death bereavement at six months but that the difference had disappeared at nine months.

Overall, the findings of control group studies are equivocal. Studies which have reported differences in grief reactions have often found differences in specific grief responses such as shame, rejection, and guilt but a number of those same studies also report similarities. One bereavement experience which appears to have found research support as being particularly difficult for suicide survivors is that of being stigmatised. However, the differences in social stigma may be more qualitative in nature than quantitative. Recent opinion in the survivorship field seems to be that control group studies show more similarities than differences (Cleiren, 1993; McIntosh, 1996; Rudestam, 1992). Where there are differences between suicide survivorship and other forms of survivorship these may be most apparent over the course of time (Farberow, Gallagher et al., 1987; Farberow, Gallagher-Thompson et al., 1992a, 1992b).

### **Relationship between Survivor and Victim**

An in depth consideration of hypothesised differences in grief reactions between different relationship groups of survivors is outside of the focus of the current study. There are, however, general considerations about kinship relations, which arise in the literature and which are relevant to the current study. These are briefly discussed below.

The issue of survivor-victim relationship is one which has attracted the attention of some researching the nature of bereavement after suicide (McIntosh & Wroblewski, 1988; Reed & Greenwald, 1991). It has been suggested that aspects of suicide bereavement are especially difficult for certain kinship groups of survivors. For example, Demi and Howell (1991) noted that expressions of guilt were not obvious amongst survivors in their support group. They suggested a reason for that finding was because their participants were children of parents who suicided and as such, that group of survivors may experience less guilt than other survivors who had different types of relationships to the deceased. Generally, findings about kinship relations have been contradictory. It

appears that although some differences have been found between survivor groups (Cleiren, 1992) especially over the course of time (Brent, Moritz et al., 1996; Brent, Perper et al., 1993), other hypothesised differences have not been demonstrated when studied directly (McIntosh & Wroblecki, 1988).

Most studies which have investigated the nature of suicide bereavement have focused on particular kinship groups such as spouses (Constantino & Bricker, 1996; Demi, 1984; Farberow, Gallagher et al., 1987, Farberow, Gallagher-Thompson et al., 1992a, 1992b; Grad & Zavasnik, 1996; McNiel et al., 1988; Pennebaker & O'Heeron, 1984), parents (Demi & Miles, 1988; Hatton & Valente, 1981; Kovarsky, 1989; Seguin, Lesage, & Kiely, 1995a, 1995b; Trolley, 1993), children (Grossman, Clark, Gross, Halstead, & Pennington, 1995; Pfeffer, 1981; Pfeffer et al., 1997; Shepherd & Barraclough, 1976), siblings (Brent, Moritz et al., 1996; Brent, Perper et al., 1993; Nelson & Frantz, 1996), and peers (Kaltreider, 1990; Mauk et al., 1994). Recently, however, there has been a growing awareness that many other people in various types of relationships with the deceased are profoundly influenced by suicide. For example, Grad (1996) includes family members, colleagues and coworkers, school or other friends, teachers, patients, and those involved in the care of the victim such as physicians, psychotherapists, psychiatrists, supervisors, and nurses in her definition of suicide survivors. Sapsford (1995) found herself in the ironic and upsetting position of being a 'researcher-suicide survivor' because one of her participants suicided.

Realisation of the potential variety of people who may be affected by a particular suicide must surely add weight to Lukas and Seiden's (1987) claim (see p. 3) that more people than the six commonly accepted in the literature are at risk for profound grief reactions following a suicidal death. Recognition of the pervasiveness of the effects of a suicide in a community reinforces the need for postvention initiatives, also (see p. 21).

From a different perspective, Reed and Greenwald (1991) suggest that it is not the kinship relation with the deceased that influences an individual's grief response. Rather, the closeness of the attachment may be the central factor which should be considered. McIntosh (1996) concurs "...an important measure in the investigation would include

the emotional closeness or in other cases the attachment of the survivor to the deceased” (p. 149).

A further factor which has been suggested as impacting on suicide survivor grief reactions is that of propinquity or physical nearness (Reed & Greenwald, 1991). Although they suggested that closer physical proximity to the victim would result in greater distress following the suicide, Reed and Greenwald found that survivors who did not reside with the deceased prior to the death reported greater feeling of guilt and shame but not other grief reactions.

### **Postvention**

In the current, exploratory study of New Zealanders bereaved by suicide, all approaches which may be beneficial in assisting those bereaved by suicide are of interest. Hence, an area of interest this study is whether participants had access to any form of postvention and, if so, what kind(s) of postvention they may have found helpful.

The term **postvention** is used to refer to “...a series of therapeutic, educational, and organizational activities that are instituted in the wake of a suicide in order to decrease the emotional distress of affected individuals, and to lessen the risk of further (imitative) suicides” (Callahan, 1996, p. 108). In 1986, Dunne-Maxim stated that few services existed for families after the suicide of a family member and she further pointed out that, usually, very little is said about how to treat suicide survivors.

In the US and Canada, the increase in research attention towards suicide survivors has had the appropriate and beneficial effect of focusing attention upon helping those bereaved by suicide (McIntosh, 1996). Postvention may involve individual counselling, school and community programs and support groups. Counsellors, facilitators, group leaders, and coordinators involved in postvention initiatives may come from a variety of professional disciplines and include Psychologists, General Practitioners, Psychiatrists, Social Workers, Nurses, and Teachers.

A variety of approaches to counselling individuals bereaved by suicide are reported in the literature. For example, Eddy (1986) reported the successful use of a 'good deeds' approach based on "an idea being developed by Cloe Madanes" (p.32). McQuaide (1995) combined psychoanalytic work and narrative therapy in her treatment of a couple who had lost their son to suicide. Watson and Lee (1993) used Systemic Belief Therapy, developed in the Family Nursing Unit at the University of Calgary, to assist a woman whose husband had suicided six weeks previously. Whatever the approach used in counselling, Trolley (1993) specifies a number of important roles which helpers can and should play. Some of these include disseminating information, assisting the bereaved to accept the reality of the suicide, listening empathically and normalising survivors' reactions, being societal role models, referring to appropriate resources, mediating in family communication, and providing a constant, lasting source of support.

School and Community programs make up a large part of postvention efforts. These focus on crisis intervention, consultation, community support, assessment and counselling, education and information, media liaison, and follow-up (Wenckstern & Leenaars, 1993). In particular, emphasis appears to have been placed upon preventing contagion effects of adolescent suicide amongst peers (Callahan, 1996; Mauk et al., 1994). One study investigated the effectiveness of a community postvention program for adolescents following the suicide of one of their peers. Sandor, Walker, and Sands (1994) found that intervening was initially beneficial but that continued intervention may also be necessary to counter decline in adolescents' functioning over time.

Suicide Support Groups are beginning to attract the attention of those interested in assisting suicide survivors. The fact that Rubey and McIntosh (1996) identified 280 groups listed with the American Association of Suicidology (AAS) throughout the US and Canada (and at least one in New Zealand) demonstrates that there is no lack of such groups. However, Rubey and McIntosh also pointed out that little is known about the nature of such support groups. In their study they collated information from 149 survey responses. Included in their results were the findings that less than ten people usually attend a particular group, that leadership often involves trained facilitators, mental health professionals or both, and that the majority of the groups are open-ended (have no set number of participants or time limit on the number of sessions).

The effectiveness of such groups requires further research (McIntosh, 1996). A few studies which have been carried out suggest that such groups are beneficial. For example, in a comparison of a number of different types of bereavement support groups including a suicide support group, Hopmeyer and Werk (1994) found that members from all groups reported strong satisfaction. They concluded that self help groups have the potential to help survivors cope with their grief and go on with their lives. Hatton and Valente (1981) reported that their eight week support group for parental survivors of suicide appeared to assist the participants to feel more confident and to become integrated into their larger social network.

One factor which appeared to assist Clark and Goldney's (1995) participants to cope with their grief, was the opportunity their support group provided to diminish the stigma associated with suicide. Clark and Goldney found that those who had been bereaved for a longer period of time in their support group acted as successful role models of survival for those who were more newly bereaved. Hatton and Valente (1981) discussed the fact that participants in their group were reassured by the universality of their grief and they found release in being able to share their stories with others. Finally, suicide groups also address participants' needs "...to talk in an environment of acceptance and understanding, which could only be provided by other people who have had the same kind of experience" (Smith et al., 1995, p.12). The role of support groups appears to be consistent with Demi and Howell's (1991) finding that sharing is a beneficial factor in promoting recovery following a suicide.

## **THE CURRENT STUDY IN RELATION TO THE LITERATURE**

Up to the present point, this chapter has reviewed the existing literature on suicide survivorship. It has been pointed out that limitations, such as equivocal findings in control group studies, are apparent in that literature. This study has been conceived of, and designed, in order to remedy some of those limitations. The remainder of the introduction focuses the reader's attention on how the current study addresses limitations inherent in the literature and it highlights the potential contribution that the

present study can make both to the survivorship literature and to helping survivors themselves.

This study makes an attempt to address an area of neglect in New Zealand suicidological research. It is a well recognised and disturbing fact that New Zealand is a world leader in rates of youth suicide. Both male and female suicides in the 15-35 year age bracket ranked either second or third highest of selected countries in 1994 (Ministry of Health, 1997). High rates of suicide equate with particularly high rates of survivors. Hence, this country can also be viewed as a world leader in rates of survivors bereaved by youth suicide.

Further, in New Zealand, in 1994, there were 512 suicides (Ministry of Health, 1997). According to Shneidman's more conservative estimate, in 1994 alone, more than 3,000 New Zealanders gained the status 'suicide survivor'. Lukas and Seiden's (1987) estimate would have the number as high as 5,120. Based on these figures, it can be expected that in the ten years from 1994 through to 2004, New Zealand will be home to somewhere between 30,000 and 51,200 people who must learn to deal with the loss of a family member or friend to suicide.

Findings in the existing literature indicate that suicide bereavement is extremely painful and some suggest it may even be more intense or prolonged than bereavement from other types of death. Such information coupled with that provided on New Zealand rates and numbers of survivors, means that there is a rapidly growing number of people who are destined to suffer a difficult period of bereavement in New Zealand. Surely these people are owed some attention and assistance?

Although the international literature on suicide bereavement has steadily increased, much is yet unknown about the nature of survivorship. For example, the above discussion demonstrates that specific grief reactions are repeatedly but not universally reported. The current study responds to general calls (e.g., McIntosh, 1996) for more research which can further knowledge on suicide bereavement.

An area which remains in the realms of the relatively unknown appears to be that of coping factors. The fact that research focuses on grief reactions within the first year following suicide has contributed to a lack of information about factors which may be involved in coping with suicide bereavement. The current study addresses this issue by investigating the experiences of suicide survivors between 3 and 6 years after the suicides occurred.

The findings of control group studies which compare suicide bereavement with other forms of bereavement, especially sudden death bereavement, appear to show similarities more often than they show differences (McIntosh, 1996, Rudestam, 1992). However, the findings are equivocal. Further, control group studies are troubled by methodological limitations (McIntosh, 1993). Control group protagonists themselves recognise the need for further exploratory investigations of survivor experiences. These may produce information which, in turn, can be examined in studies which employ more controlled designs (McIntosh, 1993, 1996).

The current study concurs with the viewpoint that closeness of attachment rather than kinship relation is an important consideration when investigating those bereaved by suicide. Accordingly, participation in this study was open to family members or friends of victims who perceived themselves to be affected by the suicide but who may not have been included in studies of "conventional" family member survivors. For example, in-laws and step relations were welcome participants in the current study.

Whether or not suicide bereavement is more painful than other types of bereavement, and whether or not some kinship groups suffer more profoundly, there can be no doubt that survivors undergo painful experiences. Research which may contribute to understanding those experiences is step toward assisting those who must learn to cope with the aftermath of a suicide. The issue of postvention is an important one and the current study is designed to contribute practical information about what kinds of postvention may be most useful for survivors.

## SUMMARY

Suicide bereavement is a relatively new research topic within the field of suicidology. After situating suicide bereavement within the broader contexts of grief in general, pathological grief, and sudden death bereavement, the current chapter reviewed suicide bereavement research. Existing findings on the qualitative nature of survivor grief were presented as were a selection of control group findings about suicide bereavement in comparison to other forms of bereavement. The literature on postvention and kinship relation to the deceased was also discussed. An overall conclusion that can be made after perusing the information provided is that there is an undeniable need for continued research in all areas. The researcher's conceptualisation of the place of the current study in continuing suicide bereavement research constituted the focus of the final section of this chapter. In the following chapter, the rationale for employing a qualitative framework will be explained. The appropriateness of grounded theory methodology in the current study will be discussed and a number of tenets and procedures of qualitative methodology will be considered.

## CHAPTER TWO:

### QUALITATIVE RESEARCH

The present chapter introduces the topic of qualitative methodology in psychological research and the writer's rationale for choosing this approach. In particular, the appropriateness of the grounded theory methodology employed in the current study is discussed. The chapter also addresses the role of the researcher in qualitative investigation. Specifically, attention is paid to the concept of reflexivity. Other tenets and procedures of qualitative and grounded theory methodology such as the use of the literature and theoretical sampling are also discussed. The current argument for a constructivist approach to generating theory is outlined. The chapter concludes by focusing on criteria for evaluating grounded theory studies since there are major differences between these criteria and the traditional quantitative yardsticks for evaluating research.

### RATIONALE FOR USING QUALITATIVE METHODOLOGY

#### Qualitative Approaches to Psychological Research

Interest in carrying out qualitative research has increased within the discipline of Psychology in recent years (Woolgar, 1996). In a predominantly quantitative field, such a change indicates increasing recognition that qualitative research has a part to play in expanding our knowledge of psychological topics.

According to Henwood and Pidgeon (1995), a qualitative approach to psychological research allows two significant contributions to the discipline. Firstly, it provides an alternative to what they refer to as "an over-reliance upon theory testing and verification..." (p. 116). Rather, qualitative study allows the researcher to become involved in the generation of theory. Secondly, Henwood and Pidgeon point out that such an approach permits the researcher to provide analyses which are "sensitive to

people's own understandings as seen from their local frames of reference, or from inside their own socially situated phenomenal worlds" (p. 116). The current research embraces the importance of both contributions within the discipline of Psychology.

### **Grounded Theory in the Current Study**

Grounded theory, (Glaser and Strauss, 1967), is one of many available methods for carrying out qualitative research. It is used to provide rich, detailed, information. It is particularly appropriate in investigations which test new waters, which attempt to gain new points of view in familiar settings, and in which the researcher wishes to enhance the possibility of a fresh perspective (Stern, 1980).

In the current study, grounded theory is seen as appropriate for a number of reasons. Firstly, as stated in the previous chapter, there appears to be only one other study which investigates the aftermath of suicide for survivors in New Zealand (Booth, 1994). Hence, a research method which is investigatory in nature, and which starts out with no initial assumptions would seem appropriate for use with a group of people about whom not a great deal is known.

There appears to be some need for a fresh approach in an area where some knowledge already exists. The equivocal nature of control group study findings suggests that a study which may provide fresh slants is appropriate.

Thirdly, most suicide survivorship studies have not focused on the nature of coping factors in those bereaved by suicide. The exploratory approach of the current study, is intended to allow the researcher to learn from participants, themselves, which factors may have been helpful in assisting them to cope with grief.

The nature of the topic in the current study requires that participants be treated with the utmost sensitivity. The qualitative nature of the study was designed to help promote such sensitivity. The semi-structured interview format, esteemed in grounded theory research (Pidgeon & Henwood, 1996), provided participants with the opportunity to choose which information they divulged rather than be required to provide specific

information as occurs in quantitative research. For example, survey questionnaires and Likert scale ratings require subjects to quantify specific aspects of their experiences. Further, it is likely that the experience of telling their story to the researcher was similar to experiences of relating their stories to interested others (such as friends). Hence, participants had the advantage of some familiarity with the format, a fact that would not have been the case in a quantitative study where filling out questionnaires and ratings place the participant in unfamiliar territory.

## **TENETS AND PROEDURES OF QUALITATIVE METHODOLGY**

In conducting the current grounded theory study and producing the final report, several tenets and procedures of qualitative methodology, and grounded theory in particular, were considered especially important. These are outlined below.

### **Reflexivity of the Researcher**

The issue of reflexivity is a complex one within the world of qualitative research (Henwood & Pidgeon, 1992). Here, the focus is on reflexivity and the researcher. "Reflexivity emphasizes an awareness of the researcher's own presence in the research project" (Smith, 1996, p. 195). By bringing her own, personal, cultural and ideological assumptions (Pidgeon & Henwood, 1996) and experience (Baker, Wuest, & Stern, 1992) to the research, the investigator shapes the research from its conception to completion.

One phase of the research where the researcher has a potentially large impact is the interview stage. In grounded theory research, the researcher is required to enter the participant's world (Bowers, 1988) and to engage with each participant. Stiles (1993) advocates empathy with participants to allow the researcher to enter the world of those being studied. A lack of engagement with participants may be detrimental to the study as participants need to feel comfortable enough to share their stories openly.

One of the practical implications of accepting that the researcher plays an inevitable role in the research process is that the role of the researcher should be emphasised in the writing up of the research (Henwood & Pidgeon, 1992; Smith, 1996). Accordingly, a discussion of the researcher's role in the current study is included in the following chapter.

### **Theoretical Sampling**

Theoretical sampling refers to the key grounded theory procedure of including participants based on the needs of the study rather than sampling a predetermined number of participants. Pidgeon (1996) contends that the onus on the researcher is not to sample multiple cases but rather to select new cases during data collection and analysis which have potential for extending and deepening the developing theory. "Sampling is therefore explicitly driven by theoretical concerns" (Henwood & Pidgeon, 1992, p. 107).

### **Constant Comparison Method of Analysis**

This is referred to by Pidgeon (1996) as the "principal analytical task" (p. 78) of the grounded theory researcher. Each occurrence that is identified in the data should be compared against others both for differences and similarities (Corbin & Strauss, 1990) and this process should occur at all stages including data collection, coding, and data analysis (Becker, 1993).

### **Using Raw Data**

Numbers are not used in qualitative studies. Rather the concepts developed and discussed in the report are supported by examples from the data (Stern, 1980). Stiles (1993) champions using a participant's own words in qualitative studies although he points out that verbal quotation is less compact than quoting numeric data.

### Writing up the Research

Differences are also apparent between writing up quantitative and qualitative research reports (Stern, 1980). In grounded theory research reports, results and discussion are frequently presented together (Bowers, 1988). "There is not usually a separate *discussion section* as there is in most hypothetico-deductive studies, because in the course of presenting the theoretical scheme, findings are usually presented in sufficient detail" (May, 1986, p. 150). Results include a balance of description and analysis (Patton, 1987) and literature is used to assist in explaining theory (Stern, 1980). Stern states "references are woven into the theory" (1980, p. 91). References can validate the findings of a study and they can be used to demonstrate ways that a particular study differs from the existing literature (Strauss & Corbin, 1990).

### **CONSTRUCTIVIST ARGUMENT FOR THEORY GENERATION**

Qualitative approaches to research have, of course, not gone uncriticised. Criticisms have come both from outside and within the qualitative fields. The discussion here focuses upon a criticism of grounded theory which appears to be particularly relevant for psychologists using the approach.

Recently, there has been debate over the nature of theory generation in grounded theory research. Originally, Glaser and Strauss (1967) conceived of theory as 'emerging' from the data. "From an inductivist perspective, theory emerges from specific observations and generated data. The theory can then be tested empirically to develop predictions from general principles, that is, the deductive research method" (Carpenter, 1995, p. 150).

However, this inductivist/deductivist view has been criticised (Henwood & Pidgeon, 1995; Pidgeon, 1996). "Theory", they say, "cannot simply 'emerge' from data, because all observation is pre-interpreted in terms set by existing concepts and theory" (Henwood & Pidgeon, 1995, p. 117). Further, Henwood and Pidgeon point out that

promoting inductivist analysis contradicts the grounded theory premise that the researcher should be creative and interpretative.

As an alternative to the inductivist/deductivist view, critics have advocated a constructivist approach to the generation of theory (Charmaz, 1990; Henwood & Pidgeon, 1992, 1995; Pidgeon, 1996). Rather than theory emerging from the data, constructivist proponents view the researcher as bringing her own perspective to the research. "Researcher perspective includes substantive interests which guide the questions asked, a philosophical stance or school of thought which provides a store of sensitizing concepts, and one's personal experiences, priorities and values" (Henwood & Pidgeon, 1995, p. 117). From her particular vantage point the researcher interacts with the data and actively builds the analysis or constructs a theory. The advantage of this, according to Henwood and Pidgeon (1995), is that the researcher stays on an analytic path rather than reproducing their original ideas unchanged.

## EVALUATING QUALITATIVE RESEARCH

Conventional psychological yardsticks for evaluating psychological research are not appropriate when considering qualitative studies (Smith, 1996). For example, the scientific neutrality so desirable in quantitative research (Dunham, 1988), is neither an aim nor is it valued in qualitative studies. The different epistemological aims and viewpoints espoused in qualitative research, such as the desirability of acknowledging the reflexivity of the researcher, require that rigour in such studies be judged according to an alternative set of criteria. A number of ways for maximising the rigour of qualitative research have been, and continue to be, developed. The current study embraces a number of general qualitative criteria (Smith, 1996; Stiles, 1990, 1993) and specific grounded theory criteria (Henwood & Pidgeon, 1992) developed to ensure the trustworthiness of such research.

**Coherence** refers to the apparent quality of the interpretations made by the researcher (Stiles, 1990, 1993). Questions which might be asked when assessing whether internal coherence is apparent include; "Does it present a coherent argument?... Are the

interpretations that the researcher makes warranted by the data presented? Does the report deal with alternative readings?" (Smith, 1996, p. 192). Referring to grounded theory, specifically, Henwood and Pidgeon (1992) underline the importance of "keeping close to the data" (p.105) so that the emergent theory "fits" the data well.

In the **Presentation of Evidence**, enough raw data should be supplied to allow the reader to judge the interpretation that is being made (Smith, 1996). This is particularly appropriate in studies such as the current one, which analyse interview transcripts.

An **Independent Audit** (Smith, 1996) requires that all of the data be recorded so that somebody else may review the steps leading to the final product (see Appendix A).

**Consensus among Researchers/Replication** (Stiles, 1993) refers to agreement between the person carrying out the research and at least one other person about the interpretation of raw data. Stiles states "It offers readers the assurance that other investigators who were familiar with the raw data found the proposed interpretation convincing" (1993, p. 612). Both the researcher and the researcher's supervisor agreed that the codes and concepts developed in the current study fit the descriptive data from participants' transcripts (see Chapter Three).

**Triangulation** "means seeking information from multiple data sources, multiple methods, and multiple prior theories or interpretations, and assessing convergence" (Stiles, 1993, p. 608). Different sources may include literature, data from different participants, and the researcher's own experience. The idea behind triangulation is that the more methods and sources of information, the more likely the accuracy of the findings (Smith, 1996).

**Member Validation** involves taking the analysis of data to participants to allow them to comment on the interpretation (Smith, 1996). Stiles (1990, 1993) refers to this criteria as "Testimonial Validity". The basic premise of this criterion is that participants, themselves, will know whether the researcher has understood their experience. Criticisms of this approach include the assertion that power relations play a role.

Participants may find it easier to agree with the researcher than to question interpretations (Smith, 1996). Further, Henwood and Pidgeon (1992) caution that this method of validating grounded theory may be flawed because participants are not always aware of reasons behind their actions. In spite of these criticisms, this method would appear, at the very least, to provide an opportunity for those whose experiences are at the very heart of the research to have their say about another's interpretation of integral aspects of their lives. Accordingly, participants in this study were asked for their views of the findings (see Appendix B).

**Catalytic Validity** refers to the impact of the research on the participants who were studied. Stiles (1990, 1993) points out that an interpretation which is catalytically valid results in change or growth in those whose experiences were described. Further, he views this as a way of empowering participants by helping them to take control of their lives.

## SUMMARY

The present chapter explained the researcher's rationale for employing grounded theory methodology. The need for a fresh approach from which new insights could be gleaned, and the newness of this topic of research in New Zealand, were primary considerations in the choice of methodology. The chapter has also provided information on a number of tenets and procedures of qualitative and grounded theory research which have been embraced in the present study. The current constructivist versus inductivist argument in grounded theory research has been discussed. Finally, criteria for evaluating qualitative and grounded theory research have been presented in order that readers may recognise that the different epistemological stance from conventional psychology, necessitates a different set of evaluative criteria. In the subsequent chapter, attention focuses on the present study. Information will be provided about the study's aims and ethical considerations. The researcher's own experience and assumptions will be revealed and the procedure followed in carrying out the research and analysing the data will be documented.

## CHAPTER THREE:

### THE PRESENT STUDY

The following chapter is in five parts. Initially, a brief discussion of the aims of the study is presented. In keeping with the grounded theory tenet of revealing the role of the researcher, an outline of the researcher's prior assumptions and experience is provided. Subsequently, the method followed in carrying out the study is detailed as are certain characteristics of participants. Ethical considerations relevant to the current study are then considered. Finally, the grounded theory method used in the analysis of the data is described. Attention is paid to the use of theoretical sampling and the constant comparison method of data analysis.

#### AIMS

The present study incorporates a number of objectives. Chief amongst these is the aim to construct a theory of the effects of suicide on family members which is grounded in the information provided by family members. Previous research (e.g., Rudestam, 1977) has suggested that those bereaved by suicide suffer profoundly and distinctly compared with those bereaved in other ways. While there are a number of general theories of grief (Cleiren, 1993), especially stage and task theories, there appears to be very few models which focus on bereavement following suicide, particularly models which incorporate coping factors. It is hoped that by taking a fresh, close look at the aftermath of suicide, an encompassing model which "fits" the data may be developed. Further, that model may be strengthened by support from concepts such as agonising questioning, preoccupation with guilt, and social isolation identified in other studies (Smith et al., 1995; Van Dongen, 1990).

While it is intended that common themes will be drawn out from the accounts of participants, the study is also intended to reflect the uniqueness of each participant's experience. It is important that each individual account is accepted as valuable in itself

in addition to being part of a larger picture. In the following chapter, each participant's story is told. The intent is to allow the reader to become familiar with participants' stories and to recognise the individual nature of each account.

It is also an aim of the current study to make a New Zealand contribution to the literature on people bereaved by suicide. The present study investigates a group of people who have been the focus of minimal research attention. It is believed that New Zealand has a duty to assist this vulnerable group of its citizens just as it has a duty to assist in the prevention of suicide.

A focus of the study is utility. While the study must fulfil academic requirements, producing a piece of work which may be useful to those who have lost a family member to suicide is paramount. With this in mind, the researcher has the aim of creating a theory with utility for those affected by suicide.

## **THE HAND OF THE RESEARCHER**

As I pointed out in the previous chapter, the role played by the researcher in qualitative investigation is an integral part of the research process. Henwood and Pidgeon state that "research that seeks to reveal rather than obscure the hand of the researcher and social bases for knowledge...has some claim to providing more adequate knowledge" (1995, p.118). Accordingly, I have made an attempt below to convey some of the preconceptions and experience that I brought to the research.

Readers will note that in this part of my thesis, the first person replaces the third person. It seemed inappropriate to juxtapose personal reflections with the "scientific" prose which is designed to assist in maintaining the neutrality of the writer. Indeed, had I recognised this sooner, I would have produced the entire thesis in the first person as some qualitative writers advocate (Wolcott, 1990).

I am a female New Zealander in my early thirties. Married, with a seven year old daughter, I have a baby due in four weeks from the time of writing. My years at University have primarily been taken up with studying Psychology and English.

My interest in carrying out this study stems from gaining the status "New Zealand suicide survivor" after my first husband took his own life six years ago. As appears to be the case for many others researching this topic, first hand knowledge of the difficult time which faces suicide survivors prompted me to engage in a study where I could learn from others and perhaps also help others in a similar situation.

I was particularly fortunate in having a family who provided constant and enduring support for both my daughter and myself. During the difficult period that ensued after Paul's death, I was prompted many times to wonder how others cope, particularly those without the support that I had. I was unaware of the existence of 'suicide survivors' support groups. Throughout the current study, particularly during data analysis, my awareness of the supportive role that such a group can play, increased. Further, I realised that there are many avenues of assistance and ways of coping of which I had not been personally aware.

Stiles (1993) states that "empathic understanding draws on the investigator's own experience and self-knowledge" (1993, p. 595). When I commenced the current study, I was uncertain about whether I should reveal my own experience to potential participants and to others I encountered in carrying out this project. As it turned out, my participants took the decision out of my hands. Most simply asked me why I chose this topic. Given their honesty in telling their stories, it seemed the least I could do to acknowledge that my interest stemmed from my own experience. A number of participants indicated that they would not have been willing to take part in a study (especially an interview) conducted by someone who did not have the understanding and empathy that comes from being a fellow survivor. Further, at the completion of the interviews, two participants commented that their awareness that I was also bereaved by suicide enabled them to reveal more than they otherwise would have done.

My training in Psychology, specifically Clinical Psychology, also shaped this research project. Elements of the study which are influenced by my training in Clinical Psychology include the desire to learn about human experience and behaviour, consideration of ethical concerns (such as the potential impact of interviewing on participants), and the belief that telling one's own story is therapeutic. Perhaps the most obvious example of the influence of conventional Psychology training is the fact that I used "scientific" prose to write up the bulk of this thesis.

In addition to the personal experiences of being a suicide survivor and a Psychology student, my increasing familiarity with the bereavement literature throughout this project shaped this research. Some of the concepts I embraced (outlined below) will be seen by the reader to have influenced the categories and codes during the data analysis stage of the research. This is in keeping with Strauss and Corbin's (1990) contention that in grounded theory data analysis, some categories are drawn from a pool of concepts relating to the researcher's discipline and understanding of the literature.

- Grief is a normal human response to the major stress of death and it contains universal aspects such as sadness, anger and denial. These ideas stem from stage and task theories of grief (e.g., Bailey, 1988).
- In spite of universal components in grief responses, individuals vary in their reactions to death. Which factors which influence individual grief responses and how they do so is a subject of particular interest.
- Grief following suicide may or may not be more difficult than after other forms of death. There is no doubt, however, that it is very painful for many survivors. In all likelihood, there are qualitative differences between grief after a suicide and grief after other kinds of deaths (e.g. Mist, in preparation).
- Research which leads to assistance for survivors is both necessary and timely, especially in New Zealand.

Overall, my prior experiences (especially being a suicide survivor and training in clinical psychology), coupled with knowledge of the bereavement literature, have played a key role in the creation, carrying out, and writing up of my study.

## METHOD

### Participants

Eight adults ranging from early adulthood through to late adulthood took part in the present study. (Participants were not asked their ages as this seemed an inadequate way to commence an interview, was totally inappropriate during the interviews and unnecessarily intrusive at the end of interviews). Four of the eight participants were volunteers who responded to advertisements (see Appendix C) in Bereaved by Suicide Support Groups. Three were gained through personal contacts of the researcher and one participated after hearing of the research 'through the grapevine'. All participants were New Zealand citizens who had lost a family member through suicide. Although the study allowed for those bereaved of a close friend by suicide to participate, no one with that experience volunteered to be involved in the study.

The study required that at least one, preferably two, years had passed since the suicide. It was perceived that the period of a least one year would allow the opportunity for the study to examine how family members' experiences of suicide change over time. All the suicides discussed in the study occurred between three and six years prior to the interview.

Although the study allowed for more than one family member or friend bereaved by the same suicide to participate, each participant discussed the experience of a different suicide. Five of the participants had lost a son or daughter through suicide. One person had lost her husband, one a sister-in law, and one a step-brother. Seven of the participants were female and one was male.

Of those who had suicided, six were male and two were female. Suicide completers ranged in age from early adulthood to middle adulthood. Methods of suicide included three hangings, two overdoses, one shooting, one carbon monoxide poisoning, and one jumped into the path of an oncoming train. Participants reported three suicide completers had made previous suicide attempts, one was unsure about the nature of a

previous life threatening situation and four had made no known previous attempt. At the time of death, three victims had imbibed alcohol or taken some other form of drug. In four cases there were histories of depression which led to familiarity with counsellors, General Practitioners (GPs), or mental health professionals.

### **Procedure**

Those who demonstrated interest in being involved in the study were provided with an information sheet (see Appendix D) detailing the study's requirements and participants' rights. An interview time was then arranged over the telephone with each participant.

Immediately prior to each interview, participants were reminded of their right to have the audiotape turned off at any stage as well as the right to withdraw from the study at any time. In all cases, the researcher attempted to establish some rapport and introduce the topic of the suicide before commencing taping. The aim was to assist a number of very nervous participants to relax a little before discussing their experiences.

The interviews took place, for the most part, in participants' homes. In the one case where this was not convenient, the interview took place at a location which was convenient for both the participant and the researcher.

A semi-structured interview of approximately one hour in length was conducted with each participant. A guide of topics to be covered (see Appendix E) was used by the researcher as a prompt to cover issues not already addressed by participants and to initiate further discussion throughout the interview. The use of the schedule also ensured some similarity in the information obtained in the interviews (Patton, 1987) while also allowing each participant to discuss their own unique issues and experiences.

Participants' accounts were in narrative form. Almost all participants began by discussing events that occurred before the suicide, then discussed the suicide itself, the events immediately following the suicide, and finally, experiences which had occurred since the suicide. In one case, the participant began by outlining the suicide itself, and

then filled in details prior to and since the suicide. Near the completion of each interview, participants were given the opportunity to comment on the study, on the experience of being interviewed, or on any other issues they may wish to address.

Each audiotape was transcribed in its entirety by the researcher. A standard orthography procedure was used in transcription (see Appendix F). Pseudonyms were used throughout each transcript. On completion of transcription, copies of individual transcripts were sent to each participant to view and to edit to their own satisfaction. Participants were required to return altered transcripts by a given date otherwise agreement was assumed. No participant made any changes. The transcripts were then analysed using the grounded theory method of analysis (see p. 43).

At the completion of the data analysis, a summary of research findings was sent to each participant and they were invited to comment on the appropriateness of the findings in view of their own experiences (see Appendix B). Although no comments or replies were received directly from participants, the researcher was contacted by the coordinator of one of New Zealand's Suicide Support Groups. This coordinator informed the researcher that one of the study's participants had recommended the findings to the support group as relevant and accurate. Further, the coordinator indicated her desire to use the findings in a practical setting.

## **ETHICAL CONSIDERATIONS**

Approval for this study was received from the Massey University Ethics' Committee prior to advertising for participants. As outlined above, informed consent was gained from all participants. Prior to the commencement of the interview, each participant was provided with a Consent Form (Appendix G) which they signed indicating that they had read and understood the Information Sheet and that they agreed to take part in the study under the conditions set out in the Information Sheet. Obtaining written consent close to the time of the interview was designed to allow participants the maximum amount of time in which to consider their involvement in the study.

The researcher was committed to preserving participants' anonymity and confidentiality. Only the researcher and supervisor had access to the accounts. All identifying information was changed or omitted from the transcripts and final thesis. Excerpts used in the thesis do not identify the participants in any way. Audiotapes were transported in a combination lockable briefcase and both audiotapes and transcripts were securely stored at the researcher's home. At the completion of the study, audiotapes were either erased or returned to participants according to their wishes. Transcripts were stored securely.

The researcher was fully aware of the delicate nature of the subject under scrutiny. Death is a sensitive subject at any time. The self chosen and self inflicted death of a family member or friend is a painful and, often, shocking reality for those people who are survivors. It has already been pointed out that the qualitative methodology with its in depth interview format was chosen in recognition of the fact that such a traumatic experience needs to be investigated with respect for the feelings of the participants. The study provided the opportunity for participants to tell their story in a non-threatening environment and no pressure was placed on participants to discuss issues they found too painful.

It is, in fact, likely that telling their story was therapeutic for some participants. Wertheimer (1991) found that suicide survivors who agreed to take part believed the interview may be personally helpful even before the interview took place. Some who had not been aware they needed to talk found the interview therapeutic without expecting that it would be. Further, many of Wertheimer's participants were happy to contribute something they felt could perhaps help others in a similar position in the future.

One study which investigated the impact of interviews on suicide survivors found that, overall, "the interviews lead to no major complications and may even be positive experiences" (Asgard & Carlsson-Bergtrom, 1991, p.31). A similar study (Runeson & Beskow, 1991) of suicide survivors' reactions to interviews concluded that many interview participants benefited from taking part in a single interview.

Other ways in which this study demonstrated concern for the welfare of its participants included the fact of allowing access to the researcher at home so that participants who may have felt very tentative about initially contacting the researcher were not required to leave a message. Ensuring that at least one year has elapsed since the suicides, was intended to minimise the likelihood of any participant incurring psychological harm from discussing a death which was still recent and intensely painful.

The fact that some participants were found through suicide support groups indicates that there had been, and continued to be, support available for those survivors. However, should any participant have suffered distress as a result of their participation in this study, they were assured that a counselling option was available.

Much ethical concern in the literature focuses on the reactions of participants in the interview setting. This is particularly true when the subject of the interview involves loss (Rosenblatt, 1995). Recent ethical interest also focuses the researcher's reactions to interviews on loss (Kitson et al., 1996). In the current study, the stories told by participants were sad and, at times, upsetting. However, the aim of contributing something that may eventually help survivors cope with such a traumatic experience offset any temporary distress felt by the researcher as a result of listening to the stories of participants. Both the researcher's supervisor and a mentor were available to discuss any distress had this been required.

## **GROUNDED THEORY METHOD OF DATA ANALYSIS**

Initially, four interviews were carried out and the researcher commenced transcribing each of these. Open coding (described below) generated a generous number of categories from these four interviews and the researcher began to formulate several higher level categories and concepts. In order to provide additional information which may support or refute these initial concept formulations, three further interviews were carried out. This process is in keeping with central grounded theory procedure of theoretical sampling. Of particular interest at this stage was the fact that the initial

interviewees were associated with suicide support groups. The next three were not. The researcher was interested to ascertain whether the data from the second set of interviews supported the original concepts. Indeed, they did reinforce the researcher's initial formulations. A second difference between the early interviews and the second set was that all the participants in the first interviews were parents of suicide victims. Those interviewed in the second set had other kinship relations with the victims. While the data obtained added weight to the initial codes, a number of other codes were also generated. A final interviewee, who was not a parental survivor, provided no new categories. However, she did provide descriptive detail which supported many of the categories already generated. Overall, 68 open codes were generated from the eight interviews and every category was supported by data from at least two accounts. Hence, it was viewed that saturation of data (Baker et al., 1992) had been reached. Because this was the case, it was deemed unnecessary to ask further participants to recount such a traumatic experience when there was every indication that the data would be repetitive.

### **Open Coding**

Open coding constituted the initial phase of data analysis. During this phase, the transcripts were examined line by line, phrase by phrase, in order to identify concepts in the data. By making constant comparisons between concepts and asking questions about emerging concepts, two procedures which are at the heart of the coding process (Strauss & Corbin, 1990), the researcher was able to link or discard concepts to identify open codes. The open codes were formed using the language of participants and by constructing implicit codes which the researcher identified in the data (Carpenter, 1995).

### **Axial Coding**

In this phase of the data analysis, connections were made between the open codes so that a number of separate categories were formed. Categories were derived from *conditions* that gave rise to them, *strategies* used in dealing with a phenomenon, and *consequences* of actions that were entered into (Strauss & Corbin, 1990). Not all

categories were made up of conditions, strategies, and consequences. Some categories may only contain one or two of these components.

Certain categories emerged which may be seen as polarised ends of the same phenomenon. For example, the categories 'Lack of Support' and 'Social Support' may be seen as opposite ends of a category more simply named 'Support'. The researcher resisted condensing the two categories, however, because it was believed that such polarisation was at the very heart of participants' experiences. Indeed, a later stage of analysis, outlined in the following section on selective coding, bore out this supposition.

### **Selective Coding**

Further comparisons saw three selective codes emerge during this phase of the research. These included Grief Responses, Intensifying Factors, and Alleviating Factors. Each code represented the most logical grouping of the axial codes. These three concepts were linked together to construct the grounded theory (see Chapter Five).

The presentation of the three levels of coding is intended to provide clarity for the reader. However, the reader should also be aware that the coding did not occur as a clear cut series of stages. Rather data analysis occurred as part of an ongoing process in which the researcher was continually creating, deleting, merging and developing codes.

A table of selective, axial, and open codes is provided in Appendix A. All codes were discussed with the researcher's supervisor and agreement was reached as to their appropriateness. The following chapters are peppered with quotations from participants' stories which exemplify and support the codes used as the basis for the grounded theory proposed in this study.

## **SUMMARY**

This chapter discussed the aims of the study, the method by which it was carried out, and the process of data analysis. The main aim of the study was to develop a theory

about the experiences of family members bereaved by suicide which was grounded in the information provided by those people. Another aim was to provide a New Zealand contribution to the literature on suicide. The study involved eight one hour interviews with family members who had been bereaved, at least one year previously, by suicide. Grounded theory methodology including open, axial and selective coding was used in the analysis of the data provided by participants. This chapter also highlighted the role of the researcher in the study and it emphasised ethical issues which were considered in the carrying out of the research. In the following chapter, participants' stories are outlined so that the reader may gain some familiarity with the individual experiences of those whose information led to the grounded theory.

PART TWO:

**Findings: Description and Analysis**

## CHAPTER FOUR:

### PROFILES AND STORIES OF PARTICIPANTS

In order to achieve clarity of presentation, the current chapter begins by advising the reader of the organisation of the Findings section of this thesis. The bulk of the chapter is devoted to introducing, and outlining the stories of, the eight people who participated in the research. Attention has been paid to the reactions and feelings reported by each participant. One of the aims of the study was to highlight the uniqueness of each participant's account. Accordingly, an attempt has been made to present issues and circumstances which were unique or appeared especially important to each participant. All participants have been given pseudonyms and the names of the family members who suicided have been changed. In some instances other details have also been altered as a further means of preserving anonymity. In deference to the views of some participants that the term, 'to commit suicide', has illegal or sinful overtones, the findings' chapters of the current study contain the word "suicide" as a verb. The term "committed suicide" is not used at all.

### ORGANISATION OF FINDINGS

The Findings of this study are reported in four chapters. As stated above, the present chapter provides an introduction to those who participated in the research. Each of the subsequent three chapters focuses on describing the three key concepts which are linked together to make up the grounded theory of the study. The order of the chapters is:

- Chapter Five: **Grief Reactions** which resulted after the suicides.
- Chapter Six: **Intensifying Factors** which prolonged or deepened participants' grief reactions.
- Chapter Seven: **Alleviating Factors** which lessened participants' grief and indicated that they were coping, or had coped with the fact of the suicides.

## STORIES OF PARTICIPANTS

**Ann-Marie**, a middle aged woman, was stunned when told six years ago that her sister-in-law, Olivia, had taken her own life. Although Olivia had a long and complex history of mental health problems including addiction to prescription drugs, the thought that she may actually take her own life never arose within her family. Ann-Marie felt a great deal of anger particularly towards the GPs and mental health professionals who had been involved in Olivia's care over a number of years. She believed that they had often been lax in their professional duties and that in the case of the prescription drug addiction, more should have been done to assist Olivia to break her habit. In fact, the professional involved did not recognise the addiction. Ann-Marie also felt anger and sadness at Olivia leaving her teenage children without a mother. She also felt angry that her brother was left a widower. She found it especially difficult to watch her brother, niece and nephew try to cope with Olivia's death. Ann-Marie found herself in the role of surrogate mother and feared that her nephew may see suicide as an option for himself. Ann-Marie's own husband was her source of strength and support and she was also appreciative of the way the police handled the necessary investigation into Olivia's death. She believed that having Olivia's body at home before the funeral was helpful, providing family and friends with the opportunity to say goodbye. Some friends appeared to change their attitude toward Ann-Marie and her family after Olivia's death. Ann-Marie remembered people telling her after the funeral that Olivia's death was not unexpected. She found that hard to deal with, wondering how her family could have overlooked the potential for Olivia to suicide when people who did not know her well were so knowledgeable. She believed that it was much easier for people to be wise after the event than before it. For Ann-Marie, the issue that has remained with her since her sister-in-law's suicide is the "helplessness of mental illness". In her view, people who are depressed and in need of mental health support would benefit from GPs and mental health professionals who are able to "find somewhere in the system to...spend the time to...dig deeper".

**Nancy** is a middle aged woman who lost her son, David, to suicide four and a half years previously. Two years prior to his death he was involved in a severe accident which left him with permanent injuries including difficulty walking due to partial paralysis. Part of

the difficulty Nancy encountered in dealing with David's suicide was the fact that she believed he "should have died at the time of the accident" rather than two years later when he had undergone what seemed to her "a miraculous recovery". Her son's suicide came as a total shock to Nancy. Disbelief was her initial reaction when informed of her son's suicide by a family member. Later, she was told by hospital staff that David had talked about suicide and made previous attempts. Due to privacy regulations, however, David's counsellor and hospital staff who knew of his suicidal thoughts did not inform David's family. For Nancy, this fact was difficult to comprehend. Nancy saw her son's suicide as having caused divisions in the family. She believed that she was expected by her family to be the mother and provide support for the other family members. However, she was unable to fulfil this role, needing to take time to grieve in her own way. Nancy believed that her way of grieving was unacceptable within her family which led to much family friction. Nancy described feelings of guilt and anger towards her son after his death. She also described feelings of rejection by friends as well as family and she referred on several occasions during the interview to the assistance she had received from being involved in a Suicide Support Group. As part of her involvement in the Suicide Support Group, Nancy has focussed on the issue of parenting. She believed that young people in New Zealand have limited 'back-up resources'.

**Peter** is a middle aged man whose son, Matthew, took his own life approximately six years ago. Peter was away on business when he learned of his son's death from the friend he was staying with. For Peter, Matthew's suicide came as a complete shock and a large amount of his account was spent reminiscing about his son and some of their times together. Of special significance to Peter was the last time that he saw Matthew and he recounted that in detail. Peter experienced guilt himself and also blamed others for his son's suicide. In particular, Peter regarded his ex-wife, from whom he separated approximately a year before Matthew's suicide, as being to blame for Matthew's death. In his view, the separation contributed to Matthew taking his own life and it prevented the family from being able to grieve together and support each other after Matthew's death. Peter also commented that it was more difficult for a man to go through such a traumatic experience than it was for a woman. He believed that women talk more and support each other better. Peter also suffered physical effects following Matthew's death. Severe headaches and chest discomfort were particularly apparent. Two of the

most helpful factors in assisting Peter to cope with the suicide of his son were close contact with his two young grandchildren and his strong religious beliefs. Peter also emphasised how important it was to him that Matthew was still talked about “almost as if he was there”.

**Lauren**, a young woman in her early twenties, lost her stepbrother, James, when he suicided four years ago. Lauren learned of her stepbrother’s suicide after her mother came and took her out of school. Sadly, Lauren had spent the previous evening with her photographer boyfriend, helping him to develop photos from a suicide scene he had been required to attend as part of his work. For Lauren, the horror of learning of her stepbrother’s suicide was compounded the realisation that she had already been a witness to the scene in which her stepbrother had died. James’ death came as a complete shock, a shock Lauren believed was intensified because it was the first time that she had experienced the death of someone close. She experienced difficulties facing her peers after James’ death and related incidents in which friends showed a lack of understanding. That lack of understanding led to the end of a number of friendships. Anger towards others, particularly James’ biological family, was prominent in Lauren’s account and she believed that James’ upbringing had much to do with his decision to take his own life. A particular fear following James’ suicide was of going to the grave site which for Lauren was associated with the finality of death. She was unable to do this until two years after James’ suicide and when she did, she had close friends to support her. Her own family and boyfriend were very supportive towards her and Lauren believed that her ability to deal with James’ suicide was greatly enhanced by that family support. Also particularly important to Lauren was the fact that she believed that she had discovered a reason that he chose to take his own life. After his death, she discovered that James was homosexual and that he had not been able to bring himself to tell his family. Lauren believed the guilt from keeping this and other secrets contributed to his decision to suicide. For Lauren, one of the hardest facts to come to terms with in James’ suicide, indeed, in any suicide, is that is unnecessary.

**Isobel**, a middle aged woman, lost her husband, Brent, when he took his own life five years ago following a period of depression. While it came as a surprise to Isobel that her

husband had suicided, she believed that she was spiritually prepared when the police informed her of Brent's death. One of the features of Isobel's story was her belief that she had a premonition of her husband being in difficulty before the police arrived although she believed that difficulty was due to an accident rather than self inflicted. The shock that Isobel experienced related to the fact that her premonition was so close to being accurate. Following her husband's suicide, it was important to Isobel to be open about the nature of her husband's death. While other members of her family had difficulty in dealing with the fact that Brent had suicided, Isobel felt that "the truth should be heard". This view applied when talking to her grandchildren about the death of their grandfather as well as when she was talking to many adults. The role of looking after others permeated her experiences since her husband's death. Isobel remembered spending much of the time during the funeral and immediately afterwards consoling others rather than having them console her. Her initial, tentative, contact with a local Bereaved by Suicide Support Group led to an ongoing involvement in which the group developed both in size and strength. She believed that being open and honest about the fact that she had been bereaved by suicide allowed many others to come forward and tell their stories and receive support. She also saw Suicide Support Groups as being essential in assisting people to deal with their grief and as being extremely useful in providing information. At no stage did she feel anger towards her husband or anybody else. However, she did find it hard to deal with cards sent from an acquaintance who informed Isobel that she was praying for Brent "to come out of hell". Isobel indicated her belief that for a person to suicide there must be "mental disablement" and that the victim is "unbalanced" mentally. She had no belief in what she saw as the largely antiquated view that suicide is a sin.

**Gwen** remembered the time surrounding her son's suicide five years previously as shocking and unreal. Her initial response to the news that her son had taken his own life was one of disbelief. Manu was away from home at the time and Gwen had to travel in order to see his body and organise a funeral director. The ordeal was exacerbated by the funeral director's refusal to release Manu's body until the bill had been paid. However, it was extremely difficult for Gwen to get the money as Manu's death occurred on a long weekend and Gwen found herself without access to her bank accounts. She believed that the funeral director insisted that she pay first because the family was Maori and as

such, "could not be trusted to pay their bills". She has since discovered that demanding money in the way the funeral director did is illegal in New Zealand. Manu was estranged from his family by his own choice at the time of his death and Gwen found it difficult to deal with this estrangement. She suffered from depression, guilt and suicidal thoughts. Other members of her family refused to talk about Manu's death and she found herself looking for someone to share her feelings and thoughts with. Her involvement a local Suicide Support Group provided her with opportunity to talk to people in a similar situation to herself. She believed that talking to others was therapeutic for all mothers who have lost child through death. At one time she experienced anger towards her son for choosing to take his own life but that anger subsided and was replaced with sadness. The anniversary of Manu's death, his birthday and Christmas are difficult times for Gwen. She misses her son and these times bring home to her the fact the Manu will never have the opportunity to enjoy many of the good things of life.

**Pauline** lost her twenty year old daughter, Kim, to suicide three years ago. Initially, Pauline and her family were led to believe that Kim may recover from the overdose she took and they left the hospital where they had been keeping a bedside vigil. However, Kim's condition deteriorated and they were called back to the hospital where they remained until she died. While this was not Kim's first suicide attempt, her death came as shock especially after the family had believed that she was going to pull through. Pauline spent much time after her daughter's death trying to work out the events that led to Kim taking the drug overdose. While she did not blame anyone else, she was angry with her daughter's fiance who she believed did not tell the full truth about the events leading up to Kim's suicide. One of the most healing and helpful experiences that occurred after Kim's death was having Kim's body at home. Pauline saw this as an opportunity to have her daughter home for the last time and to say goodbye. She believed that the whole family found that experience therapeutic. Following Kim's death, Pauline's family members had their own ways of dealing with Kim's suicide and she found herself needing someone she could talk to. A friend put her in touch with the local Bereaved by Suicide Support Group and it was through this group that she was able to find support and learn to deal with the fact of her daughter's suicide. Pauline also kept a journal in which she was able to write down her thoughts and feelings on a daily basis and this was something she found extremely beneficial in assisting her to function

throughout the trauma. After three years of coming to terms with Kim's death, Pauline believed that she had changed her life for the better. She saw herself as having learnt to communicate more clearly, be more generally assertive, and especially, put family first. On the subject of suicide in New Zealand, Pauline indicated that there was nothing available for those who make suicide attempts but who survive those attempts. She believed that providing assistance for people in this situation should be a focus of suicide prevention strategies and that parents and educators should focus on building up our country's children rather than seeing them as "no damn good".

**Tracey** is a middle aged woman. Her son, Gary, took his life five years ago, after having made at least one prior suicide attempt. Tracey described her son as "depressed" and in need of help. She was discouraged by the mental health professionals her son had been involved with and believed that more could have been done to help him. Anger towards professionals and her son's girlfriend was one of her initial emotional responses to the news of her son's death. She also experienced relief that an end had come to the ongoing problems and difficulties she had faced trying to support her suicidal son. Guilt, depression and her own suicidal thoughts were also apparent. Over time, these feelings dissipated somewhat. Tracey discussed her changing perceptions and emotions over time and saw the coroner's inquest several months after the death as a pivotal time in her being able to deal with her son's death. Having her son's body at home on the night before the funeral was a healing experience and, in fact, Tracey wishes now that she had her son home for a longer period of time before the funeral. Joining a Bereaved by Suicide Support group played a significant role in assisting to Tracey to cope with her grief. In particular, the group appeared to help her in recognising the normality of her grief reaction. Another suicide in Tracey's family, several years after her son's death brought back much of the experience of losing her son. Tracey maintained suicide prevention is vital in New Zealand and that although there is debate over whether suicide should be given publicity, "there needs to be more awareness of signs to look for".

## SUMMARY

After providing a brief overview of the findings section of this thesis, the present chapter profiled participants who took part in the current study and outlined their stories. The stories reflect personal and painful experiences which have shaped participants' lives due to the suicide of a family member. An attempt has been made to draw out some of the more unique or important aspects of their experience as reported by each participant. The following chapter will outline the grounded theory that was developed from the stories told by participants and it will focus specifically on the grief reactions identified.

## CHAPTER FIVE:

### GRIEF RESPONSES

This chapter initially presents an overview of the grounded theory developed in the current study. Specifically, the three key concepts of the study and their relationships to each other are explained. Following this, centre stage is given to the Grief Responses which participants experienced as a result of the suicides. Emotional reactions are described first in the current chapter. Subsequently, the intellectual and physical reactions are discussed. The reader will note that the majority of the Grief Responses identified concur with those documented in the existing literature. References are made throughout the chapter to the extant literature which was discussed in Chapter One.

#### OVERVIEW OF GROUNDED THEORY

Three key concepts make up the grounded theory of the current study. They include: the concepts of, '**Grief Responses**', '**Intensifying Factors**' and '**Alleviating Factors**' which were developed from the selective codes (see Appendix A).

As might be expected, all participants experienced Grief Responses. Emotional reactions were characterised by the psychological states of shock and disbelief, denial, relief, anger and blame, guilt and self blame, sadness, depression, suicidal reactions, fear, embarrassment and shame, and rejection. Participants also described intellectual reactions including questioning "why?" the suicides occurred, "what were the victim's last thoughts?", and "why did suicide in general occur?" Some participants also discussed physical consequences. In particular, somatic complaints and memory loss resulted for some participants.

Six **Intensifying Factors** were identified in participants' stories. The presence of these factors in participants' stories equated with experiences of additional and/or prolonged Grief Responses. Hence, they were conceptualised as "Intensifying Factors. The factor

of Conflict (see p. 75) can be seen as an example. Where there was either inter-familial conflict or intra-familial conflict, this led to increased and/or prolonged anger and blame.

On a more positive note, eight **Alleviating Factors** were also identified. Where these factors were present, they lightened (or alleviated) the emotional, intellectual, and physical reactions experienced by participants. In the current research, Alleviating Factors are viewed as synonymous with coping factors or factors which assisted participants to deal with their Grief Responses. An example can be seen in considering the factor of Compromise. Where participants recognised that others associated with the victim had their own reactions to the suicide, these participants experienced less anger and blame of those people (see p. 103).

It should be emphasised that no individual survivor experienced every Grief Response or Intensifying Factor or Alleviating Factor. For each participant the experience of losing a family member to suicide was made up of a unique combination of Grief Responses, Intensifying Factors and Alleviating Factors.

Overall, the grounded theory proposes that following the suicidal death of a family member, every participant suffered an individual Grief Response. For each participant, that Grief Response was aggravated by the presence of Intensifying Factors. Where Alleviating Factors were present, participants were more likely to have experienced a lessening of Grief Responses and hence, to have coped, or be coping with, grief.

## **GRIEF RESPONSES**

### **Emotional Reactions**

Participants not only discussed their own emotional reactions but also talked about the reactions of other family members. The emotional reactions discussed here pertain both to feelings experienced by participants and to other family members of participants.

Including emotional reactions of other family members not only assists in demonstrating the range of emotional reactions found in this study but it also highlights the fact that for participants, the emotional reactions of others were intertwined their own grief responses.

Initial reactions on learning the news of the suicide often involved feelings of **disbelief** and **shock**. Participants described feelings of unreality and of the news “just not sinking in”. The following quote from Gwen typifies such initial emotional responses:

*...I just couldn't believe that he was dead. I kept saying...you know, "You mean, you don't mean he's dead, you mean he's just hurt himself" [pause] yeah [pause] and [brother-in-law] said "No, he's dead" ...I, I just couldn't believe it. I just couldn't believe that he would be dead...*

Participants' feelings of shock and disbelief were not simply a result of learning that their family member had died. The nature of the death, that is, the fact that it was suicide, also prompted participants to react with disbelief. Nancy described her reaction to being told that her son's death was the result of his choosing to die:

*...they said it was suicide, you see, and I said "No, I just don't believe that".*

In most cases feelings of disbelief and shock were transitory and short lived. In Tracey's case, however, disbelief especially, was prolonged and led to difficulties. Her initial disbelief turned into longer term **denial** and the result was a delay in dealing with her son's death:

*...it was as though he'd just gone back to Varsity...and [pause] I just kept thinking "No, it hasn't happened" ...I couldn't go out to the cemetery for a long time...I really think it took me quite a long time to accept that it had happened [pause] because it was [several] months later before we had the inquest...I think it wasn't until after we'd had the inquest that I really started to [pause] feel that...it had happened, and, and [pause] I had to start and deal with things.*

The responses of shock, disbelief and denial are consistent with the findings of other suicide bereavement studies (see Chapter One). The response of refusing to acknowledge the nature of the death rather than the death itself, is particularly interesting. If, as Gyulay (1989) suggests, shock and disbelief prevent the bereaved from facing the chilling reality of the death, it may be seen that some suicide survivors find the nature of the death chilling rather than the fact of the death itself.

In Tracey's case, her initial reaction also incorporated **relief**. This was due to the fact that her son had suffered ongoing mental health problems and she had been required to care for him over a long period of time prior to the suicide. She stated:

*...and then there was just relief...I just felt so relieved. I know the next day we went in to see his solicitor [pause] and...I just said "I just feel so relieved..." I'd actually gone begging our GP and everybody for help...and it just wasn't there.*

Identifying relief as a minority (one out of eight participants) grief response in the current study fits with general findings in the literature that relief may only affect a minority of survivors, and that it is associated with cases where there has been a history of mental health difficulties (see Chapter One). However, Tracey's case does not appear to support the belief that guilt is closely associated with feelings of relief. There was no indication in her account that Tracey experienced guilt related to her relief that "the stress" was over.

**Anger** is a well recognised component of grief following a death of any nature. While **blame** is less widely identified as a response in all types of death, in sudden deaths, particularly suicides, blame has been repeatedly recognised as a common emotional response. Seven of the eight participants in the current study described feelings of anger towards, and/or blame of, others following the suicide. For some, anger and blame were directed towards members of their own family. Tracey remembered:

*...I was very angry with my daughter as well, 'cause she was nursing in [name of place]...she'd come during one part of it when Gary committed himself voluntarily to [hospital]...but then, after that...Gary kept asking*

*for her to come and she wouldn't come...And I think I was very angry at her for not coming, yeah.*

Individuals outside of participants' own families, who had close relationships with the deceased were especially likely to be the recipients of participants' anger and blame. Lauren's censure of her stepbrother's parents is obvious in the following statement :

*...and I tell you, if I had his parents...I wouldn't want to fail either [pause] and I think they are forgiving and loving [pause] to a certain extent but not [pause] the way he needed...he couldn't [pause] be [pause] what they wanted and therefore, didn't really want to be around .*

For some participants, anger and blame were directed at the suicide victims themselves.

Gwen described her anger towards her son:

*But a suicide is that your child goes out and this is what they [pause] chose to do [pause] and you have to find some way to [pause] not sort of judge your kid, you know [pause] you do and you feel angry. I felt really angry, I felt really angry with Manu, but I don't feel angry with him any more.*

Ann-Marie continued to experience strong feelings of anger towards her sister-in-law:

*...I still [pause] I don't go to the cemetery, I go past the cemetery [pause] and, um...when I used to go past it, I used to say things like [pause] oh, you know, "That's where the stupid bitch is", 'cause that was how I felt.*

As in the case of relief, the response of blaming the victim is repeatedly identified in the literature. However, in contrast to the literature, the current study found that blaming the victim did not engender feelings of guilt in the survivors. This finding may reflect the fact that participants had several years to come to terms with any initial guilt, or, it may be that they were not prepared to acknowledge deeply seated feelings of guilt in their interviews.

Participants' blame was not simply directed at others. In all eight accounts, descriptions of **guilt** and **self blame** were readily apparent. Participants discussed their feelings that perhaps there were things that they could or should have done which would have prevented the suicide. They believed that if they had done something else, or done

something differently, then the suicide may have been prevented. Tracey summed up her feelings:

*... 'cause there was a lot of guilt. I kept thinking there must have been something else I could have done...I should have done something different [pause] yeah.*

Again, the current findings can be seen to support claims in the existing literature. In particular, Tracey's belief that she should have done something else to stop her son from taking his life has strong parallels with Barrett and Scott's (1989) contention that survivors rue things they did not do.

"If only" was a phrase common amongst participants expressing feelings of guilt. Nancy berated herself for not going to visit her son in spite of the fact that she had wanted to do just that:

*If only I'd known, I would have dealt with it. If...I'd realised, I would have been there...it sort of puts an amazing amount of guilt on the people that's left behind, because they all feel that they should have been able to have done something [pause] or they could have done something, or they would have done something if they'd known.*

Such feelings of guilt can be seen to be closely linked with feelings of **regret**. Participants rued the fact that they did not act in certain ways which may have prevented the suicide. Nancy particularly regretted that she did not go to visit her son in spite of the fact that she wanted to do so:

*I've always held it against myself that I didn't go...there [crying]...so there's always, there's always guilt and there's always [pause] you know [pause] regrets and [pause] things like that.*

All participants described feelings of deep **sadness** following the death of their family member. Perhaps the most visible sign of sadness was that of crying. Lauren remembered sitting through a concert she attended not long after her step brother's funeral:

*...and I just sat there and cried [pause] and cried [pause]and that's all I did for a good three months.*

Nancy also expressed her sadness through tears:

*...you know, I just collapsed and...I don't think I stopped crying for a week.*

For some participants, the sadness they experienced bordered on **depression**. Gwen was especially prone to depression at Christmas time and at special family occasions:

*...I find sometimes I can drift along and be quite all right and...then something will happen and it'll put me on a downer [pause] like, um [pause] at Easter time, I had a nephew get married...and we went down for the wedding and that, I find when I come back I get really depressed. It's like Christmas depresses me. I hate Christmas, I hate it...*

As a result of her depression, Gwen was prescribed anti-depressant medication.

A disturbing but important finding of this study is that for a number of participants, **suicidal reactions** were a consequence of their family members' suicides. Tracey revealed that she suffered suicidal thoughts following her son's suicide:

*...I'd go out to the cemetery and they [pause] I think that was my ...they weren't my worst times, but it was just coming home from the cemetery, often, I'd be just driving along and I, I'd just think "Oh, those lampposts look so inviting, easy, an easy way out"...*

The presence of suicidal reactions supports concerns in the literature that suicide survivors are at a higher risk for suicide themselves. Possibly, the familiarity of suicide leads survivors to consider suicide as an option which prior to the experience of their family member's suicide, they might not have done.

A second possible explanation for the presence of suicidal ideation in several suicide survivors in this study concerns the fact that a number of those who considered suicide after their family member's suicide also indicated that they were prone to depression and suicidal thoughts long before the occurrence of their family member's suicide. The

trauma inflicted by family member's suicides appeared to prompt a return of thoughts and behaviour in which they had previously engaged. Gwen, admitted that she experienced suicidal thoughts after her son's death. In her interview she also indicated that she had suffered severe ongoing depression throughout her adult life.

More positively, some participants indicated that the fact of their family members' suicides had a kind of prophylactic effect on suicidal thoughts and behaviour in both themselves and other family members. Tracey whose quote (previous page) reveals her suicidal thoughts following the death of her son, further indicated that she would not have acted on those thoughts because of her concern of the consequences for other members of her family especially her second son:

*I knew I had to keep going for him.*

Her step-brother's suicide impacted on Lauren's sister:

*...I know my sister well enough to know that she's [pause] or she used to be quite a fragile person [pause] and...I guess I was afraid that one day [pause] she would [suicide]...after James, there was no way in hell that she would even consider it [pause] not even close.*

**Fear** was experienced by participants following the suicides. A broad range of fears were described by participants including inhibitions about speaking with professionals such as the coroner, and in the case of Isobel, a fear that psychic phenomena had occurred. A commonly reported fear involved concerns that others in the family may also be susceptible to suicide. Pauline worried that her second daughter may also see suicide as an option:

*...and she was also suicidal [pause] and that worried the hell out of me [pause] to think [intake of breath]... two of them doing this...*

Ann-Marie described her fear for her nephew:

*...part of me's really [pause] really scared that I'm going to find the same thing, one day. It may not be today, but it might be in twenty years time.*

The finding that survivors feared their family members' suicides may be contagious, mirrors findings in the literature. One possibility for these kinds of thoughts can be seen to explained by the principle of the "availability heuristic". Myers (1993) points out that instances such as sudden deaths, which are readily available in people's memories, remain

in people's minds and they see such incidents as being more likely to occur. This explanation is not intended to preclude the possibility that family members concerns are justified. The reader needs only to look at the literature on contagion effects to recognise that the occurrence of one suicide may lead to others.

A second fear identified in the current study, but not so apparent in the literature, was participants' apprehensions over viewing the body of the deceased. A number of participants also chose to view the body of the deceased. Apprehension in this situation seemed to be even greater where the victim used a violent means of taking his own life.

Gwen, whose son shot himself through the head, recalled:

*...I found it really hard to go in where they had the body in the coffin [pause] because...I was frightened of what I was going to see [pause] and I made my son go in first...to have a look to make sure, you know, that he looked all right [pause] and when I went in, it was like he was lying there asleep [pause] couldn't see a mark on him...*

Interestingly, where participants were able to face their fears over seeing the body of the deceased, those fears were often relieved and the longer term feeling was that they had benefited from viewing the body (see Chapter Eight).

**Embarrassment** or **shame** was experienced by several participants. Some discussed their own feelings of embarrassment while others insisted that though they felt no shame themselves at having a suicidal death in the family, other family members were ashamed.

Gwen stated:

*To start off with I felt really embarrassed [pause] ashamed. What would people say? What a dreadful mother I've been. All those sorts of things.*

While Isobel maintained that she felt no shame herself, the reaction of her son was to 'cover up' the fact that his father took his own life:

*...he was sort of going around telling everybody [pause] that he'd died of a heart attack [pause] and I'm going around behind saying "Well, he suicided" ...*

While participants acknowledged feelings of shame, no one specifically addressed the issue of reaction of feeling blamed by others for the suicide. Participants did, however,

express dissatisfaction with the reactions of others, especially friends. In the current study, the conceptualisation of participants' experiences being intensified or alleviated by certain factors, led to perceived lack of support from others being included as an Intensifying Factor (see Chapter Seven) rather than a Grief Response. Hence, reactions of others (which may be seen as stigmatising experiences for some participants) are discussed in Chapter Seven.

The final emotional response identified in the current study was that of **rejection**. A number of participants felt that by taking their own lives, their family members had rejected them. Peter explained his feeling:

*...I couldn't understand how he could love me so much as I knew he did, and do what he did.*

Ann-Marie described her brother's feelings of rejection following his wife's suicide:

*...and he used to say all the time, you know [pause] "Its like my wife's told the world [pause] that she doesn't want to live with me" ... You know "She doesn't want me. She doesn't want to live with me".*

Feeling rejected at the hands of the victim is another component of suicide grief which has repeatedly been documented in the literature.

Overall, it can be seen that participants in the current study experienced a variety of emotional responses after their family members' suicides. The specific emotional states identified, for the most part, align with those identified in the literature. A difference between the findings of this study and the literature is general is that feelings of relief and blame towards the victim were not associated with feelings of guilt. A particularly interesting finding concerns the response of suicidal ideation. It appeared that recognition of the pain that survivors undergo was a motivating factor in preventing some of those exhibiting suicidal ideation from acting on their thoughts. Implications of this finding are discussed in Chapter Eight.

### **Intellectual Reactions**

Participants actively sought to deal with a situation which was initially characterised by overwhelming shock and disbelief. Their accounts exhibited a great deal of questioning

and searching for answers about their family member's suicide as well as suicide in general.

As has been found by others (e.g., Wertheimer, 1991), the suicide of their family members was regarded as a puzzle by participants. Searching for missing pieces which might help solve those puzzles was common to all participants. In particular, the question "Why?" permeated accounts. The following statement from Lauren is typical of participants' desires to know why their family members suicided:

*...it doesn't feel like it's [pause] important enough for them to leave you...and I, I think there's very little reasons that would make you [pause] do that and...I think that's what bothered my sister as well as me [pause] a lot... "You didn't need to leave me...You didn't need to, so, why? Why did you?"*

In spite of continued searching, a definitive answer often proved elusive. The reason for this is obvious: although some clues and information may have been elicited, the one person who could have provided the definitive answer was not, and never would be, available. Even where participants thought they had some kind of answer, confirmation was still sought. Pauline stated:

*...if I could go and say [pause] get a hot line to God...I'd probably say "Why?". Although, I know why. But I'd still like to hear it.*

Participants' questioning extended to events that occurred prior to, and at the time of, the suicides. The magnitude of questioning about prior events can be seen in the following quote from Isobel:

*I went back through [pause] his childhood, and I understand a lot [pause] and he was a very withdrawn person [pause] but childhood is very interesting...I even did my childhood 'cause I felt "Well perhaps there is a problem here"...*

Participants' accounts also reflected the fact they questioned what occurred at the time of the suicides. Lauren spent time filling in the pieces of her step-brother's last movements:

*...he had glasses, so he took his glasses off and he took his wallet and he took his keys [pause] and he put them on the driver's seat [pause] and locked the car [pause] and [pause] that was quite a way away from [pause] anywhere, really, the bridge...he parked it just purposely off to the side [pause] and...I mean, imagine how he would have to have felt [pause] doing that?*

A further type of questioning saw participants looking for information which may shed light on the **victims' last thoughts**. Searching for a suicide note which may provide information was described by some participants. For example, Isobel described looking for a note from her husband:

*...the police lady came in and wanted to know how he was and had he left a note. So we went through all the drawers and...the bed and everything...*

The lack of a suicide note in cases such as this, limited participants' ability to know the victims' last thoughts. As in the case of asking "why?", questions about the deceased's final state of mind often remained unanswered.

Questioning extended beyond asking about the suicide of participants' own family members. Individuals also sought to know why **suicide in general** occurred. A second suicide prompted Lauren to query:

*...one of my sister's friends committed suicide [pause] and when my mum told me, that hit me [pause] hit me real hard [pause] and like I don't even know the person... "Oh. [pause] Can't people think these days? [laugh] I mean, hey, what the hell's going on?..."*

Even where participants were able to suggest some answers to the question of why suicide occurred in general, these answers led to more questions. Nancy's search led her to suggest that a lack of inner resources in younger people may be a causal factor in suicide in general:

*...with young ones these days, they don't seem to have any back up resources. You know, a broken relationship will send them over the edge. Losing a job will send them over the edge...*

However, her suggestion that lack of inner resources played a part in suicide in general, led her to question why there was a lack of inner resources:

*...and, I just don't understand why these young ones have no reserves. Perhaps we've all spoilt our kids rotten? Perhaps we, we don't encourage them to face any adversity? Perhaps we, we spend too much time trying to shelter them from everything?*

The finding that participants asked questions is consistent with the agonising questioning found by Van Dongen (1990, 1991a, 1991b, 1993) in her grounded theory study. However, the current study investigated participants' experiences over a longer period of time (three to six years as opposed to the average six-nine months in Van Dongen's study) and also identified that for a number of participants, questioning lessened over time (See Chapter Seven).

### **Physical Reactions**

Having discussed intellectual reactions, attention turns now to the physical and cognitive reactions identified in this study. Somatic Complaints were those which included physical discomfort or pain. The reaction of memory loss is also briefly reported and discussed.

**Somatic complaints** were described by Peter who indicated the difficulties he faced with severe headaches and tightness in his chest, both of which occurred for the first time following the suicide of his son:

*I'm getting a bit tight in my chest, now...I'm only telling you that because it was about four years before that lifted...I felt [pause] that I was really being squeezed there [gesturing to chest]...it was with me all the time. It never stopped...I used to think "God, am I ever going to [pause] get through that?", you know...I used to shut to door and lie on the ground and...tremendous headaches and things like that.*

Tracey described difficulties sleeping following her son's suicide:

*...I never slept very much, I think most nights I'd sleep two or three hours...*

As well as somatic complaints, Nancy also suffered **memory loss**. She stated:

*...I know the damage [pause] the physical and mental damage it did to me. I mean, I've still got short term memory loss...words and names go out of my mind...sometimes I used to take three days for it to come back. Well, now, they're waiting an hour or two hours, then it comes back. So, I, I do know that it's had a physical effect on me.*

Isobel also experienced difficulties with memory. She pointed out:

*The only thing I have been left with, and it's so frustrating [pause] is [pause] I can't think of people's names [pause] and I put it down to that because I was very [pause] alert [laugh] if one could say that...I could remember everybody's name, their telephone numbers...and everything. Now I have to think [pause] even with my work...*

Again, the reader will have noted that the physical reactions identified concur with those identified in the literature, particularly that of chest discomfort. The long term memory loss reported by Nancy and Isobel to have lasted several years is an interesting finding which possibly extends knowledge of the range of long term responses to a suicidal death. It is also possible, of course, that the memory loss over a period of several years is not related to the suicides. Rather, these participants may have perceived a relationship between the suicides and their memory loss when the course of time or another factor such as medication, may have contributed to memory impairment.

## SUMMARY

For the most part, the emotional, intellectual, and physical reactions of participants found in the current study are expressions of grief which are commonly referred to in the literature on suicide bereavement. As they do in the literature, such reactions clearly show that participants suffered emotional and mental anguish as a result of the suicidal death of a family member. The following chapter describes the Intensifying Factors identified in the current study. Intensifying Factors led to increased and prolonged Grief Responses.

## CHAPTER SIX:

### INTENSIFYING FACTORS

The current chapter details six Intensifying Factors identified during data analysis. Intensifying Factors' impacted on participants in such a way as to prolong or deepen their Grief Responses. The factors include: Perceived Lack of Support; Impediments to Gaining Information; Conflict; Death as a Surprise; Minimising; and Additional Exacerbating Factors. In the current chapter, each Intensifying Factor is discussed with reference to the open codes which gave rise to it (see Appendix A). Where relevant, reference has been made to findings in the literature. However, as was intended in carrying out an exploratory study, some of the factors detailed in the current chapter appear to be unique. Hence, emphasis has been placed on providing examples from participants which demonstrate that the factors are grounded in their accounts.

#### Perceived Lack of Support

A theme of Perceived Lack of Support emerged clearly in this study. All participants' described ways in which they felt let down by other family members and/or friends when they needed support. In some cases, the suicide precipitated the end of a friendship or relationship. Perceived lack of support was seen in the insensitivity of people often described by participants as acquaintances rather than friends. Some participants were critical of the role played by professionals.

A feeling of **disappointment with friends** was described by a number of participants. One reason for this disappointment appeared to be the fact that initial support was often unsustainable. Nancy stated:

*Everybody rushes around for the first week and then everybody gets on with living...life goes on for them...everybody makes that mad dash round in those first few days, you know, and it's all terribly sympathetic, but then*

*life goes on for them. Um [pause] you really do need the help and support...it would have been very, very helpful...*

Disappointment with friends also resulted from the fact that some friends avoided all contact entirely following the suicide. Gwen summed up her experience that many friends simply avoided the situation altogether:

*...most people shy away...*

Isobel explained her reaction to people who crossed the street to avoid her:

*When the people crossed the road...I'd cross over and say "How was your day?". They'd be so flabbergasted, they'd say "Fine, how was yours?". They, they really didn't mean to say that because they weren't sure if I was going to break into tears or something...*

These "avoiding" reactions on the part of others may be viewed as stigmatisation due to the suicidal nature of the deaths. Barrett and Scott (1989) point out that social avoidance on the part of others is implicated in stigmatisation of suicide survivors. However, avoidance may also have been due to the fact that people simply did not know what to do or say as has been suggested by a number of researchers (e.g., Range et al., 1992).

Unfortunately, for certain participants, the perceived lack of support led to the end of friendships. Such a **loss of friends** was described by Lauren who could not accept her friends' awkwardness following the death of her step-brother:

*...the rest of my friends were basically from church [pause] and I never went back. They [pause] didn't really talk to me and [pause] if they saw me, they kind of shied away...most of my friends were [pause] pretty much like that.*

If it is the case that Lauren's friends simply did not know what to do or say, rather than that they were judgemental about the fact of her stepbrother's suicide, there are implications for postvention programmes. Survivors need to be provided with reassurance that many people simply do not know how to react and those dealing with survivors could be educated about how best to give required support.

**Disappointment with family** was also common in a number of accounts. A need to talk about the suicide and the person who died was mentioned by a number of individuals. However, in some cases, the desire to talk remained unfulfilled, because other family members were reluctant, or refused outright, to discuss the suicide. Gwen's husband and son were both reluctant to talk about Manu's suicide:

*...if I ever do, sort of, bring up his name, I always feel [pause] they always give me the feeling that...they'd prefer I didn't. So, now I just don't bother bringing it up.*

For others, family members were not available to talk to and the resulting frustration was evident. Pauline remembered:

*...if ever I needed help when I was at work [pause] I couldn't get hold of [husband]...I'd ring up the family, but it's still not the same [pause] as actually speaking to your partner [pause] and he was out dealing with it his own way. And I was thinking "Never bloody there when I need you"...*

Several participants discussed the fact that they encountered well meaning but extremely insensitive responses from others. The following quotes exemplify difficulties faced by some participants in the face of such **insensitivity**. Nancy, endured a number of comments about her son having suffered physical injuries in an accident a year prior to his death:

*...a cousin of my ex-husband came up to me at the funeral and said... "Oh, well, it was the best thing for him...It wasn't good for him to go through life like that" ...I wasn't that enthusiastic about that response because [pause] I thought "Well, no, it wasn't the best thing for him"*

For Pauline, the following encounter occurred at her daughter's funeral and led her to feel very angry:

*...and I always remember that...her fiance's mother turned around and says... "Well, you know...what's happened is probably meant to happen". She's a great believer in fate...and, I sort of thought at the time "I'd like to punch her lights out" ...it wasn't the sort of thing she should have said to me that day.*

**Disappointment with professionals** who were involved with the families following the suicides was also described by participants. Professionals included funeral directors, police, coroners, counsellors, and ministers. Peter described an oversight by the funeral director which caused him further distress following the death of his son:

*I remember seeing they had the wrong name on the [pause] on the coffin lid and, ah [pause] that really upset me...*

Gwen related her belief that she and her husband suffered unjust (and, in fact, illegal) treatment at the hands of the funeral director because they were Maori:

*...we got this phone call from the funeral parlour saying that, um [pause] when you come back to get the body, you have to front up with X amount of dollars to get the body...I know now, they're not legally entitled to ask you for money before the body...my husband took it, and I took it the same way, that because you're Maoris, you can't be trusted to pay your bills...*

Overall, a perceived lack of support was apparent in participants' views that they were let down by family, friends and professionals. Experiencing disappointment with friends, particularly those who avoided contact may have been a result of stigmatisation on the part of those friends or, it may have been that they simply did not know what to say or do. The insensitive comments made by well meaning friends and relatives at the funerals would tend to indicate that, indeed, people were not aware of the right things to say. The most obvious effect of perceived lack of support was that it led to frustration and outright anger. For example, Pauline's grief was intensified by the anger she experienced at the insensitive remarks made at her daughter's funeral.

### **Impediments to Gaining Information**

As highlighted in Chapter Five, a strong element in participants' accounts was that of searching for information about the events that surrounded the suicides of their family members. As stated in that chapter, it appeared that each suicide constituted a kind of jigsaw puzzle and participants sought as many pieces as possible to make sense of the picture. Where there were Impediments to Gaining Information, emotional reactions, particularly those of frustration and anger, were intensified and led to increased information seeking and reappraisal of the events that occurred at the time of the death.

**Secrecy and deception** on the part of others close to the victim frustrated participants who were searching for information about the suicide and led to greater attempts to uncover information. Pauline explained how her daughter's fiance lied about the events that occurred prior to her daughter taking a fatal overdose:

*I know he lied to me. Because...after she died, the police went round and interviewed him [pause] and he said that...they'd split up [pause] blah, blah, blah. After the funeral, he shot away [pause] two weeks later he came back [pause] and he said... "No, we hadn't split up at all" ...I was sort of thinking "Well, that's not what you told the police" ...*

Pauline's frustration at her daughter's fiance's lying encouraged even more information seeking

*...I thought "Well, I'll find out for sure what was said" ...*

**Delayed official information** also caused extra difficulties in piecing together information about the nature of the deaths. For some, new information meant having to discard aspects of a partially completed puzzle in order to accommodate those new pieces. Pauline obtained hospital records a few months after her daughter's suicide which led her to alter her perception of the time of death:

*...I went and actually got...the hospital [pause] records [pause] and we'd always thought she died at [pause] [time], because that's what time he looked at his watch [pause] I think that's when they turned the machines off. In actual fact, she died at [earlier time]...so [they] must have known somehow that she was dead when they called us back.*

In general, factors such as others' deception and secrecy, and a lack of official information led to frustration and an intensified need to seek answers. The need to reevaluate pieces of the puzzle arose in cases such as Pauline's where she was provided with official information which contradicted her existing knowledge of her daughter's suicide.

## Conflict

One of the Intensifying Factors which emerged very early and very clearly from the data was that of Conflict. Hostility was apparent both within the families of participants and between participants' own families and the families of others who had relationships with the suicide victims. The two types of conflict were labelled **intra-familial conflict** and **inter-familial conflict** by the researcher.

**Intra-familial conflict** was obvious. In some cases, friction was present prior to the death and was exacerbated by the suicide. Nancy described an argument between her daughter and herself prior to her son's death:

*So, one time when I got really angry and I told [daughter] off, and I said ... "why hadn't she rung me?" ...and...I just said "Oh, well that's it, then. From now on [pause]" I said "I'll make good and certain that I find out [about David's progress after his accident] for myself".*

Following her son's suicide, Nancy described the family situation as having worsened:

*So, instead of bringing the family together [pause] um [pause] it hasn't done that. It's...split everybody up, I think. It's split everybody up.*

Nancy went on to point out how such intra-familial conflict increased the grief she experienced following David's suicide:

*...you sort of felt as though you'd lost the lot, not just the one...*

Ann-Marie pointed out that relationships within her family had deteriorated as a result of her sister-in-law's suicide. When asked if her family had pulled together since the suicide, she replied:

*Ah, no. I think it's really all but blown it apart, really.*

The result of such conflict was that she found herself surrounded by family disharmony. When it was suggested that she had found herself in the middle of the storm of family conflict Ann-Marie replied:

*Yes...that's right...and that's hard...that can be really hard, too.*

For Ann-Marie, then, such intra familial conflict intensified the grief she had to deal with following her sister-in-law's suicide.

A number of participants drew a clear cut line between the behaviour of members of their own family and that of members of other families who also had a relationship with the victim. An 'us versus them' theme was evident in some accounts such as in that of Lauren who pointed out:

*...my family's very open minded...we're very honest and [pause] we're very loving...where [pause] his family aren't like that.*

Ann-Marie described her family in relation her sister-in-law:

*..our side is a very touchy [pause] cuddly, anything's wrong, it's tears, cuddles...whereas Olivia was very much [pause] you know, stay back over there...*

When asked if Olivia's whole family was similar, Ann-Marie replied that they were.

In a number of cases, the relationship between families who were close to the victim was extremely fraught. Such **inter-familial conflict** was apparent between Tracey and her son's former girlfriend:

*...and I said "I'm quite happy...for [girlfriend] to come and [pause] say goodbye to Gary, yeah, but I still don't want her at the funeral." So I rang [counsellor] back and [pause] I said...what we'd agreed to, and I said "If [girlfriend] likes to come here, she can come and say her goodbyes...but, I don't want to see her." So...she came [pause] and my daughter saw her [pause] brought her inside and that.*

Tracey pointed out that her anger towards her son's girlfriend was prolonged:

*Um, but it took me quite a long time [to deal with the anger].*

Ongoing feelings of anger and blame can be seen to have resulted from both intra-familial and inter-familial conflict. Accordingly, such conflict can be seen to have intensified participants' grief experiences.

### Death as a Surprise

Every participant described feeling shocked when informed of the suicidal death of a family member. However, for some participants the reactions of shock and disbelief were intensified because the death was a surprise. In general, a lack of warning signs was associated with greater shock and disbelief over the death. Several factors which contributed to participants receiving a greater shock are detailed below.

According to their family members, some victims 'put on a good face' or **acted** better than they were really feeling. The result was that family members and others were unaware that there was anything wrong. Pauline described her daughter's behaviour shortly before she took her own life:

*...and she didn't ask for us [pause] easy to hide the way you're really feeling, because I do it myself.*

In the case of Lauren's step-brother, there was **no history of depression** that may have alerted family that James needed help. When asked if James had ever suffered from depression she replied:

*Definitely not...he wasn't really the type of person to get down...*

Ann-Marie knew that her sister-in-law was depressed but she had believed that the **depression was without a suicidal component**. She described a prolonged depressive history throughout her sister-in-law's life. However, in spite of that history, perhaps because of the many years it had existed, it never occurred to her, or her family, that Olivia would see suicide as an option. She stated:

*...my sister-in-law had [pause] a long [pause] period of mental health, probably [pause] ten to fifteen years, I suppose. But [pause] really, suicide was [pause] something that [pause] we never, ever thought she'd contemplate...*

In some circumstances where there had been a history of both depression and suicidal ideation, the death still came as a total surprise because the victim appeared to be

'better'. Peter described the fact that his son showed **no signs of depression or suicide** at the time of his death:

*...about that time he was [pause] depressed because I, I said to [daughter]  
...I said "I don't like it. He's suicidal" ...Anyway, then he came right.*

Another factor which contributed to participants being unaware that their relative had been suicidal was the fact that there was **no help seeking** on the part of victims. Gwen explained that her son refused to seek help from her or anyone else:

*He wouldn't talk, he'd just, when you'd ask him something, he'd say "I dunno, I dunno" ...He wouldn't look at you. Um, he'd just shrug his shoulders, "I dunno" ...just couldn't communicate with him.*

*Interviewer: So, he never sought help [pause] from...anyone?  
No. Not to my knowledge.*

A final factor which was implicated in participants being unaware that their family member was considering taking their own life, was that of **distance**. Where the family member and participant lived further apart and were in less contact with each other, the suicide came as more of a surprise. Obviously, the lack of contact gave the participant less opportunity to be aware of potential problems that their family member was facing. Nancy whose son was overseas when he suicided stated:

*I thought "Well, when I'd spoken to him that three weeks before [pause]  
there was no [pause]" well, I didn't think there was a hint there.*

The examples provided show why participants were unaware that their family member may have been considering suicide. Participants who lacked previous warnings that suicide was a possibility, reacted with greater shock and disbelief than did those who had considered suicide a possibility. Consequently, the "surprise" element of the suicide was seen to intensify participants grief reactions of disbelief and shock.

## Minimising

The Intensifying Factor of Minimising is one which was reflected in participants' experiences both prior to and following the suicides. Unsuccessful efforts to get help, both on the part of relatives and suicide victims led relatives to believe that professionals minimised their ability to provide crucial information prior to the suicides. Following the suicides, ongoing anger and blame of those professionals intensified participants' grief reactions. Experiences where participants' needs were minimised occurred post-suicide. It is important to note that participants' needs were not only minimised by others but they also minimised their own needs in certain situations. Minimisation by others and by self led to intensified emotional responses, particularly increased anger towards others and towards themselves.

Some participants had been only too aware that a family member was potentially suicidal and needed help. They described **unsuccessful help seeking** which led them to believe that their relationship with, and knowledge of, the suicidal individual was minimised by some of the professionals involved. Tracey described her battle as a mother to get assistance for her depressed and suicidal son:

*So I'd actually rung [hospital] that week and [pause] said what [counsellor] had said and how depressed he was and they kept saying "Oh no, his reports [pause] he wasn't depressed" [pause] and...I was really getting quite angry and...distressed over it and I said to them "Look, I'm sorry, but...I'm his mother. I think I know him better than anybody else" [pause] and I said... "he's going to do something, you know, if something's not done".*

This statement reveals Tracey's knowledge of her son's frame of mind prior to his suicide. Following her son's death, she experienced a great deal of anger and blame towards the psychiatrist who overlooked her calls for help:

*...and then most of my anger was towards [psychiatrist].*

Minimisation by professionals also occurred in cases where suicidal individuals made their own efforts to get help. Ann-Marie, who knew of, and encouraged her sister-in-

law's attempts to get help from her GP, believed her sister-in-law's depression was minimised by that GP.

*...three weeks before she died, she went to her local doctor...and [pause] begged him to do something...and he basically said to her that she was coming to him too much [pause] and to go home and [pause] basically, try and keep herself under control...I don't know quite what terminology he...used with her, but her words back to us were like [pause] you know, "It would be really great if, if instead of trying to come to see me once or twice a week [pause] you could try and step it out so that you're not coming to me 'til [pause] two weeks apart".*

Knowing that her sister-in-law's efforts to get help were overlooked was a source of ongoing anger:

*...there's a lot of anger...I think... if anything you'd say to the GPs is...don't be so...keen to give out a handful of... tablets. You know, if someone's not sleeping, or [pause] is crying incessantly...then...try. I know their appointment times are quite close but...try and find somewhere in the system to, to spend the time to dig deeper...*

Following the suicides, events occurred in which some participants' needs were minimised. **Official procedures**, especially those involving the police and coroners, were intimidating for some individuals and constituted situations where participants minimised their own needs. For Pauline, the formality of the inquest was daunting and her inhibitions about speaking in that setting prevented her from seeking information about her daughter's suicide:

*...there was questions I wanted to ask and I thought "Now this is stupid" ...and I just couldn't ask them...*

By opting not to ask questions, Pauline minimised the importance of her need for information when faced with the solemnity of the official setting.

Official procedures also left some participants with the view that their own role was minimised by, or second to, that of others. Pauline's statement contained elements of her dissatisfaction over the official requirement that the police be present before she could identify her daughter's body:

*...then we had to identify her [laugh]. We'd been there [pause] but the police had to come and say "OK, Is this your daughter?"*

Some participants also described 'going along with' **others' wishes** at the expense of their own wishes following the suicide. Gwen described how her husband, albeit unintentionally, made arrangements which did not fit with her own needs and wishes:

*...I sort of found that...nobody asked me what I wanted...my husband just made all these arrangements and [pause] when I flew back...from [place]...and I got back to my house...all the things out of my living area had been moved out...it was just sort of like my house wasn't my own...I didn't have any control.*

Minimisation of participants' needs following the suicides led to prolonged anger and frustration both with themselves and with others. Pauline's inhibitions about speaking at her daughter's inquest were symptomatic of a more general lack of self esteem which led her to seek help.

*I had a pretty low self esteem [pause] and I wasn't very assertive...so I went to a self esteem class*

In Gwen's case, the fact that her husband minimised her needs was an ongoing problem in their relationship. Her ongoing frustration also led her to seek help:

*...he likes to tell me [pause] how I should feel and what I should do and [pause] "You can't feel like that" he says to me...but I can feel how I like...We had to end up...going to Marriage Guidance Counselling and that did help in lots of ways...*

Overall, participants' roles, needs and beliefs were minimised by others including professionals, family members, and suicide victims. Participants also minimised their own feelings and needs. Where minimisation occurred, the result was ongoing frustration, anger and blame, and, hence, an intensified grief experience. In some cases, that frustration led participants to seek help in order to deal with ongoing difficulties.

### Additional Exacerbating Factors

Additional Exacerbating Factors was the label given to the sixth Intensifying Factor identified in the current study. This label refers simply to a collection of factors which intensified participants' grief but which did not fit the Intensifying Factors previously described. The factors included below are representative of many exacerbating factors which were described in participants' stories. (Space simply did not allow for all such factors to be detailed.)

Where a participant had been the recipient of some accusation or **blame from the victim** prior to the victim's death, the participant had difficulty dealing with that issue. Gwen acknowledged that her son blamed her for his unhappiness:

*...his answer to me was that what was wrong with him was all my fault. And I said to him "How could that be?". He said to me "Because you married him" [pause] meaning my husband [pause] "and if you hadn't married him [pause] if you hadn't married a Maori, then I wouldn't be this colour".*

For Gwen, this accusation caused her to question the way she and her husband had raised their son:

*I feel in another way, that perhaps I did my kids an injustice [pause] because, um [pause] our kids were brought up basically as Pakehas. They didn't sort of mix with Maoris [pause] and, um [pause] they sort of didn't know any Maori protocol or nothing like that.*

Another factor which exacerbated the grief of participants was the presence of elements of **horror**. For many participants, thoughts of the method of death and of the family member they loved dying alone, were very disturbing. This was particularly true in the cases where the method of death was of a more aggressive nature. Lauren found herself in the traumatic position of being told by her boyfriend (a photographer for the local newspaper) of the details of her step-brother's suicide before she realised that he was the person they were discussing:

*...my boyfriend came home...and he was describing the scene...and I think...when I found out, that was the hardest thing to deal with is [pause] you know, I'd been described the scene of [pause] bits...I'd seen photographs of the scene...*

Nancy had found it difficult to describe her image of the scene of her son's death:

*And, of course, they found him on the bed [pause] and...you know, they found him on the bed and he'd been choking and [pause] ah [crying] it wasn't a pretty sight, evidently. It wasn't a pretty sight, but [pause] so he'd overdosed or [pause] he'd done something with the [drug], anyway, and that was how he died.*

Elements of horror in sudden deaths have been associated with posttraumatic stress in survivors (e.g., Rynearson, 1986). While identification of posttraumatic states was outside of the scope of the current study, the finding that participants found it difficult to cope with disturbing death imagery does suggest that posttraumatic symptoms may have been a factor in these participants' grief experiences. Consequently, those participants who experienced horror as result of the suicides faced an intensified grief experience.

The Open Code label '**tragic irony**' incorporates the two features of this category. The situations described are certainly ironic, they are also tinged with tragedy. Participants who related ironic incidents often did so early on in their interviews. This fact is perhaps, an indicator of the fact that the incidents were close to the forefront of those individuals' minds. Tracey explained the fact that her son died in prison:

*...it was on the Friday, I'd gone to see him and he kept trying to give me letters to give to this girlfriend [pause] and, um [pause] it was emotional blackmail, and he kept saying to me "Oh, if you don't, I'm going to...kill myself" or something and I just felt like...I walked out. I thought, well, he was safe in there, he couldn't [pause] no harm could come to him, so...*

Gwen also described irony that occurred following the suicide of her son which she still found it difficult to come to terms with:

*...I'd already had to... draw money out to help pay for the food and stuff like that...and when it come time to get the money to pay the funeral director I was hard pushed to...be able to get the cash because of...it being*

*a public holiday here...and that...was really stressful, trying to...find that money because then we had to...have the money to fly the body home. I had to actually [pause] fly the body home on the credit card.*

In Tracey's case, the fact that she left her son where she thought he'd be safe caused her to question her own judgement and face feelings of guilt particularly the feeling that she should have done something differently. Gwen's ironic experience of using her credit card (more often associated with pleasurable life experiences) for such a tragic reason appeared to lead to feelings of ongoing frustration.

Two participants mentioned the police's role in investigating whether the death was a **suicide or a murder**. Gwen described the stressful situation of having to wait several hours while the police 'decided' whether her son had been murdered. Isobel described her feeling that the police asked many questions because they were suspicious of her:

*...from the police, you know "Was he disturbed?" I, I know they have to go through this because I could have gone out there I suppose, and [pause] pushed him off a ladder.*

Isobel also described her contact with a man whose wife had suicided and who the police believed had actually murdered his wife. Although the man was not a participant in the current study, his experience elicited sympathy from Isobel who had felt the weight of police suspicion herself:

*Another chap...I felt very sorry for him because the police thought he'd actually murdered her [pause] and...he didn't because [it was] his pills she had taken [pause] whatever they were [pause] but it was suicide.*

These situations appeared to cause anxiety for participants, especially over what others might think. In this respect, such a situation can be seen to have elicited feelings of stigmatisation in these participants. Ironically, it is not the fact of the suicide that was viewed as stigmatising. Rather, the suggestion that murder was involved is the stigmatising element.

It appeared that for various individuals, the way in which some situations were handled after the death became a source of ongoing **regret** and compounded or prolonged the

grief reactions. The reader should note that the regrets discussed here pertain to participants' wishes that they had done certain things differently after the suicides. This is in contrast to the regret and self blame discussed as part of grief responses where participant's wished they had done things differently prior to the suicides. Pauline addressed her regrets that she didn't have her daughter's funeral videotaped:

*...we know somebody with a...video camera [pause] and he used to go everywhere and video things...and [husband] said "If he shows his damn face in here with that video camera, I'll smash it", you know, 'cause we thought he would. Then, afterwards, we sort of think... "Wish to hell we'd videoed it"...*

Tracey regretted the fact that she didn't have her son's body home for a longer period of time:

*And [pause] we could have [pause] we only had him home[pause] it was the night before the funeral. So it was only one night. Um [pause] 'cause I didn't know how I would deal [pause] with that myself. Um, but now I regret that we didn't have him home earlier, yeah...*

Participants' wishes that they had done things differently after the suicides can be seen to add to the burden of regret and self blame that they did not do things differently prior to the suicides (see Chapter Six). As a result, regret over "mistakes" made post suicide can be seen to have intensified the Grief Response of self-blame and regret.

**Stressful life experiences** which occurred both prior to the suicides and following the suicides compounded participants' grief. Peter, whose marriage broke up approximately a year prior to his son's suicide was not able to share his feelings about the suicide with his ex-wife in the way that he wanted to:

*One night, she came back, about three weeks later...and she sat on the bed and we, we talked for a couple of hours. That was wonderful, you know, we sort of went back and the things that he'd done and hadn't done and the naughty and the good and...it was a wonderful reminiscing time and, of course, it's never happened again and [pause] that's a very sad [pause] sad thing and it's sort of a grudge I probably hold against her for that, that she deprived me of that.*

Stressful life experiences that occurred after the suicide also negatively impacted on participants' grief. Tracey described how the occurrence of another suicide in her family forced her to relive her son's suicide:

*...and then, two years after [pause] Gary had died...another nephew of mine suicided [pause]...so...it was all going through things again...brought back everything, yeah.*

Clearly, stressful life experiences prior to, as well as following the suicides intensified participants' grief responses by forcing them to face many painful feelings afresh. This finding is an interesting one which adds weight to the results of a recent study by Seguin et al. (1995a). Seguin et al. stated that "pre-death life events and adversities in the family may be as important to bereavement outcome as post-death happenings" (p. 121). The findings of the current study show that losses which occur closer to the suicide such as separation and death are not only risk factors for suicide (Beautrais, 1995), but may be may also influence post bereavement outcomes for family members.

Overall, a variety of Additional Exacerbating Factors can be seen to have compounded and prolonged participants' grief. Of particular interest was the finding that posttraumatic stress may have resulted in participants who experienced distress over disturbing images of the deaths. Those who endured investigations over the nature of the death (suicide versus murder) exhibited feelings of being stigmatised and those who experienced other distressing life experiences after the suicides were forced to deal again with many of the responses elicited by the suicides.

## SUMMARY

The focus of the current chapter has been on the six Intensifying Factors identified as compounding and prolonging participants' grief. One factor which has parallels with findings in the literature is that of Perceived Lack of Support. However, in contrast to some studies which identify lack of support as a result of stigmatisation by others, the current study also offers the view that a lack of support resulted because others simply did not know what to say or do. In the following chapter evidence will be presented of

the eight Alleviating Factors which were found to assist participants in coping with their grief. In contrast to Perceived Lack of Support, one of these Alleviating Factors, Social Support, shows that participants also received help from a variety of sources.

## CHAPTER SEVEN:

### ALLEVIATING FACTORS

The focus in the present chapter is on eight Alleviating Factors identified in the current study as assisting to lessen participants' grief. Initially, a brief explanation of these factors in relation to coping and recovery is provided. As in the previous chapter, each factor is exemplified with reference its relevant open codes (see Appendix A). Because a number of the Alleviating Factors are unique to this study and hence, relatively undocumented in the suicide bereavement literature, emphasis has been placed on presenting description from participants' accounts to support each factor. The chapter concludes with a brief presentation of the researcher's conceptualisation of the role of time in participants' overall experiences of being bereaved by suicide.

### ALLEVIATING FACTORS AND COPING

As was pointed out in Chapter Five, the Alleviating Factors identified in the current study were perceived as synonymous with coping factors. It should be made clear that while the factors were perceived to lessen participants' grief responses, and hence, to help them cope, the presence of these factors did not equate with being free of all pain. Rather, participants described less emotional pain than they had experienced at the height of their grief responses. For example, Tracey explained:

*...time...doesn't take away the pain, I think, but [pause] you just learn to cope with it easier...*

In the following statement, Gwen describes learning to deal with the grief that resulted from her son's suicide:

*...I think basically, how I feel now [pause] is probably how I'll feel for the rest of my life, but...at this stage [pause] I can cope [pause] living like this.*

Originally, Alleviating Factors were perceived by the researcher to be compatible with “recovery factors”. Awareness of the fact that pain continued to exist however, led the researcher to perceive similarities between the current findings and the findings of Sapsford’s (1995) study in which she proposed a model of grief integration rather than recovery from grief. Sapsford conceptualised the women in her study as learning to incorporate their grief into their lives. In the statements quoted above it can be seen that participants in the current study also acknowledged ongoing pain to which they had adapted.

## THE FACTORS

### Social Support

In contrast to the Lack of Support identified in the previous chapter as intensifying participants’ grief experiences, the Alleviating Factor of Social Support emerged as a chief element which assisted participants to cope with the suicides. Those who received support were assisted in dealing with grief reactions such as guilt, depression, and fears. Avenues of support included participants’ own families, good friends, professionals, and suicide support groups.

Participants were extremely appreciative of the **family support** they received following family member’s suicides and viewed that support as instrumental in helping them to come to terms with the suicide. Lauren very simply described the wonderful family support she received after the death of her step-brother:

*...my family and [boyfriend] were terrific.*

In Lauren’s case, and in those of other participants, family support resulted after the suicide even though there had not necessarily been harmony before. In some cases the support that occurred was only temporary. However, it was still seen as beneficial in helping the individual to cope at that time. Tracey explained how her ex-husband provided support when she needed it:

*...my... ex-husband, had trouble dealing with our [pause] break up... but he was a tremendous support... at that time [when the suicide occurred]...*

The very influential role played by **grandchildren** in assisting several participants to appreciate positive aspects in their lives was an unexpected finding in this study. Seven participants were of an age where they might be grandparents and five of those seven participants spontaneously addressed the subject of their grandchildren. (No grandchildren were children of the suicide victims.) Tracey discussed how the birth of her granddaughter was a positive factor in her life following the death of her son:

*...my younger son at that time... he'd been going with this... girlfriend  
...and...[girlfriend] was pregnant and so they've got a wee girl...So, I  
think that sort of [pause] lifted us a lot, I think. It gave us something to, to  
look forward to...and...of course she's turned out just to be so delightful...*

Peter was another for whom grandchildren were therapeutic after losing his son:

*...[daughter] has been back a year and she stayed here for nine months,  
you know...with her two kids...and so I'm like a father to them...really...so  
there's just no way that anyone could compete with that...I know in my  
heart [pause] the love I feel for those kids...*

People other than family members played integral roles in helping all participants cope with their grief. **Friendship** was shown in many forms and participants were grateful for the help they received from those friends. Practical help was mentioned by several participants and the following quote from Tracey typifies participants' appreciation for such practical assistance:

*And...I never even thought about...afternoon tea or anything for the people  
[after the funeral] but...fortunately...my younger son's partner ...her  
mother...and that...just took over, and [pause] I was just so grateful...*

In the previous chapter, it was pointed out that participants were often disappointed with, and even lost, friends following the suicides of their family members. Positive experiences were also described where participants realised that they had loyal and responsive friends. Peter related that members of a group he was part of were supportive after his son's suicide:

*...one of the ladies gave me a hug book or something and [pause] she's a great special friend still, and...they were wonderful when things happened with Matthew...pretty wonderful...*

For some participants, the suicide led to them making new friends. Often new friends were found who had been through a similar experience. Such friends offered understanding of participants' experiences and feelings. Isobel discussed her friendship with a woman from victim support:

*I didn't have a clue who victim support was...never heard of this lady, and she also had had a suicide in her family so the relationship was there straight away...as the days went on...this lady would ring me each day, and, we would have a chat, and she was very nice and...to me, it was sufficient on the telephone.*

Five of the eight participants had been involved with **suicide support groups** at some stage following the suicides. All five were enthusiastic about the role of the support group in assisting them to deal with their grief. Support groups functioned in a number of ways which were beneficial. Isobel explained that one of the most helpful roles of her support group was the information it provided which she had not received anywhere else:

*...and a year later [pause] by actually being in the group [pause] and I would not have heard otherwise [pause] they'd had a letter from [another support group]...and they said "All those that had applied, reapply to [Insurance Company]". "What have I got to lose?" ...they paid out...for my husband's funeral...So that was something I would not have learnt had I not belonged to a support group, so good came out of that.*

A second function of support groups was simply that they provided the opportunity to talk. Pauline recalled:

*I felt, you know, I needed somebody to talk to...And, the...funeral director put us in charge [sic] with the Bereaved by Suicide Society...*

Perhaps the most integral role of support groups was that they provided the opportunity to talk to people who had been through, or were going through, a similar experience.

Smith et al (1995) indicated that the predominant theme in their support group for suicide survivors was being able to talk with others who had undergone a similar experience. In the current study a central role of support groups was the opportunity they provided to meet and relate to many others who had lost someone close through suicide. Gwen realised that she had much in common with other mothers she met through her support group:

*...I mean I know plenty of mothers from all the people I've met at the support groups since I've been going and all mothers are the same. They all want to talk about their children, but other people that have never had this happen...they don't understand...*

Although it was noted in the previous chapter that some participants' grief was intensified by lack of support from professionals, **professional support** was also appreciated by a number of participants. Such support had a positive impact on those participants. Pauline explained her appreciation of the funeral director's thoughtfulness and efficiency:

*...I wanted to have her home...and [funeral director] was quite helpful because there's Maori blood in the family...and...he [pause] basically said the Whanau [pause] would like the body home and they went in and performed the autopsy [pause] and...he had her home...that night...I was... very thankful to them for doing that, all that sort of thing was so helpful...*

Overall, it can be seen that participants benefited from support from a variety of sources including family, friends and professionals. Two of the more notable features of the study were the roles played by grandchildren and suicide support groups. For those who had them, grandchildren proved to be particularly therapeutic. Those who attended support groups advocated the importance of those groups for a variety of reasons including the opportunity to talk to others in a similar situation and the information they provided.

### **Information**

In describing participants' attempts to find answers to the suicides in Chapter Five, the metaphor of participants searching for pieces of a puzzle was used. Where participants

were able to identify and add pieces to fill in those puzzles their need to seek answers was lessened. Accordingly, Information was identified as an Alleviating Factor which lessened participants' grief responses. It should be pointed out that the information gained by participants was not always what they wanted to hear. In many cases, participants had to come to terms with the information that they had uncovered. However, in the long term, knowing the truth appeared more beneficial to participants than being unaware of unpleasant information. Pieces of the puzzles were found through official information, education about suicide in general, and through private investigations.

**Official information** provided some of the sought after 'pieces' and was seen as very helpful by a number of participants. Official information was often received by attending the Coroner's inquest. Gwen used the puzzle metaphor, herself, to describe how attending her son's inquest was an informative and therefore, helpful experience:

*I actually found it not too bad and, and in lots of ways...it filled in a lot of [pause] pieces in the puzzle [pause] like [pause] people tell you what happened before they die, but [pause] you don't really know what order it happened in. But, at the inquest, it sort of all [pause] fitted into place, and I just knew exactly what he'd done [pause] and what had happened.*

**Education** about suicide included learning about statistics, warning signs, the phenomenon of suicide clustering (where more than one suicide occurs in the same area within a close time period), suicide and the law, and the history of suicide. Participants displayed knowledge about these suicide issues which they had not had at the time of the deaths. Pauline used her current knowledge of suicide warning signs to justify her thoughts close to the time of her daughter's suicide:

*...one of the signs, they say, for suicide is, you know, that [pause] they get happy, and we thought that she was actually getting better.*

Participants also sought pieces of the puzzle through **private investigations**. Lauren believed her family had found the answer to her step-brother's suicide, through their own investigation, following his death:

*...and, like, afterward...my family know why, his family don't [pause] and that was our own investigation into it, I guess...and like...it became blatantly obvious what had triggered it...it turns out that he did it because he was gay.*

In spite of the fact that this information was initially unexpected, Lauren believed that having this knowledge, of which James' biological family was unaware, put her family in a better position to understand the suicide. Ann-Marie's brother also discovered information after his wife's death, which helped him to understand his wife's suicide:

*...my brother found, after she died, that the [type of drug] was...stashed everywhere in the house. It was in shoes and in [pause] handbags ...when she'd told him that she'd flushed it down the toilet and she'd got rid of it into the rubbish bags...*

Discovering this information led Ann-Marie and her brother to believe that Olivia's secretly continued drug addiction was a factor in her choosing to take her own life.

Gaining information about the suicide of their family member and suicide in general assisted participants to cope with their grief by filling in the puzzles of the suicides. One way in which pieces were put into place was through official channels such as Coroner's reports. Other pieces of the puzzle were discovered through private investigations and through education about warning signs.

### **Special Significance**

The third Alleviating Factor identified in this study was that of Special Significance. All participants related experiences following the suicides which had special meaning for them. Such experiences assisted participants to cope with their grief by lessening their grief reactions or pushing aside their grief, even if only temporarily. In most cases, significant experiences were instigated by participants, themselves. For example, visiting the grave site, and viewing the body were actions initiated by individuals. A small number of significant experiences occurred as a result of factors outside participants' control. In particular, two participants believed that the deceased had tried to communicate with them. Experiences of special significance are detailed below.

Several individuals in the current study addressed the issue of their visits to the **grave site** of their deceased family member. Such visits were beneficial to participants for a number of reasons. For Lauren, visiting her step-brother's grave was associated with facing up to the reality of his death. She stated:

*...I just didn't want to have to [pause] really let him go and I felt like going to the grave [pause] I had to acknowledge that he was really, really gone [pause] and that was all I had left of him.*

For Peter, who had primary care of his son, Matthew, prior to Matthew's death, visiting the grave site provided an opportunity for him to continue caring for his son:

*...through some silly way, I think I'm [pause] sort of still responsible for him and that means looking after his grave, because I don't think anyone else goes.*

For other participants, the grave site offered a place to go and be with their family member especially on special occasions such as the anniversary of the death. Grave sites were a place where they could express their feelings through gestures such as taking flowers. Tracey described visiting her son's grave:

*I [pause] just usually go out to the cemetery, yeah...I just take a special bunch of flowers and, um [pause] you know, red roses or something like that...for birthdays and...anniversaries and Christmas.*

Viewing **the body** of the deceased was also a time of special significance for participants. Those who did view the body described the experience positively. Isobel who went to see her husband's body at the undertakers remembered:

*I went to see him and...I mean, they do look peaceful...*

When asked if she was pleased that she went, Isobel replied:

*Oh, very much so. Oh, yes.*

Other participants had the body at home. This experience appeared to be a particularly positive one with participants explaining that it provided an opportunity for friends and family to express their feelings towards the deceased. Ann-Marie described the experience of having her sister-in-law's body at home:

*...the thing I felt did help...a little, was... to have the body at home [pause] with an open [pause] open coffin...that was probably quite helpful, quite helpful for the kids, too, I think...The neighbours kids...came in with little cards that they'd [pause] drawn pictures and stuff... a flower, or whatever, just to say goodbye.*

Pauline also had her daughter's body at home and stated:

*I'd recommend it to anyone...It was really good...I didn't want to close her up...a friend of ours came around and gave her a twenty-first present. She would have had it so she [pause] she took that with her...her sister went and [pause] with a friend [pause] went and did her make-up.*

Where participants had the **chance to say goodbye**, this was seen as important and helpful in coming to terms with the death. Viewing the body at the funeral director's or having the body at home, discussed previously, was one way in which participants took the opportunity to say goodbye. Participants took other opportunities as well. Pauline described her feeling of the importance of having time with her daughter immediately following her death in the hospital:

*...I remember when they said she was dead...and I just bawled my eyes out [pause] they were trying to drag me, I says "Leave me alone, it's my daughter and she's died, you know". I was thinking "God, it's the only time I've got left with her" ...*

Lauren believed that her step-brother had tried to communicate with her via a verbal message he left for her immediately prior to his death. She interpreted the message as her step-brother's way of saying goodbye and as such, it was very special to her. She recalled:

*...the last thing James said to a single person [pause] was "Tell Lauren I got her letter" ...I felt...that I got to say goodbye [pause] by the fact that...he'd told [Lauren's boyfriend] to "tell her that I got the letter" ...*

**Meaningful gestures** were made by participants following the suicides. These gestures had special significance for participants and were many and varied. The first two examples described represent the most common types of gestures and were often

associated with the funeral or burial. Pauline explained her actions at her daughter's burial:

*I suppose [pause] there's something about walking away and leaving a coffin [pause] so we filled the grave in ourselves. We pulled all the things out... and, I don't know [laugh], it seemed to help.*

When Ann-Marie's family buried Olivia, they chose a funeral and burial which was important for Ann-Marie and her family and which they also believed would be special to Olivia:

*Olivia was...at the Anglican Church in [place]. That's where she'd sort of been baptised and [pause] that's where her and [brother] were married...and they buried her in, in with her father.*

In the previous example, and in many other meaningful gestures described by participants, the fact that the gesture had special significance for the deceased, was an integral component in participants also gaining satisfaction from the gesture. In the final example, the participant did not initiate the gesture. Rather, she believed her deceased husband made a gesture which helped her following his death:

*I do believe...and, again, I'm not psychic...the day before his funeral, he came back. I felt his presence...I sat up in bed and thought "Wow" [pause] and there was a whoosh...I felt very comfortable after that.*

Some participants used **unique strategies** to help deal with their grief responses. The examples provided are only two of a much larger number of unique coping strategies employed by participants. The first example was included because it was simple and at the same time, very effective. The second example demonstrates a different type of coping strategy which was individually suited to the participant involved. Pauline explained that keeping a journal assisted her in working through her daughter's suicide:

*I've got a journal and ...a lot, sort of, came out...and I was, sort of, working through and analysing a lot of stuff in my life...*

For Isobel, books of another sort were influential in helping her to work through her grief:

*I...went through a stage, I didn't have any energy whatsoever...so, I went down to the library and I used to like 'Blood and Thunders' [pause] and 'Agatha Christie's and all that [pause] and I hadn't read books like that*

*for years. So, I got a big pile of books...and...I often wonder if it's always the way of working through it, but every book I read was "He hung himself" ...and that's true and [pause] when I first read it, I thought "Oh", and I thought "No, I have to read this", so I actually willed myself to read each book...So, perhaps I worked through a lot [pause] reading and, and [pause] penetrating [pause] this is what happened.*

Many acts which had special significance for participants, as well as for the deceased, were carried out by participants following the suicides. These acts included visits to the grave sites, having the bodies of the deceased at home, saying goodbye, making meaningful gestures at the funerals and burials, and employing unique coping strategies. Participants, themselves, reported that such acts assisted them to deal with their grief. Participants were also assisted to cope with their grief through experiences in which they believed the deceased had attempted to communicate with them. In particular, Lauren believed her stepbrother had sent her a last message and Isobel described a spiritual experience which helped to calm her after her husband's death.

### **Positive Memories**

Participants' Positive Memories of their deceased family member emerged as an important facet in dealing with the deaths and was identified as the fourth Alleviating Factor. Where participants were able to recall happy memories, painful grief reactions such as sadness and anger were put aside, at least temporarily. Instead, those participants were able to smile and enjoy thinking about their family members. Positive memories were of several types. Some were a description of the victim and what they were like and some were of the relationship between the participant and the deceased. Other memories involved reminiscing about times shared with the deceased. Another beneficial factor in participants' grief resolution was being able to share their memories with others. Those who talked about the deceased family member in everyday conversation viewed that fact as an important part of their lives since the suicide. Positive memories are exemplified below.

Most participants spent time in the interviews providing a **description of the deceased**. These descriptions included both physical and personality characteristics of the family member. The recollections were, for the most part, very positive ones and a view that the deceased was a special person with exceptional characteristics was a common one amongst the accounts. Peter described his son:

*...he was the one...that looked smart, looked like he was going to make it everywhere. He had everything going for him [pause] you know [pause] and beautiful body and looks and, ah [pause] intelligence...*

Not only did participants describe the deceased, they also provided a **description of their relationship** with their deceased family member. As with the descriptions of individuals, the relationship was often viewed as a special one. Isobel remembered the closeness of her relationship with her husband:

*...we'd been married for thirty years and we met at fifteen [pause] so I guess [pause] we moulded into each other as the years go on...*

Tracey also described a special relationship with her son:

*...there was just this bond...I, didn't, didn't love him any more than the others but it was just something different, mm...*

During their stories, all the participants **reminisced** about times they had shared with the deceased. Many memories were fond ones and it was particularly apparent in participants' facial expressions and tone of voice that this kind of reminiscing was a pleasurable experience. Tracey recalled some her son's antics when he was growing up:

*...when he was about fifteen, he...wanted to go out this, this night with his friends, and it was [pause] twenty miles to the nearest town...and...he couldn't go [pause] so he just [pause] disappeared. We didn't know where he'd gone to [laughing]. And he'd just got on his push bike...and went [pause] thirty five miles the other way from where he'd wanted to go...I said to him "Oh, well, that's all right". I said... "Just come back when you're ready...so long as you're back to go to school on Monday, that's fine" [laughing]. And it wasn't the reaction he'd expected...*

Where the deceased was **talked about** in everyday family life, participants appeared to view this as a helpful factor in their ability to deal with the death. Isobel discussed how important it was for her that her new partner accepted that she still talked openly about her late husband:

*...I'm very lucky because [partner] [pause] is quite happy for me to talk about my husband and to me that's important because [pause] for all he's died, he was a living being [pause] and he will talk...to my sons about him, and my grandchildren told him the other day they'd been up to the cemetery. That's very important.*

In their grounded theory study of suicide survivorship, Demi and Howell (1991) found that sharing their thoughts and feelings about the deceased was an important factor in survivors' being able to heal the pain of grief. The current finding adds weight to that of Demi and Howell and further, it implies that simply being able to mention the deceased openly is beneficial in itself.

Positive memories, including the special qualities of the suicide victim, participants' special relationships with their family members, and happy times spent with the deceased, were described by participants during the course of their interviews. Such memories were precious to each participant and the fact that reminiscing was pleasurable was especially obvious to the researcher in the tone of voice and facial expressions of the individual participants. An important aspect of the therapeutic nature of memories was the freedom to talk about the deceased to others.

### **Good from Bad**

An interesting feature of some participants' accounts was the fact that they were able to identify positive aspects which resulted from the suicide. It is important to note that seeing good which resulted from the suicides is not associated with viewing the suicide itself as a good thing. The fifth Alleviating Factor, Good From Bad, emerged from a combination of three Open Codes. Being in a position to help others was viewed as a positive aspect by a number of individuals as was the belief of some that they had changed for the better since the suicide. Other beneficial aspects such as financial bonuses were also identified. Each aspect is detailed below.

The view of some participants that they were in the best position to **help others** in a similar situation is closely tied to the idea that true understanding only comes from those who have experienced the same situation. Just as participants appreciated being able to talk with people who had been through a similar experience, so they believed they were in a position to offer that same service to others more recently bereaved by suicide. Isobel explained:

*...I found that a lot of people I spoke to in my course of life [pause] and I, even today, I don't make any bones about [pause] "Yes, I've dealt with a suicide"...people do talk to you. They relate to you [pause] and quite often they'll say "Oh, I've never ever talked about this" [pause] so I guess [pause] that's helping someone else.*

Peter also pointed out that his experience put him in a position to be supportive of others:

*...when [an acquaintance suicided], I went round there. I didn't know them...I've done that a bit now...because I know...I was able to say to them "I know how you're feeling"...having been there, done that, so to speak...*

One of the ways in which participants were particularly keen to help others was through maintaining and extending the role of suicide support groups. Those involved with support groups advocated their continued role in assisting others. Gwen explained why she believed that suicide groups needed to continue to be available for others newly bereaved by suicide:

*...to have to go to a complete stranger [pause] who's perhaps never experienced a suicide, they can't really know what you're talking about.*

Some individuals believed that as a result of the suicide, they had **changed for the better**. The fact of going through such a traumatic experience resulted in personal growth and strength. Pauline described how she had made positive changes in her life:

*...Whereas [pause] work was important to me...I always used to have this philosophy...if you're going to do something, do it well. I've still got it, but I'm not as fussy as what I used to be...if I'm going to be late because of something...like, there might be some family situation [pause] that*

*family situation will take precedence over work and I'll ring them up and say "Listen...I'm busy right now".*

Tracey saw herself as a stronger person:

*...I think that sometimes you come out of these things feeling probably a lot stronger.*

**Other beneficial factors** resulted from the suicides and were described by participants. Two participants, in particular described positive outcomes following their family members suicides. Tracey described how her son's suicide in prison resulted in law changes which would be beneficial for other suicidal inmates:

*I found out just recently that some good has come from it. We had a solicitor representing us and [pause] his line was...that all psychiatric reports should follow the people to prison...so that the...prison officers and that knew their state of mind and what to look for. So, apparently, that is now mandate...any psychiatric assessment does have to follow them to prison.*

For Isobel, an unexpected, but positive result of her husband's death was the fact an insurance company paid out money which allowed her to go on an overseas trip. She stated:

*I went on a holiday...we stayed in third rate dives all the way. We saw the real world...and came home with some change... it was the most wonderful experience I've ever had...I couldn't have done it if [insurance company] hadn't paid.*

The finding that participants saw positive factors which resulted from the suicidal death of their family member is consistent with findings in the literature. Clark and Goldney (1995) described "finding the positive" as an important factor in the recovery of survivors in their support group. In the current study positive outcomes included being in a position to assist others, changing for the better, and financial benefits. It should be reiterated that participants' views that good resulted from the suicides, does not in any way equate with participants seeing the suicide itself as a positive experience.

## Compromise

In the previous chapter, conflict, both within and between families, was identified and discussed as an Intensifying Factor in participants' grief experiences. The present discussion focuses on the fact that in some participants' accounts such conflict was replaced with Compromise. This sixth Alleviating Factor refers to participants' acceptance of differences between their own grief experiences and those of other family members. In most cases, compromise was reached in participants' own minds and the term does not necessarily indicate that the other family members took an active part in reaching the compromise. The result was less animosity (especially, less anger and blame). Several factors, including recognition of others' grief, allowing for others' ways of grieving, and sympathising, were instrumental in helping participants to reach compromise. The fact of offering a hand of friendship demonstrated clearly that compromise had been reached in participants' minds.

**Recognising others' grief** appeared to be a key component in achieving compromise. Some participants recognised that other' feelings after the death were not the same as their own. Gwen's statement reveals her awareness of the different emotions felt by herself and her husband several years after their son's death.

*I feel really sad. Yeah...But you see, I think my husband still feels angry, really angry.*

Where family members reacted differently from participants' expectations after the suicide, some participants came to recognise that family members' own suffering prevented them from acting in the ways participants would have liked. Nancy's statement demonstrates her awareness that her mother experienced intense grief herself and that as a result she was unable to be supportive in the way Nancy would have liked:

*...my mother wasn't very supportive at the time because she was going through her grief as well, because, after all, David was her favourite grandson. He was the favourite because he was the youngest and [pause] and I think she'd been [pause] around at the birth which makes a huge difference...*

Closely linked to the recognition that others were experiencing their own grief, was the fact of allowing for **others' coping strategies** even though these differed and even conflicted with participants' own coping strategies. The following statement from Isobel demonstrated her acceptance of her son's choice not to see his father's body even though she believed that it was the right thing to do herself:

*I...decided, yes I would [view the body], because you can't say "I wish I had" ...my middle son who was upset with his father...he said "No", he would not go and see his father...that was something he had to deal with.*

Some participants were able to **sympathise** with those for whom they had little liking. Lauren, who described her contempt for her former step-father throughout the interview, was also able to feel compassion for him when he found out that his son had taken his own life:

*...his [pause] father was a volunteer fireman [pause] and he committed suicide in that region...and his father was there. His father, though, did not climb over the fence. He...stayed back with the fire truck and [pause] just imagine...the grief [stepfather] would have felt [pause] the next day, when he found out, had he climbed over the fence [pause] I mean, he had to go and identify the damned teeth.*

Such sympathy appeared to soften participants' attitudes towards members of families they previously viewed with animosity.

The fact that some participants were able to offer a **hand of friendship** to those they had previously held in contempt demonstrated that they had come a long way in being able to deal with the suicide. Pauline extended an invitation to her daughter's former fiance to come and talk with her in spite of the fact that he had lied to her and concealed the full story of what occurred immediately prior to her daughter's overdose. When asked if she had kept in contact with her daughter's fiance, Pauline replied:

*I've tried to, but he won't keep in contact. But, hopefully, he will because I ...made contact again this month...and his mother said...she'd [pause] try and make sure that...she'd pass on that I did want to speak to him.*

Tracey believed that ongoing anger and bitterness towards her son's ex-girlfriend were obstacles to overcoming the trauma of her son's suicide, and that dealing with that ill feeling meant that she was able to get on with her life:

*...going through life feeling bitter and that...doesn't do you any good. It's just wasted emotion...and it just makes you bitter about too many other things...and I think you've just got to...see things from other people's point of view as well...I really would like to see [girlfriend].*

Compromise was a factor in participants' stories which was associated with less anger and blame. Hence, compromise was viewed as an Alleviating Factor. Participants demonstrated compromise in their recognition that others needed to deal with their own grief and that they had different ways of doing that. Compromise was also seen in participants' abilities to sympathise with, and offer a hand of friendship, to those who had formerly been the recipients of participants' blame and anger.

### Acceptance

Another indication that several participants were coping their grief was that they had reached a state of Acceptance regarding the act of suicide. They accepted that it was the victim who had completed the act of suicide and saw that the suicide was outside their hands. As a result, feelings of guilt and self blame were alleviated. Four open codes contributed to this seventh Alleviating Factor. The first of these involved participants' recognition that the deceased chose to take their own lives. Secondly, participants recognised that there was a difference between the knowledge they had at the time of the death and the knowledge they had gained in hindsight. A third factor was the recognition that being able to alter the circumstances at the time of the suicide may not have prevented the suicide from occurring anyway. Finally, participants accepted that many questions would always remain unanswered.

A number of individuals in the current study discussed their recognition that the **choice to die** was ultimately the decision of their family member. For Pauline, this recognition came relatively early after her daughter's death:

*...very early, I came to the conclusion that it was her decision to do it.  
Nobody, sort of, said "Here are the pills... go and kill yourself".*

Realising that the suicide was out of their hands appeared to allow participants to shift the onus of responsibility away from themselves, at least, in part. Lauren described her view that although her family felt some guilt about her step brother's suicide, it was her step brother who made the ultimate decision:

*I guess we all feel bad for him , for not having been there for him...in the sense that we hadn't picked it up...but he hadn't come to us either...I don't think he did anything to get help...I don't think he wanted help.*

Another realisation that participants' gained over time was that **hindsight** provided them with a great deal of knowledge that they didn't have at the time of the death. Recognition of what Myers (1993) terms "hindsight bias" led participants to accept they could only act with the knowledge that they had at the time. In her statement about her stepbrother's last actions, Lauren also demonstrated her recognition that the knowledge came with hindsight:

*it was as though he was like [pause] tying up loose ends...it's amazing what hindsight can do...*

Ann-Marie also directly discussed her awareness that hindsight can make earlier events seem a lot more predictable and preventable than they were at the time:

*...after she committed suicide, we all thought "Christ, that's what she was telling us"...but...we had completely missed it...but...it's after the event, you're a hell of a wise, aren't you?*

Some participants also accepted that having the ability or knowledge to change the course of events that led to the suicide may have only postponed the **inevitable**. Nancy recognised that even if she had been in a position to prevent the suicide at the time it occurred, this would not have ensured that the suicide would not have occurred at all:

*And, then, there's the other little theory, "Oh well [pause] even if you had been there, if he was really serious, the moment you left, he still would have turned around and done it, anyway."*

Coming to terms with the fact that many **unanswered questions** would always remain was beneficial for several participants. In terms of the puzzle metaphor used in Chapter Five, some participants realised that all the pieces could not be found and that they would never see the completed puzzle. In particular, some participants appeared to accept that they would never fully know the answer to the question “why?” and were at a stage where they could live without that knowledge. Isobel stated:

*...people wanted to know “Why?”. You know, there’s no answer. You have an answer in your brain and you think “Oh, that’s why he did it” [pause] but as [pause] time goes on and you analyse that [pause] that wasn’t why he did it.*

Overall, acceptance of the suicides was demonstrated in participants’ realisation that it was the choice of their family members to suicide. Some participants came to understand that with hindsight they could see much more (such as the presence of suspicious suicidal behaviour by the deceased) than they could at the time of the suicide. That understanding helped them to accept that they could only act (or not act) with the knowledge that they had at the time of the death. Some participants recognised that even if they had acted differently at the time of the death, there would have been no guarantee that the suicide would not have occurred anyway. Finally, acceptance was seen in the recognition of several participants that the puzzle of the suicide would remain unsolved.

### **Philosophising**

The final Alleviating Factor which was identified in participants’ stories was that of Philosophising. Several participants explained their beliefs both about the nature of their own family member’s suicide and about the nature of suicide in general. Such comments were regarded in the current study as an indication of philosophising. Many of the philosophical comments made by participants provided further evidence that they were coping, or had coped with their grief. Issues addressed included participants’ views about suicide as a mental disability, about the role of fate in determining victims were to have shortened lives, and about what happened to the deceased following their deaths.

Several participants pointed out their view of **suicide as a mental disability**. They believed that suicidal people were disabled, and that their actions were a result of that impairment. Isobel stated:

*...to suicide in my mind, and it still is, five years later on [pause] is, you are unbalanced [pause] it is a mental...disablement within your brain. People wouldn't do that if they were OK.*

Tracey believed that as a mental problem, suicide was no different from many physical conditions which end in death:

*...as far as...I'm concerned...for someone to suicide, there's got to be a mental problem [pause] and that's no different from any other illness... to me, it's through an illness that they die.*

Another belief held by several participants was that suicide victims were not destined to live a long a life. Tracey explained her belief that fate determined her son would have a **shortened life**:

*I often think that [pause] our lives are planned out from the time we're born [pause] and that's why Gary's life was to have been short...*

In the cases of Nancy and Gwen, it was their sons themselves who led them to believe that their lives were meant to be short. Nancy stated:

*Well, he always had the feeling that he wouldn't live very long...I don't think that was "Oh, well, I'm going to take my own life eventually". I don't think that at all. He just had a very strong feeling that he wasn't long for this world.*

Gwen reflected on information provided to her by her son's school counsellor many years before his suicide:

*I can remember him [counsellor] telling us that...Manu never seen any future for himself. He couldn't see anywhere where he could fit in in this world, that there was no future for him.*

Participants also discussed their beliefs about what had happened to the deceased **after death**. Nancy and Pauline believed that their children were still with them. Nancy stated simply:

*Well, I think he's still around. Very much so.*

Pauline explained her thoughts:

*I knew she'd be [pause] all around [pause] 'cause... you know, my spirituality is that you've got a spirit...I feel that she's probably even with us now.*

Participants also addressed the issue of suicide as a sin. Traditionally, in the Catholic Church, suicide was viewed as sinful. While participants were aware of this view, no one who discussed this issue believed that their family member had sinned or would have gone to hell. Peter described his beliefs:

*...Well, I guess...I could be...lenient and say "Oh [pause] he's too good to have a sin against him", sort of thing, and "God wouldn't punish him"...I'm sure he was confused and ...he didn't hurt anybody else except...perhaps, us...from a distance, so to speak but...I mean, you just can't be guilty of any thing there.*

Pauline also described her initial and subsequent thoughts about sinfulness and her daughter's suicide:

*...I said "Oh, she suicided, she's going to hell". "No, no, she's not"...I mean, that's ...what I [pause] said [pause] but, really...deep down inside, I knew she [pause] wouldn't be going to hell.*

Philosophical views about the death of family members and about suicide in general were seen in participants views that suicide was the result of mental problems, that some of the deceased were not meant to live long lives, and in beliefs about life after death. Participants had 'fitted' the suicides into their own framework of life and death and having done so, appeared to have coped to some extent with their grief.

## **THE ROLE OF TIME**

The 3 to 6 year time lapse since the suicides allowed participants in the current study to discuss experiences which occurred over a longer period of time than is the case in most suicide bereavement studies (see Sapsford, 1995). Consequently, this study not only

identified initial grief reactions. It also revealed many factors which were involved in alleviating participants' grief.

The role of time, in general, can be seen to have been such that Grief Reactions occurred closer to the time of the suicides and Alleviating Factors were more prevalent after some time had passed. Factors which lessened participants' grief such as Compromise, Acceptance, and Good from Bad were most apparent after several years had passed. Having stated this, it should also be pointed out that exceptions are apparent. One helpful factor which occurred close to the suicides was that of having the body at home.

Most Intensifying Factors occurred closer to the suicides. For example, Minimising, Conflict and Additional Exacerbating Factors compounded grief reactions in the initial days and months following the suicides. However, again, exceptions are apparent. In the case of Perceived Lack of Support, it appeared that for some, help was forthcoming initially, but, as Nancy pointed out, "then everybody gets on with their own lives". Hence, in the longer term, some participants were left to deal with their grief on their own.

## SUMMARY

The current chapter has discussed and exemplified eight Alleviating Factors. Each Factor was identified as assisting participants to cope with their grief. Where Alleviating Factors had parallels in the literature, this was pointed out. However, many of the factors identified in this research appear to be unique to this study. Consequently, description of the factors was a primary consideration in reporting these findings. Alleviating Factors lessened participants' Grief Reactions. The chapter concluded with a brief discussion of the researcher's conceptualisation of the role of time. Grief Responses occurred immediately following the suicides and Intensifying Factors were also viewed as occurring close to the time of the suicides. Alleviating Factors, for the most part, occurred after some time had passed. In the following chapter, the findings of this study will be summarised in terms of the study's main aims. Limitations of the study will be considered, and suggestions for future research will be offered.

PART THREE:

**Conclusion**

## CHAPTER EIGHT:

### **SUMMARY, LIMITATIONS, AND SUGGESTIONS FOR FURTHER RESEARCH**

The title of this chapter indicates its organisation. Initially, a summary of the research findings in terms of the study's aims is presented. Subsequently, limitations of the present study are acknowledged. Finally, suggestions for future research are made in light of the findings of the current study.

#### **FINDINGS IN TERMS OF THE STUDY'S AIMS**

There were four main aims in the current study. Briefly, these included developing a theory of the experiences of New Zealanders bereaved by suicide. That theory was to incorporate coping factors of New Zealand suicide survivors. The second aim was to reflect the uniqueness of each participant's account. The third aim was to make a New Zealand contribution to the literature on suicide bereavement. The final aim was to produce a piece of work which may be useful for survivors. The findings of the study in relation to each of these aims are outlined below.

##### **A Theory of New Zealand Suicide Survivors**

The theory developed in the current study was explained, exemplified and analysed in the previous three chapters. That theory is summarised here.

The focus in Chapter Five was the Grief Responses reported by participants. These included emotional, intellectual, and physical reactions which occurred following the suicides. Description from participants' accounts was provided to exemplify each of the reactions identified. Many of the reactions, particularly the emotional and intellectual responses, paralleled those already documented in the literature. One notable finding was

that suicidal ideation in some participants was countered by participants' fears of the repercussions for others in their family.

Six Intensifying Factors were explained and exemplified in Chapter Seven. These included: Perceived Lack of Support; Impediments to Gaining Information; Conflict; Death as a Surprise; Minimising; and Additional Exacerbating Factors. Each Factor was found to have compounded and/or prolonged participants' Grief Reactions. The Factor of Impediments to Gaining Information increased participants' frustration and led to further questioning. The Factors of Perceived Lack of Support, Conflict, Death as a Surprise, Minimising and Additional Exacerbating Factors aggravated emotional responses such as anger, blame and shock.

While this study found that, yes, survivors of suicide experienced painful grief responses, the three to six year time frame since the suicides allowed the study to reveal coping factors. Consequently, in Chapter Seven, eight Alleviating Factors were discussed. Gaining Information meant participants had less need to seek answers. By lessening specific Grief Reactions such as sadness and guilt, and blame, and providing happier thoughts, the Factors of Social Support, Compromise, Special Significance, Good from Bad, Positive Memories, Acceptance and Philosophising assisted participants to cope. Sapsford's (1995) perception of the pain being integrated into survivors' lives as opposed to their recovering from grief was seen as fitting the experiences described by participants in this study.

Grief Reactions were experienced from the time of the suicides. Intensifying Factors also occurred close to the suicides. Alleviating Factors were more prevalent after some time had passed. Exceptions to this general view of the role of time were acknowledged.

### **Uniqueness of Each Participant's Account**

Each participant's reaction was unique and consisted of a various quantity and intensity of the factors described. The research recognises differences between individuals'

experiences of suicide bereavement. An attempt to highlight participants' unique experiences was made in the profiles and stories of Chapter Four. The theory itself allows for differences between individual survivors. Unique combinations of the Grief Reactions, Intensifying Factors and Alleviating Factors were apparent for each participant.

### **A New Zealand Contribution to the Literature**

All the experiences described in this study were inherently shaped by the fact that participants were New Zealanders. Some findings show very clearly that the experiences related by participants were unique to New Zealand suicide survivors. In particular, experiences of differences between Maori and European cultures would appear to be unique to New Zealand suicide survivors. Two of these are discussed below.

An Alleviating Factor which was identified as particularly helpful by some participants in the current study was that of having the body at home. Participants indicated that this was a tradition carried out in New Zealand Maori Culture and that it lessened their grief by providing the opportunity for them to say goodbye. Because of its status as a Maori tradition such an experience can also be seen to be specific to New Zealand suicide survivors.

It is not usual to add new information in a concluding chapter of psychological research. However, one notable feature of the current study did not fit into the findings section of this study which focuses on the aftermath of suicide for New Zealand survivors. It is however, of interest when considering suicide risk factors in New Zealand youth. Of the eight participants who took part in the current study, two indicated that their families consisted of a Maori husband and European wife. The children in these two families were brought up in the European culture with very little knowledge of Maori culture. Both participants (who were mothers of two youth suicide victims) wondered whether the issue of being of "mixed blood" had led their sons to feel that they did "fit" into New Zealand society. Both the sons had indicated their distress over being half Maori and half European and one had made a concerted effort to become involved in his Maori

culture prior to his suicide. Both mothers indicated that perhaps they should have brought their children up with exposure to both European and Maori cultures.

### Utility

The grounded theory of the current study conceptualises participants' grief and coping differently from traditional "Stages of Grief" models. Rather than viewing participants as progressing through various stages of grief characterised by certain emotional responses and behaviours, the current study found a number of grief reactions (most of which are still in accordance with the grief reactions reported in the literature) which were exacerbated or lessened by a host of Intensifying and Alleviating Factors.

Such a framework of suicidal grief has practical implications. Each of the categories, Grief Reactions, Alleviating Factors, and Intensifying Factors, with their total of 68 components (see Appendix A) could be used as "Checklists" by professionals such as GPs or counsellors. The presence of Intensifying Factors, especially, may indicate to the professional that a particular individual is at risk for a particularly painful or prolonged period of grief.

Alleviating Factors provide information about how survivors in this study were assisted to cope with their grief. In particular, ongoing support was helpful as was accurate information provided by professionals, particularly coroners. Having the body at home was particularly beneficial. Coroners, funeral directors, police and others involved in dealing with survivors could be made aware of Alleviating Factors (such as the importance of accurate information and having the body at home) in order to maximise the assistance that they give to survivors.

The researcher's view that a country with particularly high rates of suicide (in young people) owes its survivors assistance was emphasised in Chapter One. Having revealed that an effective avenue of help for survivors is that of suicide survivor support groups, it is further suggested that assistance for survivors could be provided by promoting the existence of support groups in New Zealand. Government funding for such groups

would go some way towards ensuring that New Zealand suicide survivors are looked after.

As far as support groups are concerned, the Grief Reactions, Alleviating Factors, and Intensifying Factors identified in this study could also be used as a starting point for discussion. In particular, discussing these factors may help new survivors to recognise that many of their reactions are common to other survivors.

## **LIMITATIONS OF THE CURRENT STUDY**

Although the research allowed for any family member or friend who had been bereaved by suicide to participate, the sample did not include any friends of suicide victims. Further, of the eight participants, five were parents. Had participants with a wider range of relationships to suicide victims been involved in the study, this would have perhaps generated more codes and categories especially at the early stage of data analysis.

The fact of each interview being several years after the suicide occurred means that the information was gained at one point in time and retrospectively. Hence, the current findings are reliant on participants' memories for many events which occurred several years previously. Such a time lapse no doubt influenced the information supplied by participants, and consequently, the findings of the study. For example, the findings that relief and blame of the victim were unassociated with guilt (in contrast to the findings in the literature), may have been the result of participants overlooking to mention feelings that they had dealt with many years previously.

## **SUGGESTIONS FOR FURTHER RESEARCH**

As was intended by employing a qualitative framework, a large amount of rich and detailed information was revealed by a small number of participants in the current study. The theory that was created and grounded in the stories provided by those participants may be used to generate further investigation especially about suicide survivorship in New Zealand. Such investigations could be either quantitative or qualitative in nature.

Several specific suggestions for further research based on the findings of the current study are made below.

The current study revealed a variety of factors associated with coping (Alleviating Factors) which may be used as the focus of further studies. It was highlighted in Chapter One that there is a relative dearth of literature on factors which may help suicide survivors recover from grief. Studies which investigate coping factors further would help confirm, add to, or refine the factors identified in this study.

Reasons why support groups were helpful were revealed in the current study. Overseas, research attention (e.g., Rubey & McIntosh, 1996) is currently being focused upon which particular factors are involved in the success of such groups. Further research in New Zealand which concentrates on discovering the beneficial components of such groups (as well as practical support such as funding) may lead to strengthening the role such groups can play.

The relatively large number of middle aged participants in this study produced some results which may have been more relevant to that particular age group. A notable finding in the current study was the role played by Grandchildren in helping some participants to appreciate life. Further research which focuses on age group differences (as opposed to relationship differences) may uncover grief reactions and recovery factors which are specific to certain age groups.

A disturbing finding in this study was that a number of participants experienced suicidal ideation following the suicides of their family members. Of special interest is the fact that many of these survivors were not young people (often thought to be the most at risk for contagion effects of suicide). Research which investigates the prevalence of suicidal ideation and behaviour in a larger number of New Zealanders bereaved by suicide may well emphasise the urgency of effective postvention with suicide survivors.

A second finding regarding suicidal ideation in those bereaved by suicide was more positive. It appeared that fear of consequences for other family members prevented participants from acting on their suicidal thoughts. Awareness of the pain involved for

those who survive a suicide may be a central factor in preventing further suicide. Further research in this area may reveal whether fear of consequences for others is a preventative factor for suicide.

The current study focused on the experiences of *individuals* bereaved by suicide. However, each participant's story contained a clear message that the suicide impacted on the entire family of each victim. For example, conflict ensued in the families of several participants. Such family conflict intensified the grief experiences of participants and the researcher has no doubt that such conflict also impacted negatively on the other family members involved. The implication of this finding is that just as the grief literature in general has broadened its focus to include the effects of bereavement on the family, so too, there is a need to investigate the impact of suicide on the family unit. Possibly, postvention strategies which address family functioning would be even more beneficial to survivors than those which target the individual.

Previous research has identified feelings of stigmatisation in suicide survivors (see Chapter One). In the current study, participants did not indicate that others blamed them for the suicides. Rather they perceived a lack of support from others including the fact that others appeared to avoid them. Such a lack of support was not necessarily the result of others seeing the suicide survivor in a negative light. The present researcher believed that others avoided survivors because they were unsure of what they should do or say. Future research which identifies the kind of support that survivors do require, including the right things to do and say, would be a step towards helping others to help survivors.

Finally, the issue of being of mixed race, but being brought up in only one cultural environment, was mentioned above. Although further scrutiny of this subject is a task for suicidologists interested in risk factors rather than in survivorship, it is nevertheless a finding of the current study which deserves further investigation. Future research studies may support this finding as a causative factor in New Zealand suicides.

## SUMMARY

This chapter has discussed the findings of the current study in terms of the study's aims. The grounded theory which included coping factors was summarised. That the theory allows for the uniqueness of each participant's experience was pointed out. New Zealand specific findings were emphasised and the utility of the theory discussed. Limitations of the research project were pointed out including the fact that a wider variety of kinship relations to the deceased may have generated more categories. Finally, suggestions for further research were made. These included general calls for more New Zealand research into suicide survivorship and for research attention to be focused on support groups.

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**APPENDIX A**  
**TABLE OF CODES**

<u>Open</u>	<u>Axial</u>	<u>Selective</u>
Initially: Disbelief/Shock/Denial/Relief		
Anger/Blame		
Guilt/Self Blame/Regret		
Sadness		
Depression/Suicidal Reactions	Emotional Reaction	
Fear		
Embarrassment/Shame		Grief
Rejection		Response
Why?		
Victim's Last Thoughts	Intellectual Reaction	
Suicide in General		
Somatic Complaints		
Memory Loss	Physical Reaction	
<hr/>		
Disappointment with Friends		
Loss of Friends		
Disappointment with Family	Perceived Lack of	
Insensitivity	Support	
Disappointment with Professionals		
Secrecy and Deception	Impediments to Gaining	
Delayed Official Information	Information	
Intra-Familial Conflict		
Inter-Familial Conflict	Conflict	Intensifying
		Factors
Acting		
No History of Depression		
Depression without Suicide	Death as a Surprise	
No Current Depression/Suicidal Behaviour		
No Help Seeking		
Distance		
Unsuccessful Help Seeking		
Official Procedures	Minimising	
Others' Wishes		
Blame from the Victim		
Horror	Additional Exacerbating	
Tragic Irony	Factors	
Suicide versus Murder		
Regrets		
Stressful Life Experiences		

<u>Open</u>	<u>Axial</u>	<u>Selective</u>
Family Support Grandchildren Friendship Suicide Support Groups Professional Support	Social Support	
Official Information Education Private Investigations	Information	
Grave Site The Body Chance to Say Goodbye Meaningful Gestures Unique Strategies	Special Significance	Alleviating Factors
Description of Deceased Description of Relationship Reminiscing Talked About	Positive Memories	
Helping Others Changing for the Better Other Beneficial Factors	Good From Bad	
Recognising Others' Grief Others' Coping Strategies Sympathising A Hand of Friendship	Compromise	
Choice to Die Benefit of Hindsight Inevitability Unanswered Questions	Acceptance	
Suicide as a Mental Disability Shortened Life After Death	Philosophising	

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## **APPENDIX B**

### **SUMMARY OF RESEARCH FINDINGS**

Dear Participant,

#### **Re: Experiences of New Zealanders Bereaved by Suicide Research.**

Firstly, my sincere thanks for participating in my research on the experiences of New Zealanders bereaved by suicide. Working closely with the transcripts of participants' interviews has made me very aware of the courage and honesty with which such painful experiences were discussed.

As promised, I would like to share the major findings of the study. These findings constitute a summary of the results of my thesis, and are the outcome of several months spent analysing the transcripts of your interviews. It is important to recognise that the findings reported below are general ones. While it is believed that you will find much that is reflective of your own experience, it is not intended that all the findings are relevant to every individual.

The main findings of the study are as follows:

- \* Following the suicide of a family member, all participants suffered a grief reaction. Grief included the emotional responses of disbelief, shock, relief, anger, blame, guilt, sadness, depression, anxiety, embarrassment and rejection. Some people indicated that they also suffered physical problems such as headaches and inability to sleep. Memory difficulties were also discussed. Not all participants experienced every one of these responses but I'm sure that you will recognise many of them as being a part of the grief that you reported in your interview.
- \* In attempting to deal with the aftermath of the suicide, everyone sought ways of coping with their grief. Asking questions about why the suicide occurred was common in many accounts. There was also a great deal of information seeking about events that occurred prior to, and at the time of, the suicides. Searching for answers to the problem of suicide in general was also common. Another way that participants attempted to cope with grief was by seeking help from family, friends, and professionals.
- \* Recovery from grief was made more difficult by the presence of what I have labelled 'Intensifying Factors'. There were six types of 'Intensifying Factors':

The first of these was a perceived lack of support from family, friends and professionals including police and coroners. Disappointment resulted from this perceived lack of support compounding grief experiences.

A second factor was impediments in gaining information. Some participants found it difficult to obtain information from others, including officials and other people close to the suicide victim. The result was frustration and further information seeking.

Conflict within and between families proved to be a third factor and was related to prolonged feelings of anger and blame.

Fourthly, where the suicide came as more of a surprise (especially when there was no known history of depression or suicide attempts), there appeared to be greater disbelief about the nature of the death.

The fifth factor was that of minimising of participants' feelings, needs and beliefs. Participants themselves often allowed their own needs to take second place to the wishes of others and this became a source of ongoing frustration.

Finally, additional exacerbating factors such as the horror associated with the method of the suicide intensified grief responses. Where there were other stressful life events such as a separation, divorce, or another death, either prior to, or following, the suicides, this added to the burden of grief experienced by those participants.

- \* On a more positive note, your stories of being bereaved by suicide also revealed many experiences which were associated with recovery from grief. These experiences were labelled 'Alleviating Factors'. Alleviating Factors both assisted in recovery from grief and they also signalled that recovery had occurred, at least, to some extent. Eight kinds of 'Alleviating Factors' were identified:

The first factor was that of social support. Where support was available through family, friends and professionals, participants appeared to find it easier to cope with their grief. Those who were involved with support groups appeared especially appreciative of the opportunity these provided to talk with others who had similar experiences. For those who had them, grandchildren proved to be therapeutic providing an opportunity to appreciate and enjoy young life.

Secondly, being able to obtain information regarding a family member's suicide, and suicide in general, was beneficial in assisting participants to satisfy their thirst for knowledge.

A third factor was engaging in acts which had special significance. In particular, having the body at home and visiting the grave site proved therapeutic. Making gestures which would be special to the deceased (such as choosing specific clothes to be worn by the deceased in the coffin) also assisted participants to feel a little better.

Positive memories of the deceased and being able to talk to others about those memories was the fourth factor. It was especially apparent that reminiscing about happy times spent with the deceased was a positive experience.

Fifthly, recognising that good came out of the suicide helped some people to cope with their grief. In particular, playing a role in helping others through a similar experience was important to a number of participants.

A sixth factor was compromising. Where there was anger and conflict with others, the ability to feel sympathy and see others' points of view helped participants deal with that anger.

The seventh factor identified was that of acceptance. Recognising that it was a family member's choice to die and that some questions would always remain unanswered, demonstrated that individuals had, to some extent, coped with their grief.

Philosophising about suicide and death was the final factor identified. Some believed that those who suicided did so as the result of a mental problem. Some participants believed that their family member was "still around" and could see and hear them. All participants who addressed the religious view of suicide as a sin indicated that they did not believe that this was the case. Such views assisted in lessening the pain felt by those who held them.

- \* The final piece of feedback concerns the role of time. All the interviews took place at least three years subsequent to the suicides. It was apparent that a longer time since the suicide was associated with greater recovery from grief and less need to cope with intense mental pain. I am not saying that there was no pain after some time had passed. However, in spite of the pain that remained, people were able to cope and had begun to 'get on with' their lives again.

I believe that one of the best ways to judge whether research results do in fact describe what they set out to describe is to ask the people who took part in the study themselves. No one knows your experience better than you do. With this in mind, I would welcome your comments on these findings. Do they fit your experiences?

Please feel free to return the enclosed, stamped, self addressed envelope with any comments on the research findings or any other comments. In order for your views to be incorporated in my thesis, I would appreciate it if you would return any comments by June 20, 1998.

Thankyou, once again, for your participation in this research.

Yours sincerely

Maria Berrett  
Ph (06) 329 4767



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## **APPENDIX C**

### **ADVERTISEMENT**

#### **A STUDY OF THE EXPERIENCES OF PEOPLE BEREAVED BY SUICIDE**

My name is Maria Berrett. I am a Massey University MA student in Psychology and I am seeking participants for my study on the experiences of New Zealanders who have been bereaved by suicide. By giving participants the chance to tell their stories, I hope to uncover common themes amongst survivors as well as to highlight the individual reactions of people who have been bereaved by suicide.

Participants may be adult family members or friends who have been bereaved by suicide. I am looking for people who are New Zealanders and who have been bereaved for at least one year. More than one family member or friend affected by the same suicide may participate in the study.

If you agree to be involved in the study, you will be asked to take part in a 45 minute audiotaped interview with me. The information provided in the interview will be confidential to me and to my University supervisor. All identifying information will be altered so that you cannot be identified in any way.

If you are interested in being involved in this study and would like further information please telephone me at home on (06) 329 4767, or write to me: Maria Berrett, c/o Psychology Dept., Massey University, Palmerston North.



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## **APPENDIX D**

### **INFORMATION SHEET**

#### **EXPERIENCES OF PEOPLE BEREAVED BY SUICIDE**

##### **What is this study about?**

I am interested to learn about how New Zealanders react and cope with the trauma of suicide. By exploring the experiences of family members and friends who have been bereaved by suicide, I hope to gain an understanding of common themes and patterns, as well as understand individual experiences which result from the self inflicted and self chosen death of a family member or friend.

##### **The Researcher.**

My name is Maria Berrett. I am an MA (Social Sciences) student at Massey University, and this research is for my Master's Thesis. I have a BA in English, and a Diploma in Social Sciences (Psychology). I am being supervised by Dr. Keith Tuffin, a staff member of the Department of Psychology at Massey University.

##### **What would I have to do?**

You are being invited to participate in an audiotaped interview with the researcher. The interview will be approximately 45 minutes long, and will be at a time and place which suits you. In the interview, you will be asked to describe your experience of losing a family member or friend through suicide. The questions I ask will be designed to prompt you in telling your story, rather than to elicit specific information.

##### **What can I expect from the researcher?**

You have the right to decline to participate in this study. If you do agree to take part in the study, you have the right to:

- \* refuse to talk about any particular issue(s) during the interview, and to withdraw from the study at any time.
- \* ask for the audiotape to be turned off at any time during the interview.
- \* provide all information on the understanding that it is confidential to the researcher and the researcher's supervisor, and will not be shown to anyone else without your permission.
- \* have your audio tape transcribed by the researcher.
- \* be given a copy of your transcription so that you can read over your interview and edit it to your own satisfaction before the information is analysed.

- \* have all names, places, and other identifying information changed during transcription so that you cannot be identified in any way. Quotes from your account may be used in the thesis, but they will not identify you in any way.
- \* be given access to a summary of findings at the completion of the study.
- \* have your information stored securely at all times. Audio tapes will be transported in a combination lockable briefcase.
- \* at the end of the study, have your audio tape returned to you, or erased, on your say so. Your transcript will be kept in storage.
- \* be put in contact with a trained counsellor if you suffer any distress at any time, as a result of your participation in the study.

You are welcome to contact me or my supervisor, either before you agree to take part, or at any time during the study, for further information or to discuss and clarify any questions you may have about the study:

Maria Berrett, c/o Department of Psychology, Massey University.  
Home Ph. (06) 329 4767.  
Dr. Keith Tuffin, Department of Psychology, Massey University,  
Ph. (06) 350 4140.

## APPENDIX E

### SEMI-STRUCTURED INTERVIEW SCHEDULE

- Background to suicide - family functioning? Behaviour of person who suicided? Any indications of suicide at the time? In retrospect?
- The person who suicided - What was he or she like?
- The suicide - how? when? where?
- How did you find out? Who told you? Where were you? How old were you?
- Discovery of the body?
- Initial reaction
- Involvement of Professionals - police, coroners, others?
- Others' reactions - Other family members, friends, workmates, school friends acquaintances?
- Funeral - Did you go? Were you involved? What happened? Reactions of others at the suicide? Was the fact the death was a suicide mentioned?
- After the funeral - Where did you live? Any changes in residency or other areas of your life?
- Own feelings and reactions - for example, sad, angry, guilt, blame, relief, questioning, understanding, depression, suicidal thoughts?
- Health problems?
- Relationships with others - family? friends?
- Manner of death discussed at home or with others?
- Deceased still talked about?
- Social supports available? Counseling? Support groups? Other?
- Comments to others going through similar experience?
- Other comments including comments on the current study?

## APPENDIX F

### TRANSCRIPTION NOTATION

[     ]	Information added
[ <b>pause</b> ]	denotes substantial pause
[ <b>sister</b> ]	relationship to participant
...	Information omitted
“ ”	Participants' thoughts or words recalled.

## APPENDIX G

### CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand my rights as a participant including the right to withdraw from the study at any time, or decline to answer any particular questions during the interview.

I agree to provide information to the researcher on the understanding that no one other than the researcher and the researcher's supervisor will have access to the information. (The information will be used only for this research and publications arising from this research.)

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I agree that quotations from my transcription may be used in segments of the thesis, on the condition that they do not identify me in any way.

I wish to participate in this study under the conditions set out in the Information Sheet.

Signed:

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Name:

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Date:

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