Chapter 1

Suicide and the family perspective

Introduction

This thesis contains the stories of the participants who have lost a family member through suicide. All of the participants spoke of their relative who died, the circumstances leading to the death and about what happened to the participants and their families subsequently. This study is about family sagas, suicidal deaths and the sequels to a tragedy.

But it is also my story. After investigating the effects on children, adolescents and young adults who lose a parent through suicide in a previous study (Ratnarajah 2005:160), I became aware of the wider family context in which a suicide occurs. I realised that the story of the family culture and way of being with each other had an impact on the circumstances leading to the suicide. It also influences the family's ability to cope after the death, with responses that range on a continuum from a family regroup to disintegration. One of the recommendations from the previous study that I undertook was: 'to recognise there well may be a history of generational dysfunction in the family system, which contributed to and/or culminated in the suicide' (Ratnarajah 2005:244). While every effort is made not to pathologise an already grieving family, it is important to understand the context in which a suicide occurs.

Three questions were asked by audience members at the conclusion of my presentation given at the Queensland Conference on Suicide and Self-harm (Ratnarajah & Schofield 2006). These questions started my thinking for this project.

- Can the occurrence of a suicide indicate dysfunction in the family system?
- How do families re-organise the family system after a suicide?
- How can counsellors support and intervene in the family system post suicide in a way that is appropriate and non-pathologising?

One member of those attending spoke to me after the session and, as a suicide-bereaved mother, was upset by the implications of these questions. She insisted her story was of a loving, supportive and close family, yet her son had ended his life after the breakdown of his relationship. I identified with her story. My son ended his life after the breakdown of his marriage. I did not question the family context that I had a large part in creating. I experienced the family as close, supportive and loving. But on reflection, I admit that there are elements in my background, and therefore the family background of my son that are considered risk factors for suicide.

There are many negative implications that may follow the word 'dysfunction' so it is now useful to explore what is meant by the word. The definition of 'dysfunction' in a dictionary of psychology is 'broadly, generally and ubiquitously, any disruption in normal functioning' (Reber 1995:231). But how is 'normal functioning' in the family system defined or

recognised? Satir (1988:4) defines family systems to be the 'rules people use for how they should feel and act'. The traditional purpose of the family structure is the nurturing of children (Levi-Strauss 1969). Parents, as the primary caregivers and nurturers of children, have the responsibility to ensure that children are raised in an environment that fosters emotional and psychological wellbeing. Appropriate nurturing will enable those raised within the family to find resilience when confronted with a rupture or loss of a significant relationship (Schore 2003). The early attachment experiences that a child undergoes within the family can affect how the child, and later the adult, is able to adapt internally to stress and return to the earlier state of equilibrium (Schore 2003). In this thesis, the word 'dysfunction' refers to the disruption in the family's relationships that may result in a challenge to the secure attachment fostered within the family system.

Family factors listed as risks for suicidal behaviour in children and adolescents include instances where the suicidal young people came from disrupted or non-intact families (Fergusson, Beautrais & Horwood 2003; Gould, Shaffer, Fisher & Garfinkel 1998; Steele & Doey 2007; Wagner et al. 2003). There is no inference that correlation denotes causation (Davies & Williams 1999). Or to put this another way, while some research studies have explored the link between parental separation or divorce and adolescent or child suicide (Gould et al. 1998), the findings state that the parental relationship breakdown had relatively little impact on the

children's vulnerability to suicide. Rather, parental depression following the divorce tended to indicate communication difficulties between the parents and the children and this 'failure to communicate may reflect a more dysfunctional relationship' (Gould et al. 1998:160).

This explanation describes my son's family history. His biological father and I separated and later divorced when my son was very young. My son had no memory of living with his biological father, who maintained only irregular contact, and then later broke off all contact with him, signing release documentation allowing my second husband to adopt my son. So in effect my son's biological father abandoned him. That I was not wise enough during those years to encourage a continuing relationship between my son and his biological father is acknowledged. I only became aware of how hurt my son was by his father's abandonment on the day he died by suicide, through his last communication with me.

I now face that there is evidence of dysfunctional family relationships in my son's life. The lady who spoke to me at the conclusion of my presentation was also divorced from her husband and believed that the relationships in her family were loving and positive, and played no part in her son's decision to end his life. In my own circumstances, I can see that, despite a preceding trigger incident of my son's failed marriage, the seeds of the inability to survive the loss of someone he loved may lie much earlier in my son's life, possibly in the dysfunctional relationship between myself and his biological father. This insight and my years of research in

the field of family member suicide is my gift to the bereaved family members who so generously and bravely shared their history with me and allowed me the privilege of inquiring into their narratives.

The purpose of this study was to explore how individuals make sense of a suicide within the family. The study also aimed to explore the family history, their interactions, relationships, and if known, the histories of earlier generations through the retrospective reminiscences of participants who volunteered their stories. The ramifications of the suicide, which were generally confronting and destructive to the individuals and to family cohesion, were also of interest. Recollections and impressions on what it was like to be an individual in this particular family, as well as the participants' understanding of the triggers for the suicide and what happened to them afterwards were also examined. A suicide in the family often has repercussions that affect the functioning of the whole family system: as Linn-Gust (2001:120) reports: 'fault lines in family relationships grow deeper with a suicide'.

Previous suicide research studies have not reported on family dynamics that may be implicated and, therefore, may be precursors to a suicide, other than in relation to suicidal teenagers (Koopmans 1995; Wagner, Silverman & Martin 2003). A recent study where the participants were also young, links family dysfunction to suicide ideation (Chen, Wu & Bond 2009). Little research has been undertaken into other aspects of familial transmission of suicidality that may be related to the communication

style, family dynamics, boundary confusion, problem or inappropriate attachment issues, poor role modelling and lack of social cohesion or support. More importantly, there is a dearth of research into those aspects of family relationships that may promote healing and foster resilience in the members of the suicidally bereaved family.

Guiding research question

The key question guiding this research is: *How do suicide-bereaved families narrate their experience of loss in the context of familial relationships?*

Summarised aims of the project

1. To explore the recollections of adults who had experienced a family member suicidal death.
2. To understand the family history both prior to and after the suicide, the development of meaning systems and the development of resilience.
3. To identify the nature and timing of support, if any, accessed by the bereaved family members.
4. To seek information on participant vulnerability and the factors that affect coping.
5. To identify the protective external factors that encourage moderation between stress, risk, coping and the development of resilience.

Definition of terms

Suicide bereaved or bereaved by suicide

There has been recent discussion on the terminology to describe those who have suffered the loss of someone loved by suicide. Some researchers have used the term 'survivor of suicide' or 'suicide survivor' (Grad 2009), while others believe this to be confusing, as it could be misinterpreted to suggest that an attempt to die by suicide was made. In this thesis, 'suicide bereaved' and 'bereaved by suicide' are used to identify a person who has experienced grief after the suicide of a loved one.

Postvention

'Postvention' is used to describe support services offered to those who are suicide bereaved to assist in their recovery (Campbell 1997). It is believed that appropriate support services for the suicide bereaved prevent further suicides (Shneidman 1972).

Disenfranchised grief

'Disenfranchised grief' has been described (Doka 2002) as having the following attributes: 'Lack of recognition of the relationship, lack of acknowledgement of the loss, and exclusion of the griever' (Doka 2002:10).

Accommodation

The word 'accommodation' is used in this thesis as Piaget (1974) defines it: 'modification of internal schemes to fit a changing cognisance of reality' (Reber 1995:5).

Overview of thesis

The current chapter provides the context for the study, with the next two chapters containing the background information relating to the topic of suicide and the family. The need for two chapters that review the large literature on this topic arose because it was recognised that how suicide is understood to occur in families was different in scope to how families are affected by a suicide and what is known to happen in families as they endeavour to adjust—the topic of discussion in Chapter 3.

Chapter 2 outlines and critically examines the interdisciplinary literature on the history of a suicidal death as a trauma that occurs within a family. The factors that could be implicated in a family member's suicidal death are complex. These include family functioning such as belief systems, organisational and communication processes and the way families manage roles and boundaries or decision making, as well as ecological and social environmental factors. Other factors that bear on our understanding of a suicide within the family context are discussed, including genetic and biological influences, a history of psychopathology in the family, known influences of addictions and abuse derived from examining the biochemical information in the brains of the suicide deceased.

Chapter 3 outlines the background to this study as it relates to bereavement following suicide. The special aspects of the grief experience that are consequent to the nature of the relationship of the bereaved

family member to the deceased are discussed. Case studies in the grief reactions of partner and spousal losses, parental grief following the death of a child, grief consequent to sibling suicide and the grief of children following parental suicide are examined.

Chapter 4 describes the aims and methodology used in this study. It highlights the narrative inquiry and the methodology that interrogated and interpreted the data gathered from the eighteen participants' stories.

Chapter 5 introduces the eighteen participants who volunteered their story of a family member's suicide to this study. This chapter gives an outline of the family story, the preceding events and the subsequent journey the participants and other family members have made since the suicide.

Chapter 6 examines the participants' interviews through three major themes: the family story previous to the suicide, the suicide itself and the participants' lives after the suicide. It explores support that they may have sought and accessed subsequent to the event. This chapter also examines the participants as they dealt with additional stressors following the death, the challenges they experienced in moving forward and the factors that facilitated or inhibited resilience. Two main themes emerged in the participants' narratives: 'what does this say about me' and 'what does this suicide say about my family'?

Chapter 7 discusses the findings of this research study and relates those findings to the literature relating to family member suicide, reasons and outcomes. Two concepts relating to participants' relationships and family interactions are reconceptualised; 'damaging family experiences' and 'family climate'.

Finally, Chapter 8 discusses the strengths and limitations of this study and summarises the conclusions, making recommendations on directions that future research could take. Suggestions to strengthen suicide-bereavement support services are made. A postscript talks about how this study and the previous study have assisted me in my understanding of suicide through a reflection on my personal history.

Chapter 2

Literature review 1: Suicide in families

Introduction

This chapter focuses on what is known about the circumstances in which suicide deaths occur in families. The impact of a suicide death in a family is like a shock wave throughout the family, sometimes occurring in dysfunctional family systems. This chapter explores the literature on family systems, family functioning, resilience in families and a brief look at the insights provided by environmental, biological and genetic research on suicide within families.

Suicide is a major health issue in Australia. With every suicide death there are at least six family members affected by the loss (Australian Senate 2010; Clark & Goldney 2000). There were over 2000 suicide deaths reported in 2004—although the actual number may be much higher due to underreporting because of differing coronial reporting criteria in each state (Australian Bureau of Statistics 2006). A recent review of suicide statistics (Australian Institute of Health and Welfare [AIHW], Harrison, Pointer & Elnour 2009) estimated that the number of Australian deaths from suicide was approximately 2500 in 2008. In other words, approximately 15,000 people are affected by the loss of their family member each year. Suicide has a profound affect on familial relationships

(Myers & Fine 2007). Suicide prevention remains a high priority for the Australian Government (National Suicide Prevention Strategy [NSPS] 2002), and in 2006 the Australian Government allocated $7.8M (Australian Government 2007) for research into effective postvention support for suicide-bereaved people. Previous research has established that the first-degree relatives of a suicide-deceased person are at a greater risk of attempting suicide than the general population (Runeson & Asberg 2003; Jordan 2001; Brent, Bridge, Johnson & Connolly 1998).

The role of family influences across the lifespan in the history of those who have died by suicide has not been widely researched (Bongar, Goldberg, Cleary & Brown 2000). It is acknowledged that individuals who decide to end their lives can have reasons for doing so that are generated outside the family context, such as a sense of being shamed in their professional roles (Hastings, Northman & Tangney 2000). Hastings and his colleagues (2000) report how an American admiral with an exemplary career died by suicide after being questioned in a newspaper article about the circumstances of the awarding of two of his medals. This current study does not cover the reasons why people choose to end their life, but looks specifically at family relationships and influences.

This chapter critically examines the literature on suicide bereavement. The factors that promote resilience in families when facing trauma after a suicidal death are examined. The family processes that facilitate resilience and reconciliation are also outlined.

Understanding of suicidal behaviours often relates to genetic and biological factors when family functioning is examined. Therefore, studies that have examined the suicide history among twins and people who were adopted as well as biochemical information were relevant. Also discussed are family ecological, social and environmental factors that may relate to a history of mood disorders, addictions and other ways of family patterning that may be implicated in a history of suicide.

Studies into the special nature of the grief experienced following a suicidal death are also relevant here. Grief following a suicide has different meanings and shades of feelings depending on the relationship with the suicide deceased. Less has been written about the family experience of suicidal death and the consequences that have followed. What is already known follows in Chapter 3.

A significant body of research on family factors in youth suicide attempters or completers has been amassed, yet little research has been undertaken into family incidents of suicidality in other age brackets. The family factors related to youth suicide are listed as:

> Negative parent-child relationships, child maltreatment, residing with less than two biological parents, family history of affective and antisocial disorders. Parental separation/divorces and family history of suicidal behaviour and alcohol/substance abuse […] family systems problems […] insecure parent-child attachment (Wagner et al. 2003:1173).

While there is a considerable body of research on the familial transmission of suicidal behaviour, mood disorders and parental psychopathology

within this younger age group (Brent, Oquendo, et al., Mann 2004; Runeson & Asberg 2003; Statham et al. 1998; Wagner et al. 2003), little research has been undertaken into the familial transmission of suicidality in other age groups (Wagner et al. 2003). Bongar and his colleagues (2000:223) note that systemic family therapists 'address the topic of suicide infrequently'. In this small body of literature the family risk factors linked to suicidal behaviour are ineffective communication style and family dynamics (Henry, Stephenson, Hanson & Hargett 1993); boundary confusion (Cottle 2000; Koopmans 1995); poor role modelling (van Heeringen & Vincke 2000); and lack of social cohesion or support (Gould & Kramer 2001).

Little has been written about the residual effects for the individual and their relationship changes as a consequence of the prior suicide of a family member. Also examined are factors associated with negative family patterning: family-unit processes and relationships that are recognised as damaging and that may contribute to the suicide. In contrast with this, investigators have also examined aspects of family relationships that are supportive and strengthen the family unit and are healing to the individual family members and where resilience is evident in the face of trauma or loss (Walsh 2006).

Impact of suicide on family members

It is well established that the suicide of a close relative has a profound affect on the way the bereaved survivors are able to relate to each other

and in their continuing life generally (Hawton & Simkin 2003; Linn-Gust 2001; McIntosh 1999; Mitchell, Kim, Prigerson & Mortimer 2005; Myers & Fine 2007). A suicide does not occur as an isolated incident and to understand the family unit, and the place and role of the suicidal family member, the family history, family patterns and processes within the family are required.

Where in some instances suicide appears to occur unexpectedly, many families can identify causal factors attributable to the suicide (Maple et al. 2007). They view the suicide as a culmination of relationship problems—the result of a disconnection with others or of the suicidal person having feelings of isolation, rejection, shame and loss of hope (Bolton, Gooding, Kapur, Barrowclough & Tarrier 2007; Brent & Mann 2006; Eckersley & Dear 2002). In examining the links between family dysfunction and suicidal ideation, Chen and her colleagues (2009) commented on the mediating roles of self-views and world-views and how these views are formed.

Even though support may be there, and community mental-health education programs have endeavoured to advise where help may be attained (Goldney & Fisher 2008), the suicidal person has either not sought this support, or if help had been accessed, still chose death. This leaves the members of the suicide-bereaved families feeling guilt-ridden themselves, searching for answers and wanting to know what more they could have done to help (Jordon 2001). Even if a triggering event occurred

that resulted in the decision to suicide, on examination, past history of family patterning and values may have inhibited the individual's ability to rebound from a loss, trauma or conflict, or prevent a collapse into a trough of despair. Where there is evidence of a predisposition to mood or personality disorders, genetic influences may also have played a part (Brent et al. 2004).

Valuable information can be gathered from the stories of those suicide bereaved who share their experience within this particular family. The family mores and traditions, the style of the family functioning, whether perceived to be cohesive, supportive and nurturing, or isolating, damaging and limiting can offer insight into the background to the suicide and provide awareness of the needs for postvention support for the bereaved.

Previous research studies drew their samples from the high-risk offspring of suicide attempters or completers who all had mood disorders and/or had a history of familial sexual abuse and impulsivity (for example) (Brent & Mann 2006; Brent, Oquendo, Birmaher, Greenhill, Kolko, Stanley, Zelanzy, Brodsky, Bridge, Ellis, Salazar & Mann 2002; Brent, Oquendo et al. 2003; Brent, Oquendo & Mann 2004). These damaging experiences are not common to all families in which a suicidal death has occurred. No studies were found in which the family history and culture, especially the anecdotal family knowledge about previous generations were described other than in autobiographical books by bereaved family members (Deveson 1998; Gaita 1998; Groenhuizen 2006; Hammer 1991; Linn-Gust

2001; Rynearson 2001; Stimming & Stimming 1999; Woolley & Meemeduma 2006). Such personal accounts are informative to the field of suicide-survivor literature but are not generally subject to the rigour of experimental study (McIntosh 1996). These personal accounts offer rich and detailed descriptions of the individual's family life prior to the suicidal death and of the author's bereavement experience, but there are limitations in personal reports. Personal accounts can be biased by previously existing beliefs and perhaps omit important elements that may have been uncovered if the narratives were gathered as data in a research study (Paulson & Worth 2002).

Family systems

As the focus of this study is the experience of a family suicide, it is important to define what is meant by 'family' and to examine various authors who have written on family systems. The Australian Bureau of Statistics (ABS 2005) for statistical purposes defines 'family' in clause 21 of 1286.0 as:

> Two or more persons, one of whom is as least 15 years of age, who are related by blood, marriage (registered or de facto), adoption, step or fostering and who are usually resident in the same household (ABS 2005:3).

Family may be understood as a way of communicating and making meaning with one another and relating to those outside the family system—people or institutions that comprise the workings of the family system.

The term ‘family systems’ relates to the overt or covert rules, interaction and values that govern the relationships of a group of people who define themselves as a ‘family’. In the 1991 book, ‘Brave New Families’, author Stacey (1991) quotes a legal opinion of Judge Vito Titone who stated that there are:

> [F]our judicial criteria for determining what constitutes a family: (1) ‘exclusivity and longevity of the relationship’; (2) the ‘level of emotional and financial commitment’; (3) how a couple has ‘conducted their everyday lives and held themselves out to society’; (4) the ‘reliance placed upon one another for daily family services’ (Gutis 1989: A1, A13, cited in Stacy 1991).

The purpose of the internal organising of the family structure is to enable the fulfilment of basic family functioning such as the nurturing of children and to prevent boundaries being violated by acts such as incest (Levi-Strauss 1969). A system exists to fulfil a purpose or goal, and in family systems the roles and responsibilities undertaken by the various members of the family are particularly important in nurturing children. A mother who acts like a sister to her daughter is allowing confusion to arise in the mother–daughter relationship as the mother–child boundary has been transgressed (Cottle 2000; Koopmans 1995). In such a relationship a mother may encourage her daughter in autonomy of decision making, thereby reinforcing the false sibling relationship, but where the daughter turns to the mother for guidance or comfort, the daughter is reinforcing the parent–child boundary. Families in which generational boundaries are unclear can result in confusion and ‘double-bind’ interactions (Cottle 2000; Koopmans 1995). Complication and confusion is compounded if incest

codes are breached, allowing sexual relations between siblings or between child and adult (Koopmans 1995).

The influence of ethnicity was emphasised by McGoldrick (1993) and seen as deeply involved in the meaning making of events affecting the family. The roots of a family's belief system can lie in their ethnicity.

> Ethnicity patterns our thinking, feeling, and behaviour in both obvious and subtle ways, although generally operating outside our awareness. It plays a major role in determining what we eat, how we work, how we relate, how we celebrate holidays and rituals, and how we feel about life, death, and illness (McGoldrick 1993:335).

People learn how to be in relationships through the way in which they were raised within a family, by observing how parents relate to each other and to their siblings. So the 'quality' of a relationship within a family comes from a long history of relatedness that goes back through generations. The mores of the family and era, the particular culture and the ethnic roots of a family, all impact on the way people within a family relate to each other (McGoldrick 1993). There are degrees of closeness and distance, or as Nichols and Schwartz (1998:144) described in terms of Bowenian theory, 'fusion' or 'enmeshment' and 'differentiation' in family relationships.

Bowen (1988), an early family therapist, held that the emotional relationships that are developed within a family system are carried forward and acted out in future generations as new families form and perhaps disintegrate. The family is seen as an 'intergenerational emotional relationship system with forces pulling members towards

togetherness and opposing forces pulling towards individuality' (Dienhart & Avis 1991:33). These forces, fuelled by the emotional needs and climate, are transferred from one generation to future generations and new family units.

It is through these differences and similarities that we observe the different expectations that family members place on one another's relationships. Every participant would have their own expectations of the relationship that was lost in the death of their family member. The decision of the family member to die and in a literal sense to end that relationship, relates directly to the feelings and meanings that the bereaved participants endeavoured to share with me. How to hear the colours and the shades of meaning in these narratives?

Resilience in families facing the trauma of a suicide

Family units normally have community linkages (Lietz 2007; Ray 2004; Walsh 2006). It is the socioeconomic conditions in society that enable community linkages to support and connect different families and individuals within each family. The role of nurturing individuals to weather stresses is therefore dependent not only on the strength of the individuals in the family, but also on the linkages between the family unit and the wider community (Murray 2004). In writing on the socio-cultural contexts of suicide, Ray (2004) stated that the social arrangements and the environment in which families reside may be either supportive or destructive to the mental, emotional and psychological health of people.

When competitiveness and lack of social support is apparent, vulnerable members of society may seek a solution to their sense of isolation and disengagement through suicide (Ray 2004).

In contrast to those members of society who experience isolation, families that are able to stay connected, or to reconnect after a crisis exhibit resilience (Lietz 2007; Walsh 2006). Resilience has been defined as the ability to adapt, adjust and bounce back after life stressors, significant losses and traumas (Mandleco & Peery 2000). A further dimension of resilience is that through the adjustment following a trauma, an individual becomes more resourceful and is therefore strengthened (Walsh 1998). In being able to recover from a trauma, a person draws on strengths that they perhaps previously did not know they had. Further, in seeking assistance from others in the family or from social connections, the traumatised person gains knowledge and reassurance that they are not alone and that support is available (Lietz 2007). These attributes and outcomes are advantageous to both the individual and the family as a whole in dealing with the aftermath of a suicide. Whilst books containing case examples have been written on family systems and family functioning (Minuchin & Fishman 1981; Satir 1988; Walsh 2006), there is a dearth of research examining strong and healthy families. Bongar, Goldberg, Cleary and Brown (2000:222), lament 'one might assume that family and marital therapists have studied suicide extensively, but in fact this is not the case'.

The topic of family resilience was the focus of a book by Walsh (2006). She described the three key family processes that facilitate resilience, these being 'Belief Systems: The Heart and Soul of Resilience', 'Organizational Patterns: Family Shock Absorbers', and 'Communication Processes: Facilitating Mutual Support and Problem Solving'. The word 'process' comes to us from the Latin *processus* and means 'going forward' (Reber 1995:600). So in this sense, the 'family processes' that move forward from a trauma or loss, towards rebuilding or strengthening either the family unit as a whole or the individual members in the family, can be said to facilitate 'resilience'.

Shared family belief systems

We interpret the world through the lens of our belief systems (Walsh 2006). Belief systems do not relate only to the shared religious or faith-based systems, but also to the family history, narratives and myths built on a multigenerational past. It is through the shared family belief systems that the attribution of meaning to common experiences is interpreted. In this way decision making is guided by the shared expectations and views of the family members. For example, in a crisis, a family with close affiliations may draw together to face a shared challenge. Affirming beliefs held by the family members that encourage agentic decision making and creative problem solving can lead to mastery and growth.

Agentic decision making means that the person who is deciding on a course of action is their own 'agent of change'. Such a person would see that the locus of control (Barlow 2000) lies with them and that they are not being dictated to by others, or controlled or manipulated. Conversely, if life seems chaotic and tragedies appear to be randomly experienced within the family, the shared belief of the members of the family could encourage the family to see themselves as victims and may lead to despair, helplessness and dysfunction (Walsh 2006).

Organisational processes

The purpose of the family's organisation is to enable functioning and integration, and may be culturally defined (McGoldrick 1993). Each individual member has explicit or implicit roles that they fulfil to foster relationships within the family and with external society. The organisational processes within the family commonly have a hierarchy, which is understood by those within the family. The hierarchical order may be related to decision making about finances or other areas of order and authority within the family. A purpose of the family's organisational processes is the smooth running of the 'business' of the family, or how the various needs of the family are accommodated, such as who carries the responsibility to take care of the physical needs of family members.

The organisation processes operating within the family system are not normally static, but will change as the younger members of a family grow

in strength and understanding so are better able to shoulder more responsibility. Similarly, as the more senior family members become less able to carry out their previous role, responsibilities will devolve to others. As new members join a family, or previous family members depart the family, these organisational process will be renegotiated, either amicably or with tension. The family's organisational processes function as 'shock absorbers' to enable them to cope with problems and adverse events (Walsh 2006:83).

Open communication

The family processes that facilitate effective functioning and foster coherence are dependent on the quality of the communication within the family (Walsh 1998). Family communication is only effective when it is open and there is clarity: the family members are able to emotionally express a range of feelings such as happiness and empathy, grief and pain. In effective families, the individual members own their feelings and there is little allocation of blame between members. Shared humour is a sign of an open and healthy communication style. Collaborative problem solving results when open communication exists in a family (Walsh 1998).

A study conducted by Lietz (2007) examined family resilience in six families assessed as being high risk and who were experiencing stressors. The difficulties experienced in the families all rated as highly stressful. The study identified ten strength themes demonstrating family resilience in the narratives told by family members. It was also noted that resilience

was stage-based and the study listed the stages as survival, adaptation, acceptance, growing stronger and helping others (Lietz 2007).

Apart from those studies into family systems of adolescents who attempt or who have completed suicide (Koopmans 1995; Wagner et al. 2003) and those research studies that examine genetic and biological influences (Egeland & Sussex 1985; Roy & Segal 2001; Roy et al. 1995; Vinnerljung, Hjern & Lindblad 2006; Voracek 2006), no research studies have been identified that examine the historical family context as a precipitating factor of suicide or the family relationships subsequent to the suicide. The position that this research study takes is that there are a range of cognitive and emotional consequences relating to the experiences following a family member suiciding that are more difficult to define and isolate and can result in suicidal ideation and attempts by the suicidally bereaved.

Understanding suicidal behaviour through the prism of family functioning

Family functioning is affected not only by the family-of-origin patterning of communication style, family dynamics and role modelling, but also by genetic influences that may result in suicidality transmission. More studies have been undertaken by investigators into the familial transmission of mood disorder (Brent et al. 2004) including significant studies within a closed Old Order Amish community (Egeland & Sussex 1985), through examining twins (Roy & Segal 2001; Roy et al. 1995;

Statham et al. 1998) and also adoptions (Feigelman 2005; Hjern et al. 2002; Maris, Berman & Silverman 2000; Vinnerljung et al. 2006). This research is examined below.

Genetic and biological influences

In an examination of an Old Order Amish community, Egeland and Sussex (1985) used death records from the period between 1880 and 1980 to construct a six-generation genogram illustrating the number of suicides and psychiatric disorders identified as originating from one male ancestor, who would today be diagnosed under the DSM-IVR as having bipolar disorder. Within this family grouping, there was evidence of bipolar and uni-polar disorders, as well as anxiety and personality disorders among first- and second-degree descendants of the identified ancestor. The investigators reported that there was evidence that 'suicides cluster in families with major affective disorders' (Egeland & Sussex 1985:918). However, the authors point out that not all families with evidence of a heavy loading of affective-type disorders also show evidence of a major loading of suicidal behaviour. While this research offers some insight into the possible role of genetic factors in suicide, more research is needed to understand the way in which mental illness carries through generations and how this influences suicidal choices in some offspring.

In Australia, family clustering of suicidal deaths has been observed in Indigenous families (Capp, Deane & Lambert 2001; Elliott-Farrelly 2004; Hanssens 2008; Hanssens & Hanssens 2007; Tatz 2005). Indigenous rates

of suicide are estimated to be two or three times those of non-Indigenous suicide rates. Many reasons have been proposed for why these clusters occur among the Australian Indigenous population; however, a genetic or biological cause has not been explored. The reasons are usually considered to be social such as deprivation, loss of cultural identity and homelands, lack of employment opportunities, discrimination and high rates of substance abuse (Beautrais 1999).

The Finno-Ugrian suicide hypothesis (FUSH) explored the genetic risk factors for suicidal behaviour in the communities found in a J-shaped area from Finland to Austria. The hypothesis quoted in the Voracek and colleagues (2007:1212) study was: 'that the regional suicide rates in Romania would be positively associated with the respective regional proportions of ethnic Hungarians in the population'. This hypothesis was tested in the United States by investigating the suicide statistics in two periods between 1913 and 1932 in immigrant families who had migrated from these geographic areas (Voracek 2006). The findings from the earlier time periods correlated with the European countries where high suicide rates were reported. However, when the statistics were investigated for this same population in America in the period 1990–1994, no such correlation was found. Voracek (2006) stated that the results were ambiguous and difficult to interpret. In part this could be attributed to the results of internal immigration in America.

In a further study (Voracek, Vintila & Muranyi 2007), the FUSH was tested in Romania. The results of this study were reported to be a close positive correlation between the population of ethnic Hungarians living in Romania and the total suicide rate across Romania.

Twin studies

Earlier studies addressed the issue of genetic transference of risk of suicidality. Neurobiological studies related to suicide included the twin study of Roy and Segal (2001), which replicated an earlier study (Roy et al. 1995) and concluded that there is some evidence in the role of genetics in the suicidal behaviour of monozygotic twins. The investigators examined both monozygotic and dizygotic twins where one twin had died by suicide and found that there was a greater incidence of suicide attempts in the surviving monozygotic twin compared to the surviving dizygotic twin. Twenty-six of the surviving monozygotic twins had attempted suicide; however, none of the nine surviving dizygotic twins had attempted suicide at the time of the study.

This study was later replicated. The investigators (Roy & Segal 2001) recruited 28 pairs of twins where one co-twin of 27 of the 28 subjects had died by suicide. In the 28th set of twins, both twins had completed suicide. Of the 28-twin sample, thirteen were monozygotic and fifteen were dizygotic twins. The investigators reported that the monozygotic co-twin exhibited a stronger inclination towards suicidal behaviour than the surviving dizygotic twin. The authors acknowledged that there may also

be traumatic life experiences and psychiatric factors shared by the twins; however, they concluded that 'some influences in suicidal behaviour are genetic in origin' (Roy & Segal 2001:73).

Other explanations that may have a bearing on vulnerability to suicide were not addressed in this study (Roy & Segal 2001), such as the nature of the relationship between the pairs of twins. Was their relationship close or distant, is it easier or more difficult to love an identical twin in comparison to the love for a non-identical twin? Also left unanswered was whether or not the vulnerability to suicide was due to losing someone who looks identical to you and with whom you have shared your life.

An Australian study into the lifetime suicidal history of twins (Statham et al. 1998) carried out diagnostic interviews by telephone with 2718 adult co-twin volunteer respondents. The researchers established zygosity through self-reporting by the respondents. A suicidal-behaviour question involving suicidal thoughts, planning and attempts was asked of all respondents, and any history of parental suicide or suicidal attempt was taken. The authors reported that there was a 'ten-fold' stronger likelihood of a suicide attempt if a co-twin had also attempted suicide and this stronger association was marked in fraternal twin pairs (Statham et al. 1998:852). A contagion was probable in two cases and in another two cases where it could not be ruled out. In both fraternal and identical twin sisters, social closeness was observed through almost daily contact. A

contagion was defined as ‘spread of an activity or a mood through a group’ (Reber 1995:158).

The strongest predictor of attempted suicide by a twin where the other twin had attempted suicide was associated with mood disorders such as depression. There was also evidence of increased risk of attempted suicide by a twin if there was reported sexual or physical assault or a broken marriage (Statham et al. 1998).

Statham et al. (1998) stated that psychiatric history, the role of genetics, events that were perceived by the respondents as traumatic and other environmental factors, such as belief systems, create a complex picture of suicidality. The data analysis measured suicide behaviour and ideation, as well as depression, addiction to alcohol and childhood problems of conduct. The authors concluded that there was a ten-fold increase in the likelihood of a serious suicide attempt with identical twins if the identical twin had made a serious suicide attempt. The correlation between identical twins’ suicidality was considerably stronger than in non-identical twins.

It is not possible to examine the familial aspects of suicide without considering the possibility of genetic vulnerability and inheritability. The research into evidence gathered through genetic population studies (Voracek, Vintila & Muranyi 2007), twin studies (Roy & Segal 2001; Statham et al. 1998) and adoption studies (Feigelman 2005; Hjern et al..

2002) alert researchers to explore these questions when interviewing their participants.

Adoption studies

Research into the incidence of suicidal behaviour among adoptees enhances our understanding of the role of genetic and environmental factors on the incidence of familial transmission of suicidality. When adoption takes place, usually the children are separated from their biological relatives at birth or shortly afterwards, and therefore the adoptee children share the environmental experiences within their adoptive family but do not share their genes (Maris et al. 2000). The difficulties in teasing out the origins of problems evident in adoptees, including a higher probability for suicidal behaviour and mood disorders, have been reported in some earlier studies in Denmark and Sweden (Maris et al. 2000; Vinnerljung et al. 2006).

There are several compounding problems in understanding the incidence of suicidality in people who have been adopted. A Swedish whole-of-population study (Hjern et al. 2002) into suicidality and psychiatric illness among adoptees examined a cohort of 11,329 inter-country adoptees with 2343 siblings from a population total of 853,419 to assess mental-health disorders and social maladjustment in adolescent inter-country adoptees. The investigators assessed mental-health disorders from records of suicidal deaths and attempts, discharges from psychiatric institutions and substance-abuse records. They found that inter-country adoptees were

more likely to suicide than Swedish-born adolescents. The findings raise the question of country of origin, in that many children are adopted from impoverished countries such as Africa, Asia and South America. The authors contend that one factor may be that the children have a different appearance to the majority of the population in Sweden, and therefore may have emotional problems relating to an experience of difference and non-acceptance. They also posit that because the children may have originated from a country with lower socioeconomic conditions, there may have been deprivation in the intrauterine environment and poor biological maternal nutrition, possibly resulting in impairment of the child.

In a separate whole-of-population study in Sweden, Vinnerljung et al. (2006) investigated the risk of suicide attempts and severe psychiatric morbidity in a population of former welfare and child-protection clients, including 12,240 international adoptees and 3903 long-term-care child-clients, and compared these to a cohort of peers in the general population. The adoptee group in this study generally experienced more favourable outcomes than the child-welfare clients who were placed in out of family-of-origin care. However, 5.89% of adoptees experienced psychiatric morbidity symptoms and suicide attempts in comparison to 2.11% of the general population group.

A study examining whether adoptees are at an increased risk of attempting suicide (Feigelman 2005) was critical of the sampling and methodology used in earlier studies and questioned the earlier findings

that adoption can lead to an increased risk of attempted suicide. The self-reported data collected from in-school participants in earlier studies was cross-checked against information supplied by their parents, and it was found that 25% of the in-school respondents misrepresented themselves as adopted. Feigelman (2005) commented that the earlier studies based on the 1994 National Longitudinal Study of Adolescent Health (ADD Health) of 20,000 respondents between the ages of 12 and 24 years, 'erred in their attempt to ascertain adoptee mental health because of the complexity of the ADD Health Data' (Feigelman 2005:207). The study was a population-based study of adolescent health and sought information through self-reporting by adolescents of their adoption status. There were few differences in the rates of suicide attempts and depression between the adoptees and non-adopted adolescents.

Biochemical studies

In an editorial, Leonard (2005) states that some post-mortem studies on the brains of people who have died by suicide identified the role that low levels of serotonin in the brain plays in anxiety disorders and as a contributory factor of suicidal behaviour. Researchers also identified an increased concentration of norepinephrine in the prefrontal cortex of the brains of those who used violent means to take their lives (Leonard 2005). These changes have also been noted by researchers utilising brain imaging (Mann 2005). The role of the genetic transfer of impulsivity associated with the serotonin transport gene was commented on in the

report on the psychology and neurobiology of suicidal behaviour by Joiner, Brown and Wingate (2005). Researchers conclude that there is evidence that genetic control is indicated in the serotonergic system (Mann, Brent & Arrango 2001). The neurobiological studies suggest that inheritance of a genetic predisposition to affective disorders may be indicated in the transmission of suicidal behaviour within families (Joiner, Brown & Wingate 2005).

These studies admit that it may never be possible to ascertain one causal factor for suicidal behaviour. The wisdom of exploring previous and current generational histories of participants where a family suicide has occurred is validated by investigations where the links between biological, genetic and biochemical relationships have been explored.

Family, ecological and social environmental factors

The links between the family systems, ecological and social environmental influences and the family history of suicide has been examined in some studies.

Family environmental factors related to mood disorders

Researchers undertook a study into the offspring aged between ten and seventeen ($N = 299$) of suicide attempters and non-attempters who were evaluated as coming from high-risk families to assess 'suicide attempt history, impulsive aggression and exposure to familial environmental stressors' (Brent et al. 2002:801). The results of this study were then

reanalysed to ascertain if the risk of familial transmission of suicidal behaviour 'is greater with increased family loading for suicide attempts' and whether this transmission of suicidal behaviour 'is mediated by impulsive aggression' (Brent et al. 2003:1486). The adult children of these psychiatric-inpatient participants were recruited and the two probands of the offspring participants were attempters and non-attempters. Offspring of those who attempted suicide, and who had mood disorders, had an increased risk of suicide attempts themselves, especially if these offspring had tendencies towards impulsive aggression or had experienced sexual abuse.

In the 2003 study, which re-analysed the research examined above, the same researchers (Brent et al. 2003) sought to clarify if the risk for offspring suicidal behaviour was linked to parental suicide attempts and therefore weighted this variable. They also followed the same method for ascertaining the role of impulsive aggression. These two variables were weighted against other variables such as history of psychopathology and family adversity. The results of this reanalysis were that the strongest predictor for early suicide attempt was family transmission of impulsive aggression (Brent et al. 2003:1491). This study highlights the importance of the family history of those who died by suicide to inform those supporting the suicide bereaved. Awareness and understanding of the family history is also essential for those who work with high-risk groups, especially those with suicidal ideation or a history of prior attempts.

Human ecological model theory was the basis of a report on adolescent suicide and families by Henry and her colleagues (1993). These researchers used the ecological theory levels (Bronfenbrenner 1979), being organism, microsystem, mesosystem, exosystem and macrosystem, to categorise suicide predictors in a sample of adolescents. The authors categorised feelings of hopelessness and loneliness, problems in adapting to change, poor self-esteem, and the concurrent feelings of being inadequate and of loneliness under the organism level.

At the family microsystem level, factors such as unhealthy communication style, grief following the loss of a member of the family or friend, feeling unwanted or ignored by a parent/s, parental alcoholism and inadequate economic resources may be considered suicide risk factors. Also implicated at the microsystem level is a history of suicide by other family members and unrealistic parental expectations (which supports the findings of Chen et al. 2009), or conversely, parental abuse or neglect. Mesosystem level predictors of adolescent suicide risk included cultural identity and the problems of belonging to a cultural group that may be perceived as not valued by the dominant culture.

The exosystem-level predictors include mass-media influence and the effects of violent messages in popular culture. Henry, Stephenson et al. (1993) refer to Durkheim (1951/1897) to determine the macrosystem-level predictors in the way the individual is placed in society and drew

attention to 'anomie' or normlessness and the feeling that an individual's existence is meaningless. The authors conclude their report with suggested interventions on each of these levels that could form the basis for public policy responses.

A wide-ranging review of research literature on the biological profile of risky families was undertaken by Repetti, Taylor and Seeman (2002), and they identified risk factors in the family social environment such as relationships that were marked by aggression and discord and that were neglectful, unfeeling and non-supportive. The authors stated that such family behaviours result in vulnerability in family members, especially if there is also a genetic inheritability for poor psychosocial functioning (Repetti et al. 2002). The family's socioeconomic status was implicated in poor health and educational outcomes, family violence and physical abuse. The review covered a wide scope of mental and physical disorders, yet the report did not cover such factors as sexual abuse, parental psychopathology or affective disorders, family breakdown, addictive behaviours or physical health disorders (Repetti et al. 2002).

Transgenerational loss in the histories of suicide survivors was examined by Seguin, Lesage and Kiely (1995). The history of two cohorts of mothers who had suffered bereavement through the death of a son were examined. The one cohort of mothers had a loss caused by accidental death and the other by suicide. The data examined by the researchers included the history of early losses in the mothers' childhood. The results showed that

the mothers in the suicidal-loss group had experienced more losses, such as the change of a home and experiences of separation from family in their early childhood, than the mothers in the accident group. Data were also gathered on losses in the sons' lives, with some being separated from one or both parents for more than six months. The results suggested that there was no difference in childhood loss between the group of sons who died an accidental death and those who committed suicide.

The family environmental factors that resulted in a higher incidence of mood disorders in adolescents included a family transmission of impulsive aggression, poor communication between family members, low self-esteem in the younger generation, hopelessness and unresolved grief issues. Poverty and poorer educational outcomes were also negative environmental factors as was the family's cultural background if the family culture was different from society's dominant culture (Henry et al. 1993).

Family functioning

Whilst many studies address family functioning in relation to suicidal teenagers (for example Cottle 2000; Koopmans 1995; Wagner et al. 2003), there are few research studies that focus on the pre-history of the suicide event, or the effect of a suicide on all members of family, whether first-degree relatives of the deceased or more distant relatives. Whilst psychological autopsy of suicide studies have been undertaken (Martin 2006; Pouliot & De Leo 2006), concerns about methodological problems

have been mentioned by the authors (Gavin & Rogers 2006; Pouliot & De Leo 2006). These methodological problems relate to sample biases as the participants recruited by the researchers to give information about the deceased may be relatives, spouses and siblings, friends, co-workers, medical practitioners, psychiatrists or other professionals.

Gavin and Rogers (2006) re-examined the Cooper, Appelby and Amos (2002) psychological autopsy interviews of informers who were questioned about 84 young people who died by suicide. Gavin and Rogers (2006) held that the focus of the previous study was to establish:

> the mental health of the victim as the 'cause' of suicide [...] Possible meanings lying behind particular responses and the likelihood that personal agendas might be being aired do not appear to have been investigated during the course of the interviews; presumably because this approach did not fit with what, on the face of it, appears to be the implicit primary aim of such studies: that is, establishing the presence or absence of psychiatric pathology (Gavin & Rogers 2006:139).

The psychological autopsy studies as currently formulated reflect a Western medicinal approach, and this approach 'in epistemological terms' may be flawed (Gavin & Rogers 2006:142). They proposed that this limitation could be counterbalanced by including in the enquiry exploration into the circumstances surrounding the suicide as this would result in more holistic data.

However, psychological autopsy studies can contribute knowledge to the aetiology of suicide, including information about family patterning in the life of the deceased. This has been illustrated by examining the upbringing

of the author Ernest Hemingway—the subject of a psychological autopsy in which significant data were collected about his family of origin. This information included the punitive parenting style of his father, who was mood-disordered and who died by suicide himself. Also identified was the inconsistent and distanced mothering that resulted in Hemingway stating that he hated his mother (Martin 2006). Hemingway's literary efforts, and the recollections of family and friends and the different biographies about the author provide rich data for the psychological autopsy and illustrated the role of family functioning in fashioning and creating Hemingway's destructive lifestyle (Martin 2006). That there is a history of six suicides within four generations of this family speaks to the pervading influence of family patterning and the possibility of genetic transmission of mood disorders, addictions and suicidality (Martin 2006:353).

A recent study was undertaken into family system background in which 220 undergraduate students in Hong Kong volunteered to answer questionnaires which were designed to elicit information about family system background and suicide ideation. This study was devised to explore the mediating role between self-views and world-views in relation to suicide ideation. The study also sought to identify the role of family dysfunction, if any. The authors stated:

> Although the family system functions as an environmental force contributing to suicidal risk, how individuals perceive, process and react to such external problems is more crucial to determining the consequences of these predisposing forces (Chen et al. 2009:134).

The authors recognised that negative internal responses may occur for individuals in response to external stress. These negative internal responses may be the result of pre-existing depression, hopelessness and the level of emotional competence. Whilst acknowledging these emotional responses, the authors also examined the students' cognitive factors in relation to suicidal thinking (Chen et al. 2009:134). Family dysfunction may be involved in the formation of individuals' expectations about the world and negative beliefs about themselves. Cognitive vulnerabilities play a role in the development of 'maladaptive self-views' and 'dysfunctional world-views' and result in poor problem solving and may generate suicidal ideation (Chen et al. 2009:134). Beliefs about the world were also explored. World-views were defined as the way people understand the world and how it functions (Chen et al. 2009:134). These world-views may be general views such as social beliefs or can be derived from personal experiences and resultant social cynicism. World-views are developed by an individual's sense of control. Whether they believe that reward follows application, or have a belief in fate control, or whether they have a negative or positive view of human nature will affect their world-view.

Chen et al. (2009) concluded that families that displayed difficult communication styles and poor problem-solving skills were less able to model positive adaptive behaviours in stressful situations. Those people who hold a cynical view of society may also be biased and distrustful in

how they view human nature. Any family problems may compound this negative perception and such individuals may not trust authority figures and would be less likely to seek help when stressed. A pessimistic outlook would not encourage the application of hard work to result in a positive outcome (Chen et al. 2009).

Family life and family patterning exist in a continuous stream of relationships emanating from a distant past beyond the memories of the current members of the family and flowing forward into future generations. Rarely does a suicide occur in a family without some history of interpersonal difficulties or relational dissonances (Bongar et al. 2000). Grief consequent to a suicidal death affects all those in the family and all members will experience grief differently depending on the closeness of the family member to the suicide-deceased person. The subject of grief following suicide is discussed as a separate topic in the following chapter.

Family relationships through the life span

Adolescence is a time when the young person faces a multiplicity of changes including biological changes, the increasingly intellectual demands of education, as well as confusing feelings, identity issues and emotions (Murray 2005). It is a period when the desire for independence is characterised by the increased need to identify with peers. A protective factor at this time is family connectedness (Hall-Lande, Eisenberg, Christenson & Neumark-Sztainer 2007).

An American quantitative study, in which 4746 adolescents from 31 post-primary schools answered 221 questions in a survey (Hall-Lande et al. 2007), focused on peer relationships, school connectedness, family relationships, psychological health and school achievement. The study found that a connection with the family was one of the strongest protective factors, particularly for girls who were socially isolated. The findings highlighted the significance of family connectedness to the adolescents' psychological health and were seen as a protective factor against suicide ideation (Hall-Lande et al. 2007).

It is accepted that there is a complex interactive process involved in shaping the development of a young person's personality (Ge & Conger 1999). The interactive influences include genetic inheritance, family relationships, dispositional characteristics, community and educational connection and the identity within peer groups. This interplay between the influences of biological, social and dispositional characteristics can affect whether or not a young person moves towards competency or distress in dealing with the developmental challenges of adolescence (Ge & Conger 1999).

The importance of connectedness within the family is one of the contextual factors commented on by Portes, Sandhu and Longwell-Grice (2002) in their examination of adolescent suicide within an Eriksonian framework. The authors question whether adolescent suicide occurs when the young person has experienced an inability to master staged developmental tasks

as outlined by Erikson (1963). The formulation of an individual's identity takes place initially within the family, yet the authors claim that the institution of the family has been weakened in modern society. 'For suicidal individuals, the family and society may have failed to provide the necessary conditions for sound development' (Portes et al. 2002:806).

The problems that teenagers have experienced within their families have been identified as inappropriate boundaries or role confusion, or the family relationships becoming more conflicted, less expressive, unreliable or disorganised (Bongar et al. 2000). A quantitative study of 26 suicide-bereaved children and adolescents that explored parental and family functioning (Cerel, Fristad, Weller & Weller 2000) described three categories of families: (a) functional families, (b) chaotic families and (c) encapsulated pathology families. It was reported that 85% of the suicide completers had expressed symptoms of, or were diagnosed with mental illness. In regard to family stability, the suicide-bereaved families were more impaired than the non-suicide-bereaved families and reported more parental separation or divorce.

Yet after experiencing the tragedy of a parent suiciding, the majority of the bereaved children in a qualitative study (Ratnarajah 2006) expressed the longing for a stable, secure, supportive family. However, in most cases this was not the outcome of the parental suicide as in many cases the children also lost their former home, some having to live with

grandparents or other relatives. For a few, they never lived within the small family unit again.

An additional issue that may carry with it suicide ideation in young people is that of identity issues including that of sexual orientation. When young people are seeking their identity including that of a gay identity, to be confronting homophobia can be very damaging. Whether this occurs in their educational institutions, socially or within their own family, a perceived non-acceptance of a developing gay identity can result in a young person developing self-protective behaviours and living 'curtailed lives' (Gottschalk & Newton 2009:158). A study reported parental support was a protective outcome for gay, lesbian and bisexual (GLB) students against homophobic bullying and teasing experienced in schools (Espelage, Aragon & Birkett 2008). Those GLB students, or those who were questioning their sexual identity, and who had parental support, had less depression, suicide ideation and a lower incidence of alcohol and illegal-drug use than those who did not experience positive parental support (Espelage et al. 2008).

There has been a significant body of writing that links suicidal behaviour in teenage years to family processes. In order to understand the influences on adolescents who are exhibiting suicidal behaviour or ideation, family patterning and connectedness must inform counsellors and therapists working with at-risk young people to explore family-of-origin history and functioning style.

Aspects of family functioning seen as damaging

The family's function is to support individuation of family members, while having a family structure and functioning pattern that nurtures the youngest members of the family and is supportive and fulfilling for the adults (Minuchin & Fishman 1981). Those within the family structure see themselves as an individual unit which interacts with other individuals in the family group. There are family 'rules' which govern how this interaction takes place. Whilst in healthy families there are freedoms that allow the members to follow their inclinations, there are other interactions where a warning may be delivered—'be careful' or a clear message of 'no go, or stop'. These are the areas where damaging experiences will result. Not all members of a family have equal power and the youngest are the most vulnerable. Those members who transgress these boundaries experience anxiety, guilt, shame and possibly banishment and estrangement (Cottle 2000; Koopmans 1995; Minuchin & Fishman 1981). Where family cohesion and adaptability are low and negative, or insecure parent–child attachment and relationships exist, the consequences will be damaging for the youngest members of the family. Child maltreatment, be it emotional, physical or sexual abuse, or the failure to provide a nurturing environment will result in damage for the victim (Wagner et al. 2003). If there is a family history of anti-social behaviour, law breaking or alcohol and substance abuse, the family patterning is seen as damaging. Studies of adoption, or of the child not living with biological parents, often show a

history of family dysfunction. Details of previous studies commenting on damaging family patterning behaviours follow, highlighting areas including communication and deficits in problem solving.

Family communication and problem-solving deficits

The lack of clear communication amongst family members, especially the inability to express emotions or engage in problem solving, indicate damaged family interactions (Wagner et al. 2003). In such families, flexible family problem solving is not possible, especially if there is evidence of hostility between individuals. A young person in such a family may be led to suicidal behaviour in a desperate effort to communicate, because all other avenues of communication are discouraged or blocked (Wagner et al. 2003).

Open communication between family members facilitates collaborative problem solving, which is impossible without the sharing of ideas and feelings (Walsh 1998). Where communication is avoided, discouraged or blocked, risky behaviours such as suicide attempts may be an attempt to communicate feelings of distress or isolation (Wagner et al. 2003). Where differences among the relatives are not tolerated there is little family cohesion. Family secrets are established between the family members where there has been experience of fears and anxieties that are not safe to share. In such a family conflicts can escalate out of control (Walsh 1998).

Role confusion

Role confusion may be a contributing factor in teenage suicide ideation (Cottle 2000; Koopmans 1995), as the inability to communicate effectively with important others in the family can allow for a double-bind situation to exist through the delivery of contradictory messages. The basic needs of the developing family member cannot be met when contradictory messages regarding the nature of the relationships are present (Cottle 2000; Koopmans 1995).

Scapegoating

In a family where one individual becomes the focus of blame for the family's problems, this blamed person experiences the other members of the family as hostile and rejecting. They may interpret their behaviour as a desire to be rid of them. There may be poor communication and inadequate models of problem solving in this family. A person who has suffered as the scapegoat in the family may come to believe that they deserve punishment and self-destructive behaviour may result (Cottle 2000; Wagner et al. 2003).

Attachment issues

The wish to reunite with a deceased family member may be the motivation of a suicide attempt in some cases. The suicide action may be an attempt to elicit more caring support from a surviving caregiver, or to cause the degree of pain that the bereaved attempter feels. Wagner and colleagues

(2003) suggest that such behaviour could be recognised as insecure attachment.

Parental psychopathology

The linkage between parental psychopathology and suicidal behaviours in teenagers is not known. However, the possibility of an inherited genetic influence has been suggested. Environmental factors such as parental modelling of suicidal ideation or other self-destructive behaviours have also been cited as being influential. There may be an inherited mood disorder, such as depression, that may increase the risk of suicidal actions. Poor family coping methods and harsh or contradictory parental behaviour may also be evident where parental psychopathology exists (Wagner et al. 2003).

Earlier studies such as the extensive research literature on youth suicide prevention undertaken by Gould and Kramer (2001) examined, with other factors, the association between parental divorce and youth suicide and on parent–child relationships. The researchers reported that those deceased by suicide had fewer opportunities for adequate communication and less satisfying relationships with their parents. In two large controlled studies in the New York and Pittsburgh area, Gould and Kramer (2001) reported no evidence of severe punishment or negative interactions between the children and their parents in the New York sample. Yet in the Pittsburgh study, the same researchers (Gould & Kramer 2001) state that the suicide victims were more likely to have experienced physical abuse and parent-

to-child discord. Gould and Kramer (2001) concluded that future suicide-prevention strategies will need to focus on multiple risk factors that interact for these at-risk youth.

Brent and colleagues (2002) surveyed the offspring of suicide attempters assessed as having mood disorders. These surveys were compared to the surveyed results of a cohort of matched mood-disordered non-attempters. The offspring of suicide attempters were more likely to experience lower cohesion in the family and exhibit lower adaptability. In this study, the adult children of suicide attempters who were assessed as mood-disordered were found to have a six-fold increase in the likelihood of attempting suicide themselves. The adult–children's mood disorder identified in this study was aggression linked to impulsivity. There were also examples of sexual abuse in the family patterning. The researchers stated that their research data does not suggest imitation as the reason for the familial transmission of suicidality as in some cases the offspring's suicide attempt preceded the parent's attempt (Brent et al. 2002). This supports twin research reported earlier (Roy & Segal 2001) where family role modelling of suicide was not found to be contributing.

Alcohol and substance abuse

Alcoholism and other forms of substance abuse have been indicated as contributing to the familial transmission of suicide risk factors (Brent et al. 2004; Diamond & Josephson 2005; Hjern et al. 2002). Brent and colleagues (2004) recruited 141 suicide attempters from out-patient clinics

and interviewed a cohort of 285 offspring of these suicide attempters to ascertain mood disorders among these offspring. The offspring with mood disorders had higher lifetime rates of alcohol and substance abuse as well as other anxiety disorders and suicide attempts than the offspring without mood disorders (Brent et al. 2004b). While the authors were able to describe the relationship between mood disorders and impulsivity, they stated that causality could not be inferred. In this study examining the transmission of suicidal behaviour, the researchers reported that the children of parents with mood disorder were likely to have anxiety disorders, substance-abuse issues or to attempt suicide themselves.

A ten-year update of family-based treatment research by Diamond and Josephson (2005) into at-risk adolescents found that there were risk factors for adolescent suicide where substance abuse existed or cohesiveness in the family was low. However, the authors also stated that parental disapproval of adolescent drug use was protective for adolescents at risk. The abuse of alcohol and drugs has also been found to be an indicator of maladjustment across different cultures (Hjern, Lindblad et al. 2002)

Corporal punishment inflicted on children

The damaging consequences of corporal punishment experienced in childhood are linked to later depression and suicide ideation (Straus 2001; Straus 2000). This author held the opinion that the lack of empirical research into this subject was the result of 'selective inattention', similar

to the earlier invisibility of wife-beating (Straus 2000:60). In an earlier study, the 1985 National Family Violence Survey, (Straus & Gelles 1986 cited in Straus 2000), over 6000 respondents were interviewed by telephone and were asked the following: 'Thinking about when you yourself were a teenager, about how often would you say your mother or step-mother used corporal punishment, like slapping or hitting you?' (Straus & Gelles 1986:62).

Straus and Gelles (1986:72) concluded that 'psychological damage to children that results from being physically attacked by a parent is not restricted to the extreme forms of violence known as "abuse" but also applies to the ordinary and legal punishment of children'. Straus and Gelles (1986:72) stated that the findings indicated that there is a relationship between corporal punishment suffered in childhood or adolescence and depressive symptoms and suicidal thoughts, 'net of a number of variables known to be related to depression and suicidal thoughts'.

Resilient families

Families that display resilience after a traumatic event are those with a habit of nurturing family strengths. These strengths have been described as insight, boundary setting, creativity/flexibility, humour, internal and external social support, a morality or spirituality, appraisal of problems and good communication between members of the family (Lietz 2007).

Earlier studies into family resilience sought descriptions of situations in which family members were able to function at a competent level, despite facing circumstances which were assessed as high risk as the family had experienced an adversity (Lietz 2007a). This study, which collected both quantitative data via a survey from 182 respondents and qualitative data from six families, did not state whether they were able to access participants who were dealing with a family member suicide. Lietz (2007a:577) stated that the research aim was to seek information that could be used to support families from a 'strengths' rather than from a 'problems view' perspective. The factors that were used to identify family strengths were quoted from Wolin and Wolin's (1993) qualitative study:

a. *insight,* or the capacity to gain understanding about your situation.
b. *initiative,* or the willingness/ability to take charge of one's circumstances
c. *independence,* or the ability to draw a boundary between one's self and unhealthy activities
d. *creativity,* or the ability to find multiple solutions to difficult problems
e. *social support,* or the presence of at least one significant support person
f. *humor,* or the ability to be lighthearted and laugh even when things are difficult
g. *morality/spirituality,* or having a value system that helps guide a person in making decisions that are healthy.

There was also scale of protective factors incorporated into the study; these being (Lietz 2007a):

a. *flexibility,* or the ability to adapt to changing circumstances
b. *appraisal,* or the meaning that a family attaches to a negative experience
c. *social support,* or the support systems that help a family to cope with difficulty.

The findings from this study confirmed that whilst the reduction of risk factors was important, strength building was also a strategic method for assisting a family in stressful or high risk circumstances. The qualitative component of this study considered family systems theory. The relationships between family strengths and family functioning assessed how family strengths were important in identifying family resilience. It identified five stages experienced by the families in dealing with the difficulties they were experiencing (Lietz, 2007b:148)

a. *survival,* a time in which these families took one day at a time
b. *adaptation,* changes the family made to incorporate the new situation
c. *acceptance,* coming to adopt their new family situation as a new way of life
d. *growing stronger,* the recognition that the family members were growing stronger through the difficulties experienced
e. *helping others,* a need to give back and hep others.

These five stages seen as evidence of a strength based approach to resilience was also identified in the suicide bereavement studies of Feigelman and Feigelman (2008). In this study, the importance of social support was identified and this again is in agreement with much of the literature about the benefit of suicide bereavement support, whether it be through belonging to a support group or through individual family or professional support.

A resilient family has learnt how to reconnect with each other after the inevitable conflict. If a family has experienced conflict that has been intense it is not always easy to reconcile and (re-)learn mutual trust. The

process may then be gradual and will depend on each individual's will to reconnect.

Conclusion

The complexities in families that do not display resilience after trauma are various and may have their genesis in the genetic histories of its members. Those families which have a history of impulsive aggression would not be able to develop trusting relationships (Brent et al. 2003), nor would families in which there was boundary confusion (Cottle 2000; Koopmans 1995) or a punishing or blaming family culture (Chen et al. 2009; Koopmans 1995; Straus & Paschal 2009). Families that do not have good internal social support, or are closed and not able to link into external social support, may not have the ability to heal after a traumatic event (Henry et al. 1993). Similarly, families in which members try to self-medicate on alcohol, illicit drugs or have other addictions would be deficient in problem-solving skills and may not have supportive relationships within the family (Diamond & Josephson 2005; Hjern et al. 2002). The suicide of a family member is one of the most challenging traumas that a family can face. Those that can communicate and share problems will be much better able to draw strength from each other than those who feel silenced within their family.

Chapter 3

Literature review 2: After a suicide

Introduction

This chapter examines previous research regarding grief reactions following a suicide in the family. Grief has been described by Bowlby (1979) as a complex emotional response to loss, particularly the loss of a primary attachment figure. This description is in agreement with that given by Forster and Murray (2007), who also speak of grief involving internal and external processes of adaptation in dealing with loss. This grief response is described as a state of being bereaved, which Reber (1995) identifies as a state of suffering that follows the loss of someone significant, especially where the relationship was important both personally and emotionally. Walsh and McGoldrick (1991:1) commented on the family systems perspective on loss and stated that:

> loss can be viewed as a transactional process involving the deceased and the survivors in a shared life cycle that acknowledges the finality of death and the continuity of life. Coming to terms with this process is the most difficult task a family must confront in life.

Grief following death of a family member

Grief following the suicidal death of a family member is especially traumatic and may lead to a post-traumatic response or complicated grief (Beautrais 2004; Hawton & Simkin 2003; (Kristjanson, Lobb, Aoun & Monterosso 2006). Complicated grief is unresolved grief, or a grieving

process that has become 'stuck' with a chronic state of mourning as its result (Neimeyer 2000).

Earlier theorists outlined models of grief in which 'tasks' were seen to be followed by the bereaved in the process of moving towards a re-engagement with life and the integration of the loss (Kubler-Ross 1973; Rando 1992–93; Worden 1999). Whilst there are similarities between these models, Rando (1992–93) held that there were six processes in grieving, while Worden (1999) described four mourning tasks to be undertaken. Kubler-Ross's (1973) five stages were originally conceived as five stages a terminally ill person experiences when awareness grows of their inevitable death. These stages are denial, anger, bargaining, depression and acceptance. There was acknowledgement that these same stages are experienced by those grieving the loss of a loved one (Kubler-Ross 1973).

The purpose of Rando's processes (1992–93) and Worden's (1999) tasks were the relinquishing of the old assumptive world, recognising the loss and recreating a new assumptive world without the deceased. This outcome of Rando (1992–93) and Worden (1999) (being the resolution of the grieving process) is in contrast to the aims of those who seek to maintain a continuing bond with the deceased, as is the custom in some Eastern cultures (Stroebe, Gergen, Gergen & Stroebe 1992). In such cases, the widow of a deceased husband may consider what she believes would have been her husband's intentions in any decisions. Similarly, in Western

culture, bereaved children maintain a sense of the presence of a deceased beloved relative by keeping treasured keepsakes or holding imaginative conversations with them (Silverman, Nickman & Wordern 1992; Silverman & Worden 1992).

Research on the impact of a suicide on family members suggests that some bereavement issues are experienced more intensely than bereavement following other types of loss (Bailley, Kral & Dunham 1999; Beautrais 2004; Callahan 2000; Clark & Goldney 2000; Hawton & Simkin 2003; Jordan 2001; Kovacs & Range 2000; Sands 2008; Seguin, Lesage & Kiely 1995). More problems are experienced by the suicide-bereaved family members including feelings of guilt, blame, personal responsibility, abandonment, rejection and anger (Ellenbogen & Gatton 2001). There is also a greater need to find meaning in the death and to seek an answer to the inevitable question of 'why' (Jordan 2001; Sands 2008). The conclusion drawn by Jordan (2001) in the review of suicide-bereavement literature was that suicide-bereaved family members experience a range of cognitive and emotional consequences, such as, depression, self-blame, guilt, anxiety, shame and post-traumatic stress. They are also more likely to experience suicidal ideation or suicide themselves (Jordon 2001; Mitchell, Kim, Prigerson & Mortimer 2005).

Neimeyer, Prigerson and Davies (2002) reported that it is not unusual for individuals to suffer complicated grieving after suicide of a family member as the suicide challenges the survivor's sense of self. A study of parental

grief experiences following the suicidal death of a young adult child found that the parents acknowledged grief as a way of staying in connection with their dead child as it was a vehicle for remembering (Maple 2005). In contrast, Ellenbogen and Gatton (2001) reported that few studies found that grief following a suicide was markedly different to grief following other types of losses. Similarly, Callahan (2000) proposed that the increased distress of the suicidally bereaved was through a combination of post-traumatic stress and grief, rather than the suicidal grief in itself being different to grief following other types of loss.

A quantitative study into the grief experienced by survivors of suicide (Mitchell, Kim, Prigerson & Mortimer-Stephens 2004; Mitchell et al. 2005) concluded that the nature of the relationship the family member had to the deceased was a major factor in determining whether high levels of complicated grief were experienced. The investigation aimed to ascertain if close relations to a suicide-deceased family member were more likely to suffer from complicated grief than more distant relatives. Close relationships predispose the suicide bereaved to complicated grief outcomes, and complicated grief was a predictor for increased suicide ideation and negative health outcomes. However, this study did not solicit information about memories of the relationship or the family patterning and dynamics leading up to the death. The relationship between the bereaved and the deceased and the implication of the decision to die for the bereaved family member were also left unexamined.

A neurobiopsychosocial model of grief

Mann (2007) stated that suicide attempts are related to major kinds of psychiatric disorders and the literature on the neurobiopsychosocial aspects of grief is reviewed here as it provides a useful context for this study. Psychological autopsies carried out after suicide in the United States have indicated that over 90% of people who completed suicides had a psychiatric disorder. Mann (2007) contrasted this to Durkheim's theory (1951/1987) that suicide was a consequence of social factors. He went on to say that the psychiatric illness was evident for a period prior to the suicide and that the illness was left untreated at the time of the suicide. During post-mortems he examined the brains of those who died by suicide and reported that there were indications of low serotonin levels in the brains of the deceased. This low serotonin level is implicated in impulsivity and reduces the ability of the prefrontal cortex to govern impulse control. A depressed subject with low serotonin levels may be more likely to respond impulsively to the urge to suicide (Mann 2007; Mann & Currier 2007). As Mann, (2007) argues: Those grieving a suicide death may also have inherited this compromised serotonin function and therefore be more prone to a more difficult grief reaction and impulsivity.

Children's grief

The reactions of a child to the death of a family member is dependent on many interacting variables (Forster & Murray 2007). These include the ways in which the inner world of the child is constructed and the child's

ability to make meaning of the death (Silverman & Worden 1992). Little experimental research has been undertaken to assess the effectiveness of support for children bereaved by the loss of a family member (Goldney & Berman 1996; Mitchell et al. 2006 Nadeau 2003; Stoppelbein & Greening 2000). This is despite evidence showing that appropriate intervention can decrease negative feelings and assist in meaning making for those who are suicide bereaved (Goldney & Berman 1996). Researchers have difficulties with the concept of designing an intervention study, recruiting an appropriate sample and then denying treatment to some at-risk participants (Goldney & Berman 1996). As a result, there have been few potentially useful interventions undertaken by researchers.

Pfeffer and colleagues (2002) undertook a study assessing the efficacy of an intervention that aimed at evaluating any decreased suicide-bereavement symptoms among selected children over a year. Thirty-two children received the intervention support for bereavement, but only nine children were retained in the non-intervention group. Intervention effectiveness was indicated by lower anxiety, but post-traumatic stress disorder (PTSD) symptoms remained after the intervention. The non-intervention children showed continued depressive symptoms and had an increased anxiety level compared to those in the intervention group.

A review of research studies carried out by Kuramoto, Brent and Wilcox (2009) investigated the impact of parental suicide on children and adolescents. The authors stated that there was inconsistent evidence

relating to the impact on the young offspring of parents who had died by suicide and recommended that further study be carried out to identify whether this impact was different depending on whether it was the father or the mother who had died (Kuramoto et al. 2009:149).

A recent retrospective qualitative study used interviews with ten adults who were bereaved by the suicide of a parent when they were children or young adults to assess the impact of parental suicide (Ratnarajah & Schofield 2008). Three key narratives were reported by the authors: the pre-suicide stories, the impact on the family of the suicide and the participants' later relationships and experience of family. In 'pre-suicide stories' the participants spoke about their family life, often discussing the history of up to three generations. The family-of-origin history enabled the participants to comprehend their own past and the formation of their self-identity. There were stories of alcoholism, family violence and abandonment. The 'suicide' story referred to how the participant heard of their parent's suicide. A common story saw the children and young people left to grieve alone, with support offered to only one informant. The children suffered many secondary losses: many lost their home; some were placed in orphanages; other children lived with grandparents or with their surviving parent; and one child was placed with strangers and experienced sexual abuse (Ratnarajah & Schofield 2008). The participants' adult lives were explored, particularly their own relationships. Many spoke of their need to try to recreate a family and how they had married young and inappropriately. These marriages did not last and for some the

past history of abandonment was re-experienced. Of the ten participants, four spoke of their own suicide attempts in adult life. Resilience was attained by other participants as they sought education and created their own self-identities as adults (Ratnarajah & Schofield 2008).

Bereavement following parental suicide was perceived as being different from other forms of bereavement in an Israeli qualitative study (Avrami 2003, 2005). Survivors spoke of a parent's suicidal death as a 'lower ranking position in the hierarchy of causes of death' (Avrami 2005:74), with participants stating that they would have preferred their deceased parent to have died in the war or in the holocaust. Due to cultural elements in the suicidal bereavement of these participants, there was a need to keep the cause of death a secret due to feelings of shame. The author also reported the fear that other members of the family may also become suicidal when they reached the same age range as their deceased parent at the time of their death. This additional cultural meaning of parental suicide made the grieving especially difficult for the bereaved children.

While there have been very few research studies into the grief of children following a parent's suicide, there have been a number of autobiographical accounts highlighting the effect on children who lack post-suicide support or intervention. These accounts, written by adults reflecting on their childhood experiences, highlight the bewilderment and isolation of the bereaved child, especially if they were discouraged from speaking about

their feelings (Gaita 1998; Hammer 1991; Prue 2006; Stimming & Stimming 1999). If these children attempted to speak about their feelings it was common for them to be shut down as the topic was avoided by their remaining family members. In contrast, another author speaks of the support that he was able to access after his mother died by suicide (Tim 2006). The need for postvention support, especially for children bereaved by suicide, is documented in the report from Baton Rouge Crisis Intervention Centre (Campbell 1997).

The lack of support is demonstrated in the autobiographical book written by Gaita (1998), in which he wrote of parental divorce, then of his mother's partner's suicide and then of his mother's suicide. The author lost not only his mother, but a beloved friend in her partner and also his two half-sisters, who were subsequently adopted by strangers. At the time when these tragedies happened, there was little understanding of psychiatric illness. Other than the close and loving relationship between father and son, no type of postvention support was available to this family. The damage from cumulative losses resulted in the father becoming depressed and psychotic in later life. This story exemplifies the notion that the most effective postvention support can be a close and supportive family relationship.

Grief following spousal suicide

Agerbo (2006) undertook a whole-of-population study in Denmark of spousal grief following a partner's suicide to examine if there was an

upper limit to grief, which when exceeded, can lead to mid-life suicidal behaviour (Agerbo 2006). This study found that increased mid-life risk of suicide is associated with spousal admission to psychiatric hospital, regardless of whether it is the husband or wife admitted for psychiatric care. Spousal death, whether through suicide, natural or accidental causes also increased the rate of suicidality for the surviving spouse. Spousal suicide indicated a higher risk factor for the surviving partner than death from other causes and this was more pronounced in surviving men than women.

The sequelae to spousal suicide are eloquently explored by Watford (2008), who undertook an autoethnographic study into the events preceding her husband's suicide, the manner of his death and what followed afterwards for herself and her children. That her reactions following his death were the result of the extreme abuse she and her children suffered at the hands of her mentally ill and dangerously psychotic husband resulted in her grief experience differing greatly from other spousal suicide-bereavement reports. She quotes Shneidman (1972) when she uses the word 'prodromata' to refer to the events preceding a suicide and states:

> Prodromata, event, and sequelae. They're all of a piece. They can't be taken separately. How can what happened before not affect how we feel after??? How can we lump all survivors together, just because they experienced the suicide of another? (Watford 2008:357).

Grief following sibling suicide

The unique grief of losing a sibling to suicide was the focus of a book written by Linn-Gust (2001) following the suicide of the author's older

sister. She highlights the special needs of people mourning the suicide death of their sibling. Attention was drawn to the common history that siblings most usually share. With the loss of someone who shares the whole of life memories, the surviving sibling/s can feel that they have been deprived of the relationship that they would normally expect to have for the rest of their lives. Bereavement support is frequently offered to the parents who have lost a child to suicide, leaving the other children in the family unsupported and disenfranchised. Linn-Gust (2007) made a special plea that aid be directed to assist the sustaining of the whole family unit. The message that siblings bereaved by the suicide of a brother or sister are the 'forgotten bereaved' (Dyregrov & Dyregrov 2005:714) supports the comments of Linn-Gust (2001).

A qualitative study interviewed six teenagers who had lost a sibling through sudden death, with two of the deaths from suicide (Forward & Garlie 2003). This study examined the grief journey the teenagers made in their search for new meaning following the death of their brothers. The authors identified a five-stage process: finding out about the death; initial feelings of numbness; working through the pain; turning the corner; then either ending the search for meaning, which left unresolved pain, or finding a meaning in the death (Forward & Garlie 2003:34). All of the participants in this study identified their search for meaning in the death as a core response. The participants reported that they did not turn to their parents for support and hid the full extent of their pain as they felt

the need to protect them (Forward & Garlie 2003:43). The bereaved teens instead looked for support from their peers, especially those who had suffered a similar loss. The teenagers reported that they were changed forever and that they recognised the fragility of life. Their adjustment process was focused on rediscovering who they were, and in this journey of adjustment, they did not turn to their teachers or counsellors for support (Forward & Garlie 2003:47).

Sibling suicide bereavement was also investigated by Dyregrov and Dyregrov (2005). Following the death of their sister or brother, the siblings expressed feelings of shock, bewilderment and disbelief. They subsequently experienced depression and anxiety and they spoke of being afraid because of the unusual reactions they had. The research identified these feeling as related to post-traumatic stress. Some reported their own suicidal ideation and their experience of self-blame and consequential guilt, stigmatisation and feelings of rejection by their deceased sibling. Those siblings who were residing with their parents at the time of the death reported a higher level of distressing affective reactions than those who were living independently. Some spoke of being aware of earlier suicidal attempts by their deceased sibling and this generated guilt that they had kept this a secret from their parents. Some also felt disenfranchised and forgotten because most support focused on their parents.

Older siblings were involved in supporting their parents and believed that the death of their sibling was felt more strongly by their parents than themselves. Younger siblings expressed their inability to share their grief with their parents as they were trying to protect them, but some felt burdened by their parents' anxiety and thoughts that they too might suicide.

Dyregrov and Dyregrov (2005) identified that the bereaved siblings were suffering from post-traumatic stress symptoms, especially if they had discovered their sibling's body. Their feelings of marginalisation were expressed in the words 'we are *only* siblings' (Dyregrov & Dyregrov 2005:719). That the siblings were 'forgotten' following the suicide was also expressed by their parents.

Support for bereaved siblings came from their peer support network (Dyregrov & Dyregrov 2005), but some felt that after some time their friendships had changed and this was another loss. Limited community support was available for the bereaved siblings, especially for the younger siblings who showed some reluctance in asking for help. Older siblings who had formed new families were found to have coped better than younger siblings. Overall, the findings were that siblings were inhibited about expressing and sharing their grief with parents because of communication barriers. Both the parents and their other children were protective of each other and therefore withdrew so as not to be a burden on each other (Dyregrov & Dyregrov 2005).

Parental grief

Murray (2001; 2004) spoke of the particular difficulties that parents have when a child dies. The nature of parental bereavement following the suicide of a young adult child was reported by Maple and colleagues (2007), who interviewed 22 parents of young adult children who died by suicide. The study reported differing grief responses by the bereaved parents depending on their state of preparedness for the death of their child. Three differing states of preparedness were identified.

> (1) Living with a suicidal child: a turbulent-relief plot; (2) We never thought that suicide would happen to us: a tragedy plot; and (3) I didn't recognize the signs: a reflective plot (Maple, Plummer, Edwards & Minichiello 2007:129).

In the first of these narrative plots, the parents spoke of the pain and suffering of their children prior to death, and of their own desperate (and most often futile) attempts to access help for their mentally ill child. Some spoke of a sense of relief that their child found peace in death. The second of the narrative plots speaks of the tragedy of the unexpected suicide of their child—the shock, the bewilderment at the choice their child made and their inability to find a reason for their child's decision to end his or her own life. The third narrative plot speaks of the parents who, while in retrospect are able to acknowledge their child's problems or distress, did not recognise the depth of their child's distress prior to their death. The feelings of guilt were a significant part of these parents' grief (Maple, Plummer, Edwards & Minichiello 2007).

The narratives that the bereaved parents constructed about their child's death determine the nature and extent of their grief reactions. The parents who had lived with the anxiety of the threatened suicide had begun their grief journey prior to the death, whilst those parents for whom the suicide was totally outside their expectations had experiences of traumatic grief. Those parents who were able to identify the indications of suicide ideation in their child after the event have sought to understand the preceding story of their child's decision to die. All of the parents who took part in this study showed a heightened emotional reaction to the loss, regardless of the length of time between the death and the interview. The need to create a narrative about, or explanation of their child's death in a way that made sense to them was an imperative for all parents interviewed, but not all were able to achieve this (Maple et al. 2007).

An English study examining how parents make sense of their sons' suicides (Owens, Lambert, Lloyd & Donovan 2008) took the form of semi-structured interviews with the parents of fourteen young men who had died by suicide between the ages of 18–30 years. This study found that the parents portrayed their sons' deaths in one of two ways relating to moral responsibility, with the number of parents falling evenly between the two. One narrative saw that their sons were victims of outside forces which cruelly destroyed them. The other narrative saw their sons as agents of their own damaged lives. This latter narrative was described as 'he ruined his own chances' and 'he pushed himself too hard' (Owens et al. 2008:246,

248); whereas the first of the two victim narratives saw them as victims of malevolent intent and social disadvantage—'she drove him to it' and 'the system let him down' (Owens et al. 2008:241, 244). The authors reported that in seeking meaning out of their sons' deaths, the interviewees were also struggling with their own narratives as parents:

> Our findings show parents struggling to reconstruct their own lives and identities in the light of this hideous event. Although asked explicitly to account only for the actions of their sons, they clearly felt called upon to account equally for their own actions and to explain how, within the context of the family *they* created, such a thing could have happened (Owens et al. 2008:250).

Dyregrov and Dyregrov (2005), in a different study exploring sibling bereavement, reported that eighteen months after the death of their child, 128 parents in their sample identified that they were still suffering from physical problems including somatic symptoms as well as psychological and social distress. The 128 parents were drawn from a sample of 232 parents and 90 siblings from 140 families (Dyregrov & Dyregrov 2005:718). The psychological problems were anxiety, depression and an inability to operate in a social setting. Over half of the parents reported symptoms of post-traumatic stress. The parents handled their distress by withdrawing and were preoccupied with intrusive thoughts about their deceased child, which included longing and searching for the child. These consequences demonstrate complicated grief in 78% of the bereaved parents (Dyregrov & Dyregrov 2005:718).

An American 2009 study in which surveys were collected from 462 parents who had lost a child through a suicidal death explored many different

areas of interest (Feigelman, Jordan & Gorman 2009). Questions related to postvention support and experiences that were perceived as damaging, stigmatising or not meeting their expectations. The authors also explored the parents' experience of personal growth following the death of their child (Feigelman et al. 2009) and differences in the bereavement experience dependant on how the child died (Feigelman, Jordan & Gorman 2008–2009). This survey was also completed by 58 parents whose child had died from other sudden causes such as car accidents, homicide or drug overdoses. A further sample of parents who had lost a child through natural death also undertook the survey. More than half of the bereaved parents were found to have experienced harmful comments or responses to their loss from other people (Feigelman 2008:2). Over half of the respondents also reported strained family relationships.

Personal narratives written by bereaved parents (Groenhuizen 2006b; Wooley & Meemeduma 2006) are not usually subjected to the rigour of an experimental study (McIntosh 1999) or published in a peer-reviewed academic journal, but they contain rich and detailed information for those personally affected by the grief of losing a child to suicide. The motivation to tell the story of the deceased child and the circumstances surrounding the decision to end a life by suicide comes in most cases from the parent's desire to have something worthwhile emerge from their tragic loss. The stories are told with the intention that others grieving such a loss may find comfort in knowing that they are not alone.

Some researchers are also suicide bereaved and are motivated to make a difference in the field of suicide prevention and postvention. The need for a dialogue between suicide survivors and professionals who work with suicidal clients or the suicide bereaved has recently been argued (Myers & Fine 2007). Clinicians working in the mental-health field are often survivors of the suicidal death of some of their clients. However, Myers and Fine (2007) make the point that those clinicians working in mental health with suicidal clients and researchers in suicidology come to the subject voluntarily, whereas no one volunteers to become a suicide survivor.

> Whatever the lens, cognitive or experiential, thinking or feeling, separate or integrated, wanted or unwanted, our field needs both. Both are essential to advance our understanding and preventive efforts in suicide (Myers & Fine 2007:120).

The family experience of a suicidal death

Each member of the family experiences a suicidal loss differently depending on their relationship to the deceased, whether they are parent, spouse or sibling (Linn-Gust 2001). It is also dependent upon the quality of that relationship and whether there were any tensions, discords or other 'unfinished business' between the family member who died by suicide and the one grieving the death (Linn-Gust 2001:120). Differences in the timing of the various phases in the grieving process can mean that each family member feels isolated and alone in their grief, and does not seek comfort and support from each other. Linn-Gust (2001) writes of the bereaved siblings sometimes feeling as if they have lost the support of their parents because the parents are also bereft and may be incapacitated

by the tragedy. The other children in the family may be told by more distant relatives or friends to 'be strong' for their parents, so these children become the carers of their parents (Linn-Gust 2001:97) and their own adjustment and healing processes are put on hold. This may especially be the case for those children still residing with their parents at the time of the death.

The readjustment of the roles within a family occurs whichever family member has died by suicide, be it parent, spouse, sibling or child. The surviving parent of spousal suicide commonly attempts to take on the role of both parents for the sake of the children (Gaita 1998). Similarly, grieving children are adjusting to either a parent or their sibling suddenly missing from the family composition, leaving a gaping hole and the need to adjust to new and unfamiliar roles within the changed family system.

The need to make meaning of the sudden and tragic loss of a relative will be an imperative for all family members (Peluso 2002). In the aftermath of such a loss, all family members will endeavour to construct meaning in their life and their changing circumstances and relationship processes as they move through an adaptation in their sense of self within this particular family. Part of this process is the reconstruction of identity and the meaning made of significant life events (Neimeyer 2001).

A suicide in a family may indicate wider problems within the family. Some family members may withdraw as they feel some survivor guilt or

embarrassment from being a family member of someone who died by suicide. The entire fabric of the family is changed by the suicide (Linn-Gust 2001).

Intervention—postvention research

The need for postvention support for the suicide bereaved has been the focus of studies in recent years. Postvention is a word coined by Shneidman (1972) suggesting that support offered to the suicide bereaved is a prevention of their suicidal vulnerability. Postvention support for the suicide bereaved has been recommended as a way of having their grief stories heard and to begin to heal their pain at the loss (Jordan 2001; Mitchell, Gale, Garand & Wesner 2003). Participants in support groups report the benefits of being able to share their narratives of loss with others who have suffered a similar loss. The research reported by Mitchell and her colleagues' (2003) study of seven participants who met once a week for eight weeks reported that during this period, the bereaved family members changed their narratives from those of a victimic story to that of an agentic narrative.

The lack of control groups in many of the suicide-bereavement- and postvention-support research studies is a common qualification to their findings (McIntosh 1999). This is understandable, as most postvention research is qualitative so a control group is not appropriate. Further research into the form that postvention support should take was

recommended by Clark and Goldney (2000). That society does not have a record of caring for suicide survivors in a caring way is the experience that Campbell (1997) reported: many suicide survivors had not been able to access support, or where support had been available, it was found by the bereaved to be maladaptive (Campbell 1997; Campbell et al. 2007).

Earlier uncontrolled studies suggest that grief following suicide was more difficult than grief following other sudden deaths (Ellenbogen & Gratton 2001). More recent controlled studies identify some specific aspects of suicide bereavement that result in more difficult grief experiences such as shame, guilt and a sense of rejection (Clark & Goldney 2000; Jordon 2001). Specialised support for the suicide bereaved was recommended by Hawton and Simpkin (2003), who designed the Bereavement Information Pack developed by the Royal College of Psychiatrists to inform medical practitioners who may be supporting the suicide bereaved (Hawton & Simkin 2003).

The need for postvention services in Australia was emphasised at a Suicide-Prevention Australia conference in 2000 (Clark 2000). In this presentation, the recommended changes to suicide postvention support were:

1. Improved attitudes of professionals and service providers to the emotional needs of the bereaved
2. Less patronising services
3. Compassion from doctors, nurses, caregivers etc.
4. Less adversarial process in the coronial system
5. Training about judgemental values
6. Professionals need to listen to survivors
7. More education of professionals

8. Special services tailored to the needs of special groups—gay, youth, Indigenous, migrant, rural communities
9. More flexibility in the delivery of existing services (Clark 2000).

A similar enquiry regarding postvention services in Norway, Belgium and Slovenia was made and the 'collected wisdom' of the workshop attendees recommended that 'postvention practices for suicide survivors should not be prescriptive but should empower the survivors to find their own paths' (Grad, Clark, Dyregrov & Andriessen 2004).

A New Zealand study (Beautrais 2004) of postvention services for those bereaved by suicide offered suggestions to meet the bereaved family's concerns in the direct aftermath of the suicide. These guidelines suggested the sharing of information about the death and the official procedures that will follow such as post-mortem and inquest issues. It also recommended the provision of information on practical matters such as informing other family members, friends and colleagues and the differing needs for support services depending on whether the bereaved lived in a rural or a metropolitan area (Beautrais 2004).

Postvention support services were established by Campbell in Baton Rouge, Florida (Campbell 1997) after it was found that those bereaved by suicide had no access to caring support. The Baton Rouge Postvention Support Service uses specially trained volunteers who have been bereaved by suicide themselves and who have been assisted by the postvention support that they accessed. This service has groups for children and adolescents and different support groups for adults. This service is

regularly requested by the coronial team to act as the first responders to suicide. That the service is called up to do this speaks of how highly this service is valued (Campbell, Cataldie, McIntosh & Millet 2004).

In Australia, a National Activities on Suicide Bereavement Project has been established with Federal Government funding to address the needs of those bereaved by suicide (Bycroft & Scheinpflug 2006). There are 23 self-managed focus groups supported by this program in Queensland, New South Wales, Victoria, South Australia and Western Australia. Five key objectives for implementation are defined by this project.

1. Self-help
2. Local understanding and support
3. Targeted bereavement-support services
4. Specialised care
5. Individual, family and community growth and development (Bycroft & Scheinpflug 2006:18).

The healing potential of group support was the focus of a study which gathered participation observation data from those attending suicide-survivor, peer-support group meetings over a four-year period (Feigelman & Feigelman 2008). The data was analysed utilising the dynamic principles of mutual aid theory as a guide and model for the facilitators to promote the healing of those attending the support group. The members of the group shared stories of the history of their deceased family member and also of their own healing journey. Problems such as perceived stigma or the insensitivity of 'toxic' family members or friends were shared with the group, who were able to assist by sharing their own history of dealing with such issues.

The needs of suicide survivors was the focus of a study in which 63 adult survivors of suicide were recruited from the attendees at Survivors' Conferences in Pennsylvania, the United States of America (McMenamy, Jordan & Mitchell 2008). The questionnaire measured degrees of difficulty experienced after the suicide, with psychological issues recording the highest percentages, with social issues next and practical issues rated as the least difficult. Sources for healing were measured for their helpfulness. Participants reported that the support received from family members and close friends was the most helpful, closely followed by mental-health professionals and the clergy (McMenemy et al. 2008:381). Those participants who had accessed support from a 'survivors of suicide support group' reported that this involvement was helpful to a high level, including Internet websites, more so than the helpfulness experienced through individual therapy. Books on suicide and grief were found to be helpful as were the suicide-support advocacy groups. Half the respondents to the questionnaire had difficulty finding resources due to a lack of information about where support could be accessed (McMenemy et al. 2008:382).

In an exploration of the literature on suicide-bereavement support, the authors concluded that there was relatively little scrutiny of the survivors' experience. A recommendation was made that a study of survivors' experience of front-line suicide-bereavement support providers be

undertaken to identify survivor needs and specific issues (Botha, Guilfoyle & Botha 2009).

The healing potential of suicide-survivor support groups was reported by Feigelman and Feigelman (2008), who attended and observed monthly peer-led, open-ended suicide-bereavement support groups. The authors, both sociologists, are the parents of a son who died by suicide. They recommend the use of the Internet to list contact details of suicide-bereavement support groups. Also recommended was the listing of subsidised mentorship and training workshops for the facilitators of suicide-bereavement support groups (Feigelman & Feigelman 2008). A further study reported on the usefulness of Internet suicide-survivor support groups to the bereaved (Feigelman, Gorman, Beal & Jordan 2008).

The role of spirituality in the lives of those seeking postvention support was explored by Vandercreek and Mottram (2009). This study explored three dimensions of the religious life of ten females bereaved by suicide.

> The three dimensions were: (a) the function of the survivor's personal religion, (b) the function of religious support from family and friends, and (c) the function of established religious communities (Vandecreek & Mottram 2009:741).

Participants in this study were recruited from suicide-bereavement support groups in a rural state of the United States of America which reported high suicide statistics. The family members who died by suicide consisted of eight teenage or adult children and two marital partners. A question of whether their attendance at religious services was regular

brought mixed responses, with eight attending services once a week or more, one whose attendance was several times a month and one who never attended. Seven replied that their faith was very important, one said it was somewhat important and two stated that it was not very important.

Confronting responses from members of their congregations or other strangers were reported by four of the participants, who were either questioned about their deceased family member or told that the deceased would go to hell. Seven survivors spoke of a renewed or clearer purpose in their religious life after the death of their family member (Vandecreek & Mottram 2009) and nine of those taking part in this study reported that the suicide had not affected their religious faith. Many of those interviewed were disappointed in the responses of family and friends:

> A lot of people that I saw and tried to tell them about it, some would walk off because they didn't want to hear about it (Vandercreek & Mottram 2009:749).

Survivor narratives about support from their church congregations were positive and were found to be comforting and helpful, as was attendance by fellow church members at the funeral service. Three survivors stated that their clergy did not provide long-term support for them.

Common challenges faced by the suicide bereaved illustrated in case vignettes were presented by Kaslow and Aronson (2004). Clinical interventions following a family member's suicide were recommended by these authors. Management of concerns over family disintegration

following the suicide, addressing the psychological distress of the suicide bereaved and helping the family deal with stigmatisation are covered in this report (Kaslow & Aronson 2004). The value of assisting the suicide bereaved to create 'a suicide story' was highlighted (Kaslow & Aronson 2004:245).

The healing derived from a therapeutic retelling of a suicide story was the focus of a book by Rynearson (2001), a psychiatrist who was bereaved by the suicide of his young wife. In telling his own story of loss as background to the purpose of the book, he states 'Since the purpose of this book is to clarify how to balance oneself above the meaningless void of violent dying, it cannot provide a precise answer' (Rynearson 2001:xv).

This restorative retelling in support groups allows those attending to share their stories of their family member throughout the whole of their life and not just around the tragedy of their death. The 'restorative' process occurs through a shift from an incoherent retelling to a coherent narrative, and is very gradual, taking whatever length of time the particular bereaved family member needs.

Conclusion

The suicide of a family member is one of the most difficult and confronting issues someone can deal with. Understanding the way in which a suicide affects the bereaved family members and their relationships with each other helps explain how each individual may be affected by the tragedy

that has befallen them. The meaning made of the suicidal death within a family will be different for each individual depending on the nature and quality of their relationship with the deceased. How each member acts out their grief reactions will depend on the family dynamics and differing roles within the family, as well as their need to either draw closer or withdraw to deal with their painful feelings. Bereaved children may experience their parents as vulnerable for the first time in their lives.

Society's perception of the family may reinforce the family's experience of withdrawal and isolation, especially if there were expectations of stigmatisation or being judged as a family with problems. Feelings of shame in acquiring a changed identity as the spouse, parent, child or sibling of someone who died by suicide compromises the healing process of each member of the family.

By examining the narratives of suicide-bereaved family members and hearing the stories of the history of the family both prior and subsequent to the suicide, support services may be informed on how best to meet the needs of the family as a whole and to better support each individual member within the family. Such services may enhance the family unit's ability to reform in a healthy cohesive way and meet future challenges with courage and resilience.

Chapter 4

Research methodology

This chapter describes the methodology and conceptual design underpinning this research. The study explores how individuals seek to understand or find meaning in the suicide death of a family member. It is through the stories that are constructed following critical or traumatic loss that people assimilate disruptive experiences into their frames of reference and try to make sense of what has happened and of themselves. Narrative inquiry was selected as the most appropriate method for exploring the storied experiences of the participants as the way people commonly understand themselves and their world is through the medium of narrative. This chapter contains a description of the narrative orientation taken, along with an explanation of the methods employed in the study.

Conceptual framework

A number of conceptual frameworks were drawn upon to inform this study as the scope of the study sought information about the antecedents to the suicide death, surrounding events at that time and the aftermath of the suicide for the participant and other family members. As a suicide death often results in complex grief narratives for those who were in a

relationship with the deceased, grief and loss conceptual frameworks were of relevance. Early theorists recognising the experience of grief after death trace their historical roots to the theory of grief and loss of Kubler-Ross (1973) and also Rando (1992–93) and Worden (1999), The special complex issues surrounding a suicidal death may involve complicated grieving (Neimeyer et al. 2002) disenfranchised grief (Linn-Gust (2007), traumatic loss and feelings of self blame and guilt (Walsh & McGoldrick 1991). The grief journey of the bereaved includes adaptation to loss (Forster & Murray 2007) and in the bereaved person's sense of self (Neimeyer 2001). The transitions of psychosocial adjustment described by Parkes (1971) as detaching from a previous assumptive world and creating a new assumptive world without the deceased also informed the analysis of the grief stories in this study. The creation of a new assumptive world does not mean abandoning the bonds of connection with the deceased, so the acknowledgement of the strength of continuing bonds is relevant in the understanding of grief (Stroebe et al. 1992). Grief theory can also be applied to surviving violent death which necessitates creating a new coherent story out of an incoherent previous narrative (Rynearson (2001).

As the aims of the study included gathering information on the family story, conceptual frameworks were required through which to interpret the relational history within the family of origin of the participants and also within spousal relationships of participants and deceased. Among these conceptual frameworks were family systems theory (Bowen 1988; Nichols & Schwartz 1998), including human and interpersonal

relationships theory (Bowlby 1969), resilience in families theory (Lietz 2006; Walsh 1998, 2006), to identify and explain the role of relationships within families and the way the various systems work within family life. Of significance also is the theory of attachment (Bowlby 1979) as it is in the earliest stages of the bonding relationship between the child and the principal caregiver and the quality of this bonding and interaction that determines the development of the emotional and intellectual health of the children raised within families (Schore 2003; Siegel 1999). All of these conceptual theories are relevant to this study and have been utilised in the interpretation of the findings from the data. The individual family member's experience of their family life is by its nature intensely personal and draws on the history of their development within their particular family and therefore will have an effect on how an individual may react to a family member's suicidal death. The grief journey of those bereaved by the suicide of a family member may take many forms from adaptation to the loss (Neimeyer 2001) through the innate qualities of resilience (Lietz 2006; Walsh 1998, 2006), or conversely to personal and family disintegration (Owens et.al, 2008). Of importance is acknowledging that social factors could have been of relevance to the deceased and the bereaved family under consideration (Henry, et al. (1993).

These conceptual theories guided the interpretation and analysis of the data gathered from the narratives of the participants. The primary aim of this study was to explore the recollections of adults who had experienced a family member suicidal death at some time in their lives either as a

child/adolescent or young adult experiencing parental or sibling death, or at another stage in their lives. The purpose was to open the opportunity for the participants in this study to speak of their meaning making endeavours to understand the context in which the suicide occurred. This exploration was a search for comprehension about the family of which they were a part, the roles and behaviours of the various family members had and of their own sense of self. Thus attachment theory (Bowen 1988; Nichols & Schwartz 1998) provides a useful perspective through which an analysis of how the participants viewed their developmental years and also the personal history of the deceased relative.

An aim of this study was to understand the family history both prior to and after the suicide, family systems theory (Bowen 1988) which explains the way various systems operate within a family and, holds that if the behaviour of one family member within the family changes, then this will have a corresponding affect on the other family members offers a useful lens. Thus when a family member becomes so distressed or emotionally and mentally disturbed that their life culminates in a suicide death, the other family members may become aware of changes in their own emotional well being both in the period leading up to the death and in the aftermath. Similarly, in the period when the family adjust in the aftermath of the death there will be changes within the various alliances, roles and relationships within the family adjusting to the absence of a member, further illustrating the influence of family systems theory. This

adjustment period may lead to fragmentation, disintegration of the family, or to drawing together seeking mutual support drawn from the commonly held values, beliefs and strengths that defined a more resilient family system (Lietz 2006; Walsh 2006) and highlight the importance of the development of meaning systems through the processes of constructivism theory.

The conceptual framework with which to identify and understand the question of whether resilience may be exhibited by the family members after an adverse experience looks for evidence of how the family member describes themselves and the negative event. Also of pertinence is how the family member may attribute causes of the adverse experience and their manner of facing the aftermath of the event. For example, if the members of the family see themselves as victims of some external to the family destructive influence may determine whether the family members adopt a 'victimic' attribution to the event, or whether they recognise that the family can draw on its strengths and become 'agentic' about future adaptation and reconstruction (Levy & Wall 2000). In 'agentic' narratives, those facing an adverse situation recognise that the way they face the future is with their own reserves and the determination to be 'agents of change' within their own lives.

The strengths exhibited by a family that is able to have reserves to draw upon under difficult circumstances have been described by Walsh (2006) as three key family processes that facilitate resilience, these being shared

belief systems, family patterning that enables organizational strengths, and clear and open communication which encourages mutual support and problem solving. These three processes are also identified and expanded in the study by Lietz (2006, 2007) where the desirable qualities in family members demonstrating resilience were having insight, initiative, independence, healthy boundaries, creativity, humour, social support and a shared morality or sense of spirituality. Seen as protective factors are the ability to be flexible in seeking ways to be adaptive in finding solutions or support, and also the meaning construction or attribution that is placed on the adverse or high stress circumstances.

In order to capture the full breadth of the experience of many diverse informants in this study who represent all of the immediate family members of a suicide deceased person, I searched for a methodology that enabled the capture of the lived experience of the suicide bereaved family members. Qualitative research methodology is used by researchers who are interested in drawing out how people give meaning to the experiences of life and also to the way they infer meaning in relation to the actions of others where the outcome impacts on them (Grbich 1999). This inductive method of research aims to draw out the participants' interpretations of events; in this case, the events surrounding the death through suicide of their family member. The rationale for choosing narrative inquiry rests on the need for a methodology that allows in-depth exploration of participants' experiences and understanding. It is through the

construction of a personal narrative that people derive their sense of self (Neimeyer 2001) and of the family from which they have come (Owens et al. 2008). Narrative inquiry methodology traces its roots to the lineage of social constructivism. This philosophy holds that people construct their understanding of reality through their lived experience. Social constructivism proposes the view that people interpret the world and their interaction with others (Schwandt 1994) and it is through this that they come to understand and experience the world. They construct their view of reality by their lived experience and the stories that they tell themselves and others about their lived experience (Gergen 2003; Grbich 2004). This construction of understanding 'is the result of an active, cooperative enterprise of persons in relationship' (Gergen 2003:15). Social constructivism refers to the process that occurs when people speak of their experiences to others, then with the feedback that occurs, these stories are shaped and a mutual understanding can be reached (Crotty 1998).

Narrative inquiry, in contrast to an objectivistic ontological approach to investigations derives its foundations from an epistemological approach to the acquisition of knowledge. These two philosophical paradigms can be contrasted as follows. Ontological researchers seek to understand what is the form and nature of the world and reality (Cresswell & Clark 2011). This scientific form of enquiry seeks definitions about an objectivistic worldview that seeks uncontested truths and therefore the methodology utilised would be quantitative, about measurements, and descriptions. Scientific enquiries about the nature of reality seek to verify truths using

hypotheses (Guba & Lincoln 1994). Epistemological research looks to understand what can be known and of the relationship between the knower and the known. Both of these philosophical paradigms hold a worldview about the way we believe the world operates. These two beliefs may be termed 'objectivistic' or 'constructivistic'.

The epistemological paradigm relates to methodologies that define investigations that are interested in constructivism, that is, the construction of stories or narratives about interpretations and sense making. Therefore it emphasises an interpretive approach to the investigation of social phenomena which may have different meanings, depending on the assumptions and basic beliefs of the people involved. An example of this is Durkheim's theory in relation to suicide rates which he held varied depending on the social integration of the groups to which the suicide deceased belonged. Durkheim further hypothesised that a suicidal person could be either egoistic or altruistic and stated that this depended on degree of social involvement of the suicidal person (Maris et al. 2000). Social constructivism is dependent on shared meanings, interpretations of those within a socio-cultural heritage (Minichiello, Fulton & Sullivan 1999). Meanings change, evolve and develop as new experiences are gathered and are incorporated into the constructed knowledge through the narratives that are used through which we understand ourselves and share this understanding with others.

The difference between suicide research utilising quantitative methodology and that utilising qualitative methodology was explained as the difference between obtaining explanations and gaining understanding (Hjelmeland & Knizek 2010). Quantitative suicide research commonly uses 'hypothesis-deductive or experimental methodology' producing explanations about causes and effects (Hjelmeland & Knizek 2010:74). Qualitative research, in contrast, searches for understanding about the phenomena of suicide. Descriptions of behaviours, feelings and thoughts are sought, which when shared, create an opportunity for understanding. Narrative inquiry is a methodology that seeks to understand how the participants constructed and understood their lived experiences of losing a close family member to suicide.

Social constructivism refers to the process that occurs when people speak of their experiences to others, then with the feedback that occurs, these stories are shaped and a mutual understanding can be reached (Crotty 1998). In this study, the family history prior to the suicide death was sought, so these family narratives would be the result of the process of constructivism as the family lore and myths are created and told and retold through each generation. These family stories were part of the historical, social and cultural context against which the suicide death occurred with a shattering force, changing forever the family narrative for the tellers of the tale—the participants in this study (Gergen 2003). The objective of this study was to hear not only these suicide narratives, but

also the meaning making that the participants and their family undertook to accommodate this happening into their changed narrative. Of relevance was the construction of a new narrative by the participant and other family members together, or in the aftermath of a fracturing in the family system, within a smaller restructured family group. Hearing each participant's narrative allowed an understanding to be reached that was in accordance with the way the individual made meaning of these events and the resultant consequences within their socio-cultural context (Polkinghorne 1988). The need to create new stories out of disorder and to endeavour to find new meaning out of the meaninglessness of suicide was the reflexive journey that the participants had undertaken and were sharing in the interviews (Gilbert 2002). During the interview, each participant was undergoing the process of revising or constructing their narrative in conjunction with the listener, as probes or reflexive questioning allowed the opportunity for new insights or shades of meaning to be accessed by the speaker. Thus, the narrative that evolved during the interview was a co-construction between the speaker and the listener.

After an extensive search of the literature available on understanding suicide within the context of a family, this research study was designed to allow the bereaved family members' experiences to be explored. This exploration necessitates a process that allows the participants to relate their family history and climate prior to the suicide, the events surrounding the suicide, their reactions to the loss and subsequent on-

going family outcomes and adjustments. As explained by Owens and her colleagues (2008:241), the participants have a need to tell their story and, in a similar manner, the researcher feels compelled 'to listen and hear the whole story, spontaneously told'.

A methodology was required that would allow in-depth exploration of the complex and influential aspects affecting the participants' experience such as their relatedness to the deceased, the participants' age at the time of the death, developmental influences, the family patterning and the environmental and social context in which the family lived. A narrative methodology is therefore appropriate for addressing the research question and the aims of the research project. The research question is: *How do suicide-bereaved families narrate their experience of loss in the context of familial relationships?*

This question allows the interview dialogue to cover the period of time before the suicide, the events surrounding the suicide and how the participants' understanding may have changed or developed since that time. The 'time' element within the participants' narratives is important within the methodology used, as the participants searched back through the family history in their endeavours to answer their inevitable questions as to why the suicide happened. In telling their narratives, the participants described their understanding of how events happen over time, and how past family behaviours led to the present story being told—that of suicide bereavement. The effects of the suicidal loss on other

members of the family and how these changes have impacted on the informant and their relationship with their family were also explored. The interview process follows a co-construction and exploration of the meaning of these events, allowing the perspective of the participants to stand forth (Owens et al. 2008). Gavin and Rogers (2006) conclude that new understanding and insight can be gained through a narrative inquiry into the complexity of the circumstances and reasons why some people decide to end their lives. The following section reviews the use and application of narrative inquiry.

Origins of narrative inquiry methodology

Narrative inquiry has its origins in many disciplinary approaches to the analysis of biographical data and is a sub-type of qualitative inquiry (Chase 2005). Narratives speak not just about events or happenings, but also contain feelings and interpretations of the events and the reason why the narrative is told in this way. Thus, the way a narrative is told is as important as the content of the narrative (Chase 2005). A narrative is told to achieve something: it is used to explain, or inform, complain, defend, debate or create the opportunity for a change. What is said and the way in which the story is put together creates a unique narrator's voice. Narratives are produced for particular settings and purposes. A person telling a story will vary the story to make it more suitable for the particular audience (Riessman 1993).

The power relationship between the researcher and the narrator affects the narrative's telling. The difference lies in the change from interrogator to that of engaged listener; thus, a different means of open-ended questioning and encouraging a story are utilised. Narratives are shaped and influenced by the social and historical setting of the events that took place, and by geographical influences and cultural traditions (Chase 2005).

Identity and sense of self

The identity of the person in any self-story is at the heart of the meaning of the narrative. They are not only describing events, but are also conveying a sense of who they see themselves to be. Smith and Sparkes (2008) describe how individuals create a sense of self and identity from two differing perspectives, which they describe as a continuum that, at one end, has 'thick individual and thin social relational' views and at the other, 'thin individual and thick social relational' views. Identity and a self-view are moulded by the 'socio-cultural matrix of our being-in-the-world' which implies a relational context (Smith & Sparkes 2008:6). Attention is drawn to the illusion that people believe themselves to hold only one identity to describe an autonomous self, suggesting instead that people have various personas that are utilised as custom and circumstances suggest. Smith and Sparkes (2008) espouse that in narrative inquiry the 'self' and 'identity' can be seen as multidimensional because of social, cultural, historical and political influences. This

multidimensionality of the self is also described by Polkinghorne (1995). There is also the temporal aspect in narrating a self, in that narratives are constructed 'in and through time' (Smith & Sparkes 2008:7).

The cognitive capacity of a person and their ability to self-reflect enables them to develop a self-narrative with coherence (Polkinghorne 1995). A meaningful connection made across time—from the past, present and a projection into the future—allows persons to develop a unique internal configuration of themselves. This concept accords with a 'three-dimensional narrative inquiry space' (Clandinin & Connelly 2000:54) in which the time dimension is divided into 'backward and forward, inward and outward'. This concept also includes 'place', which suggests that the place or location in which events occur picks up on the influence on the narrative of the socio-cultural dimension.

Ethical issues in narrative inquiry methodology

Ethical issues when researching grief stories were explored by Gilbert (2002), who raised questions about the ownership of a story after a researcher has analysed and restructured the narrative. This relates to the ownership of the story. The culture of the narrator influences the structuring and meaning making of a story. In a similar way, the background experiences of the researcher may limit what data are emphasised or privileged from the stories that form the research project. Gilbert (2002:236) points out that the researcher also has their own

narrative in relation to the topic under investigation and warns: 'We must, then, be aware of how our own narrative limits us, and the implications of this for our work'. The researcher is a co-constructor of the research narrative, and when the focus of the research is grief narratives, it is important that the interpretive narratives remain true to the initial understanding and meaning made by the participant.

Meaning making

Meaning making is at the heart of narrating a story. There are different underlying needs that motivate people to tell their stories. Baumeister and Newman (1994:688) describe the narratives people employ in their efforts to understand themselves as 'self-interpretation'. The authors state that there are four needs that motivate people to undertake meaning making. These four needs relate to satisfying a need to describe a sense of purpose directed towards goal attainment, a need to justify decisions made in relation to values held, a need to demonstrate knowledge of useful information and a need to illustrate self-worth and competency. These prove useful in the organisation of memories, the interpretation of events and the demonstration of purposiveness (Baumeister & Newman 1994).

People understand life experiences and tell stories as a way of memorising what has come to pass and to help predict what will happen in the future. Thus, the life that is narrated leads through the present into the future (Bruner 1987). This life is reinterpreted through the narratives that are

used to explain ourselves to others and as a means of understanding ourselves, often in an unconscious fashion. Bruner (1987) argues that how we interpret events is more important than how the events actually happened in our lives. Through the use of experimental autobiography, Bruner (1987) suggests that in early family life formal structures are impressed on the mind and that it is through these structures that we view later events. We cannot easily assimilate a changed narrative in later life within the narratives that are considered to describe our life. This is exemplified as 'there is no innocent eye' (Bruner 1987:32), that new events are considered against the backdrop of the narratives that are already established.

Given this context, Hoshmand (2005:178) wrote of the need to focus on meanings contained within the 'storied nature of human life', whereby narratives contain a time element and a causal factor or plot-line in the way the narrative unfolds. The inquiry process includes consideration of philosophical concepts and involves methodological processes. Validity and truthfulness are among the chief concerns of researchers using narrative inquiry methodology. The author identifies that there are several different ways of undertaking a narrative inquiry research project and advises researchers to identify the manner in which they undertook the particular process their work (Hoshmand 2005). The special contribution that narrative inquiry can make in explaining identity development in the

context of life transitions was emphasised, especially the importance of making meaning and the construction of a coherent story.

Analysis and interpretation

Narratives explain the stories people tell and thus are a medium for analysis. Polkinghorne (1995) speaks of stories as having events, things that happened, from which a meaning can be determined. The events and the happenings have a consequential sequence or relational significance. It is this relational significance that points to stories having a 'plot' (Polkinghorne 1995:7). The identification of 'plot-lines' in the individual stories must carry the meaning that various participants give to their experiences. The purpose of narrative analysis is to derive a final meaning emanating from the synthesis of the participants' stories that is true and representative of the initial stories of each participant.

In analysing and interpreting the interview data, the researcher focuses on the social significance of the elements of the narrative as it unfolds. The initial analysis deals with character, plot, tension, end point, narrator, context, tone and the story-lines that interweave and connect. These considerations shape the analysis and interpretation of the participants' narratives. It is in the complex process of analysing the meaning and social significance of responses to questions that ultimately shape field texts into research texts.

Riessman (1993:65) describes narrative analysis not as the listener or researcher having direct 'access to another's experience', but as dealing with the narrator's representations of that experience through the stories they tell. The process of working with the stories of others was described as having five stages: attending, recording, transcribing, reading and analysing (Riessman 1993). Stories have plots and meanings, but those meanings can change over time and as such, are fluid. Analysis in narrative inquiry involves a rearranging of the text to clarify and to enable a deepened understanding of the narrative. When working with the narratives of others, Riessman (1993:65) raises issues of plausibility and the persuasiveness and cohesiveness of the researcher's interpretation of the text.

Critical-event narrative analysis in research projects was proposed by Webster and Mertova (2007) as a methodology that is capable of examining and analysing complex events in people's lives. The value of a narrative inquiry in which participants' stories are analysed was emphasised because 'stories allow us to watch what an experience can do to people who are living that experience' (Webster & Mertova 2007:20). It is the placing of the narrators of a story at the centre of their experiences that is illuminating for the researcher and allows for the classification of events into 'critical and supporting events' (Webster & Mertova 2007:71). These authors emphasise the importance of place and time, together with the characters, in identifying the critical events in a participant's story, as

do Clandinin and Connelly (2000). To identify an event that is critical in a participant's narrative requires the listener to observe a reported cognitive change or a different way of seeing and understanding the world in the narrative of the participant (Webster & Mertova 2007). With this in mind, this research uses narrative inquiry as a guiding framework. The analysis focused on the way in which people make meaning from this event.

Aims

The primary aims of this study were to explore the recollections of adults who had experienced a family member suicidal death at some time in their lives either as a child/adolescent or young adult experiencing parental or sibling death, or at another stage in their lives. Additional aims were to understand the family history both prior to and after the suicide, the development of meaning systems and the development of resilience. The importance was recognised of identifying the nature and timing of support, if any, that was accessed by the bereaved family members. Similarly, information on participant vulnerability and the factors that affect coping was of interest. In order to understand this, I aimed to identify the protective external factors that encourage moderation between stress, risk, coping and the development of resilience. This information can assist support services in designing processes to facilitate resilience.

Research aims and choosing a methodology

To achieve these aims an inquiry method was needed which could explore the recollections of adults who had experienced the suicidal death of a close family member. Specific aims were to understand the family history both prior to and after the suicide, the nature of support experienced, if any, and the development of meaning systems about the loss and the effect on the family such as the development of family cohesiveness and resilience, or alternatively, if the family fragmented.

Plan underpinning the aims

The planned scope of the research was to gather information on the family across a wide time span in order to understand suicide in the context of the family. The participants were encouraged to share the history of the family and their memories of the events surrounding the suicide so that an understanding of the family at that time could be reached. The immediate consequences following the suicide were sought, as were the participants' thoughts, feelings and their level of understanding. The family system was seen as a rich source of data. It was important to discover the reactions of the surviving family members to the suicide and whether the family was seen as close and supportive or distancing, in order to ascertain what support was available to the participants immediately after the event. An understanding of the immediate family and the extended family was sought specifically to learn if there had been

any prior history of mental or emotional disorders, substance abuse or addictions of any kind or suicides in the family. Information regarding the family's economic circumstances was gathered to ascertain whether the suicide resulted in a reduction in family income.

Information was sought about the actual suicide to understand the impact of the suicide on the participants and other family members. For example, what happened, did the participant witness the suicide and how and by whom were they told. An aim of this was to discover any support that may have been accessed by the family and the nature of that support. Was the support available to the whole family and did the participant experience the support as helpful? If no support was provided, then what kind of support would have helped them or the family unit?

An understanding of the participant's life following the suicide was seen as important as one aim was to comprehend how the participant adjusted and what effect this loss has had on their subsequent life, education and their ability to form and maintain close relationships. A further aim was to seek information about the development of resilience or lack of it in facing other losses and disappointments in life. The retrospective personal narrative of the participant was elicited specifically to discover the meaning making that had occurred. Clarification of these issues was sought only where the participants did not already speak of these topics in their narrative.

Sample

Qualitative research that aims to gather information using an in-depth interview regarding defined significant events in the participants' lives necessitates purposive selection of participants (Llewellyn, Sullivan & Minichiello 1999). The sampling was both purposive and convenient in that the selection criteria were intended to discover participants who had the experience of being a suicide-bereaved family member of a person who had died by suicide, and whose narrative would yield rich data for analysis. To be eligible for inclusion in the study, the potential participants were asked to agree to the audio-taping of an in-depth interview.

The sampling selection was also a 'convenience' sample, as some of those interviewed were volunteer participants who had read of the study in the newsletter of the Survivors of Suicide Bereavement Support Association, or who had attended a conference on suicide prevention or postvention support. Even though the media publicity about this project focused predominantly on South-East Queensland, participants resided in such diverse areas as Cairns in Far North Queensland, Perth in Western Australia, Canberra and two other state capitals. One informant resides in Central Australia and works in the outback. The sample in this project represented every class of first-degree relative of the suicide deceased: spouses and partners, children, parents and siblings. Eighteen

participants who experienced the suicidal death of a family member were interviewed with their relationships to the deceased set out in Table 4.1.

The remaining six of the potential participants did not complete the process of recruitment, in that they did not return the requested signed 'Consent to be Interviewed and Audio-taped' form (Appendix 4)'. So they self-selected out of the project. Figure 4.1 below illustrates the recruitment process.

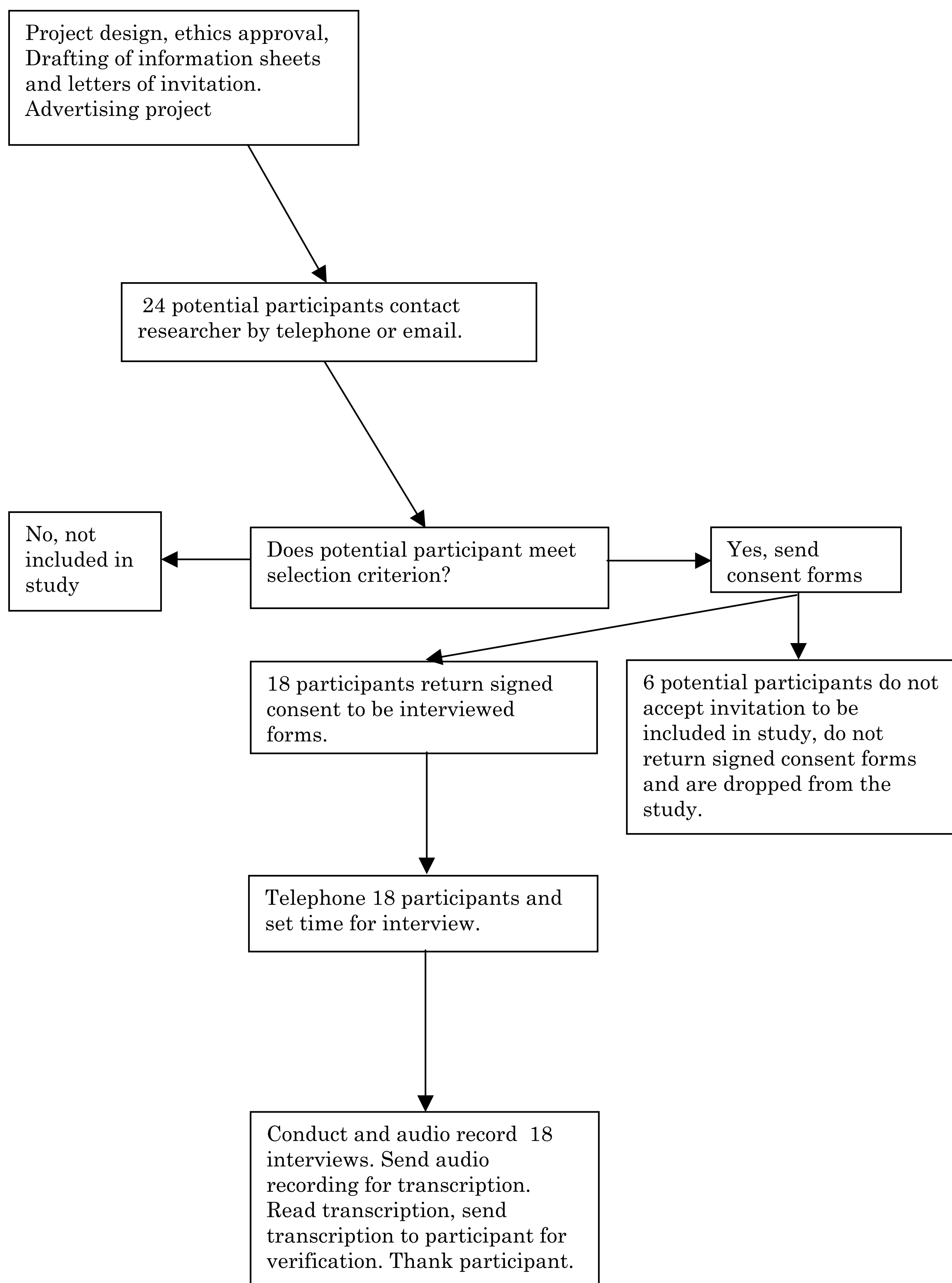
Participants ($N = 18$) reported on twenty suicide-deceased family members

Table 4.1: Participants reported on twenty suicide-deceased family members

Spousal or Partner	Adult Children	Parents	Siblings
4 husbands [1]	4 young adult sons[2]	3 mothers	3 brothers[3]
1 wife	1 teenage daughter	1 father	1 sister
1 same-sex partner			1 brother-in-law

[1] One participant lost a partner.
[2] This same participant lost an adult son whose death is included.
[3] One participant lost two brothers who died within a month of each other.

Figure 4.1: Flow diagram of recruitment of participants



Part of the research design was that participants for the study should represent various types of family relatedness to the suicide-deceased family members—this being a criterion of the purposive sampling. Suicide-bereaved parents, spouses and partners, children and siblings were sought representing all types of first-degree family relatedness among the participants.

As both a researcher and a suicide-bereaved person, I had some reservations about recruiting participants exclusively from survivor support groups as I knew that the purpose of such groups is to share stories of suicidal loss through attendance at the group. Members of such groups are therefore well practised at telling their story. I did not want to access the 'practised' stories that had been told and retold. From my own experience of being a suicide-bereaved person, I know I have the 'safe' story for me to tell, a version that is about the 'history' of my son's suicide and the events surrounding it—but I have rarely shared my deeper feelings and reactions. In order to gather rich data, I knew I needed to hear the unpractised stories—those kept closer to the private. I wished to hear not only the story of the family member's loss, but the participant's emotions. I listened for stories about how they may have struggled to reach some level of understanding or acceptance of their loss or if they are still wrestling with the move from their previous assumptive world to a new way of being and finding meaning.

These reservations concerning stories from suicide-bereavement support-group members should not be interpreted as a denigration of the healing potential and support provided to the suicide bereaved by survivor support groups. Survivor support groups offer the opportunity for the suicide bereaved to meet with others similarly bereaved and to make the progression from the first responses of shock and trauma distress, through the longing that accompanies separation distress in search of an understanding of their loss. This transitional journey has been the focus of authors such as Rynearson (2001) and Feigelman and Feigelman (2008), who speak as both suicide survivors and researchers.

The initial research design was to interview more than one member of each family group about their suicidal loss, but I was only able to achieve this on two occasions. I wished to explore the different views/narratives that family members narrate as their experience of the same incident. The aim was to hear the voices of different people regarding the same grief incident and to hear the differences in these accounts (Neimeyer & Levitt 2000). In the stories from Darryl and May, father and daughter, there are differing attributions about Darryl's wife and May's mother's suicide. However, in the stories from Delma and Phillip about the suicide of Delma's son and Phillip's brother-in-law, there is mutual understanding and agreement about the family narrative. Therefore, further analysis within this study of the ways in which interfamilial stories have common

or different content and understandings is limited and will be further discussed in the final chapter.

It was disappointing not to be able to recruit more family members of those who volunteered their stories to the study. There are many possible reasons. The most frequently given reason is that the other family members who were asked said they did not want to revisit the tragedy, and they just wanted to move on. Another reason was that one family member had already told the story of their deceased relative, so in a sense that memorial to the deceased had been created and did not need repeating. A motive for participants volunteering to tell their story was to memorialise their deceased relative (Maple et al. 2010; Ratnarajah 2005).

Recruitment process

To locate potential participants, the researcher wrote an article about the study, which was published in the Survivors of Suicide Bereavement Support Association Newsletter (Appendix 1A). I shared information about the study with attendees at presentations at a grief and bereavement conference, suicide prevention and postvention conferences, (eleven conferences in all) where I presented my earlier research. My intention to undertake this study was also shared with other counsellors, psychologists and therapists at training and networking evenings locally and also at research residential schools at the University of New England.

Following this newsletter exposure and information sharing, potential volunteer participants contacted me directly. The initial interview was conducted by telephone or face-to-face, and then once it was established that the potential participant met the criteria for the study, an information package was sent (Appendix 3) containing a letter of invitation, detailed information about the study with a 'Consent to be Interviewed and Audio-taped' form (Appendix 4). When the consent form was returned to me, a further telephone call established a date for either a face-to-face interview to take place, or alternatively, for a telephone interview to be scheduled. During the telephone interviews a speaker telephone was used so digital audio recordings could be made.

In nearly every case the potential participants questioned why this study was being undertaken. I described my earlier research and the recommendations that were made to widen the scope of this research to include all close relatives bereaved by the suicide of a family member. If further enquiries were made about why the initial research study was undertaken, which was the usual case, I shared the information that I was also a suicide-bereaved person. A frequent comment made following this personal disclosure was 'then in that case I will speak with you as I know you will understand'; in this way rapport was built readily. I admit there are possible limitations inherent in being someone with 'shared knowledge'; these limitations are addressed in the final chapter under 'Limitations'.

The research design aimed at exploring the experience of family members who have lost a first-degree relative through suicide, determined that the sample must be purposive. This decision was reached because only these bereaved relatives would be able to speak of their own and their family's experience of the suicide death of their relative. Information was also sought on the antecedents to the suicide, the family background and culture, what was known of the trigger events, if any, as well as the suicide and the consequences that followed.

Twenty-four potential participants contacted me to volunteer to be interviewed. I established the degree of relatedness of informant to the family member who had died by suicide. I was very anxious that I was able to interview a mix of bereaved relatives of both sexes, hopefully of different ages and who covered all of the possible types of family relatedness to the suicide-deceased relatives. The mix in the relatedness of the informant to the deceased I had aimed for was achieved by convenience, but as the research study progressed, the recruitment process became purposive. For example, a man offered his story of the loss of his same-sex partner. Subsequently, my principal supervisor suggested to me that it would enrich my study if I was able to hear the story of the loss through suicide of a woman in a same-sex relationship. I put out a notice in the gay newsletter but no offers to contribute a story came from this. When such an informant offered her story of the loss of a sibling to me, I accepted her offer with gratitude.

Of the eighteen participants who I interviewed, six have been sourced from the support groups, and of these, some have made contact or attended group meetings only once. The younger participants told me that the majority of people who were at the group meeting they attended were much older than they were and that they felt out of place. So my apprehension that I would gather 'practised' stories from participants sourced from support groups proved to be unfounded.

The remaining twelve participants became known to me through three different sources. Five came from professional contacts. The professional contacts were known to me through networking groups in my local area and when they indicated that they knew someone who met my selection criteria, they were sent an information sheet (Appendix 2A) and a covering letter (Appendix 2B). When the suggested participant contacted me, an information sheet (Appendix 3) was sent to them together with a letter—(Appendix 3A) and included in this letter were the two copies of the 'Consent to be Interviewed' forms (Appendices 4A and 4B)—one copy to be retained by the participant and the other copy to be returned to the researcher. A self-addressed stamped envelope was included for this purpose. Another five participants attended either suicide prevention or postvention conferences and introduced themselves to me during coffee breaks and volunteered their stories. Anticipating this eventuality, I had copies of the 'Letter of Invitation', the 'Information Sheet for Participants' and the two 'Consent to be Interviewed' forms with me at the conferences.

Two of the participants were family members of other participants. When I was advised of their consent to be interviewed, they were posted the same material as detailed above.

Ethical considerations

Obtaining informed consent

Prior to an interview taking place the participants were given or sent a letter and two copies of the consent form, which when signed, indicated their informed consent to be interviewed and audio-taped. This consent form was signed by the participant and also by the researcher and one copy was returned to the participant. As some of the interviews were to be via a telephone line utilising a speaker telephone, prior to the commencement of the interview, verbal consent was again obtained from the participant with the reminder that the recorder was being used. Ethical clearance for this study was obtained from the University of New England Human Research Ethics Committee: Approval No. HE06/159 Valid to 31/10/2009.

Confidentiality was assured to all participants in this study. They were reassured that only I, and the professional transcriber from a transcribing service with strict confidentiality regulation, would actually hear the audio tapes. Discussion took place about what pseudonyms the participant may wish to adopt for themselves and their various family members. Many of the names that were used in this report were chosen by the

participant, others wished for the actual name of their deceased relative to be used, stating they wanted the name to be remembered. If the participant did not nominate an alias, a pseudonym was chosen by the researcher.

Prior to the commencement of the interview, discussion took place about the sensitive nature of the content of the interview and that in telling the story of the loss of their relative, painful memories and emotional reactions could be expected. Those participants who belonged to a suicide-bereavement support group advised me that they would seek help from their trusted group members if needed. Other participants were provided with the Lifeline Crisis Counselling telephone number, as detailed in the information package for later use (see Appendix 3). Some participants had accessed support from therapists in the past and they assured me that they would again contact this support if needed. The participants were assured that I had extensive experience as a counsellor and also as a researcher in suicide bereavement, but my role in this connection with them was that of a researcher, not as a support person.

The participants were advised in the initial correspondence and again at the commencement of the interview that they were free to withdraw at any time, or call for a break if they needed one. Subsequent to receiving the transcript from the transcribing service, a copy of the transcript was sent to the participant. In the design of the study, it was planned that a copy of the transcript of the interview would be mailed to the participant

so they could verify, add to or delete anything that they wished. This step was intended to allow the participant the opportunity to delete anything that they may prefer not to disclose. An accompanying letter (Appendix 6) went with the transcripts to each participant warning them that reading their own story could be a painful experience for them and to make sure they had access to support if it was needed. The step of returning the transcript to each participant was to establish veracity of the transcribed interview, and also so each participant would have a copy of the story as told by them at that time. The only requested deletion concerned information about another family member that was not directly related to the subject matter of the interview. Some participants expanded on the information contained in the transcripts, giving more details about matters that were particularly important to them. I understood from this that it was their wish that this information could be included in the thesis. This was confirmed with those participants who volunteered additional information.

Procedure and data collection

The participants were encouraged to speak of the suicidal loss of their family member in their own way, and the meaning they made of this loss unfolded as they related their personal stories derived from their intimate family context. The narratives told by the participants included descriptions of the family life in which the suicide had occurred. The family background story drew on the narratives from earlier generations

of the family through the retrospective reminiscences of the participants or from stories they had heard from others. This information was gathered in order to understand the context of a suicide and their relatedness within a family.

In-depth interview method

The interview guide which was used to commence the interviews can be found in Appendix 5. Each interview commenced with the following introduction:

> *I really appreciate your willingness to be a participant in this research project and I am aware that the questions I will ask you may be sensitive. So before we commence, are there any questions you have for me? Are you comfortable here? Do you have any time restraints that we need to be aware of? If during the time we are together today you need a break, please let me know.*

Then the topic area was introduced—the circumstances of the participant's family member's suicide.

Can you tell me about your family member's suicide? It was your (son/daughter, partner, spouse, father, mother, brother/sister) *wasn't it? Can you just let your story unfold as you wish to tell it?*

The second topic area was introduced at an appropriate stage:

> *Can you tell me about your family? I would like to be able to understand how you experienced your family, including who are the*

members of your family. It would be very beneficial if you could tell me about previous generations, even if this information is what has been told to you by your parents and other family members. I would also like to have described to me later generations and especially how members of the family related to one another.

The participants were invited to tell their story in whatever way was comfortable for them. It was common for the stories about the suicide to be told in a steady stream of dialogue as suicide-bereaved family members are so often closed down when they attempt to speak of their experiences. Therefore, to be invited to share their feelings, thoughts and reactions was seen as being given permission to unburden themselves with a person they knew to be vitally interested and one who would respect their intimacies. The interview conversation was therefore quite one-sided in content, but nevertheless recursive (Minichiello, Aroni, & Hayes, 2008). For example, one participant when she introduced herself to me at a conference and offered her story, made the remark that suicide bereavement for siblings had special issues. During the actual interview which took place some weeks later, I reminded the participant of this remark and asked her if she could expand on it. Similarly, when she was speaking of the immediate period after her brother's suicide when the liaison with the police service fell to her, I asked if, for a period of time, she was the only person in her family who knew that her brother's death was deliberate. I further explored this with her by asking how she

experienced the situation during the time she was 'the keeper of the secret'.

With other participants such probes were used when necessary. With the participant who was the experienced lawyer who spoke of the death of his partner and the aftermath, he appeared to minimise or slide over his grief in the conversation. Yet he went on to tell me that he took the dog his partner had previously given him to visit his partner's grave every weekend for months after the death, travelling some 100 kilometres away from his home. I observed, 'sounds like a lot of grief there to me', after which he expanded on what this period was really like for him. In a similar way, whenever conversation lagged I referred to a previous topic or comment with a reflexive question and used recursive techniques to explore in more depth (Minichiello, Aroni, & Hayes, 2008). This always left the participant in control of what they wished to share during the interview, yet encouraging them to share their intimate experiences.

The interview concluded by asking if the participants had any further questions or comments and reminding them that I would be sending them a transcript of the interview and that they were free to delete anything that they did not want included. I also told them about the research process and that the final report would be sent to them with the recommendations. Contact is made with the participants from time to time by email or letter.

Data collection

Of the eighteen participants, nine were interviewed face-to-face and nine over the telephone. The necessity for telephone interviews arose through the diverse geographic locations of some of the participants. Telephone interviews were conducted with participants from Perth in Western Australia, Adelaide in South Australia, Cairns in Far North Queensland and Alice Springs in the Northern Territory. The remaining telephone interviews were with interviewees living in or near Brisbane, which is over 300 kilometres from my home. I did travel to Melbourne and Canberra for two interviews. The diverse locations of participants in this study were unplanned. This potentially added strength to the study as the experience of families may be influenced by where they live and the opportunities or lack of them denoted by location. For example, the participant who resides in Canberra reported that no support services were available in Canberra. The experiences of the suicide-bereaved participants in this study were markedly different depending on where they were living at the time of the suicide. All made reference to this in their interviews.

Two of the participants sent me accounts written directly after the suicide of their family member, and one father sent me a written assignment his then school-girl daughter had composed a couple of years prior. These written accounts contained valuable data and have enriched the wealth of the data obtained in the interviews. There was no discernable difference in

the quality of the data gathered between the face-to-face and telephone interviews. This was achieved by my experience as a telephone counsellor, having spent eight years serving as a crisis counsellor for Lifeline.

Three interviews took place in December 2006, fourteen interviews were made throughout 2007 and one interview was conducted in 2008. The interviews were conducted at a mutually convenient location, with two conducted in the participants' homes, three in my own home, three in my counselling room at a Health Centre, one in the participant's office at a university and the remainder by telephone. The digitally recorded audio recordings were emailed to a transcription service which was recommended to me by another grief researcher who had used this service before. I made contact with the principal of this service as I wished to reassure myself about confidentiality, but also to warn her that the material in the recordings could prove very stressful for the transcriber to listen to and type. The principal advised me that her employees were psychologists who would be advised of the topic and scope of the research project and would be familiar with self-care.

Periodical contact was made with the participants to advise them of the progress of the project. Some chose to keep in contact by email or telephone. A half-yearly report has been sent to all participants and others who expressed interest in the study, but as yet had not been interviewed. Such a degree of intimacy and acceptance is experienced by some of the participants during the interview process, that they feel very comfortable

with me. They will make contact when they wish to, and one even sent me photographs of his family. When I travelled to his regional city for a conference, he bought his family, including his four-year-old daughter, to meet me.

Background to interviews

The participants in this study knew that I was interested in their story of their experience of the death of their family member. In my pre-interviews they had been made aware that I was also interested to hear about their family background, their experience of this family and what the family life was like for the deceased. They were aware that I was interested in their relationship with their deceased relative, and of the influences as they perceived them, on their deceased family member's perspective.

When the arrangements were being made to set the time and date for the interviews, extensive pre-interviews took place, mostly by telephone, but sometimes face-to-face or occasionally by email. In these pre-interviews the participants were given every opportunity to ask any questions about the study that they may have. If the interview was to be a telephone interview, I asked that they consider a time when they could be alone without interruption, and preferably have some support available, if they wished to de-brief with a trusted friend after the interview. This pre-interview enabled the building of rapport, an opportunity to verify eligibility, and to explain and confirm consent that the interview would be recorded and later transcribed.

An invitation was offered for the participants to ask any questions about the purpose of the research study, what would happen to the data collected, as well as what steps are taken to ensure anonymity. Some participants wished to know when some report coming from the project would be available and in what form. I advised them that I would be sending a summarised report of the findings and recommendations at the conclusion of the study. It was discussed with each participant that a copy of the typed transcript of the interview would be sent to them, thus giving them the opportunity to amend or delete any sensitive material that they would prefer not to have included.

The nature of my enquiries drew out the narrative that each participant had formed from their own memories and impressions—information they had been able to gather from other family members as they attempted to construct the story for themselves about the suicide. The interview process itself allows this meaning making to continue in a co-construction with the interviewer as opportunities to explore deeper into their feelings and reactions, or conjectures about their dead relative were encouraged (Grbich 1999). Given that narratives are co-constructed at the time with the audience, this data may be unique, as discussed in Chapter 8, 'Limitations'.

Analysis

The methodology used to guide and inform data analysis followed a 'grounded' approach to order the data into core themes and categories from the transcriptions of the interviews as they unfolded. The core themes and categories were analysed with the on-going data collection. Any themes identified in the data were noted, labelled and categorised. The narratives were stories of the informant's experience of losing a family member through suicide. Participants were also encouraged to speak about their family life and their relationship with their deceased relative. Also of interest were the events affecting the informant and other family members subsequent to the suicide. Whilst the participants' relationships with the deceased are able to be categorised by type of relationship, other common elements and themes within individual stories were identified.

The transcriptions of the participants' interviews provided rich text for analysis. Many of the participants have shared the experience of not being able to speak freely about their loss and this encouraged some of them to seek survivors of suicide support groups. Some others have not felt comfortable in these groups and one of the aims of this research is to give their experience of loss a voice.

Narrative approach guiding analysis

People are story-tellers, whether this is expressed as telling stories to our children, telling our colleagues about our holiday adventures or in sharing our intimate thoughts and feelings with someone loved and trusted. Our narratives have a 'storied' form. By this is meant that there is a temporal context, a 'before', an 'as it happened' and an 'after' time sequence. We make sense of our world and understand our experiences through the narratives we construct. We actually construct our sense of 'self' by the narratives we tell others and ourselves about ourselves. This 'self-narrative' is made up of all the small stories of daily events which when collected together become the overarching story about whom we understand ourselves to be (Neimeyer & Levitt 2000). Smith and Sparkes (2008:6) speak of the self-identity being 'shaped by the larger socio-cultural matrix of our being in the world' and by telling and retelling stories based on audience approval or disapproval.

Narratives contain information about what we have done, when, where it happened, who did what to whom, how and why. Narratives have 'plots' and explain the way certain events in a wider time frame are linked together in a way that describes causal relationships between each of these events (Polkinghorne 1995). People's stories are made up of events, experiences, interpretations and feelings that are important to them.

The narrative we tell about ourselves may be a strength narrative, where will, determination and courage carry us through a disaster or loss

situation. Alternatively, the narratives we tell ourselves may be 'victim' narratives where we see ourselves as helpless victims in someone else's narrative (Ratnarajah 2005). There are some narratives that we will comfortably share with anyone who is interested to listen and other narratives we will only disclose to trusted intimates. It was my endeavour to establish this feeling of trust and intimacy with each of the participants so that I might share their story of the suicide of their family member and its subsequent effects at a deeper level.

When listening to the narratives of participants, it was important to hear how understandings of these tragic events developed over time. In some cases this occurred as the participant grew from childhood into adulthood with an increasing capacity to comprehend the complexities of relationships and life, or as they were able to seek and acquire information that had been withheld or that was simply unavailable earlier. For those to whom the suicide death occurred in their adult lives, when further facts became known, their understanding of their deceased family member changed. Their own cognition of themselves as they experienced personal growth may have followed their adjustment to their grief.

Data analysis led to being able to examine and describe the experiences of the participants according to the meta and micro themes and categories. The purpose of categorising the participants' experiences according to themes was to provide a narrative framework that described the way

people put together an understanding of the suicide of their family member.

Analytic process

The first task after recording the interviews with each participant was to listen to the audio tape and to deepen the impressions of the unique qualities that each participant had shown. It was an attempt to expand my awareness of the identity of this person who has offered to share their experiences of losing a family member through suicide. The intention was to 'join with' in order to appreciate the identity of each interviewee and to gain some understanding of the way they conceptualise themselves and their lives. As Smith and Sparkes (2008:90) explain, 'Identities are considered to be an internalized life story that develops over time through self-reflection'.

In commencing the analytic process of each interview, the task was to learn from the participant the reflexive processes they used to put together the various events in their lives, bringing them to the point of time where they were sharing their story of loss with me. Smith and Sparkes (2008:9) state that people have an innate urge to develop a sense of 'experiential unity' and that their internalised sense of self is an inner construction developed over time. In developing this inner sense of self, each participant in their own way has gathered together the various experiences of their developmental years and their relatedness with their family members.

> An individual's ability to develop and maintain a coherent, unified and positive life story is said to require the cognitive capacity and inclination to draw meaningful connections across one's past, present and anticipated future (Smith and Sparkes 2008:9).

This sense of relatedness and connection may have suffered a severe and challenging fracture when their relative decided to suicide (Neimeyer & Levitt 2000). What effect has this 'disrupted story' (Neimeyer & Levitt 2000:404) had on their sense of self and by what method have they been able to create a coherent life story? How, and whether or not, this has been managed by each of the participants was the aim of hearing and analysing each individual's stories. A thematic analysis of the narratives was undertaken to describe the experience through a temporal lens.

The audio tapes were transcribed verbatim resulting in transcripts which averaged between 20 and 30 pages. Those experiences which were unique or common across several or all of the participants were identified. In the replaying of the audio tapes and in re-reading through the transcriptions the emotional context of the stories was sought and notes made of any intense reflection of feeling, even if not expressed in words. By absorbing the meaning of each sentence or piece of dialogue spoken, the importance of each facet of narrative to the participant was gleaned. Through this process the whole narrative of the participant's life was built up and became familiar, especially the importance to them of their family member who had died, and the nature of that relationship at the time of the death. Also identified was the participant's understanding of the causal events that culminated in their decision to die. Such themes began to emerge

from the transcriptions, which then informed further analysis. An example of some of the emergent themes was whether the death had been anticipated because the participant was aware of the unhappiness within the family, or of the emotional or mental illness of the deceased. Alternatively, whether the death was unexpected, together with descriptions of the consequential shock and trauma experienced by the participant was identified and subsequently followed up in other interviews. The second line of enquiry related to the family background of both the participant and the deceased and, if relevant, if there were issues of past generations in the family on family patterning or history of mental illness.

The participants' stories typically had a temporal sequence, but this was not always as it was told. Narratives which contain high levels of emotional content may be shared in a disjointed manner and may not follow a logical or sequential story line (Smith & Sparkes 2008; Webster & Mertova 2007). In this study, the interviews would commonly start with the description of the family member who died, describing who they were and their relationship with the participant. Then they would detail the actual suicide and how the informant came to learn of the suicide if they were not present at the time. From this point the stories did not always flow in a temporal sequence. Background information or explanations may be given, or the story may move sequentially from the time of learning of the death. The initial analysis reorganised the information in the

transcripts to reflect a sequential flow of events, commencing with background stories of the family-of-origin, the story of the suicide and the antecedents and finally the reactions of other family members. The purpose of reorganising the data into a temporal sequence was so an understanding could be gleaned of the family background of the participant and the deceased. People comprehend current events through the meaning structures they have developed throughout their lives. The family background story will provide important information about the formation of meaning systems in the development of the participants. The 'after the trauma' stories were unfolded up to the time of the interview. The amount of time since the death to the time of the interview ranged from 25 years to one year.

The aim in hearing and reading the participants' narratives was not just to gather an historical record, but to ascertain the context, understanding and perspective of the participant. The way in which the narrative was constructed was considered to be valid information as this indicated how the participant made sense of their story. The meanings gave information on the 'underlying propositions' that make the telling of this story understandable to both the participant and the researcher. In such a way the emerging story was thus enabled to be congruent with the participant's experience; 'the strategy privileges teller's experience' (Riessman 1993:61).

The common attribute of all participants and the requirement for inclusion in this study was that they had experienced the loss of a family member through suicide. It was the relatedness of the participant to the deceased relative that designated the first coding definitions and as such formed the meta-stories. A meta story is the overarching narrative in which differences within the individual stories may be compared and discussed (Polkinghorne 1995). The stories were sorted depending on the relatedness of the participants to a family member who died by suicide, whether a spouse, sibling, child or parent. These different classes of relatedness defined experiences that were unique to each class, as the assumptions and expectations within family relationships colour the meaning making of the loss. The analytical process was therefore created to look for the common experiences of wives, husbands and partners who had lost their spouse, and also the differences that may be evident in the individual stories.

Within each of these differing major relatedness categories, family style and background was noted and these formed micro elements within the meta story. Colouring the participants' understanding of their relative's death were the expectations and the family life experience of each participant. It was important to note and code any history of mental illness or mood disorders in previous generations, physical, emotional or mental abuse, addictive behaviours or deprivation suffered. In identifying and coding for a genetic history, the information that two of the suicide-

deceased family members were adopted as babies was an important coding category that had not been anticipated.

In the analysis of the descriptions of family patterning or way of being together, descriptions of the parental style, whether supporting or nurturing, distant or close, open or closed in communications, was noted and coded into meta and micro themes and categories. The belief systems or religious adherence was seen as an influencing factor in the family life of the participants and their deceased family member, and whether differences identified by the participants were seen as a compounding factor in the decision of their family member to suicide.

The storied lives of the participants were shaped into life narratives as they retold the circumstances of their upbringing. Within these narratives are plot-lines which allow for exploration through data analysis. Stories of stability, regression or progression were emerging themes (Rice & Ezzy 1999). New information gathered over time alters the understanding and interpretation of the evolving narratives. Those participants who lost a parent through suicide when they were a child or young adult were able to deepen their understanding of their parent's suicide as they gained broader life experiences. This new information came, in part, from other relatives when the bereaved child matured and was able to seek this information. New narratives develop as the stories are told and retold (Neimeyer 2001).

Table 4.2 below details the study's objectives and how the micro and meta themes were divided into categories related to those themes. The initial analysis identified the relatedness of the participant to their deceased family member. The next categorisation sorted the data according to a chronological time-line: the family background information and the family patterning evident prior to the suicide, and then the subsequent aftermath or 'sequel narratives'. The details given in the right-hand column of Table 4.2 were derived from the analysis of the participants' transcriptions and coded as micro themes.

Table 4.2—Analysis of data

Links between objectives, meta and micro themes and categories
Analysis of data: Meta and micro themes and related categories

Objective	**To explore the recollections of adults who had experienced a family member suicide**	
Meta theme	**Relatedness of informant to suicide deceased**	
Micro theme	**Category of relatedness**	**Suicide stories**
Categories	Bereaved parents Bereaved spouses and partners Bereaved children Bereaved siblings	Stories of history of relationship with suicide victim Relationship expectations and assumptions challenged

Objective	**To explore the recollections of adults who had experienced a family member suicide**	
Meta theme	**Stories of family background and the suicide—Sagas**	
Micro theme	**Family background stories**	**Suicide stories**
Categories	Family-of-origin stories History of family patterning, supportive, damaging Communication style—open, closed Abuse—mental, emotional, sexual or family violence, shaming Race, sexual-identity issues Mental-health problems Relationship breakdown Impact of differing belief system Abandonment Addictions	How family member died Non-violent means Illicit/legal drug overdose, Poison, Carbon-monoxide poison, Suffocation Violent means Hanging, Gun shot, Deliberate car crash, Under a train Reason for suicide Trigger for suicide

Objective	**To explore the recollections of adults who had experienced a family member suicide**	
Meta theme	**Stories of aftermath, the immediate impact and early and later outcomes—Sequels**	
Micro theme	**Immediate-impact stories**	**Contextual-factor stories**
Categories	How learnt of family member's death Family's reactions Children's and siblings' grief unacknowledged Surviving parent's needs paramount Mourning the loss of changed living circumstances Abuse, shame, blame Supportive people	Secondary losses Financial hardship Emotional deprivation Education foreshortened Loss of friends Loss of relationships

Objective	**To explore the recollections of adults who had experienced a family member's suicide**	
Meta theme	**Stories of sequels and adjustments**	
Micro theme	**Relational-history stories**	**Adjustment-process stories**
Categories	Participants' relationships with family of origin Relational history with partners Relational history with others	Difficulties experienced by participants in adult life Self-acceptance stories Turning points Self-motivation Influence of others Adult grief issues Support accessed in adult life Meaning making—about participants' own lives, about their relative's death

Objective	**To explore the recollections of adults who had experienced a family member's suicide**	
Meta theme	**Stories of view of self**	
Micro theme	**Resilience stories**	**Plot-lines in narratives**
Categories	Stories of internal strengths Stories of external factors that fostered resilience Stories of recovery/change	Victimic plot-lines in narratives Stories in which participants see their deceased relative or themselves as victims of circumstances beyond their control Agentic plot-lines in narratives Stories in which participants have resolved to take control of their lives and be agents of positive change

The findings in Chapter 6 are based on the stories of individual participants and are set out under the core-themes structure incorporating the significant and illustrative stories under a particular narrative theme. This involves selecting, editing and identifying which narratives were most relevant to the core-meaning unit and which were representative of similar stories from other participants. This chapter was structured to enable the most descriptive overall story to be told in such a way that the significant narrational elements and key findings would stand forth.

Thematic analysis—narrative themes in the data

Key words and narrative themes were identified from the analysis of the data. This enabled the analysis of the meanings derived by the participants in their individual stories. The key narrative themes became the sub-headings in Chapter 6. Common elements and differences in the stories of the participants were discussed in these chapters. Also highlighted are the plot-lines in the participants' stories, each plot-line creating a mini-narrative (Polkinghorne 1995). For example, a mother who saw her son as the victim of a scheming mercenary ex-wife could blame the death of her son on the pressure this former partner had applied to her son over a long period. Another key theme that was mentioned by some of the participants, yet unrelated to their relatedness to the deceased, was blame and abuse from other family members after the suicide.

From the transcriptions of the full interviews, illustrative vignettes were extracted and included in the meta theme sections of Chapter 6 so that the participants' thoughts, language and feelings could be expressed. In such a way the various experiences of the participants relevant to each particular topic of the core categories could be assembled and compared with similarities or differences noted. The actual words of the participants conveyed their individual understanding, awareness and response to the circumstances being relayed in their story. The larger story formed the 'whole picture' (McLeod 1997). If metaphors were used by the participants, these were incorporated, as they were illustrative of the participants' reactions and understanding of the event.

As the participants had differing relationships with their deceased family members, not all issues were part of the experiences of all participants, even those with the same class of relatedness. Family style, patterning and ways of being with each other all meant that experiences were unique to each participant. Similar or linked issues were identified and compared with like categories of experiences. A methodology was needed that would allow for the connections between categories to be identified (McLeod 1997). One example of linked causal relationships between data was the pain of rejection experienced in childhood with perceived discrimination in professional careers in later life.

Shades of meaning’

To use an analogy to illustrate what is meant by ‘shades of meaning’: a listener can be familiar with a particular piece of music, perhaps know the score well and can listen to an orchestra, know and hear every note and every instrument and appreciate the composer’s vision. However, each time the music is played with a different orchestra or a different conductor, a new colouration or depth of feeling to the composition may be heard if the listener’s ear is sensitive and their awareness is tuned to the subtleties. It is this colouration and depth of feeling in the meaning making that is indicated by the phrase ‘shades of meaning’ and is what I endeavoured to hear and understand. The aim was to hear the differences and nuances in the shades of meaning in the grief stories told by the suicide-bereaved family members.

Searching for meaning

Meaning making is more than seeking to understand our lives and the events that impact on them through constructed narratives we tell others and ourselves about our history. Meaning making is also about gaining an awareness of the feelings evoked by, or consequent to happenings. Feelings are not as easily described to others as events and circumstances. When we describe events we can state what happened in sequence and relay the history of the event. With feelings, however, we use adjectives and these fall short of being able to really share the experience of a feeling

with another. Feelings have nuances and colour, and we utilise metaphor and analogy to help convey a feeling, or state or climate of being.

In this thesis, there are stories that contain similarities; every person interviewed had lost a family member by a suicide death. There are similarities in the narratives, but the feelings in each case are unique to the one telling the story of their loss. Every participant feels their loss differently and the death has different meanings for each of them. How to hear the subtleties? How to see the different colours or depths in the feelings described?

These narratives concern the loss of relationships. The word 'relationship' contains within it a long line of potential inferences and all of these inferences have meaning and a flavour. In a family, we are in a relationship with the various members of the family, and within these relationships there are expectations and obligations often unspoken and inferred.

Methodological strengths and limitations

Strengths

The strength of this study is that it foregrounds the reactions of a range of first-degree relatives of a suicide victim who have volunteered their stories. Very little research has been undertaken into the family experience of suicide bereavement where first-hand accounts of spouses and partners, parents, children and siblings of the deceased relative have

been heard. While the findings from this study are not representative of all first-degree relatives who have lost a family member to suicide, the experiences of the suicide-bereaved family may be similar to some of the experiences shared in this study.

The methodology selected must allow the emotional affect of the experiences of the eighteen participants to reach the reader. It is important that the data remain true and congruent to the stories as told by the participants. The methodology of narrative inquiry was selected as this would facilitate the aim and allow the story of each participant to be described by the researcher.

Limitations

The findings in this study are limited to be representative of the experiences of the eighteen participants who volunteered their story to this study. This was a convenience sample of people who heard about this research project from one of several sources. The participants also comprised a purposive sample as one criterion for selection was that the participants were all suicide-bereaved family members. t must be acknowledged that not all those who would fit the criteria for inclusion in this study may be confident to volunteer for an interview for many reasons. Such potential participants may have suffered from stigma and be silenced by family and society, for example, and therefore could not be attracted to an interview process, and therefore their stories not captured in the study. One Indigenous participant volunteered her story and all of

the other participants were Anglo-Australian. As a result, little information was available on differing cultural experiences of the suicide of a family member, although one of the suicide deceased was of mixed Asian- and European-Australian heritage. This background was seen to be a major contributor to his feelings of non-acceptance throughout his life.

The main limitation to this study is that only two family stories were contributed by more than one person from the same family. This limited the fulfilment of the initial aims of the study, not of the outcomes or the findings. It is not possible to generalise the findings from this study to all family members who are suicide bereaved as the findings in this study are representative of the journey made by these eighteen participants.

The researcher's role

I am a suicide-bereaved person, and this personal history enabled a quick identification with the participants, and an acceptable answer to the common question of why this study was being undertaken. I was also aware that there was a risk of possible bias, which may limit or effect in some way the telling of the participants' stories. The possibility that the coding and analysis of the data, the discussion and conclusions could be influenced by this was also a concern. This possibility was discussed with the supervisors and other colleagues. I am aware that it was a possibility that I may look in participants' stories for evidence that validate my own experience of loss. Or, conversely, that I might not hear or understand information relayed in the participants' stories that differed from my

experience, or that I could not identify with. For example, I did not feel anger towards my son for ending his life. I might minimise or ignore in the stories of participants if they expressed anger towards their deceased family member. I dealt with this by maintaining an awareness that each experience and story was unique to the individuals. Even though I am suicide bereaved myself, there was no presumption on my part that I could identify with every aspect of the life experiences being described to me. I was very aware to be sensitive of experiences different to my own. The benefit of my status as a suicide-bereaved researcher is that it enabled a ready joining together of participant and researcher and an understanding of the reasons why I would be engaged in this project. Therefore, trust was established and the participants realised that there would be no judgements on my behalf of them or of their deceased family member. I have trained and worked professionally as a counsellor for over fourteen years. I have the ability to be self-aware and reflexive of my own feelings and reactions and to ensure that these do not get in the way of the process of narrative inquiry.

Conclusion

This chapter described the research design and process that has been used in this study to gather and analyse family members' narratives of losing their family member through a suicide death. The meaning making described in the following chapters is that of the participants themselves.

The eighteen participants in this study are the family members of twenty individuals deceased by suicide. Their stories are summarised in the following chapter. Chapter 5 will now introduce the eighteen participants who volunteered their stories. It contains their summarised stories, using their own words and interpretations of events and reactions. The participants discuss the family history prior to the suicide and how they and their other bereaved family members have been able to take steps to face the future after the loss of their family member.

Chapter 5

Narrative portraits of the participants

This chapter gives a brief introduction to the participants who volunteered their stories to this research. These stories are the summarised core narratives of the suicide-bereaved family members and they outline the meaning of their loss in the participants' own words. In order to have uniformity in the length of these portraits, much has been left out of the more complex stories. The longest narrative is that of Hazel, as there were two losses to suicide in her story. Each portrait introduces the participant and also the relative who died by suicide. Information about the background of the deceased is outlined if known, as are the circumstances surrounding the deaths. The aftermath for the participant and family concludes each portrait.

It is not possible to impart the full consequences and emotional impact of the suicide in these summarised stories. These areas will be covered by exploring the key narratives in the findings and discussion chapters (Chapters 6–8). Here, the stories are grouped in accordance with the relationship the informant had to the deceased: spouse, partner, parent, child and sibling and to introduce the reader to the participant. As indicated in the previous chapter, pseudonyms are used where requested, and oftentimes chosen by the participant. Where the participant wished

their own name, or that of their deceased family member, that name is used.

Spousal losses

Narratives are those of participants who lost a husband, wife or partner.

Loss of a husband

Lyn's story—Lyn's husband died in 2007 aged 30 years

Lyn is a tertiary educated young woman who works in a commercial field. She and Danny were married for a year and had a baby son Zac, when Danny, without any warning to Lyn, left their home early one morning. He disappeared for a couple of days, and was found, hanging, in a motel several hundred kilometres north of their home. He had left a note for Lyn saying he had to go away. After Lyn found the note, she discovered that the medication for her postnatal depression was missing and she feared Danny had taken it. She rang the police and reported Danny as missing. Two days later the police informed Danny's father that Danny had died. Lyn was at home alone with Zac when she was notified. She tried to ascertain what had happened from the police and was subsequently told that Danny had died in a motel five hours drive away. The police had rung Danny's father first, would not give Lyn any information and even tried to prevent her from seeing Danny's body. Lyn states, '*those were the worst days of my life*'.

Danny, like his two siblings, was adopted in Darwin. Danny was close to his mother who became ill with cancer when he was in Grade Nine. He

dropped out of school to care for her, as his adoptive father would not help at all. Lyn believes that Danny was emotionally scarred by the experiences of caring for his adored mother. Danny's older brother left home and never contacted his father or sister. Lyn has subsequently learnt that Danny's older brother and sister have both attempted suicide.

Lyn told of Danny's history prior to their meeting and of his earlier marriage. When Lyn and Danny's son Zac was born the birth was registered. The day before he disappeared, Danny received a letter from the Taxation Department as he had not been paying child support for his son and daughter from his previous marriage. Immediately after Danny's death, Lynn was offered support by family and friends, but the support dropped off, and at the time of the interview, Lyn's main support was her mother, who would sometimes look after Zac. Danny's sister and her children moved in with Lyn and at the time of the interview, that was working well. Lyn started accessing day care for Zac one day a week prior to her planned return to work. Lyn has since returned to work and is learning to reclaim her professional life and deal with the difficulties of being a sole parent.

Janelle's story—Janelle's husband Gary died in 2006 aged in his early 40s

Janelle had heard that I had an interest in suicide and when her husband Gary died by suicide suddenly two years ago, she came to me for the initial counselling support. I only saw Janelle once in a counselling role. Even

though there was an offer for her to return for counselling when she felt ready to explore her reaction to her husband's suicide, she did not come back. After Gary's death, Janelle was referred by her general practitioner for psychological support and so she was not a client of mine at the time of this interview. Two years after I first met Janelle, I received a telephone call from her from the local psychiatric ward where her eldest son had been admitted, having just attempted suicide. Another two years after that telephone call, when Janelle heard that I wanted to interview the first-degree relatives of people who have died by suicide, she contacted me and volunteered to tell her story.

Janelle stated that Gary was a talented child who was brought up by his mother and grandmother. His father was distant and had little to do with Gary and his two older brothers, who looked up to him. Gary told Janelle that if she hadn't met him he would have died young. He repeatedly took dangerous risks while driving. *'He always thought that he was invincible, and didn't care if he wasn't'*. Janelle and her husband Gary were both secondary school teachers and both played the piano. Gary was a music teacher at the local high school and was adored by the students. Few friends or colleagues were aware of Gary's bizarre behaviour that was becoming increasingly evident. For Janelle, who constantly shielded him, the difficulties became increasingly intolerable.

Janelle stated that she spent twenty years protecting him until, in the last year, she stopped. Janelle spoke about shielding Gary from his impulse to

spend on himself, undertaking all of the work in the home, their country property and the parenting of their three children, whilst holding a full-time position. Janelle felt like Cinderella as she had no life of her own. When a separation was discussed, Gary mentioned killing himself, but Janelle did not think he was really considering this.

Janelle was concerned for the safety of the children but did not realise that it was she herself who was at risk until she found some coded notes describing ways Gary planned to murder her. She took these notes to the police who immediately took out a restraining order against him. Under the conditions of the order, Gary was not to have any contact with Janelle for two years. When Gary did not arrive at the courthouse for the hearing of the court order, the police began searching for him. Janelle's father and the police found Gary in his car, dead by carbon-monoxide poisoning.

At the request of the psychiatrist treating her son after his suicide attempt, Janelle sought information on Gary's family history of mental problems. She discovered that Gary's two brothers' children all have mental-health issues of varying degrees of seriousness.

After two years have passed, Janelle states that she now wishes none of these events ever happened. She wonders how she and the children were able to get out of the situation safely, and she says they are all still dealing with the after effects of the suicide. She cannot understand why she mourns for Gary. She feels very isolated and has never spoken with

anyone about these events, other than the police and me. Janelle still has trouble putting herself first as she has to overcome the fear that there will be a bad outcome for those she loves if she does consider her own needs, saying, *'I feel like unless I put myself last to everyone, something will go wrong and then I'll pay for it again'*.

Emma's story—Emma's husband Arun died in 2004 aged 50

Emma attended the session I was presenting at a postvention suicide conference. At the end of my session she came forward with a hand-written note containing her contact details and a memorial website address for her husband who had died by suicide three years earlier.

Arun was born 50 years ago to an Australian nurse and a Thai student who lived together for four years in Australia. The wealthy Thai family did not approve of this liaison and ordered their son home. Arun's mother waited to be called to Thailand to re-join her partner, but the awaited invitation never came. When Arun was three years old, she travelled to Thailand with him. Arun's father was sent to America and Arun and his mother were left without support. Arun's mother lived in South-East Asia for the next twelve years.

They experienced much discrimination because Arun was of mixed-race parentage. Arun was placed in various boarding schools and at one time was severely neglected. When he was nine, his mother sent him back to New South Wales, so that he could attend school and be cared for by

maternal relatives. When he first arrived, he could not speak English. He looked different and he was constantly asked where he came from, where he was born and who his father was. He never felt he belonged in Asia, but was constantly queried about his belonging in Australia. Arun asked his mother where his father was, and she told him the facts of his birth and the rejection of them both by the Thai family.

After high school he joined the Australian Navy. For the first time in his life he felt a sense of belonging, he was rapidly promoted and was sent to university to learn Thai. He met Emma and they married after Emma graduated. Shortly after their wedding, he said to Emma, *'You will find out what I'm really like now; I'm no good, and I'll never be any good'*. This was the first inkling Emma had of his emotional problems.

Arun was posted to Bangkok as an assistant at the Australian Embassy. During this time two sons were born and Arun learnt that his father came regularly to Bangkok to see his own family, but only on one occasion did he arrange to meet Arun. Arun reported to Emma that he felt no connection and Arun felt abandoned and rejected yet again.

They returned to Australia and another son was born. Arun applied for a shore posting and did not get it, so he left the navy. Emma stated that this was the worst thing he could have done. With difficulty finding employment, he became very depressed. However, after some months Arun joined the public service. Again he worked hard and was quickly

promoted. He acted in senior positions but when he applied for appointments to more substantive positions he was overlooked. He felt very affronted and rejected.

These cumulative rejections or lack of intimate parenting resulted in Arun being unable interact with his sons. He complained to Emma that he did not know how to be a father. Arun told Emma he would never tell anyone what happened to him in *'that place'* referring to the time spent in boarding schools. Emma had the feeling that somewhere in his childhood he had been sexually abused. Arun attempted suicide one night with carbon-monoxide gas in the car. The thought of the three boys stopped him and he came home and told Emma what he had tried to do. He still would not seek any support.

Meanwhile, Arun was to take up a public-service position he did not want and was dreading this commencing. On the last day, before having to take up the dreaded new position, he hung himself in the garage. Emma was persuaded to claim against the public service for the injustice and discrimination Arun suffered. She was awarded compensation. Arun's death had a huge impact on Emma's three boys as they have subsequently had a troubled educational history, either dropping out of university or secondary school where as previously they were high achievers.

Loss of a wife

Darryl's story—Darryl's wife Josie died in 2000 aged in her late 40s

Darryl is a 'bushie'. He and his two sisters were raised on an outback cattle property in Western Queensland where his father was a station manager. Darryl had an older and a younger sister and when Darryl was six years old his mother died from a brain haemorrhage. Unable to cope out west with three young children, Darryl's father shifted to Melbourne to find work. Darryl's father remarried again very quickly. This was an arranged marriage to ensure that a mother figure was present for his children but in Darryl's words, she was *'the wicked step-mother from hell'*, with no connection to the three children.

When Darryl was twenty, he met Josie. Josie was already a teenage mother of a very young son from a teenage romance and had been abandoned by her boyfriend. Josie's little brother was a mentally incapacitated invalid needing constant attention. Josie helped her mother care for her younger brother both before and after her marriage to Darry, in addition to her parenting role.

Darryl joined the navy to be able to provide a secure income for his family and while in the navy trained as a diesel engineer on small ships. Darryl was often away at sea for five or six months at a time. During this time Josie and Darryl had four children, one boy and three girls, resulting in a family of five children with Josie's first-born son. Darryl left the navy and

held many managerial positions until he started his own mobile diesel-repair service for country properties.

Josie trained as an age and disability carer and because of her long experience with her young disabled brother was skilled and caring in her professional life. She sustained a back injury through her work, and even though she had rehabilitation though WorkCover, her injury persisted. A frustrating period of repeated visits to specialists, tests and physiotherapy ensued, and ultimately WorkCover would not accept that Josie could no longer work. Josie felt discredited by the WorkCover doctors. She felt she had lost her identity and was letting down the family. With Darryl's mobile service necessitating his frequent travelling, many of the daily tasks of housework, cooking and mothering the younger children fell to May, their eldest daughter. Josie began to feel as if everyone would be better off without her.

Darryl stated he had to *'walk on eggshells'* around Josie as she became increasingly emotionally fragile. On the morning of Josie's death, Darryl chided her for talking so much on the telephone to a friend and indicated he felt pressured. He said she looked shattered, but unlike his usual caring nature, he went off to work, leaving Josie with her feelings.

That afternoon, the two youngest teenage girls were playing outside the house and Josie told them she was going to lie down. Later, they peered into the bedroom window and saw that Josie had fallen off the bed. They

forced the door open and found their mother unconscious, having taken all of her pain and depression medication. The two girls rang for the ambulance, called Darryl and tried cardiopulmonary resuscitation (CPR) until the ambulance arrived, but Josie was beyond saving. For Darryl, there was the disbelief, shock and total devastation when he heard of Josie's death. Both sides of the family gathered around Darryl and the children, but the main support came from May, who took on the role of holding the family together.

May was also a participant in this study and her story is told separately under the sub-heading, 'Loss of a Mother'. Darryl is haunted by guilt because when he went off to work on Josie's last day, he did not kiss her goodbye. He is still actively grieving, but serves as president of the Survivors of Suicide Support Group in Queensland. He is very lonely and has kept a journal of his first year after Josie's death, which was made available to me during the interview.

Loss of a partner

Jerome's story—Jerome's partner Sean died in 1991 aged 20 years

Jerome is a lawyer and was the senior partner of a very successful law firm when his partner, Sean, died by suicide. When Jerome was 42 years of age, he was introduced by friends to a young man, Sean, who was just completing his schooling. Sean took every opportunity to spend time with Jerome and it was Sean who initiated a relationship. Jerome saw the

relationship that developed between them as *'just puppy love',* but when Sean left school in his final year, he told his parents he was leaving and rang Jerome and said, *'Come and get me, I've left home'.* Jerome, while flattered by the attention of a much younger man, felt he had been manoeuvred into the two of them residing together. Jerome says of the situation, *'I was emotionally involved enough to care, to really care. So when he came, I sort of took him in.... I felt a bit rail-roaded'*. The relationship commenced with Jerome because, for the first time in his life, Sean felt he was accepted.

Jerome encouraged Sean to complete his secondary education and apply to study law. Sean also worked in Jerome's law firm. While this arrangement appeared promising, Sean, who was artistic, preferred to occupy himself with the artists' community that revolved around Jerome and did not apply himself to study.

Sean and his sister were adopted while his adoptive parents lived in Darwin; Sean and his sister were not genetically related. The family shifted to another state and Sean was sent to a private school where he suffered discrimination because of his sexual orientation.

Sean asked Jerome to use his political and legal connections to find his birth parents. Jerome endeavoured to do this, but the Northern Territory authorities at the time refused every attempt to obtain birth and adoption

records. Jerome encouraged Sean to visit his adoptive parents and sister during the weekends, so that he remained in contact with them.

On the night of Sean's death, Jerome and friends had arranged to go to the theatre and afterwards to a nightclub, but Sean didn't want to accompany them, and stayed home alone. Jerome arrived home in the early hours of the morning and went to bed. In the morning he woke up to find Sean dead in bed beside him. Sean had taken an overdose of Jerome's prescribed sleeping medication. Jerome said there was major panic, the police were called and Sean's parents notified. Sean did not leave a note, but later Jerome found a diary and the entries indicated that Sean had problems, also indicating that he had felt torn between his life with Jerome and his parents.

Jerome said he was interviewed by the police liaison officer and an autopsy was performed. Jerome did access some counselling for a while and kept going to work thinking he was coping, but after some time Jerome began to tire of his professional role, he sold his practice to his partner and went overseas.

Jerome now understands that Sean was looking for an identity, and was also looking for more direction and some positive confirmation from Jerome that he was wanted and belonged.

Multiple family suicide losses

Loss of partner, son and cousins

Hazel's story—Hazel's partner Larry died in 2001 aged in his late 40s. Hazel's son Warren died in 2002 aged 32

Hazel is an Aboriginal woman from Queensland. She is an only child but comes from a big maternal family and is of mixed-race decent on both sides of her family. Hazel's father was a cattle-station manager and her mother also worked on the stations. When Hazel was eight years of age, her mother could no longer home school her, and so Hazel was sent to relatives for her education.

Hazel does not consider herself as an only child because she was raised by several aunties, all of whom had many children. Hazel had 38 first cousins. Of these first cousins, many of whom Hazel considered as her siblings, thirteen have died by suicide. She believes that with many of the Aboriginal community's suicides, *'people just had given up, and copycat reasons'*.

Hazel married as a teenager to a violent, abusive man who she escaped from many times, but was dragged back. She had one son, Warren, from this marriage before she obtained a divorce. After the ending of this marriage, Hazel was in a four-year relationship with Larry. Her then partner Larry had been working in another regional city and Hazel was due to collect him. He was staying with his sister-in-law and suddenly disappeared from view, and was found a little time later hanging in a

shed. There was no note left and from this suicidal death, Hazel has no answers. Hazel gave no history of Larry's earlier life before their relationship.

The suicide of Hazel's eldest son, Warren, was seen as having a different trigger to that of the hopelessness she recognises among many in the Aboriginal male population. Four years before Warren died he had a major car accident and was unconscious for two months. He spent time in rehabilitation and a head-injury unit. In time Warren learnt the skills to live independently and married and had three children. He was awarded a large compensation payout which was managed by the Public Trustee. But once he married, he took the money out of the Public Trustee's hands. In Hazel's words, *'once he had access to this money his life began to spiral downhill through alcohol use'*. He suffered short-term memory loss and anger issues, and when this was coupled with alcohol abuse, his wife left him. Warren made several non-fatal attempts at suicide and on the day he died he went to the mental-health clinic and asked to be admitted. The psychiatric staff assessed him as just seeking attention and turned him away. He went to his maternal grandparents' home and hung himself in the doorway of their garage.

Hazel has many theories as to why Warren chose to end his life at his grandparents' home. As a young single mother she accepted her parents' offer to care for Warren. Her father was able to afford private-school education for Warren. Hazel would plan to visit Warren but her mother

repeatedly used excuses to dissuade her from coming, leading to Hazel being partially excluded from Warren's life. During this time Hazel remarried and had three other sons, all of whom were raised by her.

Hazel has since learnt from other family members that her mother told Warren that Hazel did not want him and did not love him. Hazel wonders if *'abandonment may have been a trigger for him'*. Warren told his grandmother that a priest at the school had sexually abused him. Hazel was not told of this abuse until after Warren's death. When she challenged her mother about it, her mother said she simply did not believe Warren when he told her.

Hazel has had a successful career and has been actively engaged in fighting for Aboriginal rights. She also sits on a regional Queensland Parole Board. She states that her greatest pain is that, despite fighting for all Aboriginal issues, fostering 40 children and been named as Mother of the Year, she was not able to mother her first born. Hazel believes that Warren recognised that the reason he was not able to live with his mother lay with his grandmother, and it is for this reason that he chose to suicide where he did.

Parental losses of a child

Loss of a daughter

Wilson's story—Wilson's daughter Holly died in 2000 aged 17

Wilson has had a varied career. He has worked as a journalist and been employed in managerial positions. Wilson had been corresponding with me via email for quite a few weeks prior to the interview. He had told me that he had lost his seventeen-year-old daughter to suicide seven years earlier. Wilson and his wife separated when Holly was seven and her younger brother was five years of age. Due to difficulties he had in having access to his two children, Wilson decided to move interstate and he endeavoured to maintain frequent telephone and written communication with his children, but this was often denied. He continued to financially support his two children. The children's mother relocated and Wilson employed a private detective to find them so he could regain access to his children. Prior to the interview, Wilson sent me some compositions that his daughter Holly had written during the period she came to live with him when she was fourteen years old.

After several years without communication, Holly telephoned Wilson when she was fourteen years old, and asked him to *'get her out of the situation'*. He arranged for her to come to North Queensland and live with him. He got to know a very disturbed girl who was anti-social and disliked school and discipline. But with patience Wilson was able to facilitate the change in her attitude and after six months of living with him she was

gaining A grades for her school work, had a part-time job and was playing sport. However, her mother objected that Wilson was now receiving the parenting payment and she insisted that Holly return to live with her. While she was living with Wilson, Holly told him that her mother's boyfriend had been acting in an inappropriate sexual way with her, and when she had told her mother, the matter was dismissed. Wilson also had some suspicions that Holly was exposed to illicit drugs prior to coming to live with him.

Wilson was devastated when Holly returned to live with her mother. He relocated back to Victoria, and despite many difficulties tried to see both his children regularly. He was living in Victoria when he received the telephone call telling him that Holly was dead. He drove to his ex-wife's home city and learnt that Holly had hung herself. From what Wilson could gather from the incomplete and confusing information he was given, Holly had a disagreement with her boyfriend and was alone at her mother's home when she had hung herself. The autopsy indicated that she had an alcohol content in her blood of .07 and that there were puncture marks on the inside of her elbow indicating the possible use of drugs. Wilson's wishes were ignored in the funeral arrangements and he felt disenfranchised by his ex-wife and her family.

After Holly's death Wilson returned to Far North Queensland where he contacted Compassionate Friends, the support group for parents who have lost a child, and also the Survivors of Suicide Bereavement Support

Association. He is now active in both these organisations. Wilson has since re-partnered and now has a young daughter. He is also close to his son's two children.

Loss of a son

Delma's story—Delma's son Colin died in 1995 aged 33 years

Delma was married very young to a policeman whom Delma described as a violent alcoholic. She states that she was a victim of verbal and physical abuse, yet she could not report the abuse to the police as her husband was the police sergeant. The marriage ended after Delma suffered a breakdown. Subsequently, Delma trained as a nurse and worked in palliative care and later as a hospital chaplain. During this time she raised the three children on her own, two boys, Brian and Colin, and a girl, Linda. Subsequent to the dissolution of the marriage, her ex-husband's alcohol problem became so severe that he was hospitalised. Despite a period in a detox unit, he was pensioned out of the police force. He continued drinking and died a derelict from complications related to his alcoholism.

Delma's two sons were close and worked together. Brian, the eldest son, had distinct memories of the vicious attacks on his mother and hated his father. Neither of the two younger children really remembered their father but the younger of the two boys, Colin, always longed for and missed a father figure. Both the eldest boy and the daughter have had lasting

marriages and families, but Colin has not enjoyed the support of good relationships. He had one marriage and another long-term relationship, but both ended. He had two children, a boy and a girl, from each relationship. After the end of his last relationship he went to live with Delma.

Delma was aware that Colin was withdrawn, unhappy and that he felt like a failure, but he gave no intimation that he was planning to end his life. On the day he died, he was focused on doing all the jobs that Delma needed done around the house. That evening she found him sitting with a gun under his chin. She rushed to the telephone and called her eldest son, Brian, and her daughter's husband, who is a police negotiator. Colin rejected their invitation to talk and, with Brian present in the room, he shot himself. Delma heard the shot and rushed to the room. Soon after arriving at the house, Delma's police-officer son-in-law called the police. Delma experienced the police presence as unhelpful and dismissive. The next day, Delma's son-in-law arranged for the police counselling support service, which she also described as helpful.

In the immediate period following her son's funeral Delma became suicidal herself. She tried to carry on her work as a hospital chaplain, but could not. She joined the Survivors of Suicide Bereavement Support Association and subsequently became a group leader. She remains a telephone counsellor for this service. She is very close to her surviving son and daughter and their families.

Angie's story—Angie's son Joshua died in 2006 aged 29

After a short-term relationship with a man who was later diagnosed with bipolar disorder, Angie found herself a single mother of a premature baby, Joshua. Angie had little support to assist in raising her son. Angie's ex-partner, Tony, did not want a long-term relationship or a child. She was the sole carer of a fragile child who frequently required hospitalisation for severe asthma. The medication prescribed to control his asthma had damaging side effects, and Angie's son developed a short rotund body and a round face. He was subjected to taunts at school and, following an inheritance, Angie was able to send him to a private school where he made lifelong friends. The medication was also thought to be responsible for the mood swings that Joshua exhibited and it was not until he was 25 years old, four years before his death, that he was diagnosed with bipolar disorder.

Despite being very intelligent and enrolled at university to study law, Joshua was unable to maintain steady employment. Joshua, because of his emotional and mental instability, began to have problems with the police. On one occasion Joshua had an accident and was hospitalised with a brain bleed, but he discharged himself from hospital. The police picked him up, thinking he was a vagrant, and held him in custody for a week. After this time they rang Angie and asked her to attend court for him. He was returned to hospital but there was no mental-health bed available.

Joshua then began driving cars for a massage parlour and Angie reported that he became enamoured with one of the sex-workers. This young woman was also abusing drugs and Angie believes that she may have introduced Joshua to heroin. Joshua complained to his mother that *'everyone has a mate except me',* so he was very lonely. He gave many of his possessions away and took a deliberate overdose of heroin, which ended his life.

Angie has made many complaints to the Health Department following Joshua's death as she feels he was let down by the hospital system. She feels that public patients do not receive adequate attention and are not diagnosed until they are so ill that they have a major psychotic episode, often involving the police. Even then, many are not hospitalised and helped. To try to bring some attention to the inadequate care that Joshua received, Angie has been attending suicide-prevention forums and writing to members of the state parliament to raise awareness of the needs of the mentally ill.

Olivia's story—Olivia's son Chris died in 1991 aged 21

Olivia and her husband separated when her two children were very young, and their father had little connection with the children. Olivia worked and raised them as a single mother. She was particularly close to her son Chris; she says they were soul mates. Chris shot himself three weeks after his twenty-first birthday. He was living on his father's farm and was

found by his father. He seemed to need to be with someone and his father said that they could have a boy's night at home but twenty minutes later, he found Chris dead on the bed.

Olivia said that Chris had made two suicide attempts about four years earlier, while he was still living with Olivia and his older sister. On one of these earlier attempts, he had cut his wrists and bled very badly. In the other attempt, he had swallowed poison and had been hospitalised, but he refused any psychiatric or counselling support. He stated to his mother *'if I cannot talk to you, I don't talk to anybody'*. After this second suicide attempt, when he was in the ambulance he kept saying to Olivia, *'It's not your fault; it's not your fault'*. Olivia tried to encourage him to talk about his problems and his stock answer was *'No, if you can't be loyal to your friends, who can you be loyal to'*. So Olivia knew that Chris had a secret relating to his friends. After these suicide attempts, Chris refused to consider tertiary education and went to live with his father on a rural property in Far North Queensland.

After Chris's death, Olivia spoke to some of his friends who told her that he had spoken to them about his deepest regret of being in a car with a couple of mates when someone was hurt really badly. Olivia believes that it was this guilt that haunted him—a guilt he could not speak about or let go of. Olivia believes that this relates to an earlier event when Chris was eleven years old and he and a mate went to a mountain near home. One

day some older boys found them and the two younger boys were very badly beaten. They told Olivia that they would never forget what those older boys looked like. Olivia believes there was a sexual element to the attack.

Alan, Chris's friend who was also attacked, was a year older than Chris. Olivia later heard from Chris's friends that one night, when Chris was with Alan and another friend in Alan's car, they saw one of their attackers come out of a hotel, and ran him down and fled. At the time of this incident, Chris would have been seventeen and Alan eighteen years of age. Despite telling Olivia shortly before his death that he was committed to his girlfriend and had plans for their future together, he bore a secret he could not live with and therefore he could not stay alive. She believes that Chris felt the need to pay for whatever he did and she regrets that Chris's friends did not tell her about the incident before he killed himself. She feels that if he could have made some sort of restitution it would have saved him. In the time since Chris's death, Olivia joined the Survivors of Suicide Bereavement Support Association as a founding member and has since become a group leader. She remains a telephone counsellor for this service.

Children's losses of a parent

Loss of a mother

Laura's story—Laura's mother died in 2006 and was aged in her early 50s

Laura was 24 years of age at the time of her mother's death. Laura's parents separated by mutual agreement about nine months before Laura's mother died. Following the separation, her mother had gone to live with a sister who she did not like and did not get on with. The separation also caused depression for which she was not treated. Laura's mother walked in front of a train and was killed. The police informed Laura's father who then came to give Laura the news; *'he's not good at feelings, and it was hard for him to break the news gently'*. They phoned Laura's older brother who was living in Victoria.

Laura stated that she was really shocked by the manner of her mother's death and she kept hoping it was a mistake. Laura had to contact the police herself and discovered that the police had confirmed her mother's identity from her dental records. The police dealt directly with the aunt and made no attempt to contact Laura, her brother or her father—neither did the aunt. Laura speaks of blaming herself for her mother's death, and blaming others, especially her aunt. At the time she did not suspect that her mother may take her own life, but she had sought assurances from her mother that she was not thinking of suicide so was unaware of how unwell her mother was.

Laura speaks of her mother's funeral being *'the worst experience ever—it was like a nightmare'*. The enmity in the family was so bad that police presence at the funeral was considered. Neither Laura nor her father was consulted about the funeral arrangements. Laura pleaded with her aunt not to bury her mother, but the aunt ignored her pleas, and did so anyway.

Laura is a hairdresser and is also doing external studies in justice at university. It's comforting for her to know that her mother was very proud of her undergoing university education. The coronial counsellor provided some telephone counselling to Laura and named Laura's aunt 'a psychopath'. The coronial counsellor put Laura in touch with the Survivors of Suicide Support Association. Laura also accessed a hospital-based counsellor.

Laura is very isolated now and states that there are fractures in the relationships on both sides of her family. Laura's brother, who is five years older, has a long history of illicit drug abuse and has been in trouble with the police. He also suffers from depression. Her brother is currently in custody in Victoria, although she keeps in contact with him. The relationship that she was in at the time of her mother's death has ended and Laura has had difficulties finding somewhere to live where she can feel safe and comfortable. She has continued her university studies over the last twelve months and looks forward to completing in the next few years.

Kim's story—Kim's mother died in 1980 aged 56 years

Kim and her sister were orphaned when they were barely adults. Their father died of cancer two years before their mother's suicide by suffocation. Kim's mother had bipolar disorder and after Kim's father died, the symptoms from her mother's illness became more extreme. Kim was very attached to her father and he was proud of her academic success. She felt less attached to her mother and she stated that her mother was neither warm nor affectionate. Yet Kim speaks of the degree of responsibility she felt for her mother, especially after her father's death, and that she tried to look after her. While Kim did her best, she felt burdened by the responsibility as her mother became more unstable. She left her employment and shared a flat with her sister but they visited their mother frequently to check on her. Kim enrolled in another course at university, and again changed direction before she found the course she wished to follow.

Kim's mother had been hospitalised for many months in a vegetative state after an adverse reaction to lithium to treat her depression. It was not that long after being released from hospital, when in a depressed and hopeless mood, she died by suicide by placing a plastic bag over her head, tying pantyhose around her neck and cutting the oxygen supply. Kim's mother had indicated to her a week earlier that she was thinking about dying and Kim had sought advice on how to obtain private psychiatric help for her, even asking about private hospitalisation. Her mother

rejected this and, shortly before she died, made a last visit to other family members. When Kim and her sister called on her the following morning, they found her sitting upright in bed—dead.

The two sisters were terrified by their mother's death. They were too frightened to go to sleep at night in the weeks following and clung together for support. Kim started reading about suicide after her mother's death and this led to her undertaking an extensive course in psychotherapy and she became a psychotherapist and lecturer herself. Kim's sister trained as a nurse. Kim understands well the pain family members of the suicide victim feel and vows that she would never do it herself no matter how bad life may become.

Kim now works in the mental-health field and even though she does not like having suicidal clients, she feels she is able to help them. She believes that she knows what they need: to have someone who does understand and care, who can give them the repeated message that this feeling will pass and that there is help available. Kim has found strength in her own resilience and in her philosophical attitude to life. She is a Quaker and enjoys the contemplation at the meetings.

May's story—May's mother died in 2000 aged in her late 40s

May's father Darryl was introduced earlier. May followed her mother's lead and from a young age was trained to be the carer of her younger siblings just as her mother had cared for her own brother. She states

proudly that she was *'Mum's right arm'*. May spoke with pride that her mother always believed in her and had faith that she would be able to properly carry out any jobs given to her. However, May also expressed that it was unfair that she carried more of the work load than her siblings.

May believes that she has made good choices in life. She is happily married with a young son and has returned to tertiary studies in psychology. Her biggest worry is the domino effect of a suicide in the family. She worries about all of her siblings, especially the two brothers who, in May's opinion, do not have a healthy or positive lifestyle. Her eldest brother only contacts the family when seeking money. May also fears that he may have drug-induced schizophrenia.

May's two younger sisters were home on the day of Josie's death from an overdose of her anti-depressant and pain medication. They told May that they remembered their mother was emotional. The youngest sister, Tammy, was the one who told her older sister, *'there is something wrong with Mum; we have to go in there'*. Entering the bedroom, they found their mother on the floor unconscious; they called the ambulance and their father. However, in spite of their CPR efforts, it was too late and Josie subsequently died.

May understood that Josie was torn by conflicting responsibilities between the care of her disabled brother and her own family, leaving her feeling incapacitated and useless. May knew that Josie felt trapped, yet stated

that Josie never said she was planning to kill herself. However, May also reported that her mother had made a previous suicide attempt. May expressed feelings of guilt and says she should have known her mother would suicide. She sees her mother's death as saying *'I don't love you enough to stay'*.

May's younger sisters left home as soon as they could after their mother's funeral. May says that in the end, all of her siblings left *'because Mum was the heart of the home and everyone went to where they were comfortable'*. May acknowledges that, in her father's memory, he views his relationship with Josie as perfect. May says the demands from Josie's mother to assist her in the care for her disabled brother became an intolerable conflicted situation for Josie. Since Josie's death, May, like her father, has been a volunteer telephone counsellor for the Survivors of Suicide Bereavement Support Association. Darryl asks May why four of his children are struggling so hard but she is not.

Loss of a father

Delia's story—Delia's father died in 1982 aged 38

Delia introduced herself to me at a Suicide-Prevention Conference. Delia and her younger brother were the children of a mother who Delia described as a '*cold, uncommunicative and controlling mother who was a Jehovah's Witness'*. Their father was a research scientist for a government research authority. Delia remembers her father as a loving and special father, '*who died in the prime of his life at the age of 38'*. Delia's mother

had a traumatic, abusive childhood and she dealt with problems in life by ignoring them if she could, or by just shutting down. Delia was eleven years of age and her brother was seven when their father died by suicide by swallowing cyanide in the laboratory at his work.

Sometime previously, Delia had become aware that her father was troubled and that he said some strange things, which upset her mother a lot. She knew that he had been prescribed anti-depressants but also that he did not take them. When Delia was young, her father explained to her that some adults, when they are sick, do not want to live and that if they wish to die it is called suicide. Delia feels that her father was trying to prepare her for his suicide. Within the family Delia's father became more and more isolated. The Jehovah's Witness Church told the children that their father would go to hell if he did not join the church. Delia said, *'even as a child, I thought this is very strange, so I just kept it all in my head'.*

Shortly before Delia's father died, he visited his brother to ask for help. His brother stated that he had responsibilities and had to cope with his problem. Delia remembers her father ringing his brother the next weekend to say goodbye and that he was smiling and happier than he had been for years. The next day he died.

Delia said on the day her father died she knew something was wrong, but thought he may have run away. Then the police came and her mother said to the children, *'your father took something today and it killed him'.* No

explanations or comfort were given to the children. Each was left on their own, isolated in their shock and grief.

After the death people from the church made the children throw their father's possessions on a fire. The children were told that the church believed they were from the devil. The children were told that their father wouldn't be resurrected nor would they bury him because of the way he died. Following Delia's father's death, Delia's mother would not spend any money on the children's education or health needs and Delia was ordered to leave school at sixteen and get a job. Delia was told this was because the church believed that parishioners should take a low-paid job, but then go out door-knocking to spread the church's beliefs.

Since that time, Delia has married and has gained a tertiary education. She has suffered from bouts of depression and consults a counsellor at times. She is no longer in touch with either her mother or her brother as she left the Jehovah's Witness Church. She knows that her brother is mentally unstable and has had psychotic episodes. Delia's paternal relatives have shared stories about her father and have passed on some of his possessions and photographs.

Delia concluded her interview saying *'I would like to ask everyone to please listen to your loved ones, let them speak, without judgement. Be a listening ear to someone who has lost their way, don't be afraid to ask questions, or seek whatever help is needed'*.

Sibling's losses

Loss of brother/s

Monica's story—Both Monica's brothers died in 1990. Tom, the first brother to die was aged 34; Ben, the second brother to die was aged 38 years

Monica heard of this research study and approached me saying the topic was relevant for her family. Monica was born into an Australian family of Irish descent, with strong Catholic traditions. She was one of eight children, with two sisters and five brothers. She speaks of her mother as very rigid and unable to foster any emotional connection between the siblings, and states that they grew up with no sense of family. She used the analogy of her mother being like the sun with eight satellites revolving around her, but no connection between any of them. Monica's father was a gentle hardworking Irishman who was dominated by her mother. The five boys all adored their father.

As a teenager, Monica was a rebel. She is the only one in the family who left home to live away from the family. She became pregnant at twenty, and returned home to her parents who told her that the baby would have to be adopted out. Monica left again and took herself to a Catholic single mothers' refuge in a capital city until her daughter was born. She worked and raised her daughter, and trained as a nurse.

Monica's brothers were all educated in Catholic schools and Monica suspects that they may have been physically and sexually abused, but

could not speak about it. Being boys, they were conditioned not to cry. They grew up quite frozen emotionally, and Monica states that as they grew, they all became alcoholics. Not one of Monica's brothers has been able to achieve a close and loving relationship with a spouse or partner. When Monica was teaching overseas she was contacted by her family to inform her that the brother younger than herself, Tom, had died by suicide by shooting himself. She flew home for the funeral and after four weeks returned to her overseas post. She was barely back at work when she received another telephone call saying that another brother, Ben, the one immediately her senior, had also died by suicide, again shooting himself. There was just six weeks between the brothers' deaths.

Ben, the second brother to suicide, had been retrenched from work and had gone into a detox unit, but did not have medical supervision during this period. When he came out of the detox unit he died by suicide, but was not found for two days.

Monica's daughter Phoebe ran away from home when she was thirteen years of age after being sexually interfered with by a teenage friend. Phoebe also abused alcohol from a young age, but she entered detox and abstained from drinking for a number of years. Phoebe suffers from depression and can have outbursts of anger. She has had several relationships and has four beautiful children. Monica fears that Phoebe will suicide also and tries to support her, despite the problems that geographical distance creates as Monica lives in a different city to Phoebe.

Monica also has a teenage son, Jerry, who is relaxed, happy and well adjusted. Phoebe and Jerry have a loving bond. Monica now works in a tertiary institution and life is good for her, even though she worries about Phoebe.

Sally's story—Sally's brother died in 1996 aged 36

Sally attended a presentation I gave at a grief and bereavement conference in July 2008. She spoke to me afterwards and offered the story of her brother's suicide. I accepted her offer and learnt that she was a social worker living in Central Australia, mentoring Aboriginal tertiary students. Sally had previously worked as a grief counsellor. Her motivation in offering her story to this research project was to highlight the grief of siblings who are bereaved by suicide.

Sally discussed her childhood in a regional city in a southern state where she grew up with two younger brothers, John and Tim. She stated that she welcomed the opportunity to share her story as she found speaking of her brother's death a healing experience, but one that '*doesn't happen very often for various reasons'*. Her parents were both brought up on farms and from the family stories, had a difficult time. She believes that because of this the parenting that she and her brothers experienced was *'quite authoritarian'*. John, Sally's brother, attempted to follow in his father's footsteps to study law, but decided not to continue as his first love was music. This caused a rift in his relationship with his father, with Sally

saying, '*there was a lot of tension there'*. John moved to Sydney to pursue his jazz music ambitions and became quite well known. Sally was also in Sydney at this time studying psychotherapy.

This was a difficult time as Sally became aware that John was becoming increasingly depressed. His unhappiness was reflected in his music and art. John consulted a psychiatrist who diagnosed depression of both a biological and familial origin. She regrets that she was not aware of the depths of his depression and his despair. John was killed in a railway tunnel and the police have told her that they believe he lay on the lines. He had previously made an attempt to take his life by cutting his wrists. He was found and taken to hospital where his wrists were stitched up and he was released. Sally is frustrated that the health authorities who treat suicide attempters cannot advise the families of those at risk due to client confidentiality restrictions.

John's death was particularly difficult for Sally's parents and for some time they preferred to believe that his death was an accident. '*For a period of time, I was the only one in the family who knew'*. Sally had the difficult job of dealing with the police and packing up John's flat. Sally told her father of the suicide, but he asked her not to tell her mother. When Sally's mother came to Sydney to stay with her, they visited together the site where John had died, and Sally's mother asked her if it was a suicide.

Sally's youngest brother Tim was studying for his Higher School Certificate at the time of John's death. Afterwards, Sally feared that Tim would also take his life as other tragic events followed, including the death of his girlfriend from a drug overdose and, later, a failed marriage. Tim was very close to John and emulated his musical world.

Tim still struggles with substance abuse, but Sally has introduced him to her Buddhist group in Sydney. He is beginning to find companionship with other young men who have a healthier lifestyle and are able to be positive role models for him in his role as father to his two young children.

Loss of a sister

Elizabeth's story—Elizabeth's sister Roberta died in 1987 aged 39

Elizabeth and her older sister Roberta were the only children of a disgraced British Army officer who was jailed when posted to Ghana. The girls and their mother were sent home to England with no help from the army and the girls were placed in an orphanage. They found out much later that their father had been court-marshalled and jailed. The army took any money that her father was owed and provided no support for his wife and children. Elizabeth believes they were in the orphanage for over a year. Elizabeth recollected that *'suddenly they were driven for many hours and there was their mother, both girls crying and clinging to her, and their father was back'.*

Elizabeth claims their father was very unstable. He was a teacher but still maintained his army persona, calling himself ‘Captain’ even though he was not entitled to that rank or title. Even as teenagers, both Elizabeth and Roberta were being beaten regularly and went to school with bruises and black eyes that were never investigated. Elizabeth says she was terrified of her father. Roberta hated their father with a passion.

Both girls married young. Roberta married a Spanish man, Anton. After Roberta married, she and Anton moved to Bermuda. Elizabeth became aware that Roberta’s marriage was very unhappy and she was becoming increasingly frantic. At the time, Elizabeth and her husband were living in New Guinea. However, because of her concern for Roberta, Elizabeth wanted to leave New Guinea and go to Roberta, who by that time had moved with Anton and their two sons to Spain.

Roberta attempted to kill herself several times. Following one of these attempts, Roberta’s husband sent her back to England where she was admitted to a psychiatric hospital and was given electro-convulsive therapy. When Roberta was finally released from hospital she went back to her parents. Roberta made another attempt on her life and her father sent her back to Anton in Spain. Shortly afterwards, Elizabeth received a telephone call from her father informing her that Roberta had driven off a cliff and was dead. Anton had buried Roberta before he told her parents of her death, so Elizabeth and her parents could not attend the funeral.

Anton remarried and Elizabeth has heard from her nephews that the new wife treated the two boys very badly and wouldn't allow any contact with their maternal family. Many years later, Elizabeth was able to trace the boys and discovered that their father had died and that they had been disinherited by their step-mother. Elizabeth has maintained contact with the eldest of the two boys. With Elizabeth's encouragement, Anton's will was being contested and the boys may be able to receive some inheritance.

Before her mother's death, Elizabeth wanted to know why her mother stayed with her father. Her mother said, *'we all have to do the best we can with what we have been given, sorry but I can say no more'*. There are many unanswered stories in Elizabeth's childhood that will never be resolved now with so many members deceased.

Loss of a brother-in-law

Philip's story—Philip's brother-in-law Colin died in 1995 aged 33

Philip is a police negotiation officer and is Delma's son-in-law. When Delma discovered her son Colin sitting with a gun in his mouth, she rang Philip and Colin's brother Brian and they both came straight to Delma's home. Philip arrived first. Philip said that he tried to get Colin to talk with him, but Colin was very private and would not speak with him. Colin became increasingly agitated when Philip attempted to connect with him.

When Brian arrived, Philip went upstairs to be with Delma and while upstairs they heard the shot that took Colin's life.

Philip said he had seen similar scenes in his work with the police force. Brian had not. He recognises that the shock to Brian, who was in the room trying to plead with his brother not to do it, was worse than his own reaction. For Philip, one of the hardest things was going home to tell his wife Linda that Colin had shot himself and that he couldn't prevent it. The following day Philip went to see the police human resources officer who then spent time speaking with Delma, Brian, Linda and himself. He states that the police human resources officer was able to help him distinguish between his professional role and his personal involvement. Recognising that he was not there in a professional capacity really helped him deal with it.

The night after the death Delma, Brian, Linda and Philip sat up all night talking together about it and throughout the next day. Subsequently, all of the family have spent much time talking about the tragedy, and they now have a very open relationship with each other. They can speak about anything. Philip says that no one in the family had any idea of Colin's suicidal ideation prior to that day. It helps Philip to realise that it was Colin's decision to die; no one pushed him to that.

Philip's biggest regret is that Colin's son is now disassociated from the family. Philip is aware that his life is dysfunctional and that he is leading

a drug lifestyle. Colin had a two-year-old daughter when he died, but this child's mother had a falling out with Delma over Colin's estate and now the family do not see her either.

Conclusion

These portraits present a view of the eighteen participants who have offered their family story following the suicide death of a loved one. The meaning that the participants have been able to construct from this loss will be told in the next chapter.

Chapter 6

Family sagas, suicides and sequels

Introduction

This chapter examines and explicates the stories shared by the participants about their family, including their history of past generations. It presents an analysis of the data ascertained from the participants' narratives. The data is the participants' narratives of their experience of the suicide as presented to me on the day of the interview. Also explored during the interview was the family history prior to the suicide, thus allowing a fuller exploration of the antecedents to the suicide. In order to fully understand the participants' narratives in the context of the family, three key themes are presented. This allows for constructing and retelling the story and the histories of other members of their family—both the current generation and preceding generations. This offered an understanding of the family history and patterning and formed the first narrative 'Family sagas'. The second narrative, 'The legacy of suicide', includes the participants' understanding of the reasons or trigger events that occurred around the suicide, as well as the impact on them and on the other members of their immediate family. The suicide stories identify differences in the participants' grief stories according to the class of relatedness each participant had to the deceased.

Details of the third narrative, ‘Family sequels’, conclude this chapter. These narratives tell the history immediately following the suicide. Included are participants’ descriptions of their experience of the services of those who were first responders after the death. The events following the suicide resulted in fractured families for some participants, many of whom were left without support. In some cases those offering support did not meet the needs of the family. This narrative concludes with the changes in the participants’ view of themselves, their belief systems and relationships with other family members as they look back and review the events leading them to the interview.

Family sagas

The word ‘saga’ is Nordic in origin and describes the tales of heroic adventures. In more common usage, saga means a fictional story, usually the narrating of a family story across many generations. The family sagas described in this thesis are not fictional; they are the shared stories of the participants’ lived experiences within their families from their point of view. Also retold is the historic knowledge about earlier generations, especially if this information points to difficulties experienced and tragedies suffered, very often hidden as a source of shame. These family sagas can be viewed as heroic narratives as they are the lived experiences of those who so bravely volunteered their stories of tragic loss. Like all sagas, these narratives speak of journeys into the sense of self, both of the participant and of their relationship with their family member who chose

to die. Following are the narratives that describe how participants faced family dysfunction, mental illness, conflict and damage within an environment that most expect to be safe and protective. All of these family saga narratives contain loss, suffering and grief, but there are also stories of courage and rebuilding of lives with a stronger sense of self. The family sagas are key narratives, but within these key narratives are the sub-narratives of the background stories of the family.

Background stories of the families

The family background stories describe family life, sometimes covering more than three generations. These stories contain histories of difficult, victimised relationships, damaging family climates and mental illnesses or mood disorders for every participant. There is clear evidence of what could be termed fractured families. In the context of this thesis, fractured families relates to the family culture that was reported as unsupportive, abandoning, negative, neglectful or shaming and thus creating a potentially damaging family environment. This information was willingly provided by the participants as their own family history. The participants have clearly considered the past history of their family in their process of making meaning following their family member's death.

Two of the suicide-deceased family members were adopted as babies and were never able to discover any information about their birth parents or their genetic family. No information is available as it was government policy at the time to block all attempts of obtaining information on the

birth parents of those who had been adopted. The wife and partner of the deceased former adoptees spoke of their spouse's efforts to obtain this information and their frustration when it was unavailable. As neither Sean nor Danny, who were both adopted as babies, were able to trace their biological mothers, no history is available about the circumstances in which they were given up for adoption. No inference can be made that they were abandoned by their birth mothers when babies. However, the fact that they were both actively seeking information about their birth mothers at the time of their suicide indicates that they longed for information regarding their birth family.

Early family environment

Diagnosed mental illness, brain damage, addictive behaviour or mood disorders were reported in almost every case of suicide examined here (19/20 deaths, refer to Appendix 7). In the one case where the partner of the deceased had no information about the reasons for the suicide, she also lacked any knowledge of damaging events in her partner's earlier life. Where the family history was known, there are reports of mental illness and mood disorders in many of the families of origin. In several cases, evidence of difficult or regularly stressed family relationships and communication styles were reported. The early loss of a parent or sibling illness resulted in difficulties for the families who experienced these losses. Some participants expressed bewilderment and disempowerment as a result of living throughout their developmental years in such

circumstances. Some participants spoke of their deceased family member with pride. This is exemplified by this statement by Delia at the beginning of the interview:

> *Firstly, my father was a beautiful human being. I feel privileged to have known my Dad, and miss him terribly, but take comfort in knowing he watches over me. If I could summarise the man my father was in a few words I would say he was a beautiful human being, with an inquiring mind, who was kind, generous, loving, intellectual, academic and artistic. He is remembered for having a beautiful smile and gentle temperament. He enjoyed reading about all kinds of things, including art, history, war, mineralogy, science and language. He had an unusual perspective on life and would try and share that with me as his daughter. He was a man who contemplated things a great deal, a deep and sensitive soul, who felt things far more than most other people would.*

While Delia and others expressed pride in their loved ones, their suicide death also uncovered or exposed dysfunction in the family. What follows are the narratives of fractured families—some fractured because of the disruption of mental illness evident not only in the current generation, but in earlier generations. These narratives speak of conflict within the family due to differing belief systems, or a breakdown in families that is clearly evident where there has been physical, emotional or sexual abuse initiated by the more powerful against the vulnerable. Similarly, the experience of rejection means that a member of the family is not accepted, and when some family members are abandoned by a caregiver, they are very aware of the fracture in the family as they themselves are designated as other, different or unacceptable.

The family shame about mental illness

Mental illness in the preceding generations was often a well-kept secret in several family stories. For some participants, including Delia and Sally, this information was gleaned in childhood and came with the message that mental illness was a shameful thing, not to be discussed either within the family or outside of it. For others, the possibility of mental illness dawned slowly through difficulties in adult relationships that could not be explained any other way. This was evident in the background stories of the partners of Angie and Janelle. To highlight and explain this, the following section presents Delia's background as a case study of dysfunction.

One example of a background story gradually uncovered in adulthood can be found in Delia's story. She speaks of a hidden history in both her maternal and paternal family. Her maternal grandmother had a long history of admissions to psychiatric hospitals. When her father became mentally ill with bipolar disorder and began manifesting psychotic behaviour, Delia's mother refused to allow him to be admitted to a psychiatric hospital because of her childhood experience of her own mother's mental illness. Delia recognises that her mother's fear of, and shame about mental illness resulted in her discouraging her disturbed husband from seeking mental-health support. Delia's assessment of her mother's attitude towards mental illness is that she only acknowledged it by how it may affect her.

Delia's paternal grandparents, who were very traditional farmers from a small country town, became very concerned that other people would discover their son's mental illness.

> *I found out recently that my great-grandfather's brother was a suicide, and he, my great-grandfather, would never speak of him again. It was like* persona non gratia *in their family after that. I only found out recently and that was like a shameful, terrible secret.*

For Delia, recognition that there was a history of mental illness in both her maternal and paternal family brought with it the fear that this was also her genetic potential, but Delia is being proactive and understands that help can be sought from medical, mental-health and counselling sources. She can identify with her father's distress as his illness worsened into uncontrollable feelings and fears, but feels frustrated that despite his efforts to seek help, he was left to find his own despairing solution to end his life. Similarly, Sally's family hid any history of mental illness in previous generations.

Sally's younger brother was diagnosed with bipolar disorder by a psychiatrist who said that his depression would be very difficult to treat as there was a history of depression in earlier generations and also difficult family dynamics in the current generation. She cited the psychiatrist's view as:

> *'That it's very, very difficult when you have got both, when you have got both a struggle from both of those quarters'...... The familial side, what the psychiatrist meant was more family dynamics, and self-esteem I think and all of that stuff.*

Sally believes that John may have inherited his depression from their maternal grandmother '*who was very depressed and had a major nervous breakdown'*. She remembers that their maternal grandmother had electro-convulsive therapy following this breakdown.

In both of these examples, the family's way of hiding any history of mental illness in the current or previous generations resulted in silence and shame. Further, this meant that the participants felt isolated, and at times helpless in their efforts to seek support for the troubled family member. The message given by the older generations was that mental illness is a shameful secret to be hidden and never spoken about. The consequences of hiding, denying and ignoring mental illness meant that families were overwhelmed and sometimes fractured apart.

A further cause of fracturing in the families is that of religious intolerance shown between various family members towards other family members with different belief systems to their own. Spiritual allegiance can be a cohesive influence in families, but when there is intolerance and blaming of others in the family who do not adhere to the same beliefs, it becomes a source of discord.

Conflict relating to religion or belief systems

Belief systems can dominate the everyday life of people when they are the core of what gives their lives meaning. If someone in the family is not able

to accept the values, beliefs and teachings of a spiritual tradition, then that family member who stands apart can be left isolated and constantly judged to be in the wrong. Similarly, estrangement can result if a church community at the centre of a family's spiritual and social life judges a mood disorder or mental illness manifesting in a vulnerable family member as wrong behaviour or ungodly. The depressed family member may feel shame and the urge to withdraw—the ultimate withdrawal being suicide. Strongly held spiritual, religious or philosophical beliefs can be the cause of discord and tension in family life as is evident in Delia's story.

Delia speaks of the problems that were evident between her parents. Her father was raised a Catholic, was an intellectual, a professional scientist in a research establishment and read philosophy. Delia's mother belonged to the Jehovah's Witnesses and endeavoured to persuade her husband to join her church. She told the children that the Jehovah's Witness Church is the only permissible belief system and that all other religions and belief systems are demonic and from the devil. Delia recalled that towards the end of her father's life, he feared his wife was taking the children away from him, saying,

> *He felt he was losing us, and he believed, rightly or wrongly, that my mother had said that we weren't allowed to talk to him, which she may have done.*

Delia comments that the relationship between her parents, because of the beliefs and doctrines of the Jehovah's Witness Church, was damaging to the whole family, but more particularly to her father. She said she felt caught in the middle of her paternal grandparents and her mother. As an

adult she sees the church as a very closed-minded, narrow religion, with a cult-like environment.

> *If we had still participated in normal activities and still been encouraged to develop yourself and progress, but because it was such a narrow cult-like environment, even though they deny that, the damage to the relationship is terrible, and we felt very much in the middle, I understand, in the middle between his parents, and then my Mum.*

Delia's narrative provides an example of the ways in which different spiritual beliefs can cause damaging rifts in families. In this instance, where the children did not fully understand what each parent was telling or being told.

Differences of perspective in families are not limited to religious beliefs; discipline tactics can also cause tension for all family members. This is illustrated in the narrative of the early family environment that was described by Elizabeth.

Abuse: physical and emotional

When children are abused physically or emotionally within the family home, they suffer at the hands of those whose responsibility it is to nurture and protect them. A child who feels shamed and blamed, or fears pain of physical attacks may not grow up with a belief in their own self-worth, or believing that the world is a safe place. The consequences of an abusive upbringing are evident in the family histories relayed by Elizabeth, Lyn, Delia, Sally, Delma and Emma. The following narrative illustrates the consequences of physical abuse in childhood and the resultant depression and suicidal ideation experienced in adulthood.

Sally described a lot of tension in the family home in which she and her two brothers, John and Tim, spent their childhood and teenage years. Their father was a solicitor and very authoritarian. Sally said there was unexpressed tension between her parents and, when he was a teenager John told his father *'not to talk to Mum like that'*. She remembers that they were all physically punished, but the two boys, who were younger, were punished more severely than she was.

Sally studied social work at university and through the knowledge gained by accessing psychotherapy she began to counter the damage to her sense of self that resulted from the punishing and shaming upbringing she experienced. She spoke of undertaking a lot of personal developmental work and psychotherapy in her adult years. Reflecting on her childhood, she has recognised that it was a very shame-based system. She recalls that they were spanked but that the two boys received more severe corporal punishment than she did. The techniques of punishment and control her father used on her were shame and humiliation. Sally reflects that she still struggles with this.

> *So I just think it's very hard to develop a really good solid self-esteem if you feel that you are being laughed at you know, and I suspect that it sort of started when we were quite little.*

Sally recognises that the way she and her two brothers were raised was constantly very undermining. She uses a clear analogy:

> *It's a bit like if you are always plucking the leaves off a plant or something, or you can't quite get strong enough, and it just sort of feels the legacy for me*

of my childhood is that I'm always trying to figure out how to just trust and believe in myself.

While physical abuse or patriarchal discipline was reported in the majority of the participants' backgrounds, sexual abuse was also reported in several families.

Sexual abuse

There were suggestions that sexual abuse was in the background stories of some of those who died by suicide. When the children appealed for help from their caregivers and were not believed, or the abuse was denied or minimised, the feelings of helplessness and betrayal were compounded. Those who shared their stories believed that the sexual abuse suffered by their deceased loved one was a factor in the suicide.

Hazel was informed by her daughter-in-law after her eldest son's suicide that he had disclosed to his wife that he had been sexually abused by a priest in his childhood. Hazel feels very angry towards her mother, in whose care Warren had been placed. Hazel was further distressed to hear that Warren had told his grandmother of the sexual abuse—but she was dismissive and did not believe him. Further, she failed to inform Hazel of the above.

> *He went home and told Mum. When his wife told me that, I went and said to my Mum—'Mum I have to ask you something'—and he'd been buried by this time, this was a month after I'd calmed down, and I asked her. She said: 'He did come home one day and told me that' and I said: 'Mum what did you do?' And she said: 'I told him to stop being stupid, Catholic Priests are people of God and they don't do those things'. He went home and told Mum and right up until he died, and this is probably where I'm angry part, when he told Mum, he assumed that Mum had told me and I never did nothing about it, but Mum had never told me.*

Hazel recalled that Warren's behaviour suggested he had deep-seated anger towards her. She could not understand this and always felt saddened by it. On hearing about the sexual abuse, Hazel found a reason for Warren's anger towards her. From Warren's point of view she did not support and believe him. The lack of trust experienced by a young person when they experience such violations was not limited to Hazel's family. Wilson is also troubled by what he views as insufficient action following abuse of his daughter.

Wilson had reason to believe that his daughter Holly may have suffered from sexual abuse when a very young teenager. When Holly was fourteen she came to North Queensland to live with him and while there, she wrote an essay for school. Although the essay was written in the third person, Wilson stated that he believed it related to Holly's own life experience. Wilson quotes from Holly's essay:

> *The runaway kid involved herself with heroin and other drugs because the situation at home was so bad and there was nothing else. Having to give in to the sexual advances and abuses of her mother's lover.*

After Holly's death, Wilson was told by Holly's younger brother that she had appealed to him for help when she was thirteen, but he had told her to see their mother. Wilson continued to relate:

> *She approached her brother asking for help. He told her to see her mother and tell her that her de-facto was flashing his penis at her, entering the shower and getting her to do things with his dick. Holly did see her mother. Nothing was done. Holly's mother later told me that when Holly approached her, she replied: 'Oh it's nothing, it's only flashing'. Little wonder then that it did escalate, if nothing was done.*

Wilson repeatedly expressed his frustration and helplessness at having been denied the ability to have access to his children, and fulfil his deeply held longing to protect and guide them. Learning after Holly's death that she had been raped by his ex-wife's lover, and having his ex-wife dismiss this increased his feelings of powerlessness and frustration.

Rejection through race and sexual-identity issues

Issues of identity, either racial or sexual, go to the core of one's being. Those family members who suffered rejection of their racial or sexual identity were vulnerable to self-esteem problems. Any further incidences that resulted in feelings of 'not belonging' or 'of being different' challenged feelings of acceptance. It is an essential part of bonding in childhood that children have the feeling of being wanted and accepted both by their family and also within their culture and community generally. When children are separated from their parents in childhood, it can give rise to the child wondering if they were wanted. These were the difficulties that Emma's husband Arun dealt with throughout his younger years.

Arun's mother sent him back to Australia to live with his grandparents and an aunt where he was cared for but never felt he belonged. At high school he experienced being singled out as 'different'.

> *He was always on the outer, and then people would ask him 'Where are you from, where were you born?' —'Born in Sydney'. 'Well you are not Australian' so where are you from?' —so always this 'You are different, you don't belong' and he never felt like he belonged over in Asia or anything.*

Arun spent six years of his life living in South-East Asia and from the age of seven attended various boarding schools as his Australian mother needed to work to support them both. Here he experienced discrimination.

> *He was in an International school in Vientiane run by Philippine nationals. There was a lot of discrimination there, because he was not full Thai, or Vietnamese, and where was the father sort of thing.*

The background stories contain evidence of earlier losses in the lives of the family members who died by suicide. These background stories have many components that can be seen as a mosaic of factors that the participants believe have added to their loved-one's death.

Childhood losses

Losses experienced during the early developmental years of some of the participants included the loss of a parent through death other than by suicide, separation from parent/s and abandonment. Such early childhood losses may well have compromised the quality of the child's relationship with his/her primary attachment figures, thereby impacting on the child's personality and emotional development.

This loss of a primary attachment figure when the deceased family member was without the life skills to cope with the loss is illustrated in the story of Danny. Aged fifteen and still a schoolboy, Danny lost his adored adopted mother and suffered the trauma of nursing her through a terminal illness. This was a loss that Danny grieved over all of his life. According to Lyn this left a lot of scars, and Danny blamed the

government for not providing adequate care for his mother. As a fifteen-year-old boy dealing with overwhelmingly painful and difficult circumstances with no support from his adoptive father and apparently without any appropriate health care for his mother, Danny sought someone to blame. This blame, in Danny's mind, belonged to the Australian Government for the lack of health care and support for his mother. When Danny's mother died he decided that he would never pay any income tax.

Abandonment

Children fear abandonment and can interpret abandonment as some failure or inadequacy on their part, otherwise the loved and longed for parent would not have abandoned them. The result for these children can be feelings of shame. Abandonment was evident in many of the narratives relayed by the participants, as demonstrated in Emma's description of Arun being abandoned and struggling to fit in.

The story of Arun and his Australian mother contains all of the elements of rejection and abandonment. It also demonstrates how family patterning can re-occur in subsequent generations. As described in Chapter 5, Arun's Thai father and Australian mother were estranged. This led to financial hardship and separation of Arun from all of his family.

Arun's mother continued to live in Vientiane and another boy, Rudy, was born.

> *I think that was a sore point with Arun, that Rudy was always with his mother, and Arun was sent back to live with an aunt. They looked after him, but he didn't belong there, and his mother used to send him letters, 'Hullo, how are you, what do you want for Christmas?' And that was it really.*

With little stable parenting, Arun did not know how to relate to his own children and as Arun's three boys grew up he became increasingly estranged from them. He would tell Emma that he did not know how to be a father to his boys. He loved them when they were little, but as they grew he would find fault with their behaviour. Arun grew up without a father, and related to the children in his church congregation, who also did not have fathers. Arun would seek them out and spend time with them in hobbies or craft activities.

> *I guess to make up for the hole that was in his life, he'd try and fix it for everybody else—and so yes, he did that for a couple of families in the church who were single mothers. He'd take the kids to the snow for the weekend. Or they'd come over for the afternoon, and he'd do things with them. And then I thought later, well how can you do that and then leave your kids, but the reason is that the agony was too great. His own personal agony overrode all that. He just couldn't handle it any more, totally tormented by his own perceived failure I think.*

Addictions and alcoholism

It is well documented that the abuse of alcohol and other drugs are an intractable problem in society and those whose emotional pain is intense may succumb to addictions as a way of shutting out their suffering (Catts 2008). This addictive behaviour results in the addicted person being

unable to provide support, or alternatively, isolates them from the support that they need.

Illicit drug and alcohol addictions were evident in several stories provided in relation to explaining the suicide. For example, Monica spoke of the alcoholism evident in her siblings, especially among her male relations. She believes that such widespread use of alcohol in the family made her brothers vulnerable to alcoholism.

> *There are five alcoholics, two are dead, the youngest is bordering on it. I think Ben started drinking when he was about twelve or thirteen.*

Communication styles damage family relationships

There were relationship difficulties on both sides of Delia's family. Her father's family were farmers and Delia refers to her grandfather as '[a] *lovely human being, very simple, very humble, but with very few words'*. She contrasts this with her paternal grandmother who was '[a] *very volatile person and a very difficult woman to deal with. I remember them having screaming fights, screaming at each other for hours, and she would call him terrible things'*.

Of the relationship between her paternal grandparents, Delia says, *'She used to wind him up and go on and on and on, so it wasn't very healthy—it was a very unhealthy relationship'*. Commenting on her grandmother's mental stability, Delia stated:

> *She would never have had it* (her grandmother's emotional and mental difficulties) *diagnosed and treated, because she was very proud, extremely proud—well quite regal, but she would no way have had admitted she had a*

> *mental illness or anything like that—but I think her highly emotive and manipulative and aggressiveness, was just not normal.*

It was not only Delia's grandfather who was abused by her grandmother, but also her father, '*She was quite brutal towards my Dad, quite a bully'*.

Delia also experienced her own mother as having poor communication skills, with the attitude of '*if we don't talk about it, there is no problem'*. Delia believes that this was how her mother survived a traumatic abused childhood. She would never deal with the problem or the incident. She would just sit down or keep going, never looking back. Even as a child Delia found this very strange. She did not understand many things, but could not ask her mother because she would get angry, so Delia remembers thinking: *'I just kept it all in my head'*. Delia knew she needed to speak to another adult. She had a comprehension that the situation was not normal but had no one to turn to. She would be blamed for speaking with her father as her mother saw it as '*opening him up to say—like opening Pandora's box as far as his mind is concerned, and she didn't want to deal with it or she didn't have the skills'*. Any attempt to initiate communication was forbidden and Delia's urge to know and understand was stifled.

The background environment of participants contains troubling stories of abuse (physical, sexual, verbal), abandonment, poor parenting and communication styles. The sagas described by the participants contain personal reflections of their experiences within families where the

children, the most vulnerable, were not encouraged or allowed to speak of their emotional pain or their confusion over the behaviour of some of the adults in the family. These sagas are not strength stories. They do not contain narratives of courage and resourcefulness that provide examples of coping skills and collective strength drawn from mutual problem solving, cooperation and caring. Rather, they are shaped by the stigma associated with mental illness, which resulted in available treatment being denied or not accessed and the troubled family member becoming isolated and viewed with suspicion. The children in some of the families were taught to ignore the damaging behaviour of others.

Depending on the role models available to a child, they can learn to be adaptive when facing difficult life situations. However, if the role models provided in the family have growth-inhibiting ways of dealing with emotional pain, losses and life's difficulties, these maladaptive habits may be copied by the children. This is an attempt to regulate affect and minimise unpleasant feelings. It does not lead to the development of positive coping skills.

The background presented sets the scene for the tragic decision to suicide as do the circumstances and events surrounding the actual suicidal death. The following section explores the legacy of the suicide that occurred within the context of family dysfunction.

The legacy of suicide

The legacy bequeathed to the family by the person who died includes a wide variety of responses that change over time. These include incomprehensible grief, guilt about their own actions or ignorance prior to the suicide, and for still others, blame by other family members. There was much deep reflection by some of the participants upon their childhood memories or where a spouse chose to exit life; the death challenged their beliefs about the relationship. The legacy of a family suicide can include family breakdown, guilt and pain. It can also challenge the bereaved to take a life-affirming resolution and change the course of their own life.

'I'd never do it, because I know that any person left who cares about me, that's what I would be doing to them'—Kim.

In this thematic segment, the details of the suicide are described, including degrees of relatedness to the participants and also the place where the deceased chose to take the final action. The participants shared their understanding of the reasons for the decision to die.

Reasons for the suicidal deaths

Not all of the participants who shared their stories knew of the triggering events that preceded the suicide. As explored in the previous section, some were aware of long-held pain and traumas dating back to childhood events. Others were aware of the suicide victim's perceived rejection suffered because of race, belief system, sexual orientation or physical

difference. For some, who were children, adolescents or young adults when their relative died, an understanding of the causes of the suicidal death has been built up later in adult life from family histories which were often fragmented with complex and hidden themes. The search for meaning and to understand the reasons for their family member's decision to die resulted in four quests.

1. The participants endeavoured to comprehend their family member's cognitive processes that culminated in the decision to end their lives.
2. The participants tried to get in touch with the feelings of the deceased in the final stages of their life, to conjure up the feeling space of their affected relatives. In some cases this resulted in the bereaved family member also contemplating suicide.
3. The participants spoke of their sense of responsibility to the deceased family member, that somehow they failed by not being able to give them enough reasons to keep living.
4. The participants, each in their own way, struggled to find meaning as to what this death says about their own sense of self.

These four quests undertaken by the participants were the ways they attempted to find answers to the 'why' of the suicide. The first quest of endeavouring to connect to their family member's thoughts in the pre-death stage was a result of the bereaved family member attempting to understand what was going on in their deceased relative's mind. Some

participants were more aware than others of the thinking of the deceased as they had heard the descriptions and complaints about what was wrong in the life of the deceased. But this did not completely answer the question of how the deceased family member could disregard the effect of their death on those who loved them. This first quest is exemplified by Wilson's narrative where he questioned Holly's boyfriend, his son Rolf and the police to seek information about what was happening in Holly's life that may have prompted her self-destructive action. Thus, Wilson was trying to understand Holly's thoughts at this time.

The second quest of drawing close to the deceased family member's feelings may be attempted by some relatives of the deceased to connect with their family member from a feeling of deep compassion. For some, whilst grieving for their loved lost relative, this feeling of connection is in part an attempt to travel this tragic last journey to death of their family member. Sally shared the damaging upbringing with her two brothers and understood well the consequences of damaged self-worth. Sally, who accessed years of psychotherapy to heal herself spoke of her distress when her brother John told her about his shame that he could not shake off the deep depression he was feeling. Sally said that John's sadness at this time still haunts her.

The third quest of feeling responsible for their family member who died relates to the belief that the participants carried that the wellbeing of the family was their responsibility. Therefore, if a family member removed

themselves from life and the relationship it spoke of some lack in their caring. These feelings of responsibility are illustrated by Darryl's comment that he should have known how ill his wife was. Darryl felt very much that he was the head of the family and believed it was his responsibility to ensure that all the family were well cared for and happy.

The fourth quest to find meaning is evident in every narrative shared by the participants. The meaning that was found varied in similar ways to each participant's individual philosophy on life varied. The meaning making also depended on their level of awareness as they dealt with the aftermath of the suicide and therefore the quest to find meaning was also the quest to understand what the suicide says about the self of the participant. Some participants struggled to find some meaning in the tragic event, and in this struggle blamed themselves for an inadequacy as they could not prevent the death, or because they had no prior knowledge of the suicide ideation or plans of their family member. Other participants who had strong connections to a belief system and faith community found they were questioning their faith after the suicide, as illustrated by Emma, who questioned whether prayers for her husband's wellbeing were of any benefit. Kim, in contrast, was raised in an agnostic home and after both her parents died, when Kim and her sister were so young, Kim felt overwhelmed by death and wondered if there was any point in struggling to achieve anything in life, if it all just ends in death. Even this wondering is evidence of a struggle to find meaning. Kim did not cease her meaning

making throughout her early adulthood and stated that '*life eventually flows back'*.

In the following section participants share their thoughts and understanding about the triggers to the suicide.

Spousal and partner suicide narratives

Janelle understood well the trigger that resulted in her husband Gary's suicide. She was planning to end their marriage. When Gary was missing, Janelle's father and the police went to Janelle's bush block of land and found Gary in his car.

> *By doing what he did, he never had to deal with the fact that he never had the fairy-tale sort of life, so he did away with it before he had to and other people would have found out.*

Janelle remarked that Gary's planning for his suicide was meticulous. He poisoned himself with carbon monoxide in the car. He had taken a pillow with him and he even took off his rings first, but did not leave a note—something which Janelle pondered on later.

> *No, but he did give my son (Vance) a message a night or two before and he said to Vance to tell the children that he loved them very much and to tell me that he never would have hurt me, because at that stage he was physically threatening me.*

Janelle spent the twenty years of her marriage protecting Gary until, in the end she could not do it anymore.

> *I remember only a few days, or probably a week before, when he was saying something about killing himself—and he'd never said much about that—and I said to him: 'Don't be ridiculous, the kids need you, and this isn't the solution to our problems', but I didn't realise that he seriously thought that a serious option for himself or maybe it was for me, I don't know.*

Janelle believes that Gary went to their bush block of land on a Wednesday knowing that was the day she usually checked on the animals. Janelle thought that she had the only key, but when the police found Gary's body, he had a duplicate key with him. Janelle believes that Gary had planned for her to find his body.

It is difficult for Janelle that Gary's family blames her for his death. Vance, Janelle's eldest son, knows that his grandmother detests Janelle, and Janelle believes that in some way Vance dislikes her too.

> *It's horrible because it discredits you in front of your children now. They have his name. They have a whole side of the family who for some reason detest me. They even, we had the funeral up here, and they didn't come, not one of them, and they had their own memorial service, and then they sent me the bill for it—and I didn't pay it. My friends stopped me or I would have. But you can't mend that, you can't do anything. All I try to do is move on somehow.*

Emma's husband Arun had been depressed for a number of years, and had been threatening to kill himself. Emma lived with constant anxiety—*'Is this the night?'* Arun made one previous tempt to end his life prior to his death.

> *I never really thought 'how is he going to do it', except the only thing I could think of was driving into a tree. So if the car was gone, I'd think 'This is it'. So he came home, and I said 'Where have you been?' and* (Arun said) *'I thought I might do it, I was trying to gas myself' and he was saying 'I had a hose and I put it in the back of the car, and I was trying to gas myself and I started coughing and everything full of fumes and I was coughing'—and I said 'What made you change your mind?' and he said 'I was starting to get sleepy and I thought of the kids, and decided that I couldn't do it to the kids and so I came home'.*

Emma spoke with the family general practitioner after this suicide attempt and Arun was prescribed anti-depressant medication. Their doctor wanted him to see a counsellor and Emma and their three boys went to counselling hoping to encourage Arun by example. The family counsellor wrote a letter to him inviting him to attend the sessions too, but he refused. Emma reflected that Arun said:

> *'I'll take these* (the medication) *for you, I will not go and talk about myself, because what can they do, they will not be able to help me—this is the way I am and nothing that anybody can say to me, will not help, will not change a thing'.*

This declaration by Arun clearly indicates that he saw his very being as unacceptable—that he was made that way. Arun believed there was nothing anybody could do to assist him in deserving love, acceptance and belonging. This was the legacy of the rejection he had experienced in his formative years and which was repeated throughout his adult career. Emma remembered that he would often say that he would never be able to speak about what had happened to him.

Arun continued to go to work but the transfer to a new position was really worrying him. He interpreted the refusal of his employer to confirm him in the position he had been acting in as yet a further rejection.

On his last day, Emma described that he came home, he had dinner and he sat. Emma noticed a blank look, and she recognised that he was not really there, appearing to be very depressed. There was no conversation

around the dinner table. Arun went outside, Emma assumed, to water the garden. The kids disappeared to their rooms as they usually did. At about ten o'clock there was no sign of Arun anywhere. Emma did not know where he was—she walked around the garden but could not see him anywhere.

Emma had an anxious night and the next morning thoroughly searched the garden and found him hanging in the garage.

> *So the final straw was work related, the reason being that on Friday, this is the Friday of the last day of his old job that he actually hung himself. He was to start work on the Monday in this new job.*

Teenage and adult children's suicide narratives

Delma's son Colin had returned home to live with her a few months before his death. He had left home and come back numerous times. The last time he came home he said: '*Mum I feel so safe here'*. Delma thought that was a strange thing for him to say as he was a big, masculine man. Delma reassured him that she was happy to have him there as she lived by herself when he was not with her. Colin lived downstairs in a large rumpus room with an ensuite, so he had his privacy.

Colin spent the day of his death doing lots of jobs that needed doing around Delma's house. His last job was to return some videos he had borrowed.

> *'That was the last thing I had to do'—'last thing I had to do'—so he took them back, and then he went into the rumpus room, and he had a few beers, and I cooked dinner, and I went down some time later to say his dinner was*

> *ready and he was sitting there, so help me God, the rifle on the floor under his chin, with his finger on the trigger.*

Delma asked: *'Can you imagine walking into that and seeing that?'* She had no forewarning; she was just not expecting it. Delma, as she recalled her son's death, reflected that she was a chaplain at the time. She initially thought she knew what to do in such circumstances, but in reality she did not. *'No you don't, not when it's yours'*. She went to him and said: *'Darling what's up, what are you doing?'* Delma said that he looked at her with dead eyes, and he said: *'Mum, I'm going, and I want you to think of me going on a holiday, that's how you have got to think about it'* and he said: *'And I won't be coming back'*.

Delma asked him: *'What in the name of God is that bad that you have, that you put yourself in that situation?'* And he said: *'Oh Mum'*. He said, *'I'm 33 years old, I'm living with my mother'*. Delma now recognises that Colin thought of himself as a failure, to be his age and living in his mother's home. He had two children and one step-child from two different relationships. He said: *'I'm gathering too much garbage'*. He said: *'Who's going to want me?'* Delma tried to reassure him that some beautiful girl will love him even though he had made a few wrong judgements in the past. *'No Mum'*, he said, '*it's too hard'*.

Delma's helplessness in the face of her son's despair, despite her years of training as a registered nurse and later as a hospital chaplain, compounded her anguish. She questioned the purpose of her training if

her empathy was for others. Her sense of failure and shame echoed Colin's voiced sense of shame that as a 33-year old, he had to return and live with his mother. Delma wanted to speak to Colin, but somehow was frozen.

Delma, finding herself helpless, went upstairs and rang her other son Brian and also her son-in-law Philip, who is a police negotiator. They arrived quickly and parked their cars where Colin could not see them. Philip went down first, as he had been trained to deal with crisis situations. He was walking down the steps and he said: *'Colin it's Philip, I want to talk to you mate'*. He got to the door, and Colin said—he screamed at him: *'I don't want any of your fucking police talk', he said. He said: 'Just piss off and leave me alone!'* and Philip then backed off. Then Brian went down. The brothers were very close, just eighteen months apart in age, and had worked together. Brian spent half an hour trying to connect with Colin, reminding him of his son Seth, saying: *'think of Seth'*—and he said: *'Seth will be alright. I grew up without a father, there's nothing wrong with me'*. Delma reflected on the irony of Colin saying this, with a loaded rifle in his hand.

Brian said later that he had thought of grabbing the gun. He said to Delma:

> *'If I'd have done that Mum, Colin would have chased me and caught me and thumped the shit out of me, but at least the gun would have been gone'—but anyway as soon as Brian went towards him, he grabbed the gun and he said: 'It will be on your conscience', he said, 'if you come anywhere near me'.*

While this was happening downstairs, Delma rang a crisis telephone line. She reported her conversation with the telephone crisis counsellor:

> *'My son has got a gun to his head what do I do' and they said—this guy I'll never forget, he said: 'Oh would you put him on the phone' and I said: 'Did you hear what I said' and 'in the rumpus room there is no phone there, and he's got a gun and he's thinking all these thoughts, and you tell me to put him on the phone'—and he said: 'Well if you are not going to do that, call the police and they'll take him to the nut-house'.*

From these remarks Delma identified her need for help and support, but it was not forthcoming from the telephone counsellor. Delma now realises that when you ring the crisis telephone line, the telephone number is shown on the computer and that the crisis telephone counsellor would have rung the police. Shortly after Delma rang the crisis-line the police arrived. The street was blocked off. Ambulances and the police SWOT team were running up through the backyard with their guns drawn and the dog squads were rushing in. Brian spent half an hour speaking with Colin, but it was all negative. Later Brian said that nothing Colin said made any sense. Colin said: *'Well mate, are you going or staying?'* And Brian said: '*You are my brother and I love you and I'm not going anywhere'.* Colin moved the gun into his mouth and pulled the trigger. Delma heard the shot and ran downstairs.

Delma knew from her years as a nursing sister and hospital chaplain that the family had to talk together about Colin's suicide to help them understand his death. Philip arranged for the police liaison officer to come and spend time with Delma, Brian, Delma's daughter Linda and her husband Philip.

Olivia's son Chris made two very serious suicide attempts before his final suicidal death three-and-a-half weeks after his twenty-first birthday. Chris was living with his father in the northern part of the state. The first attempt was when he was eighteen and living with Olivia in the state capital city. One morning Olivia noticed that he had his wrist wrapped up. She asked what happened and he said: '*I was just mucking around with the boys'*. Olivia did not think any more of it. Two days later as Olivia was getting ready to drive him to school, he indicated he had something to tell her. He un-wrapped the bandage and showed her his wrist.

> *The swelling was just unbelievable, and so I said: 'Oh my God, I had better take you to a doctor, you will have to have that stitched'.*

The doctor spoke to Olivia and she told him that she had no idea why her son had done that to himself. The doctor suggested a counsellor but Chris even refused to talk about his suicide attempt with his mother. When Olivia returned home, she found residue where a bin had been almost full of blood. From the terrible scars Olivia could tell that Chris had criss-crossed his wrist several times. He said to Olivia after it had healed: '*That's worse than a tattoo isn't it'*. Olivia said: '*Yes it is'*. Olivia did not continue speaking about her feelings of the suicide attempt, although she tried to explore the seriousness of his actions and the reason behind them.

Prior to this first suicide attempt Olivia could sense that Chris was disturbed. She knew it was something to do with his friends and she tried to get him to tell her what was troubling him.

Every time I asked him, you know: 'What is it? It's something probably we can fix', and I said: 'If you have done something illegal you will go to jail for it and pay for whatever it is you have done'. But I said, 'It needs to be resolved', and he just wouldn't discuss it with me, and his stock answer was: 'If you can't be loyal to your friends, who can you be loyal to'. So I couldn't get anything out of him, but I knew it had something to do with his friends; and at eighteen—I don't know whether it was a real attempt at suicide, but it was certainly a cry for help.

Chris's second suicide attempt took place about three months after his first. He swallowed a bottle of poisonous dog shampoo. Olivia smelled the strong odour of the dog shampoo and found Chris on an upstairs balcony. He was grey and heavily perspiring. Olivia screamed and her daughter and son-in-law came running. Chris jumped off the high balcony and ran away. Olivia and her daughter ran in one direction looking for Chris, her son-in-law ran in another direction. Olivia could not find him and returned home to ring the police. When she reached home an ambulance was ready to take Chris to hospital where he had his stomach pumped.

This suicide attempt happened on a Friday and there were no psychiatrists or psychologists on duty at the hospital over the weekend. It is interesting that both suicide attempts occurred on a Friday, but Olivia never explored the significance of the day of the week with Chris. Again Chris would not discuss why he had made this attempt on his life, nor would he consider seeing a psychologist or counsellor. Olivia has stated that she and Chris were very close, 'soul mates', yet the incongruity of being unable to speak about his emotional pain that culminated in suicide attempts was never mentioned by Olivia. Perhaps to remove himself from

Olivia's caring questioning, Chris decided to shift to his father's home. These questions remain unanswered for Olivia.

After Chris finished secondary school, he refused all forms of tertiary study. He travelled to the north of the state and stayed with his father, where he sought an apprentice placement nearby. Chris's father had not been close to him throughout his childhood. Chris stayed with his father for a period, then moved into the regional town and lived with friends. He returned to live with his father some 50 kilometres out of the town.

On the night of his suicide Pete, Chris' father, suggested that he would ask a couple of mates over to have a barbecue and a *'boys' night in'*. Chris had been helping around the farm all day and kept asking for something else to do. His father told him to go and have a shower and that he would come inside in twenty minutes. When Pete returned to the house he thought Chris was asleep until he saw the rifle. Chris had shot himself through the heart. Pete stayed and held him until he went cold, waiting for the police and the ambulance to arrive. Olivia and her daughter flew to Pete's regional town for the funeral, but found no answers during their long discussions as to the reasons for his suicide.

Later, when speaking with Chris's Brisbane friends, Olivia was told of the incident more than three years previously.

> *Alan was about a year older than Chris, and he got his licence first, and as I said, they used to pick him up and from what I gather from the Brisbane friends, was that they were in a car with another person, and they saw one of the guys* (a perpetrator of the earlier childhood attack) *come out of the pub*

> *and they hit and ran. So I don't know whether they ever knew whether they actually killed the guy, or whatever, damaged him, or they must have damaged him in some way, shape or form, but whether they actually killed him I don't know, and I think that just haunted him.*

The legacy of Chris's suicide for Olivia is that the close connection she believed they shared offered no protection to him. There is also the decision Chris made to leave Olivia's care and go to his father who had been missing throughout his childhood. Olivia has no knowledge of what prompted Chris to go to his father, and what triggered his ultimately death by suicide.

Parental suicide narratives

> *I feel sorry for anyone that does that, because they are obviously feeling that bad, but sometimes I kind of think, oh they are hurting, but then they leave the rest of us in hell; in fact it's never ending—Laura.*

Kim and her sister Sara endeavoured to care for their mother after their father's death from cancer. Kim believes her mother's bipolar disorder worsened after her father's death. Over time Sara began to distance herself from her mother, while Kim tried to fulfil the role of carer in her father's place.

> *I took up that supportive role for Mum by moving in with her and I used to drop her off at the Royal Melbourne Hospital sometimes if she needed admittance, on my way to work, and it was a terrible burden to me really, and I was pretty lost.*

Kim never knew what condition her mother would be in when she returned home from work. Kim's mother believed she had cancer and would tell her she was so depressed. During the year Kim cared for her mother she became increasingly unstable. Kim resigned from her

position as an accountant and decided that she could not adequately care for her mother any more. Kim and Sara set up home together but called in on their mother a few times a week. Kim's mother spent the next year in and out of hospital.

> *Early in the year she got some sort of toxic reaction to lithium, and she was really depressed and really went into a psychotic state, and I remember her being in hospital and just completely not aware of anything, just frozen into an animal state, it was terrible. It was shocking and frightening and terrible to see her like that. She had really just kind of disappeared from this—that is what they said it was, a reaction to the lithium. So the dose was never stable, and she stayed in hospital then for months.*

After Kim had moved out of her mother's unit, her mother struggled even more. Kim realised she could not spend her life propping her up. '*I just felt I was drowning in her neediness and I'd been drinking a bit too much—going to the pub after work and there until ten o'clock and time to go home'*. Kim's mother was in an awful state and she was overwhelmed. Kim's mother told her a week before the suicide that she had been thinking about it, and that she had even tried to suicide. Kim sought a private mental-health facility for her mother because she thought that she had not been adequately looked after in the public system. Kim explained to her mother that she was searching for a private facility for her. That weekend Kim and Sara went away while their mother visited other family members and thanked them for being so kind to her.

Kim believes that the next day her mother killed herself. Kim and Sara tried to ring her on the Monday night and the next morning drove to her flat with a terrible feeling of dread.

> *There she was. We walked in, we came in, walked up the hall, and in her bedroom, she is on the bed in the red nightie with this white plastic bag over her head, and the legs of the pantyhose in her hands just kind of rigidly sitting in there.*

Kim and Sara had walked up the hall and got just one glimpse before they ran out terrified. They were so traumatised that, on reflection, Kim has no idea how long they were there on their own. Then they slowly walked back.

> *We did go in there and we took the bag off, terrified that we were going to see some horrible face, but no, she looked all peaceful, and there was all this moisture, condensation on her face, that must have come from the bag.*

Later, Kim undertook some research into the actual process of death from lack of oxygen. She needed to know if her mother had suffered during the dying process. This is indicative of Kim's feelings of responsibility for her mother.

> *I found out later that they breathe in the carbon monoxide and they do die peacefully. It's not like—like I thought it would be like asphyxiation, but it's not, it's just loss of oxygen and then they fade out, but still the willpower you would have to use. And we just don't know how long it all took, because we were sort of overwhelmed and hard to remember because it was all so chaotic. It just feels now like a dream all that day and it was just the burden of it all, just that image.*

Delia, as an eleven-year-old child, knew that her father was unwell, that he was depressed and had been prescribed anti-depressants. Being a scientist, he researched the medication and when he learnt of the side effects, he refused to take them. His behaviour became increasingly bizarre and he believed that people were following him.

> *I remember him getting quite desperate, and I remember one day hearing him say to my mother that he had gone to the police and just said: 'I just can't cope any more' and I don't know if he said he was feeling suicidal, but*

all they suggested was that he drive himself down to the old mental hospital in Goulburn.

In the time between her father's death and our interview, Delia has been gathering information, recalling significant conversations with her father and more recently speaking with her paternal relatives. This reconstruction of the events preceding her father's death demonstrates Delia's efforts to get in touch with her father's thoughts and feelings as part of the meaning-making process. Delia is endeavouring to conjure up the feeling space her father was in prior to his death, listed as 'Quest two' detailed earlier.

Delia knows that towards the end of his life, her father thought he was losing the children and that her mother was taking them away from him. Delia's mother had forbidden him to speak with the children at all.

In the end like I said it all just got too much. Plus coupled with the mental illness, where you wouldn't see things so clearly, obviously things would all be very distorted.

In the week before her father died, Delia remembers he went to Sydney to visit his brother. She has since been told that her father said to his brother: *'I can't do this anymore, I can't do this, I can't be married, I just can't cope'*. But Delia's uncle sent him back to Canberra and said: *'You are married, you have children, you have to cope and that's it'*. Delia recalls that the next weekend her father said '*goodbye'* to his brother.

He said: 'Thanks for everything'—and I remember the last time I saw him—my Dad this was—he looked very peaceful and I remember thinking, one of those really crystal clear memories, that I have never seen him, I'd never seen him look that happy in a while, and he was actually smiling, and

> *then years later I found out what he said to his brother, and the next day he died.*

This is a comforting memory for Delia. Knowing that her father had so despairingly appealed for help, from the police and from his brother, that he tried to speak with his wife to make her understand how desperate he was feeling and upon finding no support or comfort, he resolved to end his torment by suiciding.

Delia spoke of the day she learnt of her father's death. The police came to the house and told her mother.

> *I remember she didn't hug us, we all just sat crying by ourselves. It was all, I was crying on my own, my brother was on the floor crying by himself and my Mum was crying. Just in a circle, but no one touched anyone else. I just sort of went very much into my shell at that time, and he* (her brother) *just kept saying: 'I want a new Dad, I want a new Dad' over and over, and he was seven.*

As an adult Delia learnt from her paternal aunt that her father put cyanide in a glass of milk and drank it in his laboratory. She understood that her father's death would have been quick, and that after he had taken the poison he could not have been saved. To Delia, this additional information learnt so many years after his death was like another piece in the jigsaw puzzle of her life. In a sense it was new information, but it only increased her sense of loss and sadness for the loved father who was so troubled before his death.

Sibling suicide narratives

When Elizabeth's father placed Roberta in an English psychiatric hospital after several suicide attempts, Roberta pleaded with Elizabeth to get her out of hospital. Elizabeth returned to England from Australia to try to have her released. Eventually Roberta left the psychiatric hospital and returned to her parents' home where her mother kept a constant watch over her. Elizabeth understands that Roberta was almost catatonic at this stage. Their father became very upset at the amount of attention his wife was devoting to Roberta and insisted on taking Roberta's mother for a walk. While they were out of the house, Roberta again took an overdose of medication and when their mother returned, she found Roberta unconscious. After this suicide attempt Roberta was sent back to Anton in Spain. Anton arranged for her to stay in a convent.

Elizabeth received a letter from Roberta saying how happy she was that she and Anton were going to split up. Roberta was having the children and she had found a beautiful apartment. Roberta continued visiting the convent, as there was a particular sister with whom she was close.

> *And then one day my father rang to say that they had just heard from Anton that Roberta had driven off a cliff on the way back from the nunnery and no, there was no way it could have been an accident, and of course my mother said 'well I've got to go' and he said 'don't bother coming—she is buried, we've done it, I don't want you anywhere near her'.*

After hearing the news of Roberta's suicide, Elizabeth had a breakdown herself. All the many losses in her life returned, as did the memories of

the abuse she and Roberta suffered at the hands of her father. She questioned whether she too had to follow her sister.

> *I emulated her so much. I really had to decide what to do. No, I'm not going to follow Roberta, I don't have to do that.*

Elizabeth accessed a self-help therapy group and found support from a counsellor. Elizabeth was able to get in touch with Roberta's boys through a friend of her sister and contacted them many years after Roberta's death.

Sally's brother John began to withdraw from her and other friends and she was concerned that his mood was becoming very dark. Sally made the effort to maintain contact and she became irritated that all contact had to be initiated by her. She said that she had not realised how much he was struggling until after his death.

> *I found out after he died was that he was very depressed, and he had actually been to a psychiatrist who I met, and had been diagnosed as having bipolar disorder, and the psychiatrist said that he really had a diagnosis of that kind of biological depression, but also a familial depression.*

John was prescribed medication by the psychiatrist but was using a lot of cannabis and also heroin.

Shortly before John died, Sally met him at a café and he said to her: *'Sally, you know I just can't, I just can't shake it'*. Sally remembers that day and that it absolutely broke her heart. She recalled knowing that he felt this deep shame that he could not shake this depression. John had previously attempted suicide by cutting his wrists, sitting in a bath of

warm water. He had also taken some drug and was dozing off. He left the water running and when his flat flooded and water entered the flat downstairs, the police were called. John was taken to a psychiatric hospital, but as soon as he could, he talked his way out and went home.

After the previous unsuccessful attempt to end his life, John chose a violent way to die.

> *He actually went down to the railway tunnel and lay down on the tracks in the tunnel. I did a lot of sleuthing after the death, and I spoke with the police and they said that, you know, it was horrible to hear, but they said that the way his body was found, was not consistent with him jumping, so I think he must have just laid down.*

John's death occurred less than 24 hours after being released from the psychiatric hospital. Sally feels very angry that John was not kept in hospital for a few days, or at least overnight. She understands that privacy laws prevent the hospital staff from informing his family. Sally states that she cannot help thinking that he could have been saved and reports feeling much anguish.

> *He could have been saved, he could have still been here, had we been able to assist him through that crisis and possibly get off drugs and alcohol, and stabilise his anti-depressant medication.*

The police notified Sally's father of John's death, and he left many telephone messages for Sally to ring him. Sally and John resided in the same capital city so much of the contact with the police and other authorities was left to her. She realised that her father did not want to know whether John's death was a suicide, but for her it was different—she needed to know. Sally understands her initial response to John's death—

to explore the police assessment of John's death and that this was a grief response.

> *It's almost a grandiose kind of thing, you just want to know, to know what happened, and I found out, so for a period of time I was the only one in the family who knew.*

So for a period of time, Sally was the keeper of the secret, which she found terrible.

> *I didn't want to keep it, you know. What I had to do was pass on the news, which was ghastly, to my own parents, you know, and be the one who told them, and so I did, I spoke to Dad first, and he didn't want me to tell Mum. He said that he didn't think she would cope with that, but I think in fact he was projecting a bit, it was incredibly difficult for him to deal with. I said to Dad: 'Look if Mum asks, I will tell her'. She came up to stay with me not long after and she is very brave, my Mum. We went to the place where it happened, we went to his flat, and she sat in the room, in my spare room, where all his furniture was for a while and cried, and she said: 'Did he commit suicide?' and I said: 'Yes' and she said: 'I thought so'. So I mean she knew anyway, Mums know these things you know.*

In some of the narratives, participants also spoke about a knowing or sensing of something impending that they experienced prior to learning of their family member's death.

The 'knowing' before the suicide

Participants spoke of having an unconscious awareness that something was about to happen, and after the suicide they were able to relate this to a sense of connection with their deceased family member. This is in contrast to those participants for whom the news of the suicide came as an unexpected shock. For those who had a premonition of the impending death their sense of somehow letting down their deceased family member was heightened, even though their premonition was nebulous. It was more

a feeling of helplessness in the face of some horror that was going to happen. This is explained clearly by Delma.

A few weeks before Colin died Delma recalls that he became withdrawn and was spending more time alone downstairs. She asked a few times if he was alright, but he reassured her saying that *'she was entitled to her own space and to get off his case—that he was like her and just wanted some time to himself'*. Delma had a sense that something was wrong and became increasingly concerned so much so that her blood pressure had risen to concerning levels. Delma said that she had this sense of impending doom, but had nothing to base it on: '*I just feel that something terrible is going to happen'*.

This sense that something was not right was also experienced by Kim. The night Kim returned from her weekend away, she could not sleep. Her following story indicates a deep connection to her mother at an unconscious level despite her acknowledgement that there was not a strong emotional bond.

> *I had the most terrible night, I couldn't sleep and I was in a horrendous state, and I didn't quite even know what it was all about, and there was no real reason for it in my life, but really I think I was, I think I was tuned into her consciousness—I really think that—because it was like an awareness, being awake, being conscious, I wanted my Dad, he was gone, there was no escape, it was terrible, a terrible state of anxiety, and really it was from out of nowhere, and I think now, and then that was the night before. So I think it must have been playing on my unconscious that she was in that state and obviously I was very connected to her and not outwardly, not in an emotional sense, but just sort of underneath.*

Whether the bereaved participants were present when the suicide occurred, or discovered the body themselves, or were told by police or other family members, learning of the suicide brought with it shock and trauma. It brings in to question the relationship they shared with the deceased family member, leading to questions such as: Why did they do this? Was it a message for me? If they knew I loved them, why did they choose to leave me? What fault of mine is implicated in this shocking decision to die?

Comprehending the suicide

Participants searched for meaning in their suicide bereavement, as outlined earlier in this chapter, as four quests, which were undertaken in their endeavour to comprehend their deceased family member's last days. In the first quest identified, the participants spoke of their need to understand what was going on in their family member's mind, to try to evoke their thoughts as they formed the decision to leave this life and so sever the life shared with the participant. This underlies the universal question of 'why' that so haunts many suicide bereaved.

Similarly, the participants' searching for meaning was not only the searching for the cognitive processes that the participants undertook, they were also trying to connect with their deceased family member's emotional state as they lived their last days or hours. Delia remembered that her father was happier than he had been for years on the day before his death. Lyn found small drawings that her husband Danny had made of a crying face in his diary.

The third quest for meaning also resulted in the participants acknowledging their own sense of guilt. In the case of bereaved parents they felt they had not nurtured their child to be resilient in the face of life's disappointments and difficulties. Perhaps they had not been caring enough, or were not loving enough or they had failed the relationship in some way. There are different nuances of meaning ascribed to this sense of responsibility depending on the degree and class of relationship that the participant had with the deceased.

The final quest for meaning was in relation to the participants' own sense of self as the close family member of someone who chose to leave life rather than continue living. This fourth quest is one that the participants live with for the balance of their days as it is an intimate part of their personal history. How this has evolved or changed for the participants is addressed in the next section, 'Family sequels'.

Family sequels—disrupted narratives

The third key narrative, named sequel stories, describes the individual journeys that the participants have made in their own lives subsequent to the suicide. These stories describe the adjustments in their lives, whether there was any accommodation with the loss of their relative, any self-development, education or searching in the endeavour to understand the phenomenon of suicide or to move beyond the damaging sequelae of suicide. These stories also pertain to the participants' search for self, as

the inheritor of their background and family history. The following are examples of the narratives they constructed as they wrestled with the meaning of their family member's suicide and whether they were able to create a new life-affirming story for themselves. These narratives are fundamental in that they relate to this search for self.

Sequel stories also contain information about any help or support received or the lack of meaningful support. Some participants' narratives also describe the experience of joining suicide-bereavement self-help groups, and their role and contribution to these groups. The participants' subsequent relationships are also of interest, as are their experiences of family after the suicide, and the efforts of the participants and the other family members to rebuild their lives, bringing their stories up to the present time of the interviews. Suicide-bereaved family members who were not able to rebuild their lives are not featured and it can be surmised that such members of the families may not have been responsive to an appeal to share their story of loss for this research project.

For all participants in this study the struggle to find meaning in their life after the loss of their relative through suicide is on-going. Any new loss or challenge calls up the unresolved pain of their loved-one's choice to leave this life. Some participants spoke about family members and others who were supportive and who gave them courage to climb from the depths of their grief. Unfortunately for others, they were either blamed for the suicidal loss or met with incomprehensible attacks from relatives or others

in their social or spiritual networks. This section describes their passage from the time prior to the death until they shared their story.

Early history after suicide—immediate impact

Indelible in the memory of all the participants were the circumstances in which they were informed of their relative's death, or as happened in two cases, the shock of finding their relative's body.

The way participants heard about the suicide

Three participants, Kim, Emma and Jerome, found their relative's body and Delma's other son Brian was with Colin when he pulled the trigger. The horror and the shock of this discovery, even for Kim and Emma, who had earlier knowledge of their loved-one's suicidal intentions, added to the trauma of their death. But Jerome, like Delma and her son-in-law Philip, had no prior knowledge of any suicide intentions. Delma and Philip heard the gun shot that took the life of Delma's son. Others heard the news from relatives—namely Lyn, Darryl, Wilson, Olivia, Hazel, Laura, May, Delia, Monica, Elizabeth and Sally. Angie and Janelle were told by the police.

Lyn heard that Danny was dead from her father-in-law, who rang on the third day after Danny had left. Her father-in-law told her that he had bad news saying: *'Danny has passed away'*. Lyn was alone with an eleven-week-old baby and she became hysterical, crying and screaming. Her parents accompanied her to the regional city where Danny had died, taking with them his father and sister.

In the morning following Arun's disappearance, Emma looked everywhere for him, even phoning hospitals to ask if there had been an accident. She opened the garage door to find him hanging. She believes that when she went back inside the house she was hyperventilating and the boys woke and came to her. Emma's three boys were nineteen, seventeen and fourteen at the time.

> *My noise got the three boys out of bed, and they were kind of in the passage wide-eyed: 'What's the matter with Mum?' and I blurted out: 'Daddy is dead, he's in the garage, don't go out there', and somehow I think I'm saying: 'What do I do, what do I do' and Greg said, 'You need to call somebody'. I called triple 0 and said: 'My husband is hanging in the garage', and they came, ambulance first, and I went and sat in the driveway waiting, and then the others came the rest of the day, police, ambulance and people coming and going.*

When Angie returned home from work on the Monday night the police were knocking on her door, waiting for her, and they walked right into her house. Angie thought that Josh must have been taken to hospital again.

> *So anyway he sat down and I'm saying to him: 'Is Joshua in hospital or is he in jail?' And he said: 'No it's worse than that'. I said: 'What is it?' and he said: 'It's a heroin overdose'.*

Angie led me to understand that it was an intentional overdose and that Joshua's death was a suicide. Angie was told that Josh's flatmates had found his body on the Sunday night.

After Kim and Sara found their mother dead in bed, their initial reaction was shock and they fled the room. Kim reports that at first they felt numb, which was followed by the trauma of calling the authorities and letting

their relatives know. Kim stated that she and Sara initially developed an irrational fear and could not bear to be apart.

When relating the story of the way they were told of the death, or of how they discovered their family member's body, the depth of the trauma felt at the time can only be alluded to. This trauma continues to echo for a long time in the lives of the participants. For the children and young people who were not told of their relative's death in a caring and supportive manner, the sequelae to learning that their relative chose to die left them with unresolved emotional trauma oftentimes lasting well into their adult lives.

Delia displayed the only way of coping in her family—she withdrew emotionally—as she had been taught by her mother. Delia had earlier learnt that she could not rely on an adult to be there to protect her and her brother.

Hearing the news of their family member's death, or more traumatically, discovering the body themselves was a narrative that is not comfortable for the participants to tell, nor for most listeners to hear in an accepting and supportive role. For this reason, it is often an inexpressible and hidden pain like a wound that will not heal, yet one that needs expressing before healing can begin. Further trauma occurred for some of the participants in that their wishes for the funeral, and in one case, the

wishes of the deceased, were overridden, ignored and invalidated, thus causing even increased trauma and pain for these bereaved participants.

Funeral arrangements—disenfranchised rights

The fragmentation in some families became very clear in the funeral arrangements. Relationships which were not recognised by the religious institutions meant that the one who felt closest to the deceased had no input into the service of farewell. Where there had been a major breakdown in familial relationships many years before, any wished for involvement in the funeral service was ignored. The determining criterion seems to be who was named as executor in the deceased's will. The already traumatised and bereaved family members in some cases suffered further anguish due to the attitudes of the religious institutions chosen by some members of the fragmented family. This is illustrated in Laura's story.

> *When I called her* (Laura's aunt) *a few times, and you know I just begged her and I said: 'Don't bury her whatever you do, don't bury her' and then she turned around and said: 'We are burying her'. And I'm saying: 'Mum wouldn't have wanted that', but at no point was our input asked for.*

Funeral services are an opportunity to reflect on the life recently ceased and what that relationship meant to family and friends. When the farewell service meets the wishes of some of the family members, but not others, it cannot fulfil the function of enabling the bereaved to make the transition from their previous assumptive life to a new reality of a life without their loved one. This is especially true where the service would

have had no meaning to the personage of the deceased during their life, or to their beliefs or values or if no reference is made of the relationship that was closest to them.

Sean's adoptive parents were Catholic and Sean had been raised a Catholic. The funeral was arranged at the Catholic Church and Sean was buried in a nearby cemetery. Jerome and Sean were in a same-sex relationship which was not recognised by Sean's parents or their church, and so Jerome had no input into the service. Jerome knew that the service which had been arranged would not have been in accordance with Sean's wishes. After the service there was no effort made to maintain contact with Jerome by Sean's adopted family.

Wilson, his son Rolf and his ex-wife arranged Holly's funeral with a funeral director, but without any consultation these arrangements were changed. When he returned to the funeral parlour, a woman he had never met before tried to exclude him. Wilson remembers: *'I'd been told by somebody else who I hadn't met how my daughter's funeral was going to be going'.* With his son Rolf, Wilson went to his ex-wife's home and asked what was going on. He was told to get out of her home.

In many ways the worst trauma for Laura occurred in the days immediately following her mother's suicide. Laura states that the funeral traumatised her further and that she felt she was in a nightmare from the time of the death that only got worse as the days progressed. Neither

Laura, nor her father was advised that the body had been released from the Police Forensic Centre. Laura and her father had been speaking to one firm of funeral directors, but they were then told the body had been sent to a different firm on her aunt's directions. Laura's father telephoned his solicitor who advised that his wife had made out a new will naming Laura's aunt as executor. In this capacity she took over the entirety of the funeral arrangements.

> *Mum killed herself at* (named) *Train Station and then they decided to have the service at the Lutheran Church down at* (named same suburb)*, which is literally 200 metres from the train station. So we had to sit through a service in a Lutheran Church for a woman who is an atheist and listen to trains running through the whole time. It was just the most disgusting thing I've ever had to do—like it was just horrible and I just sat there, because I thought, you know, this is the only time that I have to pay my respects to my Mum—but she just wouldn't have wanted it. So yeah, it was horrible—they didn't even know Mum, everything was wrong in the eulogy you know, the dates, and telling stories about Mum. The funeral was just horrible, and now she's buried in a cemetery, and she never wanted to be buried, she wanted to be cremated.*

So for Laura, not only did she lose her mother, she also lost any rights to have a say in the service that was a memorial to her life. Laura experienced the funeral as if she, her brother and her father were not meant to be there. Their presence was only possible after Laura's father had a solicitor write a letter to the aunt for the right to attend the funeral. Laura's paternal relatives came to the funeral as support for Laura and her father. The animosity directed at Laura's father, her brother Justin and herself was so intense prior to the funeral that an ex-army friend of Laura's father attended for security. Laura resolved to maintain a 'cease-fire' for the ceremony out of respect to her mother.

Delia recalls that after her father's death, people from her mother's Jehovah's Witness Church came to the house bringing meals. Delia's paternal grandparents arrived and she remembers that one of the church people suggested that the government bury her father, as the church would not because he was not a member and because he had died by suicide.

> *My grandmother just went to pieces, I can still hear them screaming, because I was in my room and I've never heard that kind of wailing before. She was just devastated. They ended up taking the body away to their community, and having a Catholic burial. So there was this constant sort of, the religion was very, very destructive really, and the cruelty of saying that, and I can still remember who it was, and it still makes me quite disgusted, to think you could judge someone so harshly, when they had paid the ultimate price and were unwell.*

These comments suggest the degree of distress Delia felt when she heard her grandmother's wailing. Such a sound for an eleven-year-old child would have been very disturbing and frightening, especially as there was no other caring adult to comfort and reassure her. Further to this, because her mother's church would not conduct the service, Delia's paternal grandparents arranged the funeral in their country town. Neither Delia nor her brother had the opportunity to attend the farewell service for their father.

None of the participants offered a story of a comforting or meaningful experience at the funeral of their family member.

Participants' early reactions

Some participants spoke of their reactions immediately after the suicide of their family member. For some the shock of the death resulted in them trying to cope by carrying on with normal activities. In one case the brother and brother-in-law of the deceased took on the dreadful task of cleaning the room in which their family member had shot himself. Not all of the shocks and traumas ended with the death of the family member. For Janelle, further surreal horror unfolded in the discovery of weapons around the house that had been secreted by her husband Gary, prior to his death. These discoveries brought with them relief that she had been able to protect herself and her children from a situation that she slowly came to realise had been dangerous for her and the children to have been in. The whole situation took on an air of bizarre unreality for her. For Janelle, this was a period of time when she was trying to comprehend what had been going on in Gary's mind, as indicated in the first quest that participants undertook, to comprehend the cognitive processes of their family member's mind prior to their deaths.

Whilst others were preoccupied with the practicalities of dealing with their family member's death for a number of months, Emma had the complication that her husband, Arun, had not left a will. Further legalities arose as Emma lodged a compensation claim against Arun's employer.

> *In the first year it was a whole fog of all kinds of continually fixing things, once again, because there was no will. We had a fair bit of debt and when the compensation finally came through six months after, it got rid of all that, which was fantastic for me, because I then had to get a proper job.*

Emma and the boys sold the house where Arun had died. The boys were very unsettled for the first few years after Arun's death.

Legalities such as these and other demands on the participants resulted in such tasks being forefront in the minds of the participants in the early days after the death of the family member. This resulted in any emotional adjustment being set aside in the initial stages of the sequel narratives and these early days were described as confused or surreal. Others, such as Jerome tried to carry on their normal roles.

After the discovery of Sean's body in bed beside him, and making it through the initial weeks, Jerome tried to carry on with his life. His words indicate that he was trying to downplay his grief: *'It was a bit devastating'*. He continued:

> *I kept going to work thinking I was okay. I was devastated. I do not have a very clear memory of that day. In retrospect at the time, I remember that day we drank a bottle of whisky and my friends came around and we sort of did the usual: 'Oh dear, dear, what are we going to do?'—And I had to notify his parents which was quite difficult.*

Reflecting on this time in retrospect, Jerome contrasts his thought processes: '*Thinking I was okay*' and his actions, in his attempts to lead a normal life by going to work each day, with his true feeling state: '*I was devastated'*. It seems that Jerome was avoiding the painful state of his true feelings by losing himself in his work.

Kim speaks of the early days after her mother's death and how she felt isolated and misunderstood by her peers. It is interesting that she speaks of being an atheist, yet thanks God she had her sister.

> *We had already been brought up to be atheists, and so there was no real big God to believe in you know, and I just felt so cynical about life....I understand now that when you are traumatised, you are really sensitive, and you are more sensitive than average, and so the slightest little bit of dismissal is really wounding, because it's almost like you have got this wound already, you know and if someone just brushes you off, you think 'oh' so I just got more and more alienated really from society. So my sister and I thank God we have each other. It took us quite a few weeks to even sleep alone.*

Elizabeth had a severe breakdown after she heard her sister Roberta had died by suicide. For an extended period of time she was heavily sedated to the extent that she could not manage her housework or go shopping as panic attacks started and she could not leave the house. Her father's damaging assessment of her made in her childhood, that she was no good and could not do anything, returned to haunt her. She remembers being determined that she did not have to follow Roberta's example.

Grief reactions in the early days following the suicide began to evolve into other thoughts and feelings through the passage of time, some changes indicating healing and accommodation with the loss, others into self-blaming and destructive thoughts. Some participants became depressed themselves and spoke of having suicide ideation. It could be suggested that their family member's suicide allowed the concept of suicide to become part of the family vocabulary.

Participants' suicidal ideation

In attempting to connect with the emotional state their family member was in prior to their death, as identified earlier in the second quest, some participants also began to have suicide ideation themselves. Thoughts of ending their own life were present in some of the participants in this study. Those who described their own suicidal ideation or questioned whether they might end their lives in such a manner were Olivia and Elizabeth.

Olivia had suicidal ideation for several years after Chris's death and on one occasion she took the step of connecting a hose to the exhaust of her car, and taking her dog in her arms, sat in the car. But thoughts of her daughter Ruth stopped her and she knew she could not do that to her. Olivia had suicidal ideation for eight years after Chris's death and says that it was only after that period of time that she had the reaction, '*I am a survivor'*. Several of the participants shared their thoughts about escaping from their painful grief by following the example of the deceased, but it was the thought of what this additional death would mean to their other family members, most commonly their children, that prevented them from taking any action to cause their own death. Olivia explains:

> *I think that to me a suicide, and I guess it depends a lot on your relationship with the person who has died by suicide as well, I had a very close relationship—to me Chris was my soul mate, and we would discuss anything and everything, but there was just the one thing that was taboo, so I think it took me a long while to reach certain steps of acceptance and to find that peace within myself. It wasn't until 2004 that I changed my will, because Chris's name was on it.*

The participants' early reactions following the death of their family member were compounded by their fears for other family members—that they may follow the example of their deceased relative.

Other relatives' suicide attempts/ideation

Some participants shared stories about other family member suicide attempts or ideation since their relative's death. This may not indicate a genetic link, for as in Lyn's story, Danny and his adopted siblings were not genetically related. When a suicide occurs, there is the possibility that it may become an option for others connected to the deceased. The emotional cost to the participants, who were already grieving the loss of one family member, when confronted with suicide attempts or ideation in other family members is explored below.

In the twelve months following Gary's death, Janelle and Gary's eldest son, Vance, attempted suicide. He was admitted to the local hospital's mental-health unit and the psychiatrist asked Janelle to find out what she could about other mental-health problems in Vance's paternal family. Janelle told the psychiatrist about an earlier incident in Vance's life; when he was in grade four, Vance began to speak of killing himself, and Janelle sought professional help for him. Janelle now believes that Vance has been depressed throughout his life.

While lifelong mental-health problems, including depression, may be implicated in suicide attempts, participants also explained ideation and

attempts not related to diagnosed mental illness. For example, Wayne, Josie's eldest son, seems to be '*lost in space',* according to Darryl, whilst Mark, his other son, has attempted suicide. Mark is angry and often blames everyone for any trouble in which he finds himself.

> *Mark, in high-pressure moments, threatens suicide and says he wants to take a sister with him. Mark blackmails people around him and says he doesn't want to be here.*

Darryl's two youngest daughters have also tried to end their lives.

> *Tammy and Kellie have both made attempts on their lives. Kellie self-mutilates and has dysfunctional same-sex relationships. May helps Kellie through all of that. Kellie has tried to kill herself by jumping out of a car and has overdosed; she took some substance and had to have charcoal treatment in hospital.*

Darryl sees that his son Mark struggles with life since his mother died. When life becomes overwhelming, usually through his own doing, Mark wants to be with Josie.

> *I sit here now with my 26-year-old son who is hopefully sleeping after an attempt to cut his wrist. It took some effort to quench his anger and resentment. His coping skills are hammered and it takes little to light the fuse. Tomorrow is another day and it may bring some answers, it may bring more struggles, I know it won't bring happiness and contentment for Mark and the emotional blackmail may just go on.*

May, Darryl's eldest daughter, has shared her story in this study also. Whilst May has spoken about episodes in her life where she has been depressed, she is the only one of Darryl's children who has not had suicide ideation or attempts.

After Sally's older brother John died she became increasingly worried about her youngest brother Tim, fearing he would follow his brother's example. Tim idealised his older brother and found his death very hard to

deal with, blaming himself that he had not picked up on the clues regarding John's suicidal intentions. Like John, Tim had an illicit drug history. Tim suffered a further devastating loss when his girlfriend died of a heroin overdose in bed beside him. After this death, Sally became extremely anxious about Tim's wellbeing.

> *My other brother became at risk also of committing suicide, so for me it was suddenly, there was the possibility that I would lose him as well and that was very scary.*

This was a very frightening time for Sally. She became aware that Tim was also using heroin and marijuana to ease his depression, and for Sally this was hard to bear as she was the only person in her family who knew.

> *I remember one terrible night when my father rang me to ask me to ring Tim and try to talk to him. Tim had just rung to say goodbye to my parents; that he couldn't go on. I rang him and asked if I could engage the assistance of the community mental-health team. They got involved, and Tim got through it. I found out later that he had left a note with the key to his motor bike for his friend to have. This was distressing for me over quite a period of time. One thing that distressed me was the possibility of being the only child left for my parents, being the only sibling of three left for myself, and a great fear that it would be too much for my parents to recover from emotionally.*

Tim, who until recently had an illicit drug lifestyle, has been endeavouring to seek other methods of coping with depression with Buddhist teachings.

This section has described the earliest reactions of the participants and also those of some of their family after the suicide death of their family member. This period of time, often a confused period, yet with the imperatives of a funeral to organise or attend, was expressed by some as a 'fog'. The legal tasks consequent to the death of their family member also

required the time of the bereaved family member, other than those who were children at the time. It was in these days of the aftermath to the death that the first steps were taken to attempt to make meaning of the suicide and the bereaved family members were wrestling with the first two quests to comprehend the mind frame and emotions of the deceased. How suicide-bereavement grief experiences manifested for the participants follows along with descriptions of their feelings of anger, guilt and self-blame. First discussed are the grief reactions of participants demonstrating those issues which were common for all participants and those which were differentiated by the relationship shared with the deceased family member.

Kinship suicide grief issues

This study reports the suicide-bereavement grief experiences across all kinship classes and therefore was able to identify common grief experiences across all suicide-bereaved family members. More importantly, it identified the special meanings and inferences that were dependent on the class of kinship the bereaved had to the deceased.

For participants whose family member died by suicide, there were conflicting feelings. They spoke with compassion of the one who died, recognising the depth of their suffering before the death. There was the realisation that the suffering for the deceased family member had ended but that instead, it had been spread over all those who cared about the one who died. Those bereaved then had the adjustment task of dealing with

these emotional consequences that also spoke to how the bereaved questioned what they had meant to the one who died. Kim was the prime carer for her mother after her father died and understands the affect of suicide on the whole family.

> *Not only is it all the suffering of her, but then there is your own suffering of the fact that your mother has done this and where that leaves her life and your life, you know, it multiplies it.*

Kim's clear statement about her feelings after her mother's suicide illustrates how the loss of a relative may affect other family members in different ways.

Parental grief

Parents who lost an adult child or a teenager to suicide also spoke of their sense of failure. They questioned their role as parents—how it was that they were not able to raise their child to be able to withstand the disappointments and problems encountered in life. One mother was aware of her son's previous two suicide attempts, after which she was unable to encourage him to speak to her about his feelings or access any professional help. The paradox of feeling so close to a child was expressed, yet the child would not discuss his suicidal ideation and attempts. Olivia noted that despite seeing herself as Chris's 'soul mate', suicide was the one taboo topic.

Other parents, Delma, Wilson and Angie, had no prior intimation that their children were contemplating ending their lives. Delma described the

huge shock of seeing Colin with a gun in his mouth. With her history in palliative care and as a hospital chaplain, she thought:

> *Here I was out there trying to save the world and I couldn't save my own son.*

Delma recalled an earlier episode when she felt a sense of failure that she could not be enough for her son after the loss of his father. Colin had cried and told her:

> *'I want my father all I want is my Dad' and I said 'I know I haven't been enough for you darling, but I'm all you've got'.*

After Colin's death this sense of failure returned to haunt her.

> *With all my training, I'd done a lot of counselling to be a chaplain, all my training, like, it's different, it's different, you can run it through your head 'what would I say', but it doesn't work when it's you—so for three years I wanted to die, honestly. I contemplated it, it was too hard to wake up every morning and feel the pain.*

Grief confronts the parents' sense of self-identity and their role as carer, nurturer and the one responsible for raising the child to be a healthy functioning adult. Wilson speaks of his low self-worth after his daughter Holly's suicide.

> *That happens all the time, unexpected time, you are going on alright for a couple of weeks and then bang whammy you are right down. A normal person's self-esteem level is high, and the parent of a suicide, the self-esteem level is very low.*

Sibling grief

The loss of a sibling is the loss of the person who has the shared experience of knowing what it was like to grow up in this family. An older

sibling may be a role model for younger siblings. A sense of responsibility for the suicide was felt by siblings of the deceased.

Sally stated that she was angry with her parents after her brother John died by suicide and when her youngest brother Tim was also at risk of suicide. She blamed her parents for the way they were raised. She felt that she could not express this anger to them, leaving her with very conflicted feelings. She shared during the interview that she was blaming them in part. She did not feel she could, or should, express this to them. Sally did, however, explore this in her own psychotherapy.

> *I am very aware of the legacy of growing up in a family like mine: emotionally distant, repression of emotions, shaming. The effect is to undercut the natural development of self-esteem in a child. I know the effects of this in myself intimately, and it feels like a lifetime challenge to deal with it.*

For Sally, it was challenging because she did not want her parents to assume guilt, although she did actually think they bore some responsibility. She understands and accepts that there are many factors that lead a person to take their own life. Sally believes how well a child has been nurtured by love and respect to love and respect themselves is one factor. Perhaps there was too little understanding of this on her parents' part.

Feelings of guilt about John's death have also haunted Sally. She tried to help John as best she could, encouraging him and recommending various psychologists or therapists to him, but she also understands that it was up to John to seek help for himself.

> *So I did what I could do. But I think had I known the extent of his despair, I would have taken much more directive action than I did.*

Sally speaks of her own grief as she lost the sibling she was closest to. She was aware that the friends who offered support were there for her parents, but she felt that her grief as a sibling was unrecognised and ignored.

> *I really feel very strongly that it's quite difficult for siblings in suicide, because a lot of the focus, in my own experience, is that a lot of attention went to my parents, which you can totally understand. I do not have a problem with that, I really understand it, but it was also very hard, because family friends would kind of, it almost felt like they would forget or ignore, and I just think that again peoples' hearts go out so strongly to the parents, and yes, the siblings can just get a little bit left by the wayside, and I feel that it is a very particular journey as a sibling, and it raises very particular issues, which are different from a parent of course.*

Sally spoke of feeling invisible after John's death. It seemed to her that her pain and the pain experienced by her brother Tim were eclipsed by the understandable focus on their parents' traumatic loss.

> *I remember feeling as if people couldn't see my pain, or consider that I too was suffering enormously. I remember being asked by family friends how my parents were, but the enquiry did not extend to my other brother and me. It really hurt.*

Children's grief

The participants who were bereaved as children spoke of feeling different from their peers, as if it was not understood why they could not be as happy and carefree as their social group. Kim, a suicide-bereaved daughter spoke of her resolve never to suicide after her mother's suicide. Kim's mother died by suicide a couple of years after Kim's father died from cancer. She was barely an adult when she was orphaned. Kim's mother had bipolar disorder, which worsened after Kim's father's death. Kim, who

was tutoring at university at the time of her mother's death, was her mother's primary carer. Following the discovery of her mother's body, Kim lost her belief in her own future at this time.

Those who lost a parent spoke of losing a complete family. Their grief was in being aware that a parent had decided to die, rather than continue their role as the protector and nurturer. The result for some was a sense of abandonment whilst others spoke of the loss of a parental connection as they moved through the stages of adulthood and significant milestones in their lives. Delia shared her longing.

> *I would love to have a normal family, where you have everyone at weddings, and together and you would have that support, I would love that.*

Similarly, May speaks of missing the whole family after her mother's death.

> *It saddens you a little bit when you see other people who've got their parents. They don't appreciate it. I look at my son and I just think she would have really loved him and I would really, would have loved for her to have met him and for them to have a relationship.*

For others it was the stigma experienced because of the nature of their parent's death, as Laura explained:

> *You can feel extremely isolated with this kind of death—because even if people ask, and I normally just tell them—it's a death like any other, but they don't know what to say. They sort of look away, and you do feel different, or that there is sort of a—I don't know if the word is stigma—and you can see that they don't know how to respond to you.*

Some participants had taken on the role of carer for their mentally unstable parent. For Kim there was also the feeling of inadequacy at a

young age, being unable to meet the enormous challenges of keeping an ill parent safe.

> *I had no idea how to help her. I tried but she was really so unstable. So when she said that she had been thinking about suicide and tried something, I got worried and I said 'I want to get her to a private psychiatrist, because I just don't think these public ones are going to do anything'—I thought there has got to be something more to offer her, you know.*

A few days later, Kim and her sister discovered their mother's body. She described their initial reactions.

> *It's very vivid I can see it. It was so shocking. You are kind of numb, but at the same time you can feel a huge amount, and it's a weird state, but probably it was just numbed down and then after that, my sister and I were so terrified after that, we just had an irrational fear especially if the other one, we had to be together, you know, we had to sleep in the same bed, and we were terrified to go to sleep, terrified to go to bed and go to sleep, but just the images of her and death, and for me it was like just an overload of death—you know like what is the point of making an effort in life, if it all comes to this, you know. I remember just thinking what is the point of it all?*

Spousal grief

Spouses questioned what their relationship had meant to their partner that he/she chose to die rather than continue that relationship. A partner suicide is not only the loss of a partner but also the loss of the previous belief in what the relationship meant to the one who chose to die. Lyn explains her feelings after her husband Danny ended his life:

> *To me I went through an angry phase. He had a little baby, who he had the responsibility for, and he left us all behind. Danny was the love of my life and I want to be with him. I just think what else, every time I turn around there is something else. It's never-ending. You think you are coping with the grief one day and then something else will happen.*

Janelle knows that Gary's behaviour towards her was not normal and that he had made her life intolerable for many years. She believes that her

decision to end the marriage was in her own best interests. She realises that Gary felt very threatened by her decision. When Janelle reflects on their dysfunctional life she feels shameful. The inner conflict that she experiences is evident in the following passages. Janelle distances herself from her feelings and judgement of her decisions by using the second person pronoun 'you' rather than the first person pronoun 'I'.

> *Like you couldn't put up with it enough to keep him alive—but you can't in the end, but it's like well if you could have given your life over to that and been content, then he would still be existing and I'd still be doing what I always did and that was keeping everyone together, and the kids wouldn't have been dealing with a Dad they don't have any more.*

Janelle too grieves for Gary, and this she finds difficult to understand.

> *Two years down the track, you are just wishing that none of it ever happened. When you think how fragile the whole situation was, you would think you would be pleased to forget about the guy and move on, that's what I don't understand.*

Darryl suffers from loneliness since Josie's death. Darryl reflects in his journal on the sanctuary of home being broken. The question arises whether he is beginning to doubt his previous perception of an ideal relationship because Josie chose to leave him. He expresses his sense of guilt that on the last day of Josie's life, he snapped at her and did not kiss her goodbye.

Jerome undertook a lot of self-exploration to try and comprehend why Sean had chosen to kill himself, and why he had not picked up how Sean had been feeling.

> *I blame myself to some degree, and I blame him to some degree for not sort of letting me know what was going on.*

Jerome was ultimately left in the dark, and this is an additional sorrow and regret that Sean may have felt neglected. Jerome's grief was evidenced in his reflections:

> *I used to go up to the grave very regularly, go to the cemetery and we used to do that most weekends.*
>
> Researcher: *It sounds like there was a lot of grief there?*
>
> *There probably was, but I didn't really let it all out. But then the inner grief doesn't really show itself until some time later, and often in a different form.*

The participants' words describe the kinship grief experiences and illustrate their thoughts and feelings following the suicide death of their family member. These comments by the participants highlight the differences in the shades of meaning derived from kinship relationship expectations that are contained in these stories of grief.

The suicide was challenging to the spiritual life of some of the participants who expressed amazement that their beliefs so firmly held prior to the death had changed. This was, in part, an awareness of a change in themselves, but was also recognised as a disappointment in the church to which they belonged.

Contact with religious bodies or congregations

Participants spoke of their contact with their former churches and their reactions when they found that either their religious leaders or the congregations seemed to have little understanding of their needs at that time. This section tells of the changed spiritual beliefs of the participants

as they began their journey of adjustment. After a traumatic loss such as a suicide, people may look to their church or other spiritual affiliation for support. Whilst some members of the church were able to offer much appreciated help in a practical way, no participant spoke of meaningful support and understanding gained from their church's congregation.

After hearing of Arun's death, the pastor of Emma's church came. She found that support comforting as the church congregation provided meals for the family and there was regular telephone support. Prior to Arun's death, Emma sought help for him within the church.

> *He became very depressed and the church didn't know how to help him. You know I'd go to them and say: 'He's depressed' and they'd say: 'Well he needs to change his attitude' type of thing, not helpful whatsoever. I'd ask many to come and visit him and encourage him and whatever, and they didn't know how to handle it either.*

After Arun's death, the pastor and other members of the congregation came.

> *They looked after me and the family really well, but there was no kind of suicide aftermath kind of support, or counselling or whatever.*

Emma's health has been affected by the stress of Arun's pre-suicide depression and all that she has dealt with following Arun's suicide. She had belonged to a Christian Outreach Church for fifteen years before Arun's death, but when she found the pastor's attitude to Arun's depression judgemental, she left that church and went to a different denomination. Emma received help from the people at her new church,

but Arun and the boys did not join the new church. Since Arun's death Emma has questioned her whole attitude to religion and God.

> *Looking back now—I don't go to church any more, since Arun died, I have looked at many things, and I'm still working through that. I've decided that God is something that gives you hope if there is some hope and that people do their own thing, you know Arun decided to do what he did, and God had nothing to do with it, so what was the point of praying to him to look after him, kind of thing. Since Arun died, people say 'well we are praying for you': 'Well thank you very much, but it's like what kind of help did it have before'—so prayer is something that helps you if you've got that attitude towards it, that it will help you—but whether there is a power that can orchestrate things to make things better, I re-evaluated that and decided that is not the case. God does not interfere in what people do, and I'm still working through that one. So I might change my mind again, I don't know.*

The Jehovah's Witness Church has made an attempt to encourage Delia back into the church.

> *They sent me a movie once about coming back to the church, which was very emotive. It was awful; they had a photo of my Dad there, as part of this pitch to come back. That really upset me, because he didn't want any part of it—he wasn't part of their religion, and I don't think their separatist philosophies helped our family one bit.*

Delia says of her mother's religion that they believe they are right and everyone else is wrong. Delia considers that the Jehovah's Witness's belief system broke her family apart. She is not antagonistic to all formalised religions, but is not drawn to any and recognises the inappropriateness of the church members who made the children destroy all of their father's possessions in the early stages of their grief.

In Delma's training to be a hospital chaplain she undertook some counselling courses. But she states that when a tragedy happens in your own life it is different.

> *It doesn't work when it's you—and everyone was like giving me bum steers to coin a phrase, because I was highly into the church, there was a lady*

priest saying, and this was mind you after a few months—'Del you have to start getting back into life now'.

Delma never went back to her hospital chaplaincy.

The spiritual seeking that some participants undertook after the family member's death was also part of the four quests to find meaning in the death and in particular, of the fourth quest to find meaning in their own lives. As such, this speaks to the lack of understanding or compassion which disappointed some of the participants in their after-suicide contact with religious bodies or with church members. However, this disappointment was not the only traumatising experience for some of the suicide bereaved. For some participants, their experience of the police service resulted in affront and emotional scars.

Contact with the police service and other first responders

Frequently, participants described the circumstances of the initial contact with the police service, most often after the death, but for other participants, the police were notified prior to the death. For some of the participants their dealings with attending police, hospital or mental-health professionals were almost as traumatising for them as the death of their family member and so enumerates part of a sub-theme of 'the legacy of suicide'. This contact suggests a power imbalance and a feeling of being disenfranchised.

The state police service is most frequently the first service contacted in the event of a suicide death or when a potential suicide is suspected. The manner in which the attending officers relate to the distressed and sometimes traumatised family members impacts considerably on them. Often when telling the story of their family member's death, one of the first descriptions participants give is of what the police officers said and did and how they felt about the manner of this initial contact. The fact that this is common among the suicide narratives points to the indelible scars such encounters can leave in the minds of the bereaved. The police officers who have to attend and deal with the sometimes horrific circumstances of some suicide deaths can themselves be victims of trauma. The following narratives shared by the participants relay their memories of who attended in the first instance after their family member's death or those who had the difficult task of relaying to them the shocking news.

Metropolitan police had assured Lyn there would be a police counsellor to assist her at the regional city where Danny died, but at the regional police station she confronted unhelpful police who wouldn't tell her anything, or allow her to identify Danny's body.

> *The police officers I was dealing with came around and said 'when you get up there, they will have a counsellor and they'll be very supportive, and they'll talk you through everything that happened and what was discovered'—ha, exactly the opposite.*

Danny had left a note in the motel room asking that his father be notified of his death, and so the police would only deal with Danny's father and attempted to shut Lyn out, thus attempting to deny her the next-of-kin rights.

The horror continued for Lyn and her parents at the regional police station. The previous evening Lyn's general practitioner who came to give her a sedative suggested that she should see Danny's body, because in time she would regret it if she did not, but when the police met Lyn, her parents, her father-in-law and sister-in-law at the airport they said to Lyn: '*No you cannot see him, you just cannot see him'*. The regional police left Lyn and her parents sitting in a small room and took Danny's father and sister to identify the body. After an hour Lyn's father tried to find out what was happening and Lyn heard all this whispering. Lyn said: *'can you please stop whispering, he is my husband, I want to know what is going on'*. Eventually Lyn and her parents were taken to see Danny's body. Lyn said she was in shock and she could not cry.

The police never contacted Laura or her father directly. This dismissal of the rights of the next-of-kin was felt deeply by Laura. It compounded the trauma of living with the disbelief of her mother's death until she herself contacted the police to confirm identification.

Delma was horrified at the police officers' behaviour immediately after her son Colin's suicide. Delma heard the shot that took her son's life and ran

downstairs. Delma saw Colin was near the window, as the impact of the bullet had knocked him down. He was lying on the floor by the time she reached him. She stated that the police were there in the house, but she could not get them to come into the room where Colin's body was lying. The police told her it was because Colin had shot himself that no officer was coming in. Delma, who is a registered nurse, could still feel Colin's pulse and was screaming for an ambulance. The police just left him there.

> *They finally came in and they just left him there until after midnight, because this was where the police went wrong, because they didn't want it to happen on their shift, so they stuffed around until someone else came in. Like on top of everything else you have all this to contend with—so they were all laughing and joking around.*

The attending policemen's behaviour increased the horror of the situation for Delma. She felt there was no respect for Colin or for her. That they were more concerned about delaying action so they could avoid the work of making the report added to her shock and outraged her. Delma first saw the loaded rifle in Colin's hand when she went to tell him his dinner was ready—which may have been any time between 6 and 8 p.m.— yet the attending police left Colin's body lying on the floor until midnight. The additional delay before any action took place increased the trauma and was an affront to Delma and her family. The attending police officers' behaviour is inexcusable considering that a member of the family was also a police officer and was in the house at the time. Philip did not comment on the behaviour of the other police officers and how offensive this was for Delma.

In contrast, although Delma experienced the police presence as insensitive and, for her, damaging she was nevertheless grateful that the next day Philip called in the police human resources officer to speak with the entire family who had gathered at Delma's home. Philip comments:

> *We all spoke to her, and the big thing talking to her made me realise that there was a distinction between my professional role and my personal involvement, and I was there, not in my professional capacity, and that was a really, really a big thing, which I suppose helped me deal with it. But, I was there as Colin's brother-in-law and Delma's son-in-law.*

Delma, Brian and Philip were able to stay together, and to speak and support each other openly, sharing their individual recollections of Colin's behaviour in the previous few weeks. They were also guided the next day through a similar process by the police support officer where they were able to work through their individual responsibilities and relationship with Colin. For Philip, the worst part of the whole episode was having to go home to his wife Linda and tell her what had happened to her brother, and that he was not able to prevent the tragedy.

Even though the police service attended the scene of the death, and some family members were able to discuss with them the circumstances of the death, some participants were left with unanswered questions about their family members last days and death.

Unanswered questions about suicidal death

Participants grieving the suicide of a family member frequently seek all of the details surrounding the death. In particular they seek information about the circumstances that may have informed their relative's decision

to die. Some may be looking for someone to blame, others wish to gather information to help them understand or connect with the last moments of the family member's life. They often seek these answers from other people in their deceased family member's life. Sometimes, however, family members of a suicide-deceased person feel guilty about their own behaviour, what they may have done or not done that could have impacted on the decision to die, and can therefore be reluctant to share information with other family members or even the police service.

There are many things about Holly's death that Wilson cannot understand. Wilson tried to make sense of the information available to him but still has many unanswered questions about the circumstances surrounding his daughter's death. Wilson arranged to meet Holly's boyfriend Ivan and his father. In this quote it can be seen that Wilson attempted to lessen the distress that Ivan may have been feeling about his role in the last hours of Holly's life.

> *He came along with his father and he wanted to meet me. I said: 'Look I want you to know there is no blame, I have no anger towards you, I just want to find out the story—you were involved, but you didn't do it, Holly took that decision herself'.*

This effort to comprehend their deceased family members' troubled state included investigating their possible mental-health problems. They also spoke of their many questions that remain unanswered.

Other family members' grief reactions

Emma sought counselling for her three sons, but she now thinks that it was premature.

> *Initially I took them all off to a couple of counsellors, but I think it was too early. I wanted to take them so that they could see that this is what counselling was and that it could help and that they can talk and stuff like that. So they still didn't talk really. Greg, I was very worried about him, whether he would commit suicide himself.*

Darryl describes his family as shattered following Josie's death. His eldest daughter, May, has been the strength of the family, trying to help all of her siblings and also Darryl.

Concern for other family members impacted on the participants' grief experience, as did having to deal with those relatives who blamed the participants for the suicide.

Blaming damaging behaviours from other family members

Among the more damaging and distressing experiences shared by the participants were stories of blame or personal attacks from other bereaved relatives. The assigning of blame has resulted in some of the families being fractured and some families were already fractured prior to the death.

Lyn spoke of the very abusive, insensitive and objectionable treatment she received from her father-in-law after Danny's suicide. On the day Danny decided to leave he borrowed $12,000 from his father, who always had money in cash in the house. Danny bought a few things then sent $9,000 to Lyn. Lyn immediately gave the $9,000 back to her father-in-law. He

then demanded the other $3,000. When Lyn, her parents and Danny's father were sitting in the police station to identify Danny's body *'his father turned around, and accused me of stealing his money; he was going to report me to the police'.*

Lyn's father-in-law then blamed Lyn for saying something to Danny that caused him to end his life.

> *'What did you say to my son that made him do that?' He was just going on and on about 'where is the $12,000, I want my $12,000' and in the end I just snapped, and I said (excuse my language), 'shut the fuck up about your money, don't you realise your son has just died and all you are worried about is the money'.*

From that time onwards, Lyn's father-in-law began to pester Lyn for Danny's death certificate. Lyn found out that her father-in-law had taken out an insurance policy on Danny's life and he intended to claim the $12,000 benefit.

> *Tom* (father-in-law) *was ringing up incessantly every single day on my phone, 'have I got the death certificate' and in the end I got it out of him why he wanted the death certificate—for the life-insurance policy. I said to him 'look Tom when I get the death certificate you will be the first to have it, and will you stop ringing me, because it is upsetting me to keep hearing about it'—well I got abused.*

Lyn was very well supported by her parents and one brother, but surprisingly, her sister, a medical practitioner, wasn't supportive at all.

> *I thought she would have some empathy there, but no. Then my sister shrieks at me: 'You are not acting like a normal person' well this isn't a normal situation and I don't think there is any normal way to react to this kind of situation. She's coming and telling me I should commit myself to the psychiatric unit.*

This exchange with her sister and brother-in-law led Lyn close to contemplating suicide, but she knew she could never leave Zac. Lyn chose

to close off all communication with her sister, who then thought that Lyn was going to take her own life.

> *She rang the ambulance, rang my doctor, rang my parents, Mum came over and reacted very angrily. So I had my sister, my brother-in-law and my Mum just hurling abuse at me. I couldn't take it and I went up to my bedroom and I tell you, I was very close to jumping off the balcony, I was so close to doing myself in.*

Since Gary's death Janelle has been blamed and ostracised by Gary's mother and brothers. Janelle is comfortable that her mother-in-law does not speak to her, but she recognises that the situation is another hurdle in her relationship with her eldest son Vance. Vance blames his mother for his father's death and idolises his father's memory. Janelle has shown her eldest two children, Vance and Halle, the notes in which Gary was planning her death. She has spoken to Flynn, her youngest child, and tried to explain suicide to him.

> *He, you know, my little fellow was upset and I said to him 'what Dad did is wrong, it's wrong, because for us forever we have to be sad about that forever now, and no one should do that to someone else'—I understand if it's a car accident or whatever, but by doing what they do, they inflict a hurt, a horrific hurt that they will never feel, for the rest of those other peoples' life. That is just horrific.*

Delia recalls that her mother was very negative after the death of Delia's father. She blamed his parents, then she blamed his music and his philosophy books—especially Nietzsche. *'She said it was all from the devil, and somehow that had infected his mind'.* The most terrible memory for Delia was when her mother made the two children destroy all of their father's things.

> *I think it was the week after he died, she got us—this was just terrible—she got us to destroy all his things. And all his clothes; and I can still remember my brother and I in the backyard, breaking up all his possessions, which in*

retrospect was a hideous things to do. She led us to believe that they were all from the devil, which of course is not true at all. They were from the devil, had to throw them all away, and that was what made him sick as well, so a combination of that and his parents.

The distress for participants following the behaviour of insensitive and blaming family members heightened the trauma of their family member's suicide. When those already shocked and grieving their loss were blamed and abused by those they had hoped would be supportive, their reaction was to withdraw themselves from further abuse and this resulted in loss of contact with some family members or a schism in the family.

Fractured families

For some families the suicide death caused a family schism and resulted in disengagement with non-supportive and blaming family members. Fractured relationships are demonstrated in the stories of disenfranchised rights where some bereaved family members were unable to have their wishes respected in the funeral service. Some families have never been able to re-join and heal, whilst others have been able to regroup and share missing information about the death or the earlier life of the deceased family member.

After Colin's death, more trauma and anguish arrived for Delma. Colin's ex-wife demanded his superannuation and other possessions. Delma felt that her grief was invaded by the two women who had been in relationships with Colin. Delma believed that these women had each played a role in Colin's sense of failure, hopelessness and being worthless

that preceded his death. That these women constantly demanded money from Delma allowed her to identify more closely with the pressures Colin had experienced over many years. She felt that their demands were an affront and an intrusion into her grief.

> *She comes bouncing in and she said: 'Oh we've just come to get Colin's computer, because my boys need it'.*

Delma's problems were compounded by Colin's large superannuation benefit and lack of a will. One of Colin's ex-girlfriends also came on the same mission. This ex-girlfriend never allowed Colin to see her daughter, yet she entered his name on her daughter's birth certificate. *'So that was the drama that went on for two years, always money and solicitors'.*

Family history of alcohol or illicit drug use

A suicide death sends waves of grief and shock through the entire extended family. These are stories of fractured narratives from fractured families. The aftermath of the suicide on other family members was a further concern for the participants in dealing with their own suffering. Some sought to self-medicate on alcohol and other drugs, thereby increasing the concern from the rest of the family. Four of five of Darryl's children, with the exception of May, have used illicit drugs since Josie's death.

Monica speaks of a third brother who is bordering on becoming an alcoholic. This brother's marriage has broken up and Monica believes this is because he cannot communicate or relate to his wife or children.

Monica's older sister's marriage also ended, and Monica was the only family member who offered emotional and practical support. Monica's marriage did not fare any better than her siblings'. She has two children who were born seventeen years apart.

Monica's daughter Phoebe also had a period in her life when she was drinking heavily. But in her late teens she went to a rehabilitation clinic and stayed there until she was dried out. Phoebe's moods are still volatile and this is a deep concern to Monica.

As identified earlier, the participants were engaged in four quests following their family member's death. In accordance with these quests, all of the participants in this study appear to be endeavouring to come to terms with their family member's suicide. In volunteering their story, they indicate that they have investigated the death and explored the reasons why this decision was taken by their relative. Sharing their story in this way demonstrates courage. This can be seen as looking at the phenomena of suicide as openly and honestly as they could. They have not hidden from the trauma or pain, but in their endeavours to understand the full story of their family member's suicide death, they have grown stronger and exhibit resilience and a positive sense of self.

In contrast with the participants' strengths, many of their other remaining family members have mental-health issues and addictions. This difference may be explained in part for those participants who have

joined suicide-bereavement support groups. These participants have had various means of support from these groups and have been able to make some accommodation with their loss. Other participants sought support from various professionals who have aided them in their grief journey. Those participants who sought professional help were wise enough to realise that such assistance would benefit them.

Other relatives' grief

Witnessing other family members' grief reactions caused pain and concern for the participants, especially those family members who were suffering self-blame and guilt feelings. The participants, already wrestling with their own grief reactions, became concerned when other family members, especially the younger family members as in Emma's case, appeared to be at risk. They feared that others may follow the example of the deceased relative.

Sally speaks eloquently about the grief of her parents and of her own grief. In her parents' case, Sally recognises that they may have thought back on the strict way they bought up the three children and the physical punishment metered out to the boys.

> *I think that John's suicide must have just been terrible for them, because it would have flushed out a lot of this stuff probably, you know, and I'm sure that he* (Sally's father) *felt that he was too hard on all of us, and too hard on the boys in particular.*

Subsequent family history of mental-health issues

Adding to the concern of the participants was evidence that other family members were also suffering from mental illness. This was the case for Delia, who tried to help her younger brother when he began showing similar behaviours and symptoms that she remembered her deceased father had exhibited prior to his death.

Delia's sadness is that she knows her younger brother is mentally unwell. Her brother did not experience the same harsh upbringing from their mother that she suffered. Delia stated that he was raised a normal little boy and, like her, he had artistic interests. When he became a teenager she said he became withdrawn and refused to go to school. Her brother has never had a job and he began to do strange things like going into the roof of his mother's home and not coming down, believing that people were following him. He saw a psychologist for a time, but then believed the psychologist was following him. Delia's mother ignored the growing evidence of her son's mental-health problems. Delia wanted to get help for her brother, so she rang the Mental Health Tribunal and told them of her brother's case and the family history.

> *I wrote them a long history about his behaviour and about the nature of his illness, and that I think he needs to be hospitalised, because they have the authority to order hospitalisation. I felt when someone is that unwell for that long, the only treatment can be to keep them in a confined place, work out what tablets they need and rehabilitate them, and hopefully get them on the right track.*

Delia's brother did not present at the tribunal and her mother's church sent a letter to the tribunal. Delia appeared before the tribunal via a

telephone link but neither her brother, mother, nor anyone from the Jehovah's Witness Church participated. Delia states that the church's letter was written by an elder from the church. The church stated that they were her brother's support system. The spokesperson for the Mental Health Tribunal said to Delia that they believed her brother was mentally ill, but that it was now the tribunal's practice that if the mentally ill are supported in the community it is better for them than institutionalisation. Six months later her brother had a major breakdown.

> *He broke a glass window. He was walking up and down in the glass and screaming that he was God. The police went to his home, and it was a disgraceful mess, it was completely feral, he'd been living almost like an animal I think. So he got extremely unwell and again my mother chose not to be involved, she chose to shut down.*

As far as Delia knows her brother is back living with her mother, drawing his income from a disability pension. She has not heard from him in some time and on the few occasions that he has made contact he requests money, which she will no longer provide for him.

When bereaved participants have lost a family member to suicide and understand that mental illness was a contributing factor in the death, they view with alarm and sorrow evidence of further incidents of mental illness in their families, even among those family members from whom they are estranged. That there are fractures and estrangements in the family system resonate as further losses. Other losses described by participants follow in the next section.

Secondary and other losses

Since Josie's death Darryl has had to deal with other losses including the death of animals that were part of the family household. These additional losses rekindle the grief Darryl feels over losing Josie.

> *Why do things have to die and cause so much grief? Frustration boiled over and I ranted and raved. I scared the girls. Things did improve, they couldn't get worse.*

Darryl's eldest daughter May has since married the boyfriend who was with her when she heard of her mother's death. There was further sadness for her that her mother was not able to see her eldest daughter get married. May recalls thinking that she could spend the whole wedding day feeling sad; but thought that if there is a spirit world, then her mother's spirit will be beside her, watching over her on that day.

May now has a baby boy and is studying psychology part time at university.

> *I look at my son and I just think she would have really loved him and I really would have loved for her to have met him and for them to have a relationship, and then I would understand her more. This is something I never had the opportunity to do before. You don't get that perspective until you're a parent yourself.*

For May, this loss of her mother and the lack of a maternal grandmother for her son, speaks to the loss of a role as is described in the following section.

Loss of relationship and loss of role

For some of the participants the loss of the relationship, and especially the loss of their role within that relationship, continues to echo in their daily lives, leaving an aching void. The loss of her brother with whom Sally felt a great affinity was a huge loss for her. This was especially so in her emotionally distant family. It was supportive and comforting to have a relationship with a brother that was a source of strength, shared values and views. *'This has been an enormous loss to me, and is simply irreplaceable'.*

Sally expressed her pain at the loss of her role as sister to John, and especially the loss of the close connection they had shared. This loss was compounded because her youngest brother Tim was absorbed by his addictions and was not able to be the support that she longed for.

> *I felt so alone and very isolated in my family. My parents had each other. My brother Tim was not available to support me because of his own problems. This was a great loss to me: that my sole surviving sibling was not a source of strength, sharing. He was getting more caught up in his own drug and alcohol issues, and getting further away emotionally.*

In the period immediately following John's suicide, Sally was the main support for her parents as they shared, perhaps for the first time in her life, their feelings and thoughts. Sally's mother stayed with her for a few days and wanted to see the railway tunnel where John had died. The openness and closeness that developed in the immediate period after John's death did not last. This was another loss for Sally.

> *The initial closeness that opened up between us as a family gradually began to close over again, as the old pattern re-emerged. I remember noticing this, and feeling a great sense of loss. Being the most open in the family, I now felt stranded, abandoned by them. I had to shore up my own support, and did. Counselling, friends, a new relationship with the same person I am with*

> *now. But feeling so isolated within a family group is painful and lonely. It seemed like they were just all trying to make it be all over. Not talking about it, drinking, denying emotional realities etc.*

The suicide death resulted for some participants in the loss of a branch of the family.

Loss of contact with branch of family

Consequent to a suicide, some people try to manage their pain and grief by distancing themselves from other grieving family members. This can occur as contact with these other relatives may invoke uncomfortable feelings such as guilt, if there have been blaming in the family, or because contact with them re-kindles feelings of grief. When adults make the decision to cut off contact with part of their family this can disenfranchise the rights of children to know all of their immediate or distant family members. These are the people who may answer the inevitable questions the child has about their deceased relation, so the fracturing of families is another huge loss in their lives.

Delia's mother broke off all contact with Delia's paternal grandparents after her husband's death. Delia's mother placed the blame on her saying that she became very depressed after visiting her grandparents. Delia recalled that her mother wrote to her paternal grandparents to say that they would no longer visit for celebrations such as birthdays or Christmas as her church did not believe in these. The children were always in trouble from their mother for accepting presents from their grandparents. Prior to

her father's death, Delia and her brother were taken to visit their grandparents monthly.

> *I remember my Mum sort of blaming me, saying: 'Oh well it's too much for you going down there, it's just too much, you can't cope, you are depressed', so that relationship sort of fell away and that suited her very, very much.*

There has been a complete loss of contact between Delma, Brian, Philip and Colin's two children. The family's biggest regret is that they have lost contact with Colin's son Seth who is now an adult. Philip is aware that Seth is living an illicit drug lifestyle. Brian contacted Seth when the family heard that his life '*was going off the rails'*. There is a sense of sadness about the loss of contact with Colin's daughter who was only two years old when her father died. Contact was lost as the relationship between Delma and this child's mother became very strained over Colin's estate. Philip laments that no one in the family has seen Colin's daughter since. '*It would be nice to see how she grew up and everything, it's his daughter. She is Linda's niece, Delma's grand-daughter'*.

For some family members the suicide death resulted in educational opportunities ceasing, because the young bereaved family members were not in an emotional state to be able to concentrate.

Education foreshortened

The abandonment or foreshortening of education was yet another loss for some young members of a grieving family. Some find it hard to concentrate and study, while for others the prospect of thinking about a

future has no meaning for them. This may result in the younger family members regarding suicide as an option in times of disappointment or despair as suicide has now become part of the family's vocabulary.
Emma's eldest son Greg's university studies have been spasmodic. He has dropped in and out of studies, with some part-time work, and after four years, he is in his second year. Greg is a perfectionist, like his father, and very artistic. Emma says that Greg is beginning to enjoy his university studies, four years after his father's death.

Emma's second son, Ken, had a more conflicted relationship with his father as Ken is more 'laid-back'. Arun could not relate to this and often called him *'a lazy boy'*. Emma would understand if Ken was angry with Arun, but even though she tries to draw him out, he does not discuss his father or his feelings about his treatment before Arun's death. Ken completed year eleven and then attended a drama course in Melbourne, but returned to his mother's home because he did not like being so poor. He took a number of casual jobs and then started an information technology course. After one term he obtained a full-time position with a newspaper working in information technology, but finds the job boring. He still wishes to do a drama course, but is staying with his paid position for now.

Ron, Emma's youngest son, stopped going to school after Arun's death. Just as Emma found there was no suicide-bereavement support or understanding in her church community, Ron found no support or

empathy from his teachers. His grief reaction of withdrawing was inexplicable to the education authorities. Emma changed his school, but this made the problem worse. At most he would go to school only one day a week. Before Arun died, Ron was a talented pianist, but after Arun's death, he stopped playing. The following passage of Emma's lament illustrates her pain and frustration as she does not know how to help her youngest son.

> *The school didn't know how to help. The schools were bloody hopeless, and said: 'Oh well you can't force a counsellor on them, if they don't go to counselling, there's nothing we can do about it'—which is probably true—but there was no support in any other way, you know you had to be assessed. 'Well Ron hasn't handed in his homework' well of course Ron hadn't done any homework—Ron doesn't give a shit about homework. 'We can't assess him'. Well I don't really care and neither does he. Well I did care, that was the problem, because going from straight A's in year 7, to un-assessable the following year was devastating. He ended up in an adolescent day-unit program, for children at risk of non-attendance, which didn't help either, because his issue was grief, and nobody really told me that. And his way to deal with grief was to just withdraw totally from everything.*

Ron spent a term with the Adolescent Day Unit where a social worker endeavoured to build his confidence. The activities included rock climbing and cooking, which he enjoyed, but after a term Ron decided it was all a waste of time and that he would try to attend school more regularly. Ron now attends school more regularly but still refuses to do homework.

> *He thought it was all boring, because he's so intelligent. You know, his father was intelligent, but drove himself to work, whereas Ron—it was all boring. Now he's just finished year eleven and he will not hand in work, getting A's for maths, because he can do that without anything, and last report he got a D something because he didn't hand in anything [...] You know he just does not care, well that's what he says 'I don't care'—and so that is something for me to get used to, letting go of the worry about trying to make your child do work that he doesn't want to do, because I can't make him do it, and you know I've just got to let it all go.*

Emma's anguish and helplessness is evident in the above passages. In contrast, Delia's mother would not support her daughter's educational aspirations.

Delia's mother was left in a very comfortable financial position following Delia's father's death. She was able to own her house, had quite a healthy balance of money in the bank and lent her church a significant amount of money interest free. She never had to work again. However, because her mother's church did not believe in education, Delia's mother refused to pay school fees for Delia. When Delia reached the age of sixteen, her mother said to her '*If you don't get a job, you are out of the house in two weeks'*. It was the church's teachings that young people left school and took a menial job part time and went door-knocking to spread their beliefs. Delia says she found a full-time job, but then felt guilty because she was not going door-knocking. Delia resents that her mother spent so much money on herself, having costly dental work, having her nose fixed, and expensive new clothes, yet Delia's clothes were bought in second-hand shops. Delia's mother would not lend her money to buy a car or pay for dental work. The treatment of Delia by her mother after her husband's death raises the question of whether Delia's mother resented the close loving relationship Delia had with her father. This resentment of Delia's relationship with her father can be seen by her mother's actions to actively discourage contact between Delia and her father.

Support accessed

Many of those bereaved by suicide recognise the need to speak to people who understand their trauma and grief and to seek information about what helped them. Darryl, Wilson, Olivia, Delma and May all joined suicide-bereavement support groups and then trained to become volunteer mentors and support for others grieving a suicide death. Not all participants, however, were able to find a support group where they lived, nor does this form of support meet the needs of all those suicide bereaved.

After the initial emergency services call, Emma found there were no support services for the suicide bereaved in her home city. This shocked her. She says the police officers were kind, but did not have any contacts for services on which Emma could call for help.

Emma started a Survivors of Suicide Bereavement Support Group and holds monthly meetings in her home. Emma began researching suicide, depression and suicide support groups and other related topics on the Internet. She also spent a lot of time just reading and finding things. She discovered a web-based memorial site and she built a memorial website for Arun, stating that this was good therapy for her. Emma discovered all the good things about Arun and listed them on the web site. This was a positive experience for her as it was also a time of reflection. She realised then that what would really help her was somebody else who had been through a similar experience of family member suicide. She longed to be able to talk to them, and bounce ideas and share reactions. Emma found online support groups very useful. Emma has a community project

background, and was able to get funding and support to set up a group which now numbers about 50. The most that ever attend the monthly meetings is about five, and usually one or two unknowns. It is held on a Sunday afternoon. Emma believes that most people suffering suicide bereavement like to know that it is there.

It is important to Emma that this survivors' group is available to anyone struggling with the aftermath of a family member's suicide. She remembers how she searched for others with whom she could relate, to share the experiences and feelings that she had been through after Arun's death. Emma gathered a lot of information that she now makes available to others. She gained skills in constructing Arun's memorial website and she mentors others who wish to do this for their deceased family member. Her sons call her survivors' group 'Mum's thing'. They do not criticise her efforts, nor do they show any inclination to attend, but she thinks that they too '*just like to know it's there'*.

Olivia explains her history with the Survivors of Suicide Bereavement Support Association.

> *I think helping other people helped me, I think anybody that helps other people it does help them. I thought there is always somebody worse off than you, you know. So yes, you can use little things as yardsticks to progress through it.*

Those participants who proactively resolved to support other similarly bereaved people benefited greatly as members of suicide support groups and find that they grow in understanding and compassion. They also

increase knowledge of themselves and their deceased family member. In these gatherings they can speak of their lost relationships without the fear of criticism or of being silenced.

Supportive influential people

Not all the participants were able to link into suicide-bereavement support groups. Some were able to find help in other ways.

Hazel initially accessed counselling after Warren's serious car accident left him brain damaged. She speaks highly of this counsellor and sought help from him again after Warren's death. A book was recommended to her titled 'Toxic Parents' (Forward & Buck 1989), and she believes that reading that book and coming to terms with her own upbringing saved her sanity.

Lyn spoke with her general practitioner about what she had been through. *'I went back last week and told him everything and he just couldn't believe it'.* Lyn's pharmacist brother and sister-in-law are helpful to her, minding Zac when she needs help. Lyn has been to a meeting of the Survivors of Suicide Support Association, and whilst she found people supportive, everyone there was older than her and she did not return.

Lyn has arranged child care for Zac and returned to her previous position. Initially she worked just three days a week, but she now works full time.

Danny's adopted sister Penny and her two children share the house with Lyn, and the blended family get on very well together.

Janelle has been accessing counselling with a psychologist for two years since Gary's death. Janelle states that she still has very mixed feelings.

> *I'm not only punishing myself, but I get punished every day when the kids get upset and miss their father and you see their grief, and you see the fact a lot of the time my son doesn't want to be around. That is punishment.*

Laura has returned to both her hairdressing position and her university studies. She was supported in the early weeks by a counsellor from the Coronial Office, after which Laura saw a bereavement counsellor at a local hospital. Laura's general practitioner has referred her to a psychologist and she has attended some sessions with her.

> *So I've been pretty proactive with it, I really try to look after myself, you know. Like I was diagnosed with depression after Mum's death, a few months after Mum's death—and apparently that is pretty normal. So I take my medication, I see my counsellor, I make sure I try to eat well and make sure that I get enough sleep.*

Delia has been able to reconnect with her paternal family and received photographs and other items that had previously belonged to her father. She proudly displays these in her home. Her father's sister told her the details of his death, that it was cyanide poison that he put into a glass of milk. On her father's birthday each year, Delia's aunt sends her a text message, and when she comes to visit they speak about the early life of Delia's father. Delia is finding healing and reconciliation through these stories relayed by her aunt.

Monica has had a period of depression and sought help from a psychologist who persuaded her to avoid alcohol due to the family's history of alcohol-linked depression.

> *He said to me: 'Don't drink', and I remember this: 'Every drink you have, every glass you have of alcohol, means that next time you have a bout of depression the hole is just that much deeper'. He said: 'Don't ever drink to blot it out'.*

Those participants who reached out for help, either from support groups or professionals, have made the decision to begin their healing journey. Initially they may have been seeking solace and understanding. But the very motivation or need that resulted in the help seeking was evidence of the resurfacing of the urge to reclaim their own lives. Instead of remaining victims of their family member's tragic story, they have become agentic by reaching out for help and endeavouring to move to a better emotional state.

Current view of self

This section explores further the fourth quest—to understand what the family member's suicide says about the self of the participant. All participants acknowledged that their experience of loss has changed them in many ways. Their grief has encouraged some to further their understanding of suicide.

Emma believes she has grown and sometimes wonders how her beliefs have changed. She sees this change as a positive process. She also recognises that her boys are their own persons and she cannot make them

think or do anything. She has to let them go. Emma supports her boys if they need to withdraw, believing that they will heal in their own time. She is interested in how teenage and young adult males can be encouraged to seek help if they have suicidal ideation, knowing her three boys have refused all offers for counselling.

Darryl suffers from a long-standing back injury that affects his ability to work with heavy machinery as a diesel engineer. Many friends rallied around Darryl in the initial months after Josie's death. Darryl felt that his life became just one of fulfilling responsibilities for his family.

> *If life were measured on a Happy Meter, I would not rate 1 out of 10. I was quoted a few days ago as saying: 'If you don't feel joy, you can't give joy'. It is just my nature now from stopping me from being a very bitter person. I hope I can hold out until the sun shines again.*

Angie says she hasn't sung or hummed since Josh's death. She finds it difficult to see the good in the world. Angie has had so much disappointment and anxiety in her life that she finds little to be joyful about. She feels a strong bond with Joshua. She has fought for him all her life, from the time he was a small ill baby, through his many illnesses and fragility in childhood and through his school years. Angie recognises that he did not inherit good health, physically or mentally, and now that he has ended his life, Angie feels committed to continue her fight for those who are mentally ill.

> *I just feel I know so much, I've learnt so much and I feel a lot more compassionate and understanding and knowing about life. I am waiting for the day when I can see him again. Not tomorrow. I wouldn't go out tomorrow, that I wouldn't do anything to cause it to happen, but it wouldn't worry me. I'm not frightened of death. I have to be a spokesperson for mental*

health—I can speak openly now, when I couldn't before. Joshua's life has to count for something.

Some time ago Kim became depressed and consulted a psychiatrist in whom she had faith. He conducted some tests and she asked him if she had bipolar disorder also. He assured her that she did not and she felt validated and was reassured.

I know I'm labile and I know I've got more moods than the average person, I have such a strong kind of reality streak there, which probably comes from having looked at Mum lose control, but I could never let myself get extravagant and waste money or run around. There were a few areas where I acted out, but not in a way that you would call bipolar—I've obviously gone into the mental-health field for work and I work with a lot of clients, and obviously my mother, my legacy from her is one that has affected me doing therapy myself, also training in that field, learning and reading, and you know I've had suicidal clients I've helped to not kill themselves.

Kim's sister, Sara, completed her training in nursing, spent some years nursing cancer patients and is now in a management position in community nursing. Sara married and has a daughter with whom Kim is very close. Kim has been an intimate part of her niece's life from babyhood and this has helped ease the grief for Kim who had to give up her own baby for adoption when she was fifteen. Kim has recently re-partnered and is happy creating a new home with her partner.

Losing both my parents so young, it was hard to imagine, I feel I know what grief is like now—there's not going to be a lot that would ever be worse than that, because your parents, they were the foundation, and when that is ripped away, you are faced with being on your own. You realise eventually that this is kind of like the way it actually is and the rest is a nice buffer. It is great when you have people and when you have security, when you have got your health and got joy, but I learnt then that they are not givens in life. They are not things that you can just expect of life. I learnt they can go and that you have got to find them, and create them.

Kim's history of being the prime carer for her seriously ill mother and then later, orphaned in her early twenties, resulted in a forced

developmental push into adulthood with the consequent estrangement from many of her carefree peers.

> *I felt that people lived in their little bubbles of happiness because nothing bad had happened to them and they believed that was the truth, and if anything, they would judge those who hadn't got into such a bubble for being inadequate, and I just felt very alienated from people who didn't understand and from people… just the fact that they didn't understand or they were insensitive.*

Kim and the daughter she gave up for adoption established contact when Kim’s daughter was 21. For a period they shared a unit and found that they had an amazing amount of interests, values and lifestyles in common. Both are vegetarians and are engaged in animal protection. Kim’s daughter has suffered with depression, but is now married, and is the mother of her own baby girl and the step-mother of two more. Kim enjoys her role as grandmother.

> *I believe also, in the long run, that life is bigger than all that, and this is not a religious point of view, but I think it’s nature—life does win out, you know, but it takes a long time, it takes a long, long time for life to finally heal.*

Delia has been hospitalised for depression on a few occasions and she has been prescribed anti-depressant medication, which she takes.

> *So at times you can be a bit self-pitying and think it's quite a lot to have on your shoulders, but like I said my goal is to try and keep being positive in building up a life, but in those quiet, dark moments by yourself, sometimes it hurts a bit when you see other people, they've had all those opportunities, they have a great family around them and that is all taken for granted.*

Exploring further the fourth quest to understand the self of the participant after the suicide of their family member, participants spoke of the adjustments that have occurred in their lives.

Adjustment processes and reconnections

After Warren's death his widow returned to the regional city where she had lived previously. Hazel has therefore been able to reconnect with her daughter-in-law and her grandchildren. '*So I've got these three little beautiful granddaughters now, and so yes, that helped me through that part of it'.*

Jerome tried to keep working in his legal practice, but he became sick of the legal work. Jerome decided to enrol in a postgraduate diploma at university. He found carrying his responsibilities as the senior partner in a busy legal firm too much and so when the relationship between Jerome and his business partner further deteriorated, he decided to sell out to his partner.

> *I had a bit of major depression at the same time, and Sean came back into my mind at that time.*

Jerome can be seen as different, and more complex in a way, compared to the other participants interviewed in this study. The son of wealthy establishment family, educated in a private boarding school, he became a well-recognised figure who was accepted in affluent social circles. To openly acknowledge his grief would not be congruent with the style of the glamorous senior legal man that Jerome was at the time. As explained by Jerome, his upbringing and family culture allowed no public display of unseemly emotions.

Jerome spoke of burying himself in his work and additional tasks. He now recognises he did this to avoid the grief following Sean's death and what that meant. The fact that Sean chose to die like this, in Jerome's bed, beside him, and in this way, can be seen as a rejection of all that Jerome offered him and the lifestyle they lived. Not long after he sold out to his partner, Jerome adopted a completely different lifestyle. He has re-partnered and now lives on a rural property.

Laura's relationship with her boyfriend did not survive this period of grief and adjustment. She was without a permanent home for some months, but she continued working and continued with her studies.

> *Then I just made a decision, and I thought 'well I'm just going to keep going with my life, and try and make my life as good as it can be' and that is the greatest revenge of all, to not let her* (her Aunt) *affect me.*

Kim wanted to understand more about suicide and underwent a lengthy period of somatic psychotherapy. She studied to become a psychotherapist and now has a private practice and lectures on the topic. She intends to study for her master's degree next year.

Delia is estranged from her mother and also her younger brother. She recognises the very damaging effects on the whole family of her mother's adherence to a very restrictive religion. Delia left her mother's church and has shifted interstate. All contact between Delia and her mother has been broken off because she chose to leave the church. She has married and advanced in her career. Delia gained admittance to university and is

enjoying her tertiary part-time studies. Even though Delia has no contact with her mother, she is able to think of her kindly and with forgiveness.

> *I think the older I get, like I said with my Mum, there is less hostility there and I think you get more forgiving, and you can say 'look I don't agree with what you did—I recognise that it was actually quite wrong—or quite cruel and unkind at times' and that was where she was at. I do accept that she has very limited skills. She didn't have any role models as parents, and in a way I'm luckier than her, because at least with my Dad particularly, I remember him very fondly, as a very good decent person and I'm proud that that was my Dad.*

Delia and her husband recently had a baby boy.

While Sally recognises the healing benefits of sharing her story of her brother's suicide, she is self-protective and very selective as to whom, and in what circumstances she will share her story. She is now beginning to take risks with her story and will share her experience more readily. She explains her motivation in volunteering to participate in this research project.

> *For me to also contribute as a sibling just raises that profile a little bit more, and maybe that will have some benefit for others. I think that is important.*

Conclusion

This chapter relayed the background stories preceding the suicides and details the first narrative titled 'Family sagas'. The participants spoke of their own experience of being a member of these families, either families of origin or the family they formed when they married or partnered. The family lore of past generations was shared if the participant believed it was relevant to the researcher's understanding of the circumstances surrounding their deceased family member's decision to take their life.

Knowledge of family history of mental illness and conflicts, possibly generated by differing beliefs or religious affiliations, were also related. Also offered were the emotional, mental and physical suffering following incidents experienced as abusive. There were stories of early losses, rejection and abandonment as participants shared their reflections on family patterning. This first narrative, 'Sagas', explored all of the facets of what the suicide says about the family to which both the participant and the deceased belonged. This was often a very confronting history and story for the participant to share and identify.

The second key narrative, titled 'Family suicides', described the incident and circumstances of the suicide. The history immediately after the suicide is given including how each participant learnt of the suicide—some in the most traumatic way by finding the body or being present when the suicide occurred. This second narrative also addresses the question of what this suicide says about the family.

The third narrative, titled 'Family sequels', explored the aftermath of their relative's suicide. All the participants spoke of the tragic consequences that followed the loss of their loved one. Arrangements for the funeral were not carried out as some participants wanted and also against the express wishes of the deceased, thus adding to the pain for those grieving. In some narratives there were suicide attempts or ideation among the suicide-bereaved family members, and for others, expressions of self-blame and guilt compounded their grief. Other bereaved participants in this

study told of their religious leaders and congregations condemning the deceased, and even the participant's grief. The interface with police officers and the coronial services produced a mixed reaction from participants.

It was common for the participants to share stories of fractured families and the loss of connection with some of their family. As described by family and relationship therapists, a family is acknowledged as a group of people who are connected to each other by blood or commitment for the mutual benefit of those within the family system (McGoldrick 1993; Satir 1988; Stacey 1991; Walsh 2006). When a suicide occurs in a family, this death may result in the questioning by the participant as to the nature and reality of the relationship he/she shared with the deceased. In such a way, the suicidal death can result in the participant questioning what this death says about their self and themselves.

Suicide-bereaved families in their distress may display non-helpful behaviour that gets worse after suicide. An example of this difficult behaviour was reported by Darryl, who lost his wife to suicide. His eldest daughter, May, also a participant in this study, was the only one of his five children who was supportive for the whole family. The other four children fought with Darryl when he endeavoured to discourage their illicit drug use.

Some of the participants who experienced parental suicide also lost their connection to the surviving parent. When discord between the parents culminated in the suicide of one parent, as happened in the cases of two participants, the bereaved child blamed the surviving parent. In one case where the suicide loss occurred when the participant was a child, upon reaching an age when she could live independently, Delia chose to break off all contact with her surviving parent. Delia, after being distanced from her mother now for over ten years, can look back on her damaged childhood with forgiveness.

When a traumatic event such as a suicide occurs within a family, the normal reflexes and instincts of mutual caring and support may not occur. There can be blaming and shaming, challenging the cohesion of the family. The family system could be described as 'fractured'. These family losses also included addictions to alcohol and illicit drugs among the immediate family. Secondary losses were also detailed—the loss of the previously valued role with the deceased. For some their educational opportunities were foreshortened or delayed until adulthood, when the lost ambition to acquire a tertiary education was recovered. Participants shared their encounters with support services, some becoming actively involved in the formation and running of the support services. When discussing their current view of self, some participants described changed spiritual beliefs and also their questioning of the relationship they once shared with the deceased.

Chapter 7

Discussion

Introduction

This chapter discusses the family experience of suicide. Following the analysis of the data described in the previous chapter, two main themes along with sub-themes emerged in the form of questions inferred by the participants. These are:

1. What does this suicide say about my family?

   Under this question the following sub-themes are discussed:

   (a) Fractured families—this sub-theme describes the experiences of the families of those participants, who as a consequence of the family member's suicide were unable to regroup as a family and be supportive to the bereaved family member.

   (b) The legacy of suicide—including descriptions of the different grief experiences and meanings dependent on the kinship relationship the bereaved had to the deceased.

   (c) Negotiating changed relationships—in the context of the disrupted family either remaining disrupted or regrouping.

2. What does this suicide say about me?

   The following sub-themes are discussed:

(a) Managing trauma—including suicide ideation, on-going grief and mental health.

(b) Making meaning—making sense of the loss.

(c) Longing to speak with someone who had been through a similar loss.

The strengths of this current study come from the stories of the eighteen suicide-bereaved people who volunteered their stories of twenty family member suicides. Among these participants every type of first-degree relationship to the suicide deceased is represented. This range of relatedness allows for the differing experiences of a family member's suicidal death to be explored. The study examines the nature of the grief experience itself, and how this experience may differ because of earlier losses or traumas in the life of the bereaved or because of the history of the relationship with the deceased.

Participants shared their understanding of their deceased relative's life and the ways in which other family members have changed since the time of the traumatic loss. When traumatic events happen as a child, only time will bring the maturity and ability to construct meaning from the events that was not possible when the storyteller was young. Narrating a life story is a reflexive process and a continuous rethinking and construction of meaning takes place each time the story is told (Gilbert 2002).

With narrative inquiry, the researcher can trace the changes in the suicide-bereaved participant as the passage of time allows the focus of that person's attention, their feelings and their thoughts, to gradually recede from totally absorbing them as they reconnect to their own lives. This is a process of 'separation' from a state of being 'possessed' by the trauma, to having an awareness that this tragic event is one episode in their lives but does not define who they are.

What does this suicide say about my family?

The first theme to discuss explores the ways in which participants come to understand what the suicide says about their family. Participants shared narratives about their family including the background stories and descriptions of how they inter-related with each other. These narratives are explored as the family patterning stories and gave the suicide a context and an additional depth of meaning into the relational aspects of the family. This would have been missing if the sole focus was on the suicide death of their loved one. The role of earlier losses in the family or details of family conflict explained the way in which the grief experience for each participant was unique. Among these grief narratives any possible dependency of the participant on the deceased family member added extra layers of meaning.

The events following a suicide can further compound the grief experience. Remaining family members were either able to regroup and draw strength and comfort from each other or, in some cases, the already traumatised

family disintegrated. Any postvention support sought or accessed and the nature of that support is discussed. These family histories both prior to and after the suicide including the accessing of any support, were explored in the data analysis and inform this chapter.

Darryl's story of his early history illustrated this well. Darryl lost his mother when he was six years old when she died of a brain haemorrhage. That tragedy and the consequent suffering of the young family left motherless was the background story for Darryl. His guilt-ridden, anguished self-blaming outcry when Josie, his wife, died by suicide spelt out how much he was judging himself harshly for believing that things will get better and for not recognising the degree of distress that Josie was feeling.

This was perhaps echoing similar beliefs of his father when Darryl was young. Josie's centrality to Darryl's life was confirmed by his daughter May. Darryl's grief when Josie died would have been compounded by his earlier experiences of loss and grief. For Darryl to see his life deteriorate after his mother's death could have resulted in an unconscious fear that the death of the central female figure in the family results in tragedy and suffering for all members of the family, thus adding a possibly unrecognised layer of meaning to Josie's death. Darryl's story illustrates the importance of support for young children when they suffer the loss of a loved family member (Forster & Murray 2007; Goldney & Berman 1996; Silverman & Worden 1992).

Fractured families

Earlier studies have commented on the influence of damaged relationships and dynamics in families where suicide ideation or deaths have occurred (Cerel et al. 2000; Cottle 2000; Ge & Conger1999; Wagner et al. 2003). This study reports on the family climate of participants that, in some

cases were unsupportive, abandoning, negative, neglectful, damaging and shaming. No studies were located that had previously examined this question across all of the kinship categories in families.

Among the background stories shared by the participants were many examples of damaging relationships that preceded the death of the family member. The previous relational history of the suicide deceased family members was related by the participants. An example is the story of Lyn's husband Danny who was adopted by a father who repeatedly told him throughout his childhood that no-one wanted him and that he 'owed' his adopted parents. When his mother became ill with cancer, teenager Danny became her sole carer until her death as no support was provided for nursing care. Danny's earliest relational history was painful and disappointing resulting in a breakdown of the relationship and a feeling of betrayal. This history illustrates how the family patterning experienced in childhood, if uncaring and emotionally abusive can ill prepare a person to withstand later traumas and losses. That Danny himself, a father of a two month old baby and in a loving relationship abandoned this family and fled to the place where he chose to die reflects a continuing of his early experience of abandonment illustrating the early developmental theories of (Bongar et al. 2000; Cerel, et al., 2000: Portes et al. 2002; Repetti et al., 2002). Similarly, the developmental history of Delma's son Colin, who witnessed the extreme violence suffered by Delma at the hands of his alcoholic father, ill prepared him to survive the breakdown in his own adult relationships, leaving

him with a feeling of utter failure and despair. Colin's story exemplifies how childhood family patterning can result in a adult without the necessary emotional repertoire to recover from relationship losses experienced in adulthood (Eckersley & Dear 2002).

The story of her parents' relationship as told by Delia, further illustrates the theories of Henry et al. (1993) of the potential damage from ineffective communication style and family dynamics. Delia's father became increasingly isolated from his wife and children in that Delia's mother discouraged any communication between Delia and her father, thus attempting to 'triangulate' with her daughter (Bowen 1988; Nichols & Schwartz 1998). These are but three examples among those shared in this thesis that illustrate the conceptual theory of Cerel et al. (2000) who spoke of the damage to developing children raised in chaotic or encapsulated pathologic families.

The findings in this study highlight the impact of damaging family experiences that have resulted in a disrupted family narrative that spoke of losses of connection with part of the family or of foreshortened education for some of the younger bereaved family members. The damaging family experiences relayed by the surviving family members include histories of violence, whether physical, sexual or mental violence, poor communications and decision making, unhealthy boundaries and neglectful or uncaring behaviours.

This study also identifies the need of the suicide bereaved to create memorial stories of their deceased family member. This is inspite of, and in contrast to the many messages of shame and stigma that society burdens the suicide bereaved as if somehow they had transgressed a social-order boundary. The fact that the suicide bereaved feel silenced in their grief has been recognised (Maple, Edwards, Plummer & Minichiello 2010). There is a strong inner need to tell who the deceased relative was, that this was his/her place in the family and in the participant's life and that their life mattered and was valued. The bereaved family members wish others to know the importance of their deceased family member, that they were loved and that their whole life is recognised, not just the final, painful closing chapter. Often the first comments made by the participants were descriptions of their lost family member. These were shared with some hesitation and there was a guarded effort to ascertain how their story was being received.

In the earlier literature the role of relationships in the examination of the lives of the suicide deceased was identified. The behaviours or influences which were seen as damaging and resulting in the fracturing of families were those described by Cerel and colleagues (2000) as chaotic or pathological. The role of boundary transgression was similarly identified as damaging to the family system, especially in the nurturing of children (Cottle 2000). The study of Ge and Conger (1999) identified the interplay

between inherited biological traits and the social and dispositional characteristics of the adults in the family on developing adolescents and, therefore, these were seen as damaging to the family functioning. Wagner (2000) named child maltreatment, whether physical, verbal or sexual as inherently damaging to those subjected to this abuse and, therefore, a further cause of fracturing in the families. Some of these behaviours were evident in some of the narratives of the participants in this study and so resulted in the fracturing of those family systems and relationships. Next discussed in this section is the legacy of the suicide death of the family member and how this is told in the grief narratives of the bereaved family members.

The legacy of suicide

There were many damaging events described by bereaved participants as consequences of the family members' suicidal death. The participants' grief narratives are discussed in the following section and differentiated according the type of relatedness to the deceased as the nuances in the grief narratives relates in some ways to the expectations the participants held of their deceased family member. Other ways that the suicide resulted in a legacy experienced by the participants is illustrated in the following narratives: Some participants spoke of their own suicide ideation and that of other immediate family members following the death. This accords with the suicide grief reaction theories which identified bereaved family members reporting their own suicide ideation or attempts (Jordon 2001; Mitchell, et al., 2005) thus suggesting their inability to detach from their

previous assumptive world as described by Parkes (1971) as a psychosocial transition needed for healthy adjustment following grief. Whilst for other bereaved family members, the legacy was a history of mental illness sometimes together with addictive behaviours and suicide ideation accords with the earlier theories about the familial transmission of suicidality of Brent et al. (2004).

That some bereaved participants reported the loss of contact with a part of their family subsequent to the suicide illustrated the family systems theory of Bowen (1988) where various pressures within a family may cause families to pull together or conversely fragment and distance themselves. The blaming and shaming that often follows a family suicide death is one of the factors that may result in this fracturing of family relationships thus causing an additional layer of grief for some family members (Chen et al. 2009; Koopmans, 1995; Owens et al. 2008; Straus & Pascal 2000).

The trauma of actually discovering the body as happened for three participants, or the increased suffering reported by the bereaved through perceived inappropriate police behaviour further resulted in emotional scars. Kim speaks of being haunted by the vision of her deceased mother sitting up in bed and of feeling isolated from other young people her own age. This feeling of being different from their peers as experienced by young people or children who have suffered the loss of a family member was identified in the earlier research study (Ratnarajah & Schofield 2008). Kim also related that she felt overwhelmed by death and for a period could

not see any purpose in life as she had also experienced the cancer death of her father just a few years earlier than her mother's death. Kim's descriptions of the early stages of her grief narrative exemplifies the conceptual framework of complicated grief described by Dyregrov and Dyregrov (2005), by Kristjanson et. al. (2006), and Neimeyer et. al, (2002).

The earlier study of Ratnarajah (2005) identified that young people and children who experienced the suicide death of a parent suffered the consequence of having their education cut short. This was the experience of some of the younger family members of the deceased. Emma spoke of the effects of their father's death on her three young sons who up to the time of the death had all been high achievers in education, but afterwards, all experienced disruption and several years of floundering in their education. Delia who was told by her mother to leave school and get a job even though her mother was left in a comfortable financial situation after Delia's father's death felt as if her aspirations for tertiary education died with her father (Ratnarajah & Schofield 2008).

The participants struggled with their need to make meaning out of the suicide and of their feelings of grief. One way in which this desire was expressed was through the creation of memorial stories about the deceased. In these memorial stories, the participants spoke not only about the biographical history of their family member, but made special reference to the relationship they continue to share with their lost

relative. In describing this relationship, they described the nuances of their different grief experiences depending on the type and quality of that relationship with their deceased family member. These grief narratives are explored next.

Family member grief narratives

In examining the legacy of a family member's suicide, the participants' grief narratives are explored. The family grief narratives included parental, sibling, offspring and spousal narratives in order to examine the different nuances of meaning depending on relationship.

Different grief-narrative themes were identified dependent on the type of relationship the participants had with the deceased. Therefore, the search for meaning undertaken by the bereaved participants produced different reasons for the suicide and differences in the consequential aftermath for the participants. Grief following the suicidal death of a family member is especially traumatic and may lead to complicated grief or post-traumatic responses (Kristjanson et al. 2006).

These narratives display the shades of meaning that are linked to the degree and nature of the connectedness to the deceased family member. Where the relationship was genetic, concern for surviving relatives was paramount. Where the relationship was through commitment, doubt as to the authenticity of the relationship was called into question. Each relationship type is explored below, commencing with the genetic

relationship of parents, children and siblings and finishing with committed relationships.

Parental grief narratives

The parental narratives described here support earlier research which highlighted the importance of preparedness in meaning-making narratives of the suicide of their child. All three described plot-lines previously reported (Maple et al. 2007) were evidenced in this study.

For a parent whose child, whether teenager or adult, has decided to take their life, many special challenges are presented. The loss of a child by suicidal death confronts the parent's self-identity and their role as carer, nurturer and the person responsible for raising that child to be a healthy functioning adult. The grief response following the suicidal death of a son or daughter may result in one of three previously reported grief narratives (Maple et al. 2007). These grief narratives are, 'I Did Not Recognise the Signs: A Reflective Plot' (Maple 2007:131), which corresponds to the circumstances of Delma's shock at the sudden and unexpected death of her son. Another parental grief narrative 'Living with a Suicidal Child: A Turbulent-Relief Plot' (Maple et al. 2007:130) is one to which Olivia would relate as her son had two previous suicide attempts prior to his death. Neither Wilson nor Angie were anticipating the suicide of their children, Holly or Josh, so their grief narrative is reminiscent of 'We Never Thought that Suicide Would Happen to Us: A Tragedy Plot', (Maple et al. 2007:130). Angie was very concerned about Josh's mental-health

problems, and was prepared for either his hospitalisation or his arrest, but she was not expecting his suicide. This could explain the need to further expand the three previously identified narratives.

Parents discussed the circumstances in their child's life that may have left them unprepared to face later traumas and disappointment. As they wrestled with the 'whys' of their child's suicide, parents sought answers that would help them address their own life narrative. One study found that parents of sons who died by suicide discussed four differing ways of looking at the antecedents to their sons' death. The first of these four themes is that their sons were seen as victims of external forces or as agents of their own destruction (Owens et al. 2008). This theme relates to both Delma's and Angie's stories.

Delma saw her son as the victim of mercenary and uncaring former partners who bled him dry for financial support. That Delma was herself pestered for money by her former daughter-in-law after Colin's suicide confirmed this narrative for her. Angie is convinced that the system let her mentally ill son down by not providing the mental-health care that she believed was needed. Olivia also believes that her son was let down by mates to whom he had given a promise never to disclose a deliberate act of harm to another person. He could not live with his guilt and regret, yet he could not break the promise he had made. Wilson was denied the right or the opportunity to parent his daughter and so could not protect her from the sexual abuse she suffered as a very young teenager. Holly fled her

mother's home and went to live with Wilson where he saw a huge change in her attitude and her feelings of self-worth. Her view of appropriate behaviour had become forward looking, but her mother insisted that she return to her care after six months. Wilson's feelings are not so much as a failure as a parent, as frustration that the child welfare system manipulated by his ex-wife prevented him from parenting his two children. In this sense Wilson sees Holly as a victim of forces beyond her control. Wilson therefore believes he could have done more to protect Holly by preventing her from returning to her mother. As Owens and colleagues (2008) argue, parents can judge themselves as failing to protect their children if the child chooses to die because their life is intolerable.

The narratives that the parents were able to create fulfilled the purpose of not only telling the circumstance that caused these young people to take their lives, but also served as a self-narrative they could take with them into their future lives (Owens et al. 2008).

Parental grief narratives reflect the anguish of the parents who wonder how they failed their child, either by not raising them with enough resilience to face life's traumas or disappointments, or by not being able to secure the support for their suffering children. Commonly their self-story is one of failure in some way. These parental grief narratives are carried by these parents throughout the balance of their lives, and with some

similar issues, so do the suicide-bereaved siblings whose narratives are next discussed.

Sibling grief narratives

The narratives of the siblings of the suicide deceased follow. These narratives vary depending on whether the participant whose narrative contributed to this study saw themselves as a role model for their deceased sibling or whether they had looked to the deceased sibling as their role model. Participants in this study who had lost a brother or sister described being the 'forgotten bereaved' (Dyregrov & Dyregrov 2005:714). By this, the authors referred to the bereaved sibling/s having the need to be there for their parents, yet having their own grief and pain ignored and unsupported. They spoke of losing the one who shared all of their life experiences, the one person who knew what it was like to be a child raised in that family. It is with siblings that we spend our childhood and with whom we commonly have the longest relationships in our lives. No one else really knows what it was like to grow up in this particular family. Siblings are the people who share our childhood games, dreams and discord. To lose a sibling is to lose part of one's own life (Linn-Gust 2001).

Some bereaved siblings spoke of feeling invisible to other family members and friends offering support (Dyregrov & Dyregrov 2005). Sally poignantly stated that grief following a sibling suicide is unique because relatives and friends commonly offer their support to parents. Siblings can therefore feel that their grief is invisible and of little importance.

Older siblings are frequently the role models for younger siblings. When an older sibling dies through suicide, the other siblings may wonder if they have to follow the example of their deceased sibling. This was illustrated in the questioning of Elizabeth who asked of herself if she had to follow a similar path as her sister had done.:

In families where there had been blaming and shaming and more importantly, physical punishment in the way children were raised, the surviving sibling may experience anger towards the parents for an environment that contributed to the suicide. Or, on the contrary, they may feel the need to comfort them. Sally was open about the anger she felt towards her parents and sought psychotherapy to help her deal with this and her intense grief. She believed that the shaming and punitive upbringing that the two boys, in particular, had experienced at the hands of their father resulted in their low self-esteem and depression. She nevertheless responded to her parents' needs by comforting them, but spoke of this role as being a conflicted one for her.

In a study on the grief of adolescents following the sudden death of a sibling, similar special issues were discussed by Forward and Garlie (2003). Further, Linn-Gust (2001:100) draws attention to the type of relationship that one sibling has to the other and suggests that the sibling relationships can take on three different types of roles: 'second parent, role model, and friend'. The grief reaction will be influenced to some degree by

the role the deceased sibling played in the developmental life of the grieving sibling/s. In this study, Sally was the eldest of the three siblings, and spoke of feeling responsible for her two younger brothers especially when they were having emotional and mental-health problems. The fact that Sally's two younger brothers followed her to the capital city suggests that she played a second-parent role in their lives. That John had Sally's name listed as a person to contact if he was having suicidal ideation supports his assessment of this caring and nurturing function. Forward and Garlie (2003) further report the intense relationship between siblings saying:

> It is with siblings that we share the same parents and grow up within the same household. Later in life, siblings may be the only family we have, and for many of us our relationships with our brothers and sisters may last the longest. When a sibling dies, the surviving child loses a unique participant in his life (Forward & Garlie 2003:24).

Siblings share the special memories and knowledge of the circumstances in which they were raised. When a sibling chooses to die, the surviving sibling/s question their own future and question what the death implies about their family.

Offspring grief narratives

Children whose parent has chosen to die are often bewildered by the event. How they learn of their parent's death is also a pertinent factor in the consequences that follow. Whether the surviving parent was able to support and comfort the bereaved child is of great importance.

The findings of this project support those reported previously (Ratnarajah 2005). Now adults, suicide-bereaved children speak of their feelings of abandonment, isolation and being different from their peers. They discussed their grief being ignored as the focus of support was on their surviving parent. Similar to other stories of grief following a suicide, these young people spoke of feeling guilty that they had done something, or not done something, that had caused their parent's death. Laura's statement of feeling guilty, and blaming herself for her mother's death, yet she recognised that she was also blaming others.

A key finding relating to childhood bereavement through suicide in earlier studies (Ratnarajah 2005; Cain 2002) has been the importance of how the suicide bereaved heard of their family member's suicide. In relation to this, Cain (2002) recommended that support for the child or young person be a gentle on-going process, one that is adapted to the child's level of development and their ability to understand and absorb. For young people, meanings and understandings are shaped gradually, which is why Cain (2002:135) recommended that the 'telling be a process not an event'. How the suicide death was imparted to the family members was not just important for children. Whether this was done with sensitivity or in a manner that worsened the shock and grief is discussed in the other kinship grief narratives.

Of the children's stories about the suicidal loss of a parent only one participant, Delia, was a child at the time. The other three participants

(Laura, Kim and May) were in their early twenties when their mothers died. Delia's father died when she was eleven years old and her younger brother was seven. The key theme of abandonment was reported in a previous study into children's grief following parental suicide (Ratnarajah & Schofield 2008) and this theme was evident in all the stories of parental loss, including the stories of the three young adults. When children lose a parent through suicide they may lose the reassurance that a responsible adult will be there to care for them, especially if their surviving parent does not have the parenting skills to provide a nurturing and supportive environment (Ratnarajah & Schofield 2008). This was the case for Delia and her younger brother.

The bereaved children repeatedly spoke of seeing other complete families and feeling like they had lost the precious parental connection. Delia spoke of seeing parents and daughters shopping together and knowing she would never experience that. Both May and Delia have recently had their first babies. Their joy in the birth of their sons is dimmed knowing that they cannot share this new life with the parent who is no longer in their lives. In families where the loss of a parent occurred through illness, accident, or break-up in the family, there would have been similar feelings of loss to these circumstances (Wood 2008). However, there is an extra dimension to this loss following a parental suicide death as they know their parent chose not to continue the relationship and took their own life. The bereaved offspring, whether they were an adult or a child at the time

of the parent's suicide, expressed feelings of self-blame. For Delia, her grief was compounded by the fact that she was the only family member that her father chose to share his pain and increasing feelings of desperation with, having been turned away by both his wife and brother. As a child she was unable to help him. May's feelings were different after the death of her mother. There had been recent discord and May regrets that she was not given enough time to resolve the issues. The death of a parent through suicide brings with it many reoccurring feelings of loss when a significant life milestone is reached, such as a marriage, graduation from university and the arrival of children. The loss of a parent through suicide is an unexpected and traumatic loss that brings with it special challenges for the bereaved child (Beautrais 2004). The consequence of this traumatic loss results in the child questioning what does this suicide say about me?

Spousal grief narratives

While genetic or biologically based relationships bring vulnerability for those bereaved, committed relationships share an additional dimension. That is, when a partner or spouse dies by suicide, whether anticipated or not, the bereaved spouse often asks the question: '*What had the relationship meant to my partner, that he/she chose to die rather than stay with me?'* Doubt over the importance of the relationship to the one who died throws the meaning of the whole relationship into question. Some bereaved partners, Lyn and Jerome, spoke of their frustration at not being

able to identify any reason for the death. The bereaved spouses spoke of feeling betrayed, especially in the cases where the suicide was unexpected and there was no perceived mood disorder or known depression.

Some partners and spouses (Lyn, Jerome and Hazel) questioned why their suicidal partner was unable to share their pain and distress with them, and instead chose to end their lives rather than continue with the relationship. Other partners (Janelle, Darryl and Emma) were aware of their spouses' troubled state of mind, but were still shocked when the suicide happened. This was especially so for Janelle, who discovered in the days before her husband's suicide that he was planning to kill her because she wished to end the marriage. Janelle wonders why she mourns for her husband two years after his death and feels she is being punished. She stated that she feels punished because her children are upset because their father is no longer alive and available to them. This is especially so because her eldest son has also made attempts on his life and is depressed. Janelle recognises her children's grief and stated that seeing their grief, she feels punished because she sought a better life.

Three of the six examples of partner suicide were totally unexpected—those of Hazel, Lyn and Jerome. In the three other examples of spousal loss, prior suicide attempts had occurred or been threatened.

The sudden and totally unexpected death of a partner is confronting as it calls into question the meaning of the relationship itself, which up to that

point had appeared to be loving and mutually rewarding. Therefore, these surviving spouses were grieving not only the loss of their partner, but the loss of their belief in the relationship that had meant so much to them. Issues of abandonment compounded the grief for Lyn, Darryl and Jerome and with it came questions as to the value they had to their partners as they had chosen to die rather than continue to live in the relationship.

Janelle was already facing the disintegration of her relationship prior to Gary's death and Emma was well aware of the depression and unhappiness under which Arun was struggling. Even so, understanding the reasons for the suicide does not really mitigate their hurt.

Summary of family grief narratives

The strength of a qualitative study is its ability to elicit rich information from a collection of people who may otherwise be hard to reach. Information about the feelings and experiences of the suicide bereaved is necessary to inform and guide those who provide services to what could otherwise be a hidden group of people. A narrative methodology allows family members of the suicide victims to provide stories about the deceased and the circumstances that they understand may have been implicated in the decision to suicide (Gavin & Rogers 2006).

The way in which that story is put together by the narrator allows the listener to appreciate whether it is a coherent narrative, or a fractured life

story with missing pieces and a victimic plot (Levy & Wall 2000). Narratives are not immutable, but change, develop and evolve as each person gathers more information about themselves, the rest of the family and society itself. Reflecting on their past can bring changes for people as new insights are gleaned. This is evidenced by Delia's reflective and forgiving understanding of her mother's limitations. It is evidenced in Delia's self-reflection about her now adult feelings towards her mother, which illustrate that there has been a growth of understanding and compassion that would not have been shared if Delia had simply related an historical account of her father's death. Owens and colleagues (2008) make a similar point:

> Treating stories *as* stories, rather than simply grist for the epidemiological mill, serves to remind us that, far from being straightforward factual accounts of what led these young men to take their lives, they are sophisticated and selective reconstructions that are designed to serve the needs of the narrator as much as those of the researcher, and that can tell us much about the state of mind of the bereaved as about the life of the deceased (Owens et al. 2008:251).

The analysis of the grief narratives of the suicide-bereaved family members reflect not only the loss of their deceased relative, but also the cost to them of the consequential disrupted narratives of the bereaved and also of the family system which has similarly been disrupted by the death. The disrupted narratives follow in the next section.

Disrupted narratives

As part of their grief journey and also in their attempts to grasp the meaning of their family member's death within the story of their own life,

the participants described their own and their family's changed and disrupted narrative consequent to the death. The participants' search for meaning and understanding is driven by four different quests: comprehension, accommodation, responsibility and meaning. The participants struggled in the first quest with the need to comprehend their deceased family member's feelings and cognitive processes culminating in their decision to end their lives. This second quest is the difficulty to accommodate the intentionality of their relative's death (Sands 2008) and so the bereaved aimed to conjure up the same feeling space of the person who had died. The third quest is one of a sense of responsibility—that they have failed in some way in their role as partner, child, parent or sibling. When a bereaved family member suggests or indicates some lack in themselves in their relationship with their deceased family member, they are describing a sense of responsibility, which is acknowledged by Sands (2008:108):

> Every time the bereaved say something that indicates they blame or feel in some way responsible for the death they are responding as if the death contains a personal message for them. The deceased cannot explain why they killed themselves and the bereaved are left to try on the shoes of the deceased in order to fill in the missing pieces and make an account of the state of mind, concerns, thoughts and feelings and events that would cause the deceased to make such a tragic decision.

The first three quests identified are similar to the tripartite model described by Sands (2008) in her study of suicide-bereavement groups. The fourth quest adds another dimension to this tripartite model. This fourth need is the struggle to find the meaning as to what this death says about the participant and their family. Who we are and how we conceive

ourselves to be is a culmination of experiences within relationships. It can be a shattering challenge to our concepts of how we describe and understand ourselves that a significant relationship in our life ended by that relative deciding to exit life through choice and sever that physical relationship. This narrative not only makes a statement about the deceased, it also makes a statement about those who cared for them and lived in relationship with them.

Through exploring these four quests the participants served the common need to comprehend and derive meaning from their family member's suicide. For many, the compelling desire was to seek information and understand why their relative decided to end their lives in the manner in which they did. Neimeyer and colleagues (2002) explain this need to make meaning in the following way:

> A guiding theme […] is that human beings seek meaning in mourning and so by struggling to construct a coherent account of their bereavement that preserves a sense of continuity with who they have been while also integrating the reality of a changed world into their conception of who they must be (Neimeyer et al. 2002:235–6).

In this way the participants explored and constructed meaning through sharing their story with an interested listener. The narratives of their deceased relative were created simultaneously as their own narrative of self was also being constructed. This telling and retelling allows for the re-evaluation and assimilation process to occur. The participants struggled to fit together the different elements of their stories in such a way that created meaningfulness (Smith & Sparkes 2006).

Some answers seemed to come easily and often in these cases the causal factors were attributed to abusive treatment by other family members or to an inherited predisposition to mental illness. These narratives often had a blaming or victim theme, which has been explored elsewhere (Owens et al. 2008). For all the participants, the sometimes unspoken desire was to understand what their relative's death said about themselves, the relationship they had and how well they were able to fulfil their role as parent, spouse, partner, sibling or child. It is in the inherent roles within relationships that roles and responsibilities are learnt or implied, although not always carried out with empathy, understanding or awareness. In some of the families described in this study, we learn of those families where the family patterning and behaviours were not nurturing. Even in families that were experienced as loving and supportive, not every member was able to fulfil their roles and responsibilities as others within the family may need or wish. It is these lacks that may give rise to the participants judging themselves as inadequate to the needs of the family member who died. Kinship relationships influenced the different shades of meaning in the grief narratives reported by the suicide bereaved.

An earlier quantitative study that examined the grief experienced by survivors of suicide (Mitchell et al. 2004) concluded that the degree of kinship between the family member and the deceased was a major factor in determining whether high levels of complicated grief were experienced.

As mentioned previously, earlier studies reported on the suicide grief experience of classes of family relationships, but this current study had the benefit of examining the narratives of every class of first-degree or immediate relationship to the suicide bereaved. Research on the impact of suicide on other family members identified that there are unique issues that are experienced more intensely than other types of loss (Callahan 2000; Jordon 2001; Maple 2005; Mitchell et al. 2005; Ratnarajah & Schofield 2008; Sands 2008). Some of these studies examined the grief experiences of different classes of relatedness to the deceased. These differing classes of relatedness between the bereaved family member and the deceased are reported in the following studies: parents of the deceased (Maple 2005), spouses (Agerbo 2006), children (Avrami 2005; Ratnarajah & Schofield 2008) and siblings (Dyregrov & Dyregrov 2005). However, grief stories were not the only content of the narrative themes in the participants' contributions to this study, and the wider content of these themes are explored next.

Exploration of narrative themes in the data

The way in which family members question the relationship with the deceased are explored below. The themes emanating from the data demonstrate how disrupted narratives impact upon families. These themes reflect the family culture as experienced in both childhood and adult experiences. First discussed will be the family culture and childhood experienced by the participants. Then will follow a discussion on adoption

issues, as two of the deceased family members were adopted as children. Some participants discussed the family culture from their perspectives as adults, either relating the stories of family violence, family relationships, the functioning of the family and the effects of alcohol and illegal substances on the family. Damaging experiences within the family resulted in vulnerabilities being discussed and whether these vulnerabilities could be an inherited condition.

Family culture—childhood experiences

The family culture of several of the participants suggests evidence of damaging experiences or poor communication within the family. This includes where violence was reported in the lives of several of the participants or in the life of their relative who died by suicide. Sally's story of the punitive and shaming family culture in which she and her two younger brothers were raised exemplifies this. Similarly, Delia's narrative is one where intergenerational violence and a non-nurturing family environment are evident. Monica's recollections of her family life during childhood in which there was no mutual support among the siblings is a further example.

These examples of physical, mental and emotional abuse when perpetuated by the hands of a parent are damaging to a developing child or adolescent and impact on the child's personality (Straus 2001). Young children are totally dependent on their parents, not only for physical care but for emotional nurturing. The child learns to trust in their infant years,

to develop control of their bodies physically in their toddler years, and are then socialised by learning what is acceptable behaviour and what actions earn displeasure (Erikson 1963). Similarly, in their teenage years they are developing and testing their identities as individuals. In families where children are raised in a climate of blaming and shaming, or where physical punishment is experienced, the developmental stages are not successfully mastered and psychological damage may occur. This was graphically described by Sally, bereaved by the suicide of her deeply depressed younger brother, when she described the upbringing that she and her two younger brothers experienced. She used a metaphor of what would happen to a young plant, where instead of nurturing it, the new shoots are constantly pulled off so that the plant is not able to grow into its true shape, and is weakened and distorted.

Neurobiological research supports the view of the critical importance of adequate nurturing during developmental years. Schore (2003) reports on findings that support this:

> Discoveries in the developmental sciences now clearly show that the primary caregiver acts as an external psychobiological regulator of the 'experience-dependent' growth of the infant's nervous system…..The social environment can positively or negatively modulate the developing brain (Schore 2003:184–5).

Further, the damaging effects of relational violence or discord witnessed or suffered in childhood or adolescence is also commented on by Schore (2003:187):

> The long term consequences of relational trauma (is) an enduring deficit at later points of the life span, in the individual's capacity to assimilate novel (and thus stressful) emotional experience.

Investigations into the links between family culture and suicide undertaken by Repetti and her colleagues (2002) identified risk factors such as parental relationships that are marked by discord and aggression, and that were neglectful, unfeeling and non-supportive. The early life of Delma's son Colin, who witnessed the extreme violence Delma suffered at the hands of his alcoholic father, was acknowledged by other family members as a damaging influence in Colin's life. Yet Colin adored his father and grieved for him all his life, even after his father abandoned the family rather than give up alcohol.

The story of Sally and her two brothers spoke of an upbringing that was punitive and resulted in poor self-esteem for the three siblings. Sally's brother who died by suicide shared his feelings of hopelessness, inadequacy and shame with her just prior to his death. These factors were identified by Henry and colleagues (1993) in a report following an ecological model study of families in which an adolescent suicide had occurred and the study listed the following predictors for adolescent suicide: feelings of hopelessness, poor self-esteem and feelings of inadequacy and loneliness. Damaging communication styles within the family, addiction issues and parental abuse or neglect have also been implicated in the body of research on youth suicide. Problems relating to cultural identity, such as belonging to a cultural group that was not

valued by the dominant culture, were also mentioned as a risk factor in this study.

The link between parental divorce and youth suicide is reported by Gould and Kramer (2001), who found that parental divorce slightly increased the risk of suicide for adolescents. These authors explain that the association between divorce and suicide could be explained by parental psychopathology in the lead up to, or consequent to the divorce. Depression suffered by the main care-giving parent may be a consequence of a divorce and possibly result in them not being available for the adolescent (Gould & Kramer 2001). Many participants in this study encountered these deleterious parenting and family life experiences. For example, Lyn's husband Danny was emotionally abused by his adoptive father. Emma's husband Arun was abandoned by his Thai father and paternal family, separated from his mother throughout his childhood, and discriminated against in his career and was constantly questioned about his belongingness, because of his Asian appearance, throughout his childhood.

Those who experienced violence and/or shaming in their developmental years are at an increased risk of later suicide ideation and attempts. In summary, it is extraordinary to find such blanket coverage of traumatic upbringing in the families of the sample in this study.

Mental states are more than simply 'cognitive' states of mind; they are psychobiological states which involve the whole organism or mind–body (Schore 2003). The developing child establishes the pathways that will allow functioning of this mind–body psychobiological system through attachment with their primary caregivers, most commonly the mother. Attachment is recognised as a system that builds in the brain of infants and influences the organisational, emotional, memory and motivational processes developed through the relationship with the mother (Siegel 1999). This innate attachment system in the infant motivates the child to seek to be close to the mother and to communicate with her. As the immature brain of an infant develops it uses the mother's mature brain processes to organise its own brain. This process occurs through the mother's responses to the signals the child sends to the mother, thus creating a secure attachment. The mother's reactions to the child's signals guide the child to build positive emotional states or to moderate negative states. This is particularly so for negative states such as anxiety, fear or distress. When the mother's reaction to the child's distress is soothing it creates a sense of safety for the child (Siegel 1999).

For a child raised in a family where trauma such as violence or the death of a parent occurs, this important attachment may not be developed. This is particularly the case if the mother is unresponsive to the child's signals due to her own stress reaction. In seeking information about the background of a family in which a suicide has occurred, the therapist

gains an understanding of how the ability to handle stressful situations may have been compromised. Information on the type of attachment that was formed within the family is also relevant. A coincidence in the stories of two of the suicide-deceased partners, Danny and Sean, is that they were both adopted as babies, and both lived in Darwin at the time of the adoption.

Childhood history in relation to experiences, attachment and family culture are all important in the way in which later trauma is experienced.

Family culture—adult experiences

The lasting impact of childhood abuse, insecurity and a lack of a nurturing family culture ill-prepared those adults who also experienced violence and trauma in adulthood. The following section explores how different facets of these early experiences effect later trauma.

Exposure to violence

Many participants reported family violence, either to a parent at the hands of the other parent, or to the participants themselves. Being a victim of, or witnessing family violence was one of the risk factors for suicidality also identified by Repetti and colleagues (2002). The claim was made by Repetti and colleagues (2002) that in families in which aggression and violence occurs, vulnerabilities are created that may interact with genetically inherited traits that may result in unhealthy psychosocial functioning. This is evidenced in the stories of Roberta,

Delma and Hazel. Appendix A7.1 lists the violence and abuse that many of the participants suffered or were witness to.

Family culture and relationship influences

For some, when their adult relationships ended or were marked by stress and discord, the instinctive reaction was to withdraw and isolate themselves from the stressors. In some of the narratives shared by the participants, there is evidence that both shame and guilt were contributing factors leading to suicide. This was poignantly illustrated when Emma shared Arun's shame and feelings of guilt because he did not know how to be a father to his three sons. Emma believed that he tried to expiate his guilt feelings by taking fatherless children from his church on outings. Janelle's husband Gary chose to die rather than face the shame of a failed marriage. Janelle, who days before her husband Gary's suicide death discovered his plans to kill her, saw as the genesis of Gary's emotional and mental problems the damaging parental style he experienced. Commonly, the reaction to difficulties in adult relationships was one of shame. A strong link between shame and depression has been reported by Hastings and colleagues (2000). Lester (1997) wrote of the difference between shame and guilt. He saw shame as being experienced when a goal or ideal is not reached, which differentiates from guilt, which is felt when a boundary is transgressed. He stated that 'shame threatens to lead to abandonment (by the parent), guilt to punishment' (Lester 1997:353). When shame is felt, the instinct is to withdraw, and the

ultimate withdrawal is in the decision to die, as explained in the following section.

Although marriage and family breakdown is more commonly accepted in contemporary Australian society than it was in previous generations, there are repeated themes of feelings of shame and inadequacy in the stories told about family members dying by suicide when family breakdown had occurred. For men who centre their sense of who they are within the family, the loss of their prime relationship can cause a feeling of rejection and abandonment. Eckersley and Dear (2002:1902) describe this as: 'For men, marriage and family can often be their most important source of belonging and defence against isolation'. The overwhelming feelings of despair when a relationship ends can lead to the decision to end their lives (Bongar et al. 2000). They may live with this feeling of despair for many years, before it suddenly overtakes them. However, their family may see their decision to take their lives as a huge and unexpected shock. Delma's deceased son Colin shared with his mother his shame and despair that he had needed to return to live with her after his failed relationships. Delma views this as a contributory factor to Colin's death.

Family systems theories of Bowen (1988), Nichols and Schwartz (1998), Bowlby (1969) were clearly illustrated by the narratives of some of the participants whose relationships were difficult such as Janelle, who spoke of the different ways she and Gary were distancing from each other prior

to his death. That they could not communicate with each other in a meaningful way and so create a bridge across this distance is illustrative of the relationship theories which stress the importance of clear communication between family members that enable the family to be resilient in the face of difficulties (Lietz 2006, 2007; Walsh 1998, 2006). Similarly, Jerome spoke with regret how he recognised that his partner Sean was unable to share with him his conflicted feelings prior to his death, about his sense of belonging and his sexual orientation as demonstrated by Henry and colleagues (1993) who explored adolescent suicide. Sean was twenty years old when he died and had experienced damaging bullying at school and discord within his adoptive family about his sexuality.

The theme explored in this section is that of the influences of damaging family culture on adult experiences. It explains how events in adult life can bring forth the echo of unresolved childhood traumas that amplify the latter crises. To better understand these factors the following section explores the role of family functioning. The inter-relatedness of psychiatric illness, substance abuse and the possibility of genetic and biological influences are also explored.

Family functioning

The impact of family functioning is illustrated throughout this study in the narratives of *every* participant. Whilst earlier research focused on the effects of family functioning on teenagers and suicidal ideation (for

example, Cottle 2000; Koopmans 1995; Wagner et al. 2003), the findings in this study highlight the importance of family functioning in the psychosocial wellbeing of the whole family.

Family functioning can be a catch-all phrase as it involves relationship patterning, the communication styles between the various family members, attachment issues and whether there was evidence of violence or other forms of abuse in the family. Also included and affecting the functioning of a family would be addictive behaviours, whether substance abuse or other types of addictions such as gambling or serial infidelities are evident. The allocation of roles and responsibilities within the family affect the ability of the family to function as a healthy environment for all members and whether the family system is an open or closed family system. All of these aspects of family functioning were described in the earlier review of the literature on this subject. To illustrate the earlier statement that the impact of the style of family functioning was evidenced in the narratives of all the participants, Appendix A7.1 details the abuse suffered by either the deceased family member or the participant—ten examples are listed. Appendix 9 summarises disorders of the deceased family relative and background family and includes the stories of all twenty deceased family members.

It is a given that in any family where abuse is evidenced, the functioning of the family for all those who are part of the family are affected in an unhealthy way. Even where the abuse is hidden and not spoken of the

functioning of the family is stressed and non-supportive. An illustration of damaging family functioning can be seen in the story of Wilson, whose wife disappeared taking the two children with her while Wilson was recovering from a work injury. Thereafter, the children were kept hidden from Wilson throughout much of their childhood. Wilson was only able to parent his daughter in her teenage years when she appealed to him to rescue her for her mother's sexually abusing boyfriend. Even after Holly's death from suicide, Wilson's ex-wife minimised and dismissed this sexual abuse.

That family functioning was such a central element in every narrative suggests that research into the whole family experience of suicidal death has been neglected. The following section discusses the affect on families of psychiatric illness, alcohol and drug use.

The mix of psychiatric illness, alcohol and illicit drug use

There are many stories in this study where the suicide victims were self-medicating on alcohol and illicit drugs prior to their death. This was a complicating factor for those who had been diagnosed with a psychiatric disorder. The use of alcohol and illicit drugs used to alleviate the distressing symptoms of their disorder, often negatively affected their ability to maintain a prescribed medication regime for their psychiatric illness. An inability to follow their mental-health program frequently meant that the doctors at psychiatric facilities would not treat them and often refused to admit them when they were very ill. In this study, Angie's

narrative about her mentally ill son, Joshua, and Hazel's story of her son, who was depressed, suffering an acquired brain damage and grieving the loss of his marriage and children speak graphically of this experience. This spiralling course that so frequently leads to death is graphically described in Ann Deveson's (1998) book about her son Jonathon, in which she quotes a Canadian mother speaking at a human rights conference. Deveson (1998) reports:

> We are the people who mop up the blood of our sons and daughters when they have killed themselves, released from hospital all too soon, or not considered sick enough to be hospitalised…When we ask our psychiatrists why they do not declare our obviously ill relative incompetent, they reply that the Mental Health Act ties their hands. When we ask the bureaucrats and the politicians how such a law can be passed, they say the psychiatrists are interpreting the law too narrowly. When we turn to the lawyers they tell us that the rights of the individual are paramount…We are left helpless and alone in our struggle to save our children (Deveson 1998:244).

Examining the possibility of genetic and biological influences

The consideration of the transmission of suicidal potential through genetic or biological factors is beyond the scope of this study. However, this qualitative research study suggests there is evidence of genetic and biological transmission of psychiatric or mental illness in the findings and supports the literature. In other research, the probability of a genetic link has been acknowledged by some mental-health professionals. The influence of a genetic tendency for psychiatric or mental illness to manifest is pertinent and is described in detail elsewhere (De Leo 2010). Of the eighteen participants speaking of sixteen families, eleven of these families reported professionally diagnosed psychiatric or mental illness. In

eight of these families there are repeated occurrences of emotional, mental or psychiatric disorders manifesting across several generations. The background information seen by the participants as contributing to the family member's suicidal death is summarised in Appendix 9.

In all, half of the stories included in this study had the dual potentiality of a history of mood disorders or hospitalisation for mental illness in the family of origin and also conditions within the family that may have contributed to vulnerability towards persistent negative feelings. This illustrates the complex antecedence to suicide ideation and attempts. The participants in this study share many of these same issues: a family history of mood disorders or diagnosed psychiatric conditions, and also a family climate in their upbringing that was not conducive to building strength and resilience. This highlights the importance of support for those bereaved by the suicide of a close family member for they also share this same family inheritance and may go some way in explaining the increased risk of suicide for those bereaved family members.

Vulnerability and coping

Those who suffered from violence in their childhood, or whose family culture was marked by stress, reported wide-ranging affective disorders. The recurring themes were vulnerability to depression and anxiety, feelings of unresolved grief, loss and shame about the families. They spoke of inappropriate boundaries and consequential low self-esteem as well as an inability to tolerate stress. If parental behaviour exhibits a stress

reaction, the children in the family also feel stressed. A suicide death within a family is a major disruptive event which can throw the entire family into crisis. A family's ability to withstand a major crisis depends on the legacies of previous generations, as a family is a multigenerational system. How well the family is able to withstand such a crisis will depend on the family's coping mechanisms. For example, families in which violence was a sudden or unpredictable occurrence can predispose the most vulnerable members to anticipatory anxiety and leave them with an inability to cope with new stressors.

The background narratives were identified by the analysis of meta and micro themes detailed in Chapter 4. The first of these background narratives concern the family culture which may have included troubled relationships and inadequate or inappropriate communication styles. The family culture background narratives may also include reports of abuse and trauma suffered or witnessed. The family climate ill-prepared the participants and other family members to withstand later adult losses and difficulties.

The second background narrative concerns evidence of inherited mental-health issues or psychiatric illnesses diagnosed during the deceased person's life. A common theme amongst the participants who were concerned about their family member's mental health was the suggestion that, with appropriate treatment, their relative could have been helped. Some of the stories describe appeals to the mental-health authorities for

help, and either non-compliance by their family member or admission to the mental-health facility being unavailable or denied.

In some of the families these two background narratives were intertwined and contained elements of both a troubled or damaging family culture and a history of mental illness or disorders within the family. There are also reports of the mentally disturbed suicidal relative attempting to self-medicate on illicit substances, leading to a cascading disastrous journey to death similar to that described by Catts (2008):

> Traumatic life events in childhood also induce brain sensitization. Unfortunately, both genetic vulnerability to schizophrenia and trauma put people at risk of substance use, presumably to cope with negative feelings, building a pathway of accumulating risks for schizophrenia or other behavioural disorders (Catts 2008:2).

Both contributing background narratives contain plot-lines where the narrator saw themselves and their deceased family member as 'victims' either of an inherited predisposition to mental and emotional illness, or of the damaging relationships in their family of origin. Such background narratives expressed a victim theme.

Negotiating changed relationships

After a suicide death has occurred in a family, a task for all family members is to renegotiate their relationships with the remaining family members. All have been affected in various ways by the tragedy and the actual way the family system works may have to be realigned as the members adjust to the gap in the family. Those families that have an open

communication style and are able to discuss the tragedy and their reactions to the loss will process this transition more healthily than those with a difficult or conflicted family relationship. This adjustment process is one of the tasks that may be facilitated by either counsellor or other professional support. It can also be one of the reasons bereaved family members seek out suicide-bereavement support groups.

Two of the narratives illustrate various ways the participants sought help to rebuild their family. Delma and her son-in-law Philip both spoke of the help that was provided to the family after Colin's death by the police support officer and then later, Delma joined a bereavement support group and for many years led a group herself. Similarly, Emma sought Internet bereavement support when no support group was available in her capital city and then started and led a support group. She was also most concerned for her three sons, all of whom withdrew from her and each other following their father's suicide death. Again Emma sought professional help, but the boys rejected this and had to find their own way. This family could have disintegrated, but are still together and are now very supportive of each other.

It can be seen that the unique qualities in each of the families discussed in this section determined the methods that they used to be able to regroup after the tragedy of the suicide death of their family member. Next follows the narratives of the participants who were not able to reconnect and support each other in the recovery phase of their bereavement.

Disrupted families that stay disrupted

The particular dynamics of some of the family systems in which a suicide has occurred may not lend themselves to facilitate reconnection and mutual support after a tragedy. The data from the previous chapter are discussed, demonstrating these dynamics in the family narratives described earlier. There are many reasons why a family may stay disrupted after a suicide. One reason may be the recognition that a continued relationship with some of the family members may not be conducive to healing and the ability to move forward. For example, Delia's mother decided to break off all contact with her deceased husband's family, and this added to Delia's sense of loss, but may have assisted Delia's mother to move on. The acknowledgement of these fractures in the family comes from the experiences of the participants themselves within the family. Another reason may relate to some family members blaming others for the death. This blaming may be the only way some can absolve themselves of the role they played in the life of the deceased.

Many of the disrupted family narratives in this study would support the proposition of Linn-Gust (2001); that is, that the entire fabric of the family is changed by suicide. The breakdowns eventuated because continuing the relationship would have caused even more trauma for the grieving bereaved participants.

The preceding discussion explicates the thematic question that all of the participants were wrestling with: 'What does this suicide say about my family?' And highlights the importance of this question for all the participants as it speaks of their family of origin, and for the adult participants, it speaks of the family culture that they helped create. This question also leads to the second major narrative theme: 'What does this suicide say about me?' The second narrative theme follows, which addresses the participants' sense of their self-hood following the suicide.

What does this suicide say about me?

This explores the second theme of the emotional and intellectual journey that the participants made as they questioned what the suicide said about themselves. The previous theme explored the first theme, looking at ways in which the participants reviewed their family life in the light of the suicide. The next section presents the second theme. In this theme, the ways in which the participants have had to review themselves in the light of the suicide is explored. This is done through the theme of 'what does this suicide say about me?' There are seven components to this theme of self-hood, which are explored in turn.

Participants' exploration of their self-hood

This section discusses the participants' views of themselves and relates those changes that have occurred as they attempt to pick up the threads of their own lives after the suicide. How the participants managed their trauma and grief, and either tried to support other family members or in turn sought support, will be discussed in relation to their changed view of themselves.

Managing trauma

There were many reports of negative stress reactions within the sample and this heightened sensitivity to stress may have occurred through a shared genetic predisposition, as suggested by Stoppelbein and Greening (2000). The behaviour of adults in the family witnessed in the developmental years by those participants who lost someone during childhood set a pattern of stress responses for the participants themselves over their life-spans. Some participants expressed the need to withdraw and isolate themselves when confronted by grief and pain in adult years, and recognised that this was the example that was given to them by their remaining parent when confronted with difficulties. This was especially so for those who were unable to depend on emotional support from their surviving caregiver and therefore suffered a lack of interpersonal security. These participants have learnt to survive by adopting defensive coping strategies as this was the only response they knew and was their attempt to adapt to their circumstances. A defensive adaptation to a stressful situation does not allow for stressors to be encountered as challenges to be met, thus exhibiting growth, integration and resilience. The grieving child's reliance on self-protectiveness when faced with the lack of emotional support may damage the child's emotional and psychic development potential. This is explained by Fosha (2000):

> The roots of resilience and the capacity to withstand emotionally aversive situations without resorting to defensive exclusion are to be found in the sense of being understood and existing in the mind and heart of a loving self-possessed other (Fosha 2000:60).

Common was the need to seek out ways of being in the future. Ways of being in this context means common, repeated behaviours intended to protect the participant from further loss or of negative judgements by others. The death caused questions of personal accountability. Owens and her colleagues (2008) explain person accountability as integrated or infused with bereavement as:

> For the bereaved parent, it is impossible to disentangle the events leading to the son's death from the impact of that death on their own life and their identity as a surviving parent. The story of the son is therefore set within the context of the profoundly disrupted biography of the surviving parent, who is trying to understand not only 'Why did it happen to *him*?' But also 'Why has this happened to *me?'* (Owens et al. 2008:239).

These questions of personal accountability plagued all of the participants, even though different reasons for their sense of personal culpability were dependent on their kinship relationship with the deceased and on cultural expectations. For example, parents expect to know what is happening in their child's life even when the offspring is an adult. Yet a more distant relationship, such as that of a brother-in-law, may not feel a similar degree of personal responsibility. This is especially so in the case of Philip, who says of his brother-in-law Colin, 'that he was a private person. Therefore, Philip had no expectations that Colin would share his feelings with him. This is in contrast with Delma who, even though she had some premonitions of a looming disaster, did not connect her feelings with Colin's moods or behaviour. These feelings of personal accountability colour and deepen the kinship grief experiences discussed earlier in this chapter.

The alternative to these victim plot-lines are narratives which are agentic. Agentic narratives are those whereby the bereaved identify a determination in themselves to understand their history and that of the deceased. These narratives demonstrate resilience as illustrated by the participants' resolve to take control of their direction in life or restore what was lost in their lives. They tell of the efforts that the narrator undertook to find help for their troubled family member prior to the death. Similarly, those who were bereaved by suicide as children or young adults and who overcame their damaged background and accessed education later in adulthood were agentic, as they actively formed their own future (Ratnarajah & Schofield 2008).

Kim, May and Delia are all examples of these agentic narratives as they all accessed further education to better understand their own experiences. Delia worked full time, yet studied to gain entrance to tertiary education, a longing that was denied to her by her mother's insistence that she leave school in her teenage years and work. Their mother's suicidal death prompted both May and Kim to undertake tertiary studies to understand more about what insights psychology and psychotherapy may offer into suicidal ideation and motivation. Laura was studying for a justice degree prior to her mother's suicide, after which she continued her studies showing great fortitude. Similarly, Sally qualified as a social worker and accessed years of psychotherapy for herself in order to heal the damaging effects of her upbringing. Other participants, namely Delma, Olwen and

Emma formed and led suicide-bereavement support groups, thereby not only taking action to facilitate their own healing, but reaching out and assisting others who were similarly suicide bereaved such as Wilson. They researched via the Internet for guidance in conducting support groups and Olwen has produced the quarterly newsletter for the State-wide support group of which she was a founding member.

In families where a schism had occurred, or where the suicidal death was seen as a shaming secret and not to be spoken about, the search for meaning continued into adulthood. Delia was able to reconnect to the lost paternal relatives and was able to hear stories of her father's formative years. She was also given some keepsakes and photographs of her father, whose belongings had been destroyed. This information gathering and sense making is an integral means of creating the personal narrative of the participants as they endeavour to bring their stories to a unified whole—an important task in making meaning from disruptive events (Bruner 1987; Gilbert 2002).

Making meaning

People endeavour to make sense from their lived experience by reviewing events, interactions with others and listening to reasons offered for why some things have happened. The meaning making that the bereaved undertook enabled them to create some structure around what commonly was a chaotic and shocking event (Neimeyer et al. 2002). This process of meaning making continues for years after the loss and is an adaptive

process as the participants reconstruct their lives without their deceased family member. The reminiscences of the participants cited in this study are from differing stages of this reconstruction of meaning about their loss. In this section, which discusses the meaning-making journeys that the participants undertook, the elements which follow explore the common experiences within the participants' grief narratives. Also discussed is the urge to create memorial stories about their deceased family member. This strongly felt need was a central part of the meaning making for their own individual story, but also related closely to the family narrative and it also served the need to honour the life of their family member. Also covered within this sub-section relating to meaning making is the discussion on the process of transformation that related to narratives about any recovery since the death of the family member. A key focus of the recovery process for some participants was a narrative of their spiritual- and belief-system changes that have evolved as a consequence of the loss of their family member and the meaning that, for them, was attached to the manner of that loss. The meaning making was evident in their discussion of the period of adjustment and accommodation with the knowledge that the loss was one of a suicide.

Common elements in narratives of the suicide bereaved

Those who are suicide bereaved may feel anger towards other family members or authorities who were perceived to be unhelpful and sometimes they have difficulty voicing this anger. Similarly, the inhibition

that prevents the bereaved family from speaking of their loss often results in the suicide bereaved feeling different from their peers. Kim was orphaned when she was in her early twenties and spoke of this sense of alienation from her peers as the death of both her parents so early in her life resulted in a developmental push (DeSpelder & Strickland 1999). A 'developmental push' is an event or experience happening in a young person's life that results in a sudden maturing, for example, if a teenager takes on the responsibility for caring for younger siblings. The young person then may no longer consider themselves a child.

Some participants acknowledged their anger towards their parents, such as expressed in Sally's story. Whilst others, for example, Angie, were angry with the mental-health authorities that they did not consider adequately cared for their family member. Others spoke of their anger felt towards the police service in the immediate aftermath of their family member's death: Delma and Lyn.

Commonly, the participants in this research study experienced feelings of guilt and shame or spoke of the suicidal death of their family member as being stigmatised. Guilt and shame were frequently mentioned in spousal or partner suicides where the death came as a complete surprise, as in Darryl's narrative of Josie's death.

Through the construction of stories following critical or traumatic loss people assimilate disruptive experiences into their frames of reference and

try to make sense of what has happened (Neimeyer 2001). The search for meaning is focused in the initial stages on trying to understand why the family member died, to understand their family member's decision to die. The bereaved family member may seek to experience their deceased relative's mental state and their feelings at the time before death. This allows an identification with the deceased family member and can result in the bereaved also contemplating suicide (Sands 2008).

This search for meaning has a wider focus than the decision of the relative to die; it also concerns the meaning making of the self of the narrator. Owens and her colleagues commented that:

> The stories show parents struggling to understand what went so wrong in their sons' lives that death seemed as preferable as living. As such, they are tales of biographical disintegration, chronicling lives that 'fell apart' or became unliveable. At the same time they are narratives of the *self* as well as the *son*. For the bereaved parent it is impossible to disentangle the events leading to the son's death from the impact of that death on their own life and on their identity as a parent (Owens et al. 2008:239) [italics in original].

Therefore, for all of the participants in this project the following question applies, whether implied or voiced: *What does this suicidal death say about me?* At the heart of this question lies the fear that there may be something wrong with the family. Either there could be a genetic inheritance predisposing the family to mental illness and an inability to handle stress, or perhaps the family patterning and communication style is not nurturing. This form of questioning indicates not only uncertainties about the sense of identity of the participant, but raises questions about any children that the participant might have. It infers questioning about

‘me’ and my offspring. Where there is a genetic link to the deceased, this self-questioning allows for the fear that they might also contemplate suicide. They may also fear that their children may become suicidal, as is the case in Janelle’s story about her son Vance’s suicide attempts, Delia’s concerns about her brother and the future of any children she may have and Emma in relation to her three sons.

Participants who recognised the prior history of damaging family patterning were determined to guard against this in their own parenting style. Herein lay their fear that their parental love of itself may not be enough to protect their children from the effects of a possible damaged family inheritance. For Delia it meant monitoring her own moods and thought patterns and seeking professional help when she felt overwhelmed.

Creating memorial stories of their deceased family member

As part of the healing journey undertaken by the suicide bereaved, there is often an expressed need to develop a narrative about their deceased family member. Rynearson (2001) describes this need as developing a coherent narrative of what was an incoherent act. This is illustrated by the urge that the bereaved family member had to tell their story of loss, but also the story of their relationship with their deceased relative. This second major narrative theme derives in part from the common experience of the participants of having their voices silenced, as has been demonstrated elsewhere (for example Maple et al. 2010). In contrast to the

experience of being unable to speak of their loved-one's death, it is the personal stories of remembrance that are really important to the bereaved. The suicide bereaved do not want to forget their deceased family member, yet the community misconception is that in order to help the suicide bereaved recover from their grief, any mention of the deceased must be discouraged. So there is a hunger in many of the suicide bereaved for the chance to speak about their deceased relative and to be able to share not only the story of suffering that culminated in a death, but also the whole of their life, and to be able to describe who they were and how they were loved and about their place within the family. For example, following Arun's death, Emma built a memorial site on the Internet for her husband and found this to be a healing experience. In the suicide-bereavement support group she established, she taught other members to build memorial sites for their lost loved ones.

This need to share a narrative about the deceased may be a rejection of the self-silencing and self-censoring of the participants, but is also done in safe environments such as with a trusted relationship, or through engaging in memorial exercises, such as in Emma's case. The healing for Emma resulted from the process of creating a record of the happy experiences that the family had enjoyed together. Her view of Arun shifted to a wider focus than that dominated by the horror of his death and the difficulties in their relationship as Arun became increasingly depressed and withdrawn. She incorporated in this memorial web record all the good

things that Arun had done in his life and thereby reclaimed these memories for herself. In this activity Emma not only found comfort for herself but created for her sons, who had been distanced from their father in the years prior to his death, a more positive picture of their father's life and personality.

Not only were the participants creating meaning out of their own experience but they also made meaning out of their deceased family member's life. This natural urge to memorialise the whole of the life of a deceased is identified by Rynearson, a psychiatrist, whose wife died by suicide following the death of their youngest child.

> (V)iolent dying needs a restorative retelling.... The terror and incoherence of Julie's dying isn't dispelled. I will always feel that. But in re-establishing who I was in her life, I am reconnecting my memory of our lives together and that returns me to a time and space of meaning and value. It is this realignment of myself from 'her dying' to 'our living', that allows a restorative direction to my retelling (Rynearson 2001:xiv).

The restorative process which Rynearson (2001) discusses occurs through the shifts from an incoherent retelling to a coherent narrative and is confirmed by the findings of this project. This innate urge to create a memorial narrative was missing in earlier suicide-bereavement postvention support literature.

Further research is required to understand if this restorative retelling, which is the primary function of support groups, is a key factor in their popularity among the suicide bereaved. These groups allow those attending to share their stories, not only of the death of their family

member, but more particularly, of happenings throughout the whole of their life. The restorative process therefore occurs through the gradual shifts from an incoherent retelling to a coherent narrative and this takes whatever length of time the particular bereaved family member needs. The support groups offer a safe space to discuss the deceased person's life and death during this process. Restorative retelling could be seen as a process involving transformation, but more than narrating the life of the deceased takes place. Personal qualities of the participants are also critical and these are discussed next.

Transformations

For every participant in this study there have been stories of recovery and change since the trauma of the family member's death. Undoubtedly every participant would acknowledge that from their pain has come personal growth, often at the greatest cost of courage and determination. Resilience can be the natural surge of determination to move on from that painful state and points to the innate qualities of the bereaved. These qualities include self-reliance, determination and stoicism. These inner qualities may also be the product of their family culture. External factors that can promote resilience are those that are found in the community, such as suicide-bereavement support groups and peer support from family and friends. The benefits of these support groups were acknowledged in a study surveying the growth experience of the suicide bereaved. In this study, Feigelman and his colleagues (2009:201) state: 'Survivors carve out

new identities for themselves as they assume these humanitarian enterprises'.

Resilience is demonstrated through the number of the participants who have, and continue to contribute their time, their understanding and care with such support groups. Others devote themselves to raising their children, accessing tertiary education and rebuilding their lives within their remaining families. As Linn-Gust (2001:51) observes:

> Grief isn't going to be over in one day. Understanding suicide doesn't happen in a period of hours. It was my experiences, both of coping within myself and with others that showed me I would be stronger when I came out on the other side.

An aspect of personal transformation related to changed spiritual beliefs or allegiance to a church community.

Spiritual issues: changes in belief systems and practices

Information relating to the spiritual beliefs of participants or their deceased family members came spontaneously as they narrated their experiences. It was not a specific question listed on the questions for the interview (see Appendix 5A). Of the eighteen participants, eight spoke about either their family's traditional belief-system allegiance or their own connection to either a church or spiritual practice. Events in the lives of some participants caused them to have critical thoughts about the church to which the family belonged or where they had previously worshipped.

Those participants who referred to their religious- or spiritual-belief system also often spoke of their disappointment or disillusionment with members of the clergy or the congregations for their lack of understanding. They felt that this was attributable to the nature of their loved-one's death being suicide. This is in contrast to the findings in a separate report into the needs of suicide survivors, where 63% of the participants reported that they found the support of their clergyperson helpful (McMenamy et al. 2008). Cultural differences between America and Australia may go some way in explaining this difference. Further research would be required to understand and dissect what these cultural differences relating to religious allegiance may be. Relying on statistics from census data collection in the two countries would not necessarily provide an answer, as these statistics would not identify regularity of practice, attendance at services or strength of belief. Other differences in these two countries, while both have large populations of European migrant derivation, would relate to the differences in racial origin and the differing religious-belief style of practices defined by their racial-group preferences.

Whilst some of the participants in the study by Vandercreek and Mottram (2009) reported confronting comments from members of their congregations and other strangers about the likely afterlife of their deceased family member, seven out of the ten reported that their beliefs had not changed after their family member's suicide. The spontaneous

comments of the eight participants regarding their altered belief systems after the suicide of their family member in this study contrast to the reported findings from these two American studies and therefore suggest that this may be a fruitful area for future research. The findings from this study demonstrate the importance of participants making meaning from an incoherent trauma in their lives. For many to successfully achieve this, support from others was necessary. This support came in the form of bereavement groups, for others psychological support was accessed. The bigger picture of the consequences of suicide bereavement could not be appreciated without an awareness of the bereaved family members' meaning-making journey. That many sought support either in the form of professional grief counselling, or from suicide-bereavement support groups necessitates discussion on this topic and adds to the suicide-bereavement support literature, which follows.

Support

Participants who were proactive in seeking support from professional grief counsellors or from others similarly bereaved were agentic in their endeavours to heal. Their healing narrative story-lines commenced as they struggled to come to terms with their loss through seeking suicide-bereavement support groups, or forming such groups themselves. The participants who sought counselling or other psychological assistance or who read and studied the phenomena of suicide, endeavoured to claim back some of their lost sense of power following the death of their family

member. Those participants who sought suicide-bereavement support groups found comfort in the knowledge that others would be able to relate to their experiences and that they may be agents of change for others similarly bereaved.

The purpose of such support groups is to provide a safe venue to share the suicide-bereavement experiences and therefore provide mutual support. Being suicide bereaved is an isolating experience for many participants. The healing function of support groups is explained by Sands (2008), who suggests that through the acceptance of others who are similarly bereaved those attending such support groups may begin to feel connected again. The support groups attended or led by the participants were described as being open-ended and the suicide-bereaved attendees continued in the groups for the length of time needed to derive understanding, companionship and healing. Through the support of group members, the suicide bereaved may begin to learn to trust again, as they feel listened to. The participants who attended support groups reported healing experiences, which confirmed the findings in the earlier study reported by Sands (2008).

Some participants, particularly those in their early adult years, attended support groups only once. When questioned as to why they did not return, the reason provided was that most of the attendees were much older than they were and that they did not feel like they belonged. However, for older participants and of particular benefit to one participant, Emma, was

online support from Internet support groups. At her time of greatest need after the death of Arun, there were no suicide-bereavement support groups in her home city of Canberra, so with the guidance of the online support groups, Emma started her own, which continues to this day. Other participants found support from their general practitioners, from counsellors, psychologists and psychotherapists, from a hospital counsellor, from telephone suicide-bereavement crisis lines and one participant spoke of the support she received from the coroner's counsellor. Those counsellors who are supporting the suicide bereaved need to be aware that those who have suffered a suicide within their family may have strong thoughts of joining them.

Conclusion

The traumatic event of the family member's suicide led the participants to search back through their family lore to look for reasons or explanations that could throw some light on why the suicide occurred. Many recognised evidence of fractured families or spoke of disrupted family narratives in which violence or abuse occurred. Family culture and family functioning that was not conducive to preparing family members to face difficulties were described.

The legacy of the suicide was described, including the grief experiences of the participants and the nuances of meaning within these which were dependant on the nature and quality of relationship between the bereaved

and the deceased. For some, the whole meaning of that relationship changed after the suicide. Connections with the wider family group were also changed by the suicide, as some participants encountered blame from other family members. Some families have stayed disrupted, while others have been able to regroup and be of mutual support to each other.

The second theme related to the participants' understanding and exploration of themselves. These narratives spoke of their meaning making after the suicide, how they expressed the urge to create memorial stories about their family member despite the stigma and the consequent silencing of many of the suicide bereaved. The participants also spoke of transformations and healing that occurred since the suicide and how their own belief systems had changed as a consequence of this traumatic event.
It describes the way participants construct new understandings about themselves and their relationship with their deceased family member consequent to the death. Relationships both with the deceased and within the remaining family are presented as pivotal in the meaning-making process.

Chapter 8

Conclusion

Introduction

The concept for this study followed on from an earlier research study undertaken examining parental suicide and the effects on bereaved children (Ratnarajah 2005). A recommendation from that study was to examine the family experience of suicide, especially to elicit information on family dynamics, including pathologising communication styles and the intergenerational transmission of suicidality, addiction problems, violence and abuse. This study fulfilled that recommendation.

The stories shared in this study demonstrate that these influences were present in the family history of the majority of participants both prior to *and* following the suicide. The intergenerational transmission of mental disorders was evident in several of the families, as were patterns of violence and addictions. Suicide ideation or attempts by other family members had occurred in six of the families. Whether this was due to the inheritability of suicide tendencies or from the shared family cultural climate was not within the scope of this study; however, it is worthy of further attention.

One difference noted between the previous study into parental suicide and the effects on bereaved children (Ratnarajah 2005) and this current research, is that the participants who contributed to this study were now much more aware of the availability and the need for support following the loss of a family member through suicide. This is in part is due to the events in this study being more recent. The time span covered by this current project is no more than 24 years, with most deaths occurring in the last ten, whereas the previous study included case studies from as long ago as 1930. Support services are now more widely available and the public is also better educated about the benefits of counselling and psychological support.

It is also important to recognise the positive qualities and values that also have their source in family culture. Hazel's life story contains all the elements of family violence and abandonment in early childhood. She was handed over to other relatives to be raised, yet she has spent all of her adult life working to support her community. The interpretation of an event, rather than the event itself, determines whether it will be damaging or seen as offering a chance for a different experience. The metaphor that Hazel used of being '*pass the parcel'* in her family could so easily have been a story of disadvantage and rejection, yet she saw value in her experience of a wider family and culture.

Even though all of the participants in this study spoke of their love for their deceased family member and the intense pain and trauma at their

loss, all acknowledge that this tragedy has spurred them into personal exploration and growth.

This chapter presents the strengths and limitations of the research, the contribution to research, practice and education, as well as presenting future research directions. There has been a deficit of knowledge about the experience of suicide bereavement by various family members depending on their relationship with the deceased. This study describes the different meanings that the bereaved have made from their loss.

Strengths and limitations of the study

The strengths of this research study are discussed next with comment on the appropriateness of the chosen methodology: narrative inquiry. Also discussed are the limitations of this research into the wider topic of family member suicide and the effects on the suicide-bereaved family members.

Comments on methodology

A methodology was required that would enable the gathering of the participants' grief narratives, and also that would allow the collection of the pre-suicide story—that of the family in which the suicide occurred. When experiences, thoughts and feelings are melded together into a story and are told and retold to an interested audience, meaning making occurs (Beebe & Lachmann 2002). The way in which that story is put together in the consciousness of the narrator allows the listener to determine whether

it is a coherent narrative or a fractured life story with missing pieces and a victimic plot (Levy & Wall 2000).

Using a narrative inquiry methodology allowed the gathered family stories to be told by the participants. These are summarised in Chapter 5. Narratives are not immutable. They change, develop and evolve as each person gathers more information about themselves, their other family members and society itself. This study seeks to understand the experiences of the participants at one time period only—the time of the interview in which they shared their story—although all participants had the opportunity of reading their transcripts and modifying it if they wished. One participant added an introductory paragraph in which she described her deceased father and the only other amendment to the transcripts was made by a participant who volunteered some information about a family member that was not relevant to the study and she deleted it.

Reflecting on the past can bring potential changes for people as new insights are gleaned. Participants were also able to share the way in which their understanding of their deceased relative and other family members has changed since the suicide. One example of this is the mellowing of Delia's view of her mother and how she is now able to understand her less judgementally—a position that has taken some years to come to. When young people experience a tragedy, maturity brings the ability to construct different meanings about events that was not possible

when the storyteller was young. Narrating a life story is a reflexive process and allows a continuous rethinking and construction of meaning to take place each time the story is told.

A qualitative research study relies on the researcher's openness and honesty in disclosing their position and perspectives on a topic (Malterud 2001). Being suicide bereaved myself must colour my research observations about the participants and my analysis of their narratives. The fact that one of the two supervisors for this study is also a suicide-bereavement researcher allows for a broader and more critical examination of the findings and the subsequent analysis. The other supervisor, a sociologist, whose enquiring mind broadened discussions, shared with me that he was deeply affected by reading these theses about suicide.

Reflexivity

Reflexivity for a qualitative researcher means that the researcher is aware of their own beliefs, values, and experiences, and how these may influence the choice of research topic and the research design and methods of the study to be undertaken. These are multiple influences and cannot be discounted as influential in the choice and methods of this study. That these influences may be operating in myself as the researcher has been discussed in the earlier chapters of this thesis. I have made apparent the personal meaning the topic of family member suicide has for me. I

discussed my own subjectivity with my two supervisors, both of whom are very experienced qualitative researchers and this was also explored with other research colleagues.

> 'Reflexive ethnography maintains that the ethnographer is not separate from the object under investigation' (Kincheloe & McLaren, 2005:3280.

Reflexivity in a researcher also includes the ability to be aware of self-consciousness, that is, monitoring and inquiring into my own feelings and reactions to the narrative that I am hearing through a self-reflexive process. Similarly, when reading through and listening in the replaying of the audio recordings of the interviews, I paid particular attention to anything that I had missed at the time of the interview or that in the reviewing I became newly aware of an intonation or inference that offered the opportunity of more in-depth exploration. Examples of where this happened are also included in the thesis.

Strengths

One strength of this study is that the eighteen participants cover every class of first-degree relationship to the deceased. This does not mean that the participants represent all suicidally bereaved family members; rather, the experience of suicide is that some of the experiences of other suicide-bereaved family members may be found to be similar. This study therefore offers insight into the family experience of suicide from differing relational experiences.

A further strength of this study is that the voices of the suicide bereaved are heard as they describe their experience of family prior to the suicide, the circumstances of the suicide and their own and other family members' lives following the suicide. In some stories the suicide was not completely unexpected. In other cases the suicide was a shock, traumatising and changing the way in which the bereaved view their life and their relationship with the deceased. This shock leads to personal inquiries into the nature of the relationship with the deceased family member. The participants also queried what their family member's decision to leave this life meant to the narrative construction of their own lives, as well as their role in being a family member of someone who has died by suicide. This is one of the three special contributions that this study offers to those who work in suicide prevention or postvention support.

A second important contribution that this study makes to the field is a comparison and analysis of the different suicidal grief narratives that vary due to the categories of kinship within the family. In other cases the participant spoke of understanding the emotional and mental pain their deceased relative had been experiencing prior to suicide, and they felt compassion for them. This was especially so where mental illness had been previously diagnosed and where the mental-health services were either rejected or the services would not or could not admit them as a seriously disturbed patient. The situation was exposed recently in the media by an investigative reporter who wrote that in the last eighteen

months 175 people died by suicide within seven days of their contact with the New South Wales health system (Pollard 2009). Therefore, it is vital that new insights into the experience of those in mental-health systems, along with the experiences of their families, be used to inform the way in which these systems respond.

This study also contributes some comparisons of different grief narratives within kinship relationships. Grief themes which are experienced across all areas of kinship were identified but so were the special classes of meaning, depending on whether the deceased family member was a spouse, partner, parent, child or sibling. This is an important awareness for those who offer support to the suicide bereaved to acquire in order that their services can be more sensitive to the nuances of relational suicide grief issues. Where family suicide-bereavement support is offered, the needs of the various family members may be different, also the timing when such support may be beneficial will differ.

A strength of a qualitative study is its ability to elicit rich information from a category of people who may otherwise be hard to reach. Information about the feelings and awareness of what could be a hidden group of people is important in informing and guiding those who provide services to the suicidally bereaved. A narrative methodology allows family members of suicide victims to provide stories about the deceased and the circumstances that they consider may have been implicated in the decision to suicide (Gavin & Rogers 2006). This study achieved this through all the

participants volunteering to contribute their stories to this study. Comments from all participants on the therapeutic value of having their story heard are rewarding for me. As a researcher, I am also very aware of the emotional cost of revisiting such a painful event. The therapeutic nature of being involved in research where one is permitted freedom to tell one's story has been documented (Stuhlmiller 2001). While research is not intended to be a therapeutic tool, being allowed the space to have your story listened to is not an experience that the suicide bereaved are often permitted. All participants in this study were grateful of the opportunity to engage with their story with a willing audience. It is another testament to the validity of the research that participants were not only drawn from support groups, but from everyday life whereupon hearing of the study, they were motivated to volunteer. This is a strength because some of those who heard or read of this study and volunteered to be a participant, who had not previously accessed a bereavement support group, stated that they shared information during the interview for the first time. This allowed them to bring forth memories and feelings that may have been buried and not previously acknowledged to themselves.

Two levels of validity need to be established in qualitative research projects utilising interviews. These are: i) that the narrative of the participant has to be valid and representative of their meaning and ii) the analysis of this data that is incorporated in the story told by the researcher must reflect this. Narratives shared in interviews in a

qualitative study are more than an historical reporting of an event. They are a reflection of the stories told by an informant from their point of view with the intention of sharing these experience and interpretations of events with others with the view the incidents may generate a common understanding. The coherence of the interviewee's story and the researcher's analytical interpretation of that story must be present to establish trustworthiness (Riessman, 2008).

Cultural diversity was achieved in a limited fashion in this study as the history of two suicidal deaths from an Aboriginal family was shared. The observations of Hazel, who has a wide experience of giving professional support to members of the Aboriginal community, enriched this study. This is of further value as she shared her beliefs about the difficulties some Aboriginal males have in finding a role in contemporary Aboriginal family life. Emma's husband was from a mixed-race relationship and his inability to find acceptance and a sense of belonging in either Australia or Asia was a critical feature in his life, and many difficulties he experienced in life were seen through this prism.

Limitations

As with all research designs, this study has limitations. The first limitation is the small sample size. While speaking with these particular eighteen people, they discussed their extended family and how they too were affected by suicide. In total, twenty suicide deaths are represented. There was an awareness that in the immediate and extended family of

each of these participants, there were between six and twenty other people, all affected by the suicidal death to a greater or lesser degree than the volunteers. The exact number of people bereaved by each death remains unknown (Campbell 1997; Cerel 2008; Clark & Goldney 2000; Jordan & McIntosh 2010).

The interviews with the participants were conducted at varying times after the death of the family member who died by suicide to the time of the interview. These time frames vary from 1 year to 25 years since the death. Therefore issues such as recall bias are acknowledged. This is pertinent in that the longest lapse of time was for the participant, Delia, whose father died when she was an 11 year old child. Her memories of the preceding events in the family, the trauma of learning of her father's death and especially how she and her brother were treated by members of her mother's church in the week after her father's death are very clear. Her emotional journey from the time of her father's death and the insights that maturity have brought was described by her and features in the 'transformation' narratives. Other participants for whom the time period between the suicidal death and the interview was not such a gap, all retained vivid memories of the occasion of finding their deceased family member's body, of witnessing the event, or of how they were told of the tragedy. The changes and transformations that can happen in the narratives of a suicide-bereaved person occur through developmental

issues, or attending support groups or accessing professional help. This is acknowledged and was discussed under research methodology.

The original research concept proposed to interview at least two people from each of the families. It is acknowledged that much rich data may have been obtained if the narratives of these family members were included. However, only two other family members of volunteer participants were willing to also be interviewed. In one instance, the story from the mother of a deceased son and that of his brother-in-law had a significant degree of mutual interpretation of the death and understanding of the causal factors resulting in the suicide. However, in the other family, the husband of the deceased and the eldest daughter had significantly different views on the way the family system operated and even of the relationship between the deceased mother and her husband.

In separate interviews with Delma and her son-in-law Philip, the stories they told shared much in common including that the family discussed at length the circumstances of Colin's suicide and reflected on his life leading up to the decision to die. While the suicide was totally unexpected and inexplicable, all the family members agreed that the seeds of his despair lay in his longing for his lost father. This was despite his awareness of the suffering his violent father inflicted on his mother. Both participants were both present when Colin died.

In the contrasting family story of Darryl and his daughter May, both participants had totally different memories of their individual relationship

with the deceased. For Darryl, his marriage to Josie was the ideal, deeply bonded and loving relationship he had sought since his mother died when he was six years old. Darryl blamed himself for Josie's death and carried guilt about a casual remark he made on the last day of her life. He also blamed the health authorities who were not able to verify Josie's work-related injury therefore necessitating a continuous round of specialists' appointments and painful tests after which Josie believed she was suspected of fraud. May, however, was barely out of her teenage years and had been undergoing a struggle for more independence from her mother just prior to Josie's death. There was discord between the two before Josie's death and this increased May's grief as she was not able to finish the argument and resolve their relationship on a different footing. May was also taking on many of the mothering roles as her mother was unable to carry out this role. The question arises if the discord mentioned by May arose out of resentment, either from Josie towards May for supplanting her, or from May towards Josie as Josie's disabilities took away May's later teenage years. Another difference in the bereavement stories of Darryl and May is that May was her mother's confidant, and she knew that Josie was not happy in her marriage and longed for freedom to make decisions independently.

May states that she and her siblings were very close to their mother prior to her death, and it was only after this that she came to know and appreciate her father as he attempted to support them in their

bereavement. These two contrasting stories point to the rich data that might have been attained if more participants from the same bereaved families were willing to speak of their loss. It is well reported that some members of a suicide-bereaved family withdraw into silence and loneliness (De Leo 2010) and other people need differing lengths of time before they are able to speak of the events surrounding the suicide loss. Some are silenced by the perceived stigma believed to be attached to the suicide bereaved (De Leo 2010).

Another limitation in this study was the inability to reach similarly bereaved people who had not heard of the study. It is without question that other members of the same families would have contrasting insights into the suicide and the family system in which it occurred. A much deeper understanding of the background story of the suicide and its aftermath would have been available had there been an opportunity to speak with more family members from within the same family.

Implications of the results

This study highlighted the needs of the family members who are suicide bereaved. Whilst most of the participants chose to access support after their loved-one's death, either through professional counselling services, from their general practitioner or by joining a support group, there are those for whom stigma or other reasons resulted in withdrawal and isolation. It is of particular concern that frequently these are the youngest members of the bereaved family who are not offered support, or if it is

encouraged and available, are reluctant or unable to trust that such help might assist them. Other family members, who after their experiences in being turned away from mental-health services sought prior to the death of their family member, also lacked trust in the availability of care for the mentally ill. This potentially isolates them from services they may need in the future.

Support for the family

That all of the participants in this study had accessed support, either from a private psychologist, counsellor, psychotherapist or a survivors of suicide support group suggests that support for the suicide bereaved is generally available, especially in major cities. However, no such support group could reportedly be found at that time in the national capital. This may also say something about how people find and access services. Some participants utilised this support for a short time, while others returned whenever they needed to do so. Six of the participants have had a connection with a support group for a period of years, some holding office in the group and manning a 24-hour telephone crisis hotline. Three participants founded their own support groups and believe that their experiences help them connect with the newly suicide bereaved.

It was recommended in a report from a pilot study that facilitated support, that support should be provided as a means of addressing the specific needs of the suicide bereaved (McMenamy et al. 2008). It was further noted in this pilot study that support groups usually did not address the

needs of children with emotional problems and other traumatisation after a family member suicide. This study supports these recommendations. That is, interventions should be designed and developed to meet the needs of a variety of suicide-bereaved family members. In the case of Emma, she was able to encourage her three teenage sons to come to counselling with her initially, but they soon refused. Perhaps most tellingly Emma asked at the end of the interview how to reach suicide-bereaved young men. She stated that if any of her three sons had suicide ideation they most certainly would not tell anyone, especially someone in the family. Further understanding of the needs of high-risk groups, along with the best ways to reach them is vital to reducing on-going high rates of suicide among young men.

It is clear from the experiences of these participants that they have experienced stigma related to their loved-one's death. This stigma restricted their ability to speak about their lost family member or to share stories about their role in the family and what the deceased meant to them. Action to reduce stigma associated with a suicide death, or suicide ideation, would lead to a healthier and more tolerant society. The reduction of stigma would also encourage dialogue among those who are suicide bereaved, and those with suicide ideation to seek help.

Lay expectations of the mental-health services

In several of the stories, the participants spoke of their frustration in being unable to access appropriate care for their mentally ill relative. The

main concern was that hospitals and psychiatric facilities release patients while they are actively suicidal, or will not, or are not able to admit patients who are suicidal. While it was recognised that privacy provisions prevent health facilities from notifying the family members of the mentally ill when they are being discharged from care, the participants expressed helplessness and frustration that they were not given the opportunity to continue the care of their family member upon release from hospital. There is a lack of information available to the public and family members about the availability of inpatient hospital care. Participants expressed their belief that their family member could have been helped if only appropriate and timely mental-health care had been provided.

Recommendations

The main findings in this study were that the suicide-bereaved participants explored widely to discover or uncover meaning in their loved-one's death. In the process of this exploration they raised questions about what the suicide said about their family, and in particular what the suicide said about themselves as a family member of the deceased and of the relationship they had shared with the deceased. This wide range of seeking and meaning making gave rise to the family sagas and the circumstances surrounding the suicide death and generated the title of this thesis. The meaning-making journey that the participants undertook subsequent to the death of their family member is told in the sequel narratives. The pain of the loss that the participants spoke about was

evidenced in their stories, and their bewilderment at the treatment they were subject to from the first responders added to this pain, sometimes in a traumatic way. The recommendations that follow are derived from the narratives of the participants and are an attempt to provide guidelines for those members of the helping professions who support the suicide bereaved, the mentally ill and those with suicide ideation and those emergency services who have the unenviable responsibility of attending a suicide event.

Specific recommendations for those who practice in the suicide-bereavement field, in mental-health services, the clergy, for the first responders to a suicide event and the volunteers and others who support the suicide bereaved are now discussed. There are also recommendations relating to the education of those professionals who chose to work in this demanding, but worthwhile field.

Sensitive treatment by those who responded first to the death was viewed positively by those who experienced this, while those who reported insensitive treatment found this problematic for long periods of time. Therefore, it is recommended that the first responders to a suicidal death, such as the police and other emergency service staff, hospital medical staff and funeral staff, receive better training in how to communicate with family members following a suicide. This suicide-bereavement sensitivity training for first responders should include knowledge of where and how specialised support services may be contacted. Whether this initial contact

is done sensitively or in a manner in which the bereaved are further traumatised or disempowered (as evidenced in Delma's and Lyn's experience) can have a major impact on the bereavement experience. The need for sensitive contact by the first responders has been previously recommended and is also in accordance with the recently released position statement from Suicide-Prevention Australia (2010) 'Crisis Response and the Role of First Responders to Suicide and Suicide Attempts'.

Many participants in this study went to their clergy for support, and yet few found this to be a positive experience. Therefore, there is a need for better education of clergy in how to respond at a time when a family approaches them for support. An example of how this may be achieved would be if the clergy and those who wish to offer counselling or support study the narratives of the suicidally bereaved to deepen their understanding of the complexities and nuances of suicide bereavement. Information on the rights of the mentally ill and the family members of a suicidal relative should be made more available. This information should also identify limitations on what care or service can be provided to the suicidal patient.

This thesis provides a depth of information on the familial experience of suicide bereavement and therefore provides therapists who are working in this field with first-hand reports of those affected. A further recommendation is that therapists recognise that there will be different shades of meaning and different qualities to the grief story depending on

the nature of the bereaved's relationship with the deceased. For example, children who lose a parent to suicide will make their own interpretation of what the loss means to them depending on the closeness of their relationship and the role that parent was playing in their lives at the time of death. Similarly, partners and spouses lose not only their partner in life, but may also question the value of the entire relationship; so this is a loss of the past as well as the future. Parents whose children decide to die lose their future too; the death of a child before the parent's life ends is against the natural order of life. The grieving parents question their role as parents. Those grieving the suicide of a sibling lose the relative who knew them for almost the whole of their life. So often the grieving sibling is not offered support but is told to be strong for their parents. The findings of this research project support McGlothlin's (2006) recommendation that therapists working with suicide-bereaved family members be made aware that the whole family system needs to be considered as a suicide can affect the family system in many different ways.

Recommendations for education

Recommendations derived from the findings in this study to future curriculum development for tertiary counselling and social-work courses follow.

Family members are most intimately affected by suicide. It is therefore recommended that the entire family be encouraged to support each other in their needs, which may be very different in one family member from the others. It is those with these professional backgrounds who are most likely to be available to family members in the initial period following the death. How this may be done sensitively will be determined by the needs of each family member, and the degree of empathy and ability to connect with their more troubled relative.

Among other findings, this study discovered that one response to trauma and bereavement was the need to withdraw into isolated mourning. This supports an earlier research finding (Ratnarajah & Schofield 2008). It is therefore recommended that in the curriculum of counselling and social-work courses attention is given to the need for awareness raising of the benefits of empathic support in 'at-risk' families following a suicide or where suicide ideation is present following a suicide death.

A beneficial inclusion in the curriculum would be transforming skills, enabling a person who has suffered a traumatic loss to regain control of their lives, understand change processes such as setting of goals and task identification and the ability to identify and assess alternative choices.

It is important that grief counselling is included in the core curriculum. It is acknowledged that not all counsellors can be comfortable and effective in their support of those grieving a traumatic loss. This is particularly

true for younger graduates who may not have had the depth of life experiences to be able to effectively support the suicide bereaved. Whilst grief counselling may be addressed in undergraduate courses, it may be that this topic is more suited to postgraduate studies as a speciality. Postgraduate training focusing on facilitating the transition from a previous assumptive world prior to the loss, to a worthwhile new life which is changed forever, is warranted. Understanding the issue of suicide within a social context would be a valuable addition to the curriculum. It has been suggested by Eckersley and Dear (2002:1891) that 'suicide is the tip of the iceberg of suffering', suggesting the inclusion of an understanding of the social-health framework.

Also of importance would be understanding family systems and attachment issues. These skills would be of assistance to the therapist in understanding whether the particular family member can speak of their upbringing as having enabled secure attachment, or avoidant or ambivalent attachment, or alternatively disorganised or disorientated attachments, that can guide the therapist in understanding the family system and style of relating to each other (Siegel 1999). This may have particular relevance to those families where the bereaved or the family member with suicide ideation was adopted. Questions about rejection and abandonment by their birth families had been raised by two participants, Danny and Sean, as reported by their partners, but no indication was

given by the partners of the deceased men that this was a dominant issue for them.

It would be of great help to a therapist supporting a family confronted by a mentally ill, potentially suicidal relative to have information on the available mental-health services and mental-hospital beds in their vicinity and how to access them. It would be useful if training were given to educate the therapist so they may better inform individuals on what can and cannot be provided to help their mentally ill relative. Information on which services can help when dealing with a suicidal family member would also be valuable. Advice about the required forms and procedure necessary to schedule a mentally ill relative would be useful information to have at hand so that the family member can instigate a psychiatric assessment for their relative if they believe this is required.

Further research

This research study examined the research question: *How do suicide-bereaved families narrate their experience of loss in the context of familial relationships?* From this question the following further research suggestions are made.

It would be of value to those who work with the suicide bereaved to identify what support services were seen as helpful to those similarly bereaved. It is likely that the type of support for the bereaved will change over time. In this study the frank and simple answers provided by the

counselling services of a coronial counsellor in the immediate aftermath of the death were considered to be very valuable. The coronial counsellor was able to respond with information to all the legal-procedure questions of the participant.

Other participants spoke of their need to speak to someone such as a similarly bereaved person. This need to share with others similarly bereaved was validated in a pilot study in which all of those interviewed stated that this was helpful (McMenamy et al. 2008). The need to share with a similarly bereaved person very often leads to a survivors of suicide support group. Or in one instance in this study, when no such group could be found in her home city of Canberra, one participant started her own support group. This participant also found enormous value in Internet-based suicide-bereaved support groups. Research that identified the location and contact details of suicide-bereavement support groups would be invaluable, especially if this information was published in all the helping-profession journals. The immediate post-event response to a suicidal death was found to be critical to the survivors' grief experiences.

Devising a research methodology for those who are not comfortable speaking about the suicide of their family member would be a challenge for further research. A research methodology that was less threatening for those who could not face an interview with a researcher may allow their stories to be accessed in a way which could not be done in this study. For example, an Australian Internet site could offer a research questionnaire

on suicide-bereavement experiences that may be lodged anonymously. This would enable those disinclined to contact support groups to express their needs following the loss of a loved one by suicide and access a broader sample. The information volunteered in such a questionnaire could then be analysed and compared to data gathered in interviews to assess the effectiveness of such a service to garner information that may not be otherwise available.

As so many of the participants were disappointed and felt misunderstood by the clergyperson or congregation of their church, additional knowledge for professionals and also the clergy would be provided if a research study investigated the experiences of clergymen or women who have supported the suicide bereaved in their congregations. This exploration could gather the clergies' interpretations of their aims and role in suicide-bereavement support. This study found no narratives of positive contact between the bereaved and their particular church, either clergy or congregation.

Further required research is indicated into the needs of mentally ill patients who become suicidal and the mental-health services ability to respond. That there are shortfalls in every facet of health care in Australia, particularly public-hospital-based health care, is widely known but planning cannot take place unless these broader challenges and dimensions of the needs are assessed.

Research is warranted into the outreach mental-health services so that patients who have been discharged from a hospital following a suicide attempt can be followed up. Similarly, privacy provisions that prevent a hospital or treating medical professional from contacting the families of their suicidal patients can result in vulnerable people being released from hospital without support. Most of the family members of the mentally ill patients whose stories are included in this study were more than willing to provide care and support for their relation, but were not given that opportunity. Exploring the factors that inhibit this from happening would be valuable.

An ethnographic research study accessing all living members of a suicide-bereaved family would hear the narratives of different people which were coloured by their relationship to the deceased family member and their place in the family. Such a study would be difficult to organise considering the difficulty I encountered in finding more than one person from the same bereaved family to interview. However, attempting to do this within other circles may yield more connections with families.

Further research is indicated to ascertain if the restorative retelling of the whole of the life of a family member who died by suicide that occurs and is encouraged in support groups is a reason for the popularity of these bereavement support groups.

Summary

This chapter discusses the implications of this study for future research and education, and the contribution made for counselling practice. The strengths and limitations of the study are listed and comment is made on the methodology chosen to examine the experience of family member suicide. Of particular benefit are propositions for further research in this area and also suggestions for areas that would deepen the understanding of family member suicide grief for inclusion in the curriculum of counselling, social-worker and psychology courses.

Postscript

In the first chapter of this thesis, I shared the personal history that motivated the enquiries made into the family experience of suicide. When my son died at age 39, he left behind a wife already commencing a new relationship, and a son aged twenty months. I learnt shortly afterwards that a second baby was expected, and this child was born eight-and-a-half months after my son's death. When I first considered undertaking a research project, I was asked by one of the professors at the research residential: 'what is it that you really wish to find out?' This was an easy question for me to answer— 'what can assist my two little grandsons in their lives, having to grow up knowing their father died by suicide?' This question led to the focus of the first research project into parental suicide and the bereavement experience of children (Ratnarajah 2005). This first

research study deepened my awareness and understanding of the dynamics of family relationships and I recognised that a family crisis event has its genesis not only in the past history of relationships in the current family, but back through time into the heritage of many generations. The first research study led naturally to this thesis.

I realise from my own experience of the search for meaning—a search for which all those who loved a suicide decedent experience—that it is easy to look for the motivations to remove oneself from life in recent events and relationships. From undertaking these two studies, I recognise that this is in effect a tunnel vision that seeks a recent cause and person or event as the target trigger incident for the suicidal impulse. While there may be some truth in this interpretation it is far from the whole picture. The wide reading undertaken for these two projects has shown me that there are two primary requirements for such an action. The first is a feeling of 'not belonging'; the second is that of 'burdensomeness' (Joiner 2010:7). The first reason speaks to feelings of isolation and rejection, of feeling unlovable, or being a failure, of being superfluous and not needed. The second requirement relates to the thought that their death can relieve those they love of the burden of worrying and caring about them. It is almost a sacrificial gesture that becomes possible through the intense emotional and psychic pain that the suicidal person feels at the time. This study also recognises there is often an untreated or an under-treated emotional and/or mental illness, which may have its roots in the

attachment deficit in the developmental years of the deceased or in their genetic inheritance. The complete story of why a particular person died by suicide may never be fully known, as they took their reasons with them.

The isolation of the suicide bereaved is an experience I identify with personally. In my own family of origin my son's name is never mentioned. I know this is in the mistaken belief that the best way for me to 'get over' my son's death is for them to never mention his name. It is also because those remaining family members wish to avoid the stigma of having a 'suicide' in their family—but this hurts. To me Chris lives on as a living presence in my life. His life mattered to me and has far more meaning than just the manner of his death. Undertaking these two research projects has given me the opportunity of living with the topic of suicide and suicide bereavement for almost ten years. The topic is familiar and holds no terror for me. I have found companionship with others who have shared their stories, the participants who volunteered their stories in the two research projects, and also with the authors of books written by the suicide bereaved or by researchers exploring this topic. Sharing time and dialogue with fellow suicide researchers and authors is deeply rewarding for me, as in their company, I find fellow travellers who share the aim of reducing the incidence of suicide and of bringing understanding to the suicide bereaved.

The stories told by the participants in both these studies have deepened my understanding of my own story. I can face with more clarity the

antecedents to Chris's death and can relate at a deeper level and with more empathy to his journey to that death. I am very aware of the truth, both in relation to the stories of the participants and also in my own story, in the words of Monica McGoldrick at the recent American Association of Suicidology 2010 Conference when she said 'remember that what you are told is really threefold, shaped by the teller, reshaped by the listener, concealed from them both by the dead man in the tale' (McGoldrick 2011). In her keynote address, she spoke of a suicide being a 'systemic experience which ripples out and down the generations affecting many who never even knew the deceased' (McGoldrick 2011). She continued: 'none of us are alone, we are all a part of those we belong to'. I am grateful that I belong to Chris and that he remains in the emotional embrace of belonging to me.

The remaining comment I make in this postscript is in answer to the question— 'has the knowledge and understanding of suicide from these two projects been of assistance to my two grandsons as they face life knowing their father died by suicide?' I have not seen or spoken with my grandsons for nearly seven years. It was the greatest loss to me that all contact between us ceased following accusations made by their mother. I was very aware that she was fearful of what I might tell my grandsons about their father's death. At her insistence, I never mentioned how their father died to the boys, even though I knew the accepted wisdom is that children are told the truth in an age-sensitive manner (Cain 2002). When my eldest grandson was six years old, he accused me of lying to him by

saying his father died from an illness after he had heard the truth of his father's death from another child as a taunt. I answered, 'Yes it is true that your Dad died by suicide, but he was very sick and very sad, and that is the true story of what happened'. His mother was present at the time; she never told my grandson that concealing the truth was her instruction to me. I was determined to support my grandsons' mother as I knew how important that attachment was in early childhood and when children have only one parent, that parent is especially precious to them. I would never have done or said anything that would have undermined the relationship between the boys and their mother, but my positive intentions and attempts to give them a good education meant nothing to their mother. Her fears of my influence with the boys resulted in all contact being broken off and their faith and trust in me destroyed.

So I do know that there is little hope of my grandsons benefiting directly from this research. But I can hope that the research that is undertaken into suicide and suicide bereavement will result in a more compassionate and wiser society. To quote again from Monica McGoldrick, (2011) 'how the story is told is very important, but <u>that</u> the story is told is crucial'.

REFERENCES

Agerbo, E 2006, 'Midlife suicide risk, partner's psychiatric illness, spouse and child bereavement by suicide or other modes of death: a gender specific study', Journal of Epidemiology and Community Health, vol. 59, pp. 407–412.

Arnott, P 2003, No time to say goodbye—revised and expanded edition, Acorn Press, Adelaide.

Australian Government 2007, National suicide prevention strategy—Fact sheet: Council of Australian Governments.

Australian Institute of Health and Welfare (AIHW), Harrison, JE, Pointer, S & Elnour, AA 2009, A review of suicide statistics in Australia. Injury research and statistics series no. 49, in Australian Institute of Health and Welfare (Ed.). Australian Government, Australian Institute of Health and Welfare, Canberra, pp. 1–107.

Avrami, S 2003, '"I wish he had died in the war": suicide survivors—The Israeli case', Omega, vol. 46, no. 4, pp. 273–286.

Avrami, S 2005, '"I wish he had died in the war": suicide survivors—The Israeli case', Omega, vol. 51, no. 1, pp. 65–75.

Bailley, SE, Kral, MJ & Dunham, K 1999, 'Survivors of suicide do grieve differently: empirical support for a common sense proposition', Suicide and Life-Threatening Behavior, vol. 29, no. 3, pp. 256–271.

Barlow, DH 2000, 'Unravelling the mysteries of anxiety and its disorders from the perspective of emotion theory', American Psychologist, vol. 55, no. 11, pp. 1245–1263.

Baumeister, RF & Newman, LS 1994, 'How stories make sense of personal experiences: motives that shape autobiographical narratives', Personality and Social Psychology Bulletin, vol. 20, pp. 676–690.

Beautrais, AL 1999, Risk factors for suicide and attempted suicide among young people, National Health and Medical Research Council, Canberra.

Beautrais, AL 2004, Suicide postvention: support for families, Whanau and significant others after a suicide, a literature review and synthesis of evidence, Ministry of Youth Affairs, New Zealand.

Beebe, B & Lachmann, F 2002, Infant research and adult treatment, co-constructing interactions, The Analytical Press, Hillsdale, NJ.

Bongar, B, Goldberg, L, Cleary, K & Brown, K 2000, 'Marriage, family, family therapy and suicide', in RW Maris, AL Berman & MM Silverman (eds.), Comprehensive textbook of suicidology, The Guilford Press, New York, pp. 222–239.

Botha, K, Guilfoyle, A & Botha, D 2009, 'Beyond normal grief: a critical reflection on immediate post-death experiences of survivors of suicide', Australian e-Journal for the Advancement of Mental Health, vol. 8, no. 1, pp. 1–11.

Bowen, M, 1988, 'Family therapy in Clinical practice, Jason Aronson, Northvale, NY.

Bowlby, J 1979, The making and breaking of affectionate bonds, Tavistock, London.
Brent, DA & Mann, JJ 2006, 'Familial pathways to suicidal behavior—understanding and preventing suicide among adolescents', The New England Journal of Medicine, vol. 355, no. 26, pp. 2719–2721.
Brent, DA, Oquendo, M, Birmaher, B, et al. 2002, 'Familial pathways to early-onset suicide attempt', Archives of General Psychiatry, vol. 59, pp. 801–807.
Brent, DA, Oquendo, M, Birmaher, B, et al. 2003, 'Peripubertal suicide attempts in offspring of suicide attempters with siblings concordant for suicidal behavior', American Journal of Psychiatry, vol. 160, no. 8, pp. 1486–1493.
Brent, DA, Oquendo, M, Birmaher, B, et al. 2004, 'Familial transmission of mood disorders: convergence and divergence with transmission of suicidal behavior', Journal of the American Academy of Child and Adolescent Psychiatry, vol. 43, no. 10, pp. 1259–1266.
Bronfenbrenner, U 1979, The ecology of human development, Harvard University Press, Cambridge.
Bruner, J 1987, 'Life as narrative', Social Research, vol. 54, pp. 11–32.
Bycroft, P & Scheinpflug, S 2006, National activities on suicide bereavement project: a new paradigm for addressing the needs of those bereaved by suicide, Suicide Prevention Australia National Conference 2006. Adelaide.
Cain, AC 2002, 'Children of suicide: the telling and the knowing', Psychiatry, vol. 65, no. 2, pp. 124–136.
Callahan, J 2000, 'Predictors and correlates of bereavement in suicide support group participants', Suicide and Life-Threatening Behavior, vol. 30, no. 2, pp. 104–124.
Campbell, FR 1997, 'Changing the legacy of suicide', Suicide and Life-Threatening Behavior, vol. 27, no. 4, pp. 329–338.
Campbell, FR, Cataldie, L, McIntosh, JL & Millet, K 2004, 'An active postvention program', Crisis, vol. 25, no. 1, pp. 30–32.
Campbell, FR, Noonan, K & Sands, D 2007, Adolescents and children's bereavement after suicide. Paper presented at the Living Hope, Inaugural Australian Postvention Conference, University of New South Wales, Sydney.
Capp, K, Deane, F & Lambert, G 2001, 'Suicide prevention in Aboriginal communities: application of community gatekeepers training', Australian and New Zealand Journal of Public Health, vol. 25, no. 4, pp. 315–321.
Catts, S 2008, Research corner—latest findings relating to illicit drugs and mental illness. The official e-newsletter of the Mental Illness Fellowship of Australia, pp. 1–3.
Cerel, J & Campbell, FR 2008, 'Suicide survivors seeking mental health services: a preliminary examination of the role of an active postvention model', Suicide and Life-Threatening Behavior, vol. 38, no. 1, pp. 30–34.

Cerel, J, Padgett, J, Yeates, C & Reed, G 2009, 'A call for research: the need to better understand the impact of support groups for suicide survivors', Suicide and Life-Threatening Behavior, vol. 39, no. 3, pp. 269–281.

Cerel, J, Fristad, MA, Weller, EB & Weller, RA 2000, 'Suicide-bereaved children and adolescents', Journal of American Academy of Child and Adolescent Psychiatry, vol. 39, no. 4, pp. 437–444.

Chase, SE 2005, 'Narrative inquiry: multiple lenses, approaches, voices', in NK Denzin & YS Lincoln (eds.), The Sage handbook of qualitative research, 3rd edn, Sage, Thousand Oaks, pp. 651–679.

Chen, SX, Wu, WC & Bond, MH 2009, 'Linking family dysfunction to suicide ideation: mediating roles of self-views and world-views', Asian Journal of Social Psychology, vol. 12, pp. 133–144.

Clandinin, DJ & Connelly, FM 2000, Narrative inquiry: experience and story in qualitative research, Jossey-Bass, San Francisco.

Clark, S 2000, Bereavement after suicide: mountains, milestones and the new millenium—Where to now? Suicide Prevention Australia, Sydney.

Clark, S & Goldney, R 2000, 'The impact of suicide on relatives and friends', in K Hawton & K van Heeringen (eds.), International handbook of suicide and attempted suicide, John Wiley & Sons, Chichester, pp. 461–478.

Cooper, J, Appelby, L & Amos, T 2002, 'Life events preceding suicide by young people', Social Psychiatry and Psychiatric Epidemiology, vol. 37, pp. 271–275.

Cottle, TJ 2000, 'Mind shadows: a suicide in the family', Journal of Contemporary Ethnography, vol. 29, no. 2, pp. 222–255.

Crotty, M 1998, The foundations of social research: meaning and perspective in the research process, Allen & Unwin, Crows Nest, New South Wales, Australia.

Davies, H & Williams, F 1999, Confounded by confounding: separating association from causation. Hospital Medicine, vol. 60, no. 4, pp. 294–297.

De Leo, D 2010, Turning points: an extraordinary journey into the suicidal mind, Australian Academic Press, Bowen Hills.

DeSpelder, LA & Strickland, AL 1999, The last dance: encountering death and dying, 5th edn, Mayfield Publishing Company, Mountain View.

Deveson, A 1998, Tell me I'm here (New Edition) Penguin Books, Camberwell, Victoria.

Diamond, G & Josephson, A 2005, 'Family-based treatment research: a 10-year update', Journal of the American Academy of Child and Adolescent Psychiatry, vol. 44, no. 9, pp. 872–887.

Dienhart, A & Avis, J 1991, 'Men in therapy: exploring feminist-informed alternatives', in M Bograd (ed.), Feminist approaches for men in family therapy, Harrington Park Press, New York, pp. 25–44.

Doka, K 2002, Disenfranchised grief: new directions, challenges, and strategies for practice, Research Press, Champaign, Illinois.

Dyregrov, K & Dyregrov, A 2005, 'Siblings after suicide-"The forgotten bereaved"', Suicide and Life-Threatening Behavior, vol. 35, no. 6, pp. 714–724.

Eckersley, R & Dear, K 2002, 'Cultural correlates of youth suicide', Social Science & Medicine, vol. 55, pp. 1891–1904.

Egeland, JA & Sussex, JN 1985, 'Suicide and family loading for affective disorders', Journal of the American Medical Association, vol. 254, no. 7, pp. 915–918.

Ellenbogen, S & Gratton, F 2001, 'Do they suffer more? Reflections on research comparing suicide sufferers to other survivors', Suicide and Life-Threatening Behavior, vol. 31, no. 1, pp. 83–90.

Elliott-Farrelly, T 2004, 'Australian Aboriginal suicide: the need for an Aboriginal suicidology?' Australian e-Journal for the Advancement of Mental Health, vol. 3, no. 3, pp. 1–8.

Erikson, E 1963, Childhood and society, 2nd edn, W. W. Norton, New York.

Espelage, D, Aragon, S & Birkett, M 2008, 'Homophobic teasing, psychological outcomes, and sexual orientation among high school students: what influence do parents and schools have?' School Psychology Review, vol. 37, no. 2, pp. 202–216.

Feigelman. W 2005, 'Are adoptees at increased risk for attempting suicide?' Suicide and Life-Threatening Behavior, vol. 35, no. 2, pp. 206–216.

Feigelman, B & Feigelman, W 2008, 'Surviving after suicide loss: the healing potential of suicide survivor support groups', Illness, Crisis & Loss, vol. 16, no. 4, pp. 285–304.

Feigelman, W, Gorman, BS, Beal, KC & Jordan, JR 2008, 'Internet support groups for suicide survivors: a new mode for gaining bereavement assistance', Omega, vol. 57, no. 3, pp. 217–243.

Feigelman, W, Jordan, JR & Gorman, BS 2009, 'Personal growth after a suicide loss: cross-sectional findings suggest growth after loss may be associated with better mental health among survivors', Omega, vol. 59, no. 3, pp. 181–202.

Feigelman, W, Jordan, JR & Gorman, BS 2008–2009, 'How they died, time since loss, bereavement outcomes' Omega, vol. 58, no. 4, pp. 251–273.

Fergusson, DM, Beautrais, L & Horwood, LJ 2003, 'Vulnerability and resiliency to suicidal behaviors in young people', Psychological Medicine, vol. 33, pp. 61–73.

Forster, E & Murray, J 2007, 'Loss and grief', in M Barnes & J Rowe (eds.), Child, youth and family health: strengthening communities, Elsevier, Sydney, pp. 189–205.

Forward, D & Garlie, N 2003, 'Search of new meaning: adolescent bereavement after the sudden death of a sibling', Canadian Journal of School Psychology, vol. 18, no. 1/2, pp. 23–53.

Gaita, R 1998, Romulus, my father, The Text Publishing Company, Melbourne.

Gavin, M & Rogers, A 2006, 'Narratives of suicide in psychological autopsy: bringing lay knowledge back in', Journal of Mental Health, vol. 15, no. 2, pp. 135–144.

Ge, X & Conger, RD 1999, 'Adjustment problems and emerging personality characteristics from early to late adolescence', American Journal of Community Psychology, vol. 27, no. 3, pp. 429–459.

Gergen, M & Gergen, KJ 2003, Social construction: a reader, Sage Publications, Thousand Oaks.

Gilbert, K 2002, 'Taking a narrative approach to grief research: meaning in stories', Death Studies, vol. 26, pp. 223–239.

Goldney, R & Berman, L 1996, 'Postvention in schools: affective or effective?' Crisis, vol. 17, no. 3, pp. 98–99.

Goldney, RD & Fisher, LJ 2008, 'Have broad-based community education and professional education programs influenced mental health literacy and treatment seeking of those with major depression and suicidal ideation?' Suicide and Life-Threatening Behavior, vol. 38, no. 2, pp. 129–142.

Gottschalk, L & Newton, J 2009, 'Rural homophobia: not really gay', Gay & Lesbian Issues and Psychology Review, vol. 5, no. 3, pp. 153–159.

Gould, M & Kramer, RA 2001, 'Youth suicide prevention', Suicide and Life-Threatening Behavior, vol. 31 (Supplement, Spring 2001), pp. 6–31.

Gould, M, Shaffer, D, Fisher, P & Garfinkel, R 1998, 'Separation/divorce and child and adolescent completed suicide', Journal of the American Academy of Child and Adolescent Psychiatry, vol. 37, no. 2, pp. 155–162.

Grad, O, Clark, S, Dyregrov, K & Andriessen, K 2004, 'What helps and what hinders the process of surviving the suicide of somebody close?' Crisis, vol. 25, no. 3, pp. 134–139.

Grbich, C 1999, 'Qualitative research design', in V Minichiello, G Sullivan, K Greenwood & R Axford (eds.), Handbook for research methods in health sciences, Addison-Wesley, Frenchs Forrest, Sydney, pp. 123–146.

Groenhuizen, R 2006, Undiagnosed' up until now, Groenhuizen Family Trust, Burwood.

Groenhuizen, V 2006, 'Editor's note', in V Groenhuizen (ed.), 'Undiagnosed' up until now, Groenhuizen Family Trust, Croydon Hills, pp. 8–11.

Gutis, PS 7 July 1989, <http://www.nytimes.com/1989/07/07/nyregion/new-york-court-defines-family-to-include-homosexual-couples.html?pagewanted=all. http://www.invispress.com/law/lawmaking/braschi.html> downloaded 13-4-2010). Court widens definitions to gay couples living together. Times, New York, pp. A1, A13.

Hall-Lande, JA, Eisenberg, ME, Christenson, SL & Neumark-Sztainer, D 2007, 'Social isolation, psychological health, and protective factors in adolescence', Adolescence, vol. 42, no. 166, pp. 265–286.

Hammer, S 1991, By her own hand, Soho Press Inc., New York.

Hanssens, L 2008, ‘Clusters of suicide: the need for a comprehensive postvention response to sorrow in Indigenous communities in the Northern Territory’, Aboriginal & Islander Health Worker Journal, vol. 32, no. 2, pp. 25–33.

Hanssens, L & Hanssens, P 2007, ‘Research into the clustering effect of suicide within Indigenous communities, Northern Territory, Australia’, Aboriginal and Islander Health Worker Journal, vol. 31, no. 3, pp. 6–11.

Hastings, M, Northman, L & Tangney, J 2000, ‘Shame, guilt, and suicide’, in TE Joiner & MD Rudd (eds.), Suicide science: expanding the boundaries, Kluwer Academic, Boston, pp. 67–79.

Hawton, K & Simkin, S 2003, ‘Helping people bereaved by suicide: their needs may require special attention’, British Medical Journal, vol. 327 (26 July 2003), pp. 177–178.

Henry, C, Stephenson, A, Hanson, M & Hargett, W 1993, ‘Adolescent suicide and families: an ecological approach’, Adolescence, vol. 28, no. 110, pp. 291–308.

Hjelmeland, H & Knizek, B 2010, ‘Why we need qualitative research in suicidology’, Suicide and Life-Threatening Behavior, vol. 40, no. 1, pp. 74–80.

Hjern, A Lindblad, F & Bo, V 2002, ‘Suicide, psychiatric illness, and social maladjustment in intercountry adoptees in Sweden: a cohort study’, The Lancet, vol. 360, no. 9331, pp. 443–448.

Hoshmand, LT 2005, ‘Narratology, cultural psychology and counselling research’, Journal of Counselling Psychology, vol. 52, no. 2, pp. 178–186.

Joiner 2010, Myths about suicide, Harvard University Press, Cambridge, Massachusetts.

Joiner, T, Brown, JS & Wingate, LR 2005, ‘The psychology and neurobiology of suicidal behavior’, Annual Review of Psychology, vol. 56, 287–314.

Jordan, J 2001, ‘Is suicide bereavement different? A reassessment of the literature’, Suicide and Life-Threatening Behavior, vol. 31, no. 1, pp. 91–102.

Jordan, JR & McIntosh, JL 2011, ‘Suicide bereavement: why study survivors of suicide loss?’ in JR Jordan & JL McIntosh (eds.), Grief after suicide: understanding the consequences and caring for the survivors, Routledge, New York, pp. 3–19.

Kaslow, N & Aronson, S 2004, ‘Recommendation for family interventions following a suicide’, Profession Psychology: Research and Practice, vol. 35, no. 3, pp. 240–247.

Kincheloe, J & McLaren, P 2005, 'Rethinking Critical Theory and Qualitative Research', in NK Denzin & YS Lincoln (eds.), The Sage handbook of qualitative research, 3rd edn, Sage, Thousand Oaks, pp.328..

Koopmans, M 1995, ‘A case of family dysfunction and teenage suicide attempt: applicability of a family systems paradigm’, Adolescence, vol. 30, no. 117, pp. 87–93.

Kristjanson, L, Lobb, E, Aoun, S & Monterosso, L 2006, ‘Violent and traumatic death’, in A systematic review of the literature on complicated grief, WA Centre for Cancer and Palliative Care, Edith Cowan University, Churchlands, Western Australia, pp. 42–49.

Kubler-Ross, E 1973, On death and dying, Tavistock, London.

Kuramoto, S, Brent, D & Wilcox, H 2009, ‘The impact of parental suicide on child and adolescent offspring’, Suicide and Life-Threatening Behavior, vol. 39, no. 2, pp. 137–151.

Leonard, BE 2005, ‘The biochemistry of suicide’, Crisis, vol. 26, no. 4, pp. 152–155.

Lester, D 1997, ‘The role of shame in suicide’, Suicide and Life-Threatening Behavior, vol. 27, no. 4, pp. 352–361.

Levy, A & Wall, J 2000, ‘Children who have witnessed community homicide: incorporating risk and resilience in clinical work’, Families in Society: The Journal of Community Human Services, vol. 81, no. 4, pp. 402–411.

Lietz, CA 2007a, ‘Uncovering stories of family resilience: a mixed methods study of resilient families, Part 1’, Families in Society, vol. 87 no. 4 pp. 575-582.

Lietz, CA 2007b, ‘Uncovering stories of family resilience: a mixed methods study of resilient families, Part 2’, Families in Society, vol. 88 no. 1, pp. 147–155.

Linn-Gust, M 2001, Do they have bad days in heaven? Surviving the suicide loss of a sibling, Chellehead Works, Albuquerque.

Linn-Gust, M 2007, Do they have bad days in heaven? Surviving the suicide loss of a sibling, Living Hope: Inaugural Australian Postvention Conference, University of New South Wales, Sydney.

Llewellyn, G, Sullivan, G & Minichiello, V 1999, ‘Sampling in qualitative research’, in G Sullivan, V Minichiello, K Greenwood & R Axford (eds.), Handbook for research methods in health sciences, Addison-Wesley, Frenchs Forest, Sydney.

Malterud, K 2001, ‘Qualitative research: standards, challenges, and guidelines’, The Lancet, vol. 358 (August 11), pp. 483–488.

Mandleco, BL & Peery, CJ 2000, ‘An organizational framework for conceptualizing resilience in children’, Journal of Child and Adolescent Psychiatric Nursing, vol. 13, no. 3, pp. 99–111.

Mann. J 2005, ‘What does brain imaging tell us about the predisposition to suicidal behavior?’ Crisis, vol. 26, no. 3, pp. 101–103.

Mann, J & Currier, D 2007, ‘Prevention of suicide’, Psychiatric Annals, vol. 37, no. 5, pp. 331–339.

Maple. M 2005, Parental portraits of suicide: narrating the loss of a young child, University of New England, Armidale. <https://e-publications.une.edu.au/vital/access/manager/Repository/une:3248>.

Maple, M, Edwards, H, Plummer, D & Minichiello, V 2010, ‘Silenced voices: hearing the stories of parents bereaved through the suicide

of a young adult child', Health and Social Care in the Community, vol. 18, no. 3, pp. 241–248.

Maple, M, Plummer, D, Edwards, H & Minichiello, V 2007, 'The effects of preparedness for suicide following the death of a young adult child', Suicide and Life-Threatening Behavior, vol. 37, no. 2, pp. 127–134.

Maris, R, Berman, A & Silverman, M 2000, 'The biology of suicide', in Comprehensive textbook of suicidology, The Guilford Press, New York, pp. 376–406.

Martin, CD 2006, 'Ernest Hemingway: a psychological autopsy of a suicide', Psychiatry, vol. 4 (Winter), pp. 351–361.

McGlothlin, J 2006, 'Assessing perturbation and suicide in families', The Family Journal: Counseling and Therapy for Couples and Families, vol. 14, no. 2, pp. 129–134.

McGoldrick, M 1993, 'Ethnicity, cultural diversity, and normality', in F Walsh (ed.), Normal family process, Guilford Press, New York.

McGoldrick. M 2011, 'Exploring the ripples of suicide in families through time', in J Rogers, K Benson & N Kerr (eds.), Suicide 2010: Proceedings of the 43rd Annual Conference of the American Association of Suicidology: Families, Community Systems and Suicide, American Association of Suicidology, Orlando, Florida, p. 23.

McIntosh. J 1996, 'Survivors of suicide: a comparative bibliography update, 1986–1995', Omega, vol. 33, no. 2, pp. 147–175.

McIntosh. J 1999, 'Research on survivors of suicide', in M Stimming & M Stimming (eds.), Before their time: adult children's experiences of parental suicide, Temple University Press, Philadelphia, pp. 157–180.

McLeod, J 1997, Narrative and psychotherapy, Sage, London.

McMenamy, J, Jordan, J & Mitchell, A 2008, 'What do suicide survivors tell us they need? Results of a pilot study', Suicide and Life-Threatening Behavior, vol. 38, no. 4, pp. 375–389.

Minichiello V, Aroni R, Hayes TN, 2008, In-depth Interviewing: Principles, Techniques, Analysis, Pearson Education, SydneyMinuchin, S & Fishman, H 1981, Family therapy techniques, Harvard University Press, Cambridge MA.

Mitchell, A, Gale, D, Garand, L & Wesner, S 2003, 'The use of narrative data to inform the psychotherapeutic group process with suicide survivors', Issues in Mental Health Nursing, vol. 24, pp. 91–106.

Mitchell, A, Kim, Y, Prigerson, H & Mortimer-Stephens, M 2004, 'Complicated grief in survivors of suicide', Crisis, vol. 25, no. 1, pp. 12–18.

Mitchell, A, Kim, Y, Prigerson, H & Mortimer, M 2005, 'Complicated grief and suicide ideation in adult survivors of suicide', Suicide and Life-Threatening Behavior, vol. 35, no. 5, pp. 498–506.

Mitchell, AM, Wesner, S, Brownson, L, et al. 2006, 'Effective communication with bereaved child survivors of suicide', Journal of

Child and Adolescent Psychiatric Nursing, vol. 19, no. 3, pp. 130–136.
Murray, J & Murray, M 1989, Personal grieving, Chi Rho Books, Adelaide.
Murray, J 2001, 'To honour their gift', in G McLean (ed.), Loss and grief: our stories, Rose Education, Narellan, pp. 9–15.
Murray, J 2004, 'Editorial', Grief matters, vol. 7, no. 2, p. 27.
Murray, J 2005, 'Children, young people and mental health: confusion in the ranks, confusion among the commanders', Australian Journal of Guidance and Counselling, vol. 15, no. 2, pp. 182–194.
Myers, M & Fine, C 2007, 'Touched by suicide: bridging the perspectives of survivors and clinicians', Suicide and Life-Threatening Behavior, vol. 37, no. 2, pp. 119–126.
Nadeau, JW 2003, 'Family construction of meaning', in RA Neimeyer (ed.), Meaning reconstruction and the experience of loss, American Psychological Association, Washington, pp. 95–112.
Neimeyer, R & Levitt, H 2000, 'What's narrative got to do with it? Construction and coherence in accounts of loss', in J Harvey & E Miller (eds.), Loss and trauma: general and close relationship perspectives, Routledge, Philadelphia, pp. 401–412.
Neimeyer, RA 2001, 'Reauthoring life narratives: grief therapy as meaning construction', Israel Journal of Psychiatry and Relational Science, vol. 38, no. 3–4, pp. 171–183.
Neimeyer, R, Prigerson, H & Davies, B 2002, 'Mourning and meaning', American Behavior Scientist, vol. 46, no. 2, pp. 235–251.
Nichols, M & Schwartz, R 1998, Family therapy: concepts and methods, 4th edn, Allyn & Bacon, Needham Heights.
Owens, C, Lambert, H, Lloyd, K & Donovan, J 2008, 'Tales of biographical disintegration: how parents make sense of their sons' suicides', Sociology of Health & Illness, vol. 30, no. 2, pp. 237–254.
Parkes, CM 1971. 'Psychosocial transitions: A field for study'. Social Science and Medicine, 5, pp.101–115.
Paulson, BL & Worth, M 2002, 'Counselling for suicide: client perspectives', Journal of Counseling & Development, vol. 80 (Winter), pp. 86–93.
Pfeffer, CR, Jiang, H, Kakuma, T, et al. 2002, 'Group intervention for children bereaved by the suicide of a relative', Journal of the American Academy of Child and Adolescent Psychiatry, vol. 41, no. 5, pp. 505–513.
Peluso, PR 2002, 'Counselling families affected by suicide: an interview with Iris Bolton', The Family Journal: Counselling and Therapy for Couples and Families, vol. 10, no. 3, pp. 351–357.
Plutchik, R 2000, 'Aggression, violence and suicide', in R Maris, A Berman & M Silverman (eds.), Comprehensive textbook of suicidology, The Guilford Press, New York, pp. 407–423.
Polkinghorne, D 1995, 'Narrative configuration in qualitative analysis', Qualitative Studies in Education, vol. 8, no. 1, pp. 5–23.
Pollard, R 2009, Revealed: Australia's suicide epidemic. Sydney Morning Herald. 21-8-2009.

Portes, PR, Sandhu, DS & Longwell-Grice, R 2002, 'Understanding adolescent suicide: a psychosocial interpretation of developmental and contextual factors', Adolescence, vol. 37, no. 148, pp. 807–814.

Pouliot, L & De Leo, D 2006, 'Critical issues in psychological autopsy studies', Suicide and Life-Threatening Behavior, vol. 36, no. 5, pp. 491–510.

Prue 2006, 'My mum Elaine', in B Woolley & P Meemeduma (eds.), If only... Personal stories of loss through suicide, The University of Western Australia, Crawley, pp. 161–172.

Rando, TA 1992–1993, 'The increasing prevalence of complicated mourning: the onslaught is just beginning', Omega, vol. 26, no. 1, pp. 43–59.

Ratnarajah, D 2005, The construction of meaning following parental suicide, Unpublished Master of Counselling with Honours, University of New England, Armidale.

Ratnarajah, D & Schofield, M 2006, Suicides, sagas and sequels, Queensland Suicide and Self-Harm Prevention Conference 2006. Brisbane.

Ratnarajah, D & Schofield, M 2008, 'Survivors' narratives of the impact of parental suicide', Suicide and Life-Threatening Behavior, vol. 38, no. 5, pp. 618–630.

Ray, G 2004, 'Sociocultural contexts and suicide', Counselling Australia, vol. 4, no. 3, pp. 77–83.

Reber, AS 1995, The Penguin dictionary of psychology, 2nd edn, Penguin Books, London.

Repetti, R, Taylor, S & Seeman, T 2002, 'Risky families: social environments and the mental and physical health of offspring', Psychological Bulletin, vol. 128, no. 2, pp. 330–366.

Rice, P & Ezzy, D 1999, 'Narrative analysis and life history', in Qualitative research methods: a health focus, Oxford University Press, Oxford.

Riessman, CK 1993, Narrative analysis, Sage Publications, Inc., Newbury Park.

Riessman, CK 2008, 'Narrative Methods for the Human Sciences, Sage Publications, Inc., Los Angeles

Roy, A & Segal, NL 2001, 'Suicide behavior in twins: a replication', Journal of Affective Disorders, vol. 66, pp. 71–74.

Roy, A, Segal, NL & Sarchiapone, M 1995, 'Attempted suicide among living co-twins of twin suicide victims', The American Journal of Psychiatry, vol. 152, no. 7, pp. 1075–1076.

Runeson, B & Asberg, M 2003, 'Family history of suicide among suicide victims', American Journal of Psychiatry, vol. 160, no. 8, pp. 1525–1526.

Rynearson, EK 2001, Retelling violent death, Routledge, New York.

Sands, D 2008, A study of suicide grief: meaning making and the griever's relational world. University of Technology, Sydney. <http://epress.lib.uts.edu.au/dspace/bitstream/handle/2100/777/01front.pdf?sequence=1>.

Satir, V 1988, The new peoplemaking, Science and Behavior Books, Inc., Mountain View, California.

Schwandt, TA 1994, 'Constructivist, interpretivist approaches to human inquiry', in NK Denzin & YS Lincoln (eds.), Handbook of qualitative research, Sage Publications, Thousand Oaks, pp. 118–137.

Schore, AN 2003, Affect dysregulation and disorders of the self, Norton, New York.

Seguin, M, Lesage, A & Kiely, M 1995, 'History of early loss among a group of suicide survivors', Crisis, vol. 16, no. 3, pp. 121–125.

Shneidman, ES 1972, 'Foreward', in A Cain (ed.), Survivors of suicide, Charles C. Thomas, Springfield, IL (p. ix).

Siegel, D 1999, The developing mind: how relationships and the brain interact to shape who we are, The Guilford Press, New York.

Silverman, P, Nickman, S & Wordern, J 1992, 'Detachment revisited: the child's reconstruction of a dead parent', American Journal of Orthopsychiatric, vol. 62, no. 4, pp. 494–503.

Silverman, PR & Worden, JW 1992, 'Children's reactions in the early months after the death of a parent', American Journal of Orthopsychiatric, vol. 62, no. 1, pp. 93–104.

Smith, B & Sparkes, A 2008, Contrasting perspectives on narrating selves and identities: an invitation to dialogue. Qualitative Research, vol. 8, no. 1, pp. 5–35.

Smith, B & Sparkes, AC 2006, 'Narrative inquiry in psychology: exploring tensions within', Qualitative Research in Psychology, vol. 3, pp. 169–192.

Stacey, J 1991, 'Introduction', in Brave new families: stories of domestic upheaval in late twentieth century America, Basic Books, New York, p. 4.

Statham, D, Heath, A, Madden, P, et al. 1998, 'Suicidal behaviour: an epidemiological and genetic study', Psychological Medicine, vol. 28, pp. 839–855.

Steele, MM & Doey, T 2007, 'Suicidal behaviour in children and adolescents. Part 1: etiology and risk factors', Canadian Journal of Psychiatry, vol. 52, Supplement 1, no. 6, pp. 21S–33S.

Stimming, M & Stimming, M 1999, Before their time: adult children's experiences of parental suicide, Temple University Press, Philadelphia.

Stoppelbein, L & Greening, L 2000, 'Posttraumatic stress symptoms in paternally bereaved children and adolescents', Journal of the American Academy of Child and Adolescent Psychiatry, vol. 39, no. 9, pp. 1112–1123.

Straus, M 2000, 'Corporal punishment of children and adult depression and suicidal ideation', in J McCord (ed.), Coecercion and punishment in long term perspective, Cambridge University Press, New York, pp. 59–77.

Straus, M 2001, 'Depression and suicide', in Beating the devil out of them: corporal punishment in American families and its effects on

children, 2nd edn, Transaction Publishers, New Brunswick, NJ, pp. 67–79.
Straus, M & Gelles, RJ 1986, 'Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys', Journal of Marriage and the Family, vol. 48, pp. 465–480.
Straus, M & Paschall, MJ 2009, 'The effects of corporal punishment: corporal punishment by mothers and development of children's cognitive ability: a longitudinal study of two nationally representative age cohorts', Journal of Aggression, Maltreatment and Trauma, vol. 18, pp. 459–483.
Stroebe, M, Gergen, M, Gergen, K & Stroebe, W 1992, 'Broken hearts or broken bonds', in D Klass, PR Silverman & SL Nickman (eds.), Continuing: new understandings of grief, Taylor & Francis, Briston, pp. 31–44.
Stuhlmiller, C 2001, 'Narrative methods in qualitative research: potential for therapeutic transformation', in K Gilbert, The emotional nature of qualitative research, CRC Press, Washington.
Suicide Prevention Australia 2010, Position statement: crisis response and the role of the emergency services and first responders to suicide and suicide attempts, Suicide Prevention Australia, Leichhardt, NSW, pp. 1–24.
Tatz, C 2005, Aboriginal suicide is different: a portrait of life and self-destruction, 2nd edn, Aboriginal Studies Press, Canberra.
Tim 2006, 'My mum, my rock', in B Woolley & P Meemeduma (eds.), If only...Personal stories of loss through suicide, The University of Western Australia Press, Crawley, pp. 148–160..
Tolstoy, LN 1877, Anna Karenina [electronic resource], Joshua James Press, Claremont.
van Heeringen, C & Vincke, J 2000, 'Suicidal acts and ideation in homosexual and bisexual young people: a study of prevalence and risk factors', Society of Psychiatry and Psychiatric Epidemiology, vol. 35, pp. 494–499.
Vandecreek, L & Mottram, K 2009, 'The religious life during suicide bereavement: a description', Death Studies, vol. 33, pp. 741–761.
Vinnerljung, B, Hjern, A & Lindblad, F 2006, 'Suicide attempts and severe psychiatric morbidity among former child welfare clients—a national cohort study', Journal of Child Psychology and Psychiatry, vol. 47, no. 7, pp. 723–733.
Voracek, M 2006, 'Ancestry, genes, and suicide: a test of the Finno-Ugrian suicide hypothesis in the United States', Perceptual and Motor Skills, vol. 103, no. 2, pp. 543–550.
Voracek, M, Vintila, M & Muranyi, D 2007, 'A further test of the Finno-Ugrian suicide hypothesis: correspondence of country suicide rates in Romania and population proportion of ethnic Hungarians', Perceptual and Motor Skills, vol. 105, no. 4, pp. 1209–1222.
Wagner, BM, Silverman, MAC & Martin, CE 2003, 'Family factors in youth suicidal behaviors', The American Behavioral Scientist, vol. 46, no. 9, pp. 1171–1191.

Walsh, F 1998, Strengthening family resilience, The Guilford Press, New York.
Walsh, F 2006, Strengthening family resilience, 2nd edn, The Guilford Press, New York.
Walsh, F & McGoldrick M 1991, Living beyond loss: death in the family, W. W. Norton & Company, New York.
Watford, M 2008, 'Bereavement of spousal suicide: a reflexive self-exploration', Qualitative Inquiry, vol. 14, no. 3, pp. 335–359.
Webster, L & Mertova, P 2007, Using narrative inquiry as a research method, Routledge, New York.
Wolin, S & Wolin, S 1993, 'The resilient self: How survivors of troubled families rise above adversity', Villard, New York.
Wood, FB 2008, 'Grief: helping young children cope', Young Children, vol. 63 no. 5, p. 28.
Woolley, B & Meemeduma, P (eds.) 2006, If only...Personal stories of loss through suicide, University of Western Australia Press, Crawley.
Worden, JW 1999, Grief counselling and grief therapy: a handbook for the mental health practitioner, 2nd edn, Tavistock/Routledge, New York.

Appendices

Appendix 1A

Media release

Advertisement and media release for the research study ‘Sagas, suicides and sequels’

Dorothy Ratnarajah, a doctoral researcher from the School of Health at The University of New England wishes to speak with adults who have lost an immediate family member through suicide as part of a research project that aims to increase understanding of the familial experiences of suicide.

Ms Ratnarajah hopes that by listening to the stories of those bereaved by suicide, understanding can be gained of how this has had an impact on their own lives and the lives of their family members. Little research has been undertaken to date into understanding the families and the family systems in which a suicide has occurred.

By listening to the stories of those who have been most intimately involved in the suicide death and its aftermath, more appropriate intervention strategies can be developed so that those bereaved by suicide can be better supported.

All participants and any information they provide to the research project would be treated confidentially.

For further information, please phone Dorothy

Ratnarajah at the Hervey Bay Neighbourhood Centre, 07

4124 3544 or at Wide Bay Women's Health Centre, 07 4125

5788 or email dratnarajah@bigpond.com.ppendix 1B

Media release in Survivors of Suicide Bereavement

Support Association Inc. (SOSBSA) Newsletter

January/February 2007

Information for a Research Project titled
Sagas, Suicides and Sequels

This research is being undertaken by a Doctoral student researcher: Dorothy Ratnarajah from the University of New England.

This study aims to explore the experiences of those who have lost a close or immediate family member through suicide. Participants who agree to be part of this study must now be 18 years of age or older. I'm interested to explore how the participants made meaning of the loss of their family member and to understand the family system in which the suicide occurred. If the participant agrees to take part in this study, this will involve being interviewed by me at a time and location place of their choice (for example, their home, my office at the Wide Bay Women's Health Centre or the Hervey Bay Neighbourhood Centre or at another office where their privacy can be assured). During the interviews I will ask the participant to talk about being the family member of someone who died by suicide. They will be asked to speak of their family and the relationships within their family. A participant will have the freedom to introduce any information that they would wish to share or that they believe would assist the study. The length and number of interviews will depend on the participant's story. It is envisaged that two interviews will take place for about 60–90 minutes each. With their permission the interviews will be tape-recorded on audio tape.

A participant is under no obligation to participate in this project. All information that I gather from participants (including audio tapes) will be coded to ensure that only I and the supervisors know their identity. After a period of five (5) years this data will be destroyed, in keeping with the policies of the university.

Since I will be asking participants to speak about very sensitive events in their lives I will take every care to support them in telling their story. If subsequent to participation in the study, any participant wishes to access counselling, this will be made available to them with a counsellor other than me. In the event that they wish to contact a telephone crisis counselling service the telephone number of Lifeline, 131114 will be provided. I will be assuring all participants that they may withdraw their consent to be a participant in this study at any time, for any reason, without penalty of any kind. If this happens, any information that has been collected from a participant will be destroyed if they so wish.

I will be pleased to answer any questions or concerns that any participant or referring counsellor may have. Any questions concerning the conduct of this project titled 'Suicides, family systems and resonance' can be made to me or to my supervisors whose details are given below.

If you wish to take part in this research, please contact:
Dorothy Ratnarajah
(h) 07 41284358
(w) 07 41255788
Email: dratnarajah@bigpond.com

RESEARCH TEAM CONTACT DETAILS

Doctoral Researcher: Dorothy Ratnarajah

Phone (w) 07 4125 5788 (h) 07 4128 4358

Email: dratnarajah@bigpond.com

Supervisors:
Professor Victor Minichiello
Position: Dean of School of Health
Telephone 02 67733862
Email vminichi@pobox.une.edu.au

Dr. Myfanwy Maple
Position: Senior Lecturer School of Health
Telephone 02 67733661
Email mmaple@pobox.une.edu.au

Appendix 2A

Information for other professionals

School of Health
Armidale, NSW 2351,
Australia

Date

Counsellor's Information Sheet for Research Project

'Sagas, suicides and sequels'

This study aims to explore the experiences of those who have lost a close or immediate family member through suicide. Participants who agree to be part of this study must now be 18 years of age or older. I'm interested to explore how the participants made meaning of the loss of their family member and to understand the family system in which the suicide occurred. If the participant agrees to take part in this study, this will involve being interviewed by me at a time and location place of their choice (for example, their home, my office at the Wide Bay Women's Health Centre or the Hervey Bay Neighbourhood Centre or at another office where their privacy can be assured). During the interviews I will ask the participant to talk about being the family member of someone who died by suicide. They will be asked to speak of their family and the relationships within their family. A participant will have the freedom to introduce any information that they would wish to share or that they believe would assist the study. The length and number of interviews will depend on the participant's story. It is envisaged that two interviews will take place for about 60–90 minutes each. With their permission the interviews will be tape-recorded on audio tape.

A participant is under no obligation to participate in this project. All information that I gather from participants (including audio tapes) will be coded to ensure that only I and the supervisors know their identity. After a period of five (5) years this data will be destroyed, in keeping with the policies of the university.

Since I will be asking participants to speak about very sensitive events in their lives I will take every care to support them in telling their story. If subsequent to participation in the study, any participant wishes to access counselling, this will be made available to them with a counsellor other than me. In the event that they wish to contact a telephone crisis counselling service the telephone number of Lifeline, 131114 will be provided. I will be assuring all participants that they may withdraw their consent to be a participant in this study at any time, for any reason, without penalty of any kind. If this happens, any information that has been collected from a participant will be destroyed if they so wish.

I will be pleased to answer any questions or concerns that any participant or referring counsellor may have. Any questions concerning the conduct of this project titled 'Suicides, family systems and resonance' can be made to Dorothy Ratnarajah, doctoral student, School of Health, University of New England, Armidale, telephone, (02) 6773 3647, or (07) 41284358, or to my supervisors whose details are given below.

Yours truly,

Dorothy Ratnarajah

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No.HE06/159)

Should you have any complaints concerning the manner in which the research is conducted, please contact the Research Ethics Officer at the following address:

Research Services, University of New England

Armidale, NSW 2351

Telephone (02) 6773 3543; *Email:* *Ethics@metz.une.edu.au*

RESEARCH TEAM CONTACT DETAILS

Doctoral Researcher: Dorothy Ratnarajah
Phone (w) 07 4125 5788 (h) 07 4128 4358
Email: dratnarajah@bigpond.com
Supervisors:
Professor Victor Minichiello
Position: Dean of School of Health
Telephone 02 67733862
Email vminichi@pobox.une.edu.au

Dr. Myfanwy Maple
Position: Senior Lecturer School of Health
Telephone 02 67733661
Email mmaple@pobox.une.edu.au

Appendix 2B

Letter to other professionals

School of Health
Armidale, NSW 2351,
Australia

(Professional contact details)

(Postal address)

Re: Research Project: Sagas, Suicides, and Sequels

Dear (Name)

Thank you for discussing with me the research project 'Sagas, Suicides and Sequels' when we spoke on the telephone on (date). This project forms part of my doctoral research. As mentioned in our telephone conversation, I have enclosed the 'Information for Participants' sheet which provides information to the potential participant regarding the project and specific information detailing what their participation would include. I have also included a sample cover letter that you could send with my information package.

Participants who fit the inclusion criteria are those who:

- Lost an immediate family member through suicide
- Are over 18 years of age at the time of participation in the study

I would appreciate if you would mail the information about the project to potential participants and ask them to contact me directly about the project. My contact details appear on the Information Sheet. I am happy to return STD calls to reduce the cost to the participants and potential participants.

If you, or any potential participant, wishes to have any further information regarding the study I would encourage you to contact me on (07) 4235 5788 Mon, Tue, Thurs or (07) 4128 4358 other days including weekends.

Thank you for your support of this project.

Dorothy Ratnarajah
Doctoral Student.
School of Health, UNE
Email: dratnarajah@bigpond.com

Supervisors:

Name(s): Professor Victor Minichiello

Position: Dean of School of Health

Telephone 02 67733862

Email vminichi@pobox.une.edu.au

Dr. Myfanwy Maple

Position: Senior Lecturer School of Health

Telephone 02 67733661

Email mmaple@pobox.une.edu.au

Appendix 3

Information sheet for participants

School of Health
Armidale, NSW 2351,
Australia

Information Sheet for research project

'Sagas, Suicides and Sequels'

This study aims to explore the experiences of those who lost a first-degree relative through suicide. Participants who agree to be part of this study must be 18 years of age or older. I'm interested to explore how you made meaning of the loss of your family member, what you understood of your relative's death and how this has affected your outlook on your life as it has evolved. If you agree to take part in this study, this will involve being interviewed by me at a time and location place of your choice (for example, your home, my office at the Hervey Bay Neighbourhood Centre, or the Wide Bay Women's Health Centre or at another office where your privacy can be assured). During the interviews I will ask you to talk about being the family member of someone who died by suicide. You will be asked to tell how you heard of this loss, if reasons were given and if you sought information or support and from whom to help you deal with this loss. I also wish to hear about your family, your own generation, the previous generation/s, subsequent family members and the interactions and nature of the relationships within your family. You will have the freedom to introduce any information that you would wish to share or that you believe would assist the study. The length and number of interviews will depend on your story. It is envisaged that two interviews will take place for about 60–90 minutes each. With your permission the interviews will be tape-recorded on audio tape.

You are under no obligation to participate in this project. All information that I gather from you (including audio tapes) will be coded to ensure that only I and the supervisors know your identity. After a period of five (5) years this data will be destroyed, in keeping with the policies of the university.

Since I will be asking you to speak about very sensitive events in your life I will take every care to support you in telling your story. If subsequent to your participation in the study, you wish to access counselling, this will be made available to you with a counsellor other than me. In the event that you wish to contact a telephone crisis counselling service the telephone number is 131114. I would like to assure you that you may withdraw your consent to be a participant in this study at any time and for any reason. If this happens, any information that has been collected from you will be destroyed if you so wish.

I will be pleased to answer any questions or concerns that you may have. Any questions concerning the conduct of this project titled 'Suicide, family systems and resonance' can be made to Dorothy Ratnarajah, Doctoral Student, School of Health, University of New England, Armidale, telephone, (02) 6773 3647, or (07) 41284358, or to my supervisor whose details are given below.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE06/159 Valid to 31/10/2009)

Should you have any complaints concerning the manner in which the research is conducted, please contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351
Telephone (02) 6773 3543
Email: Ethics@metz.une.edu.au

RESEARCH TEAM CONTACT DETAILS

Doctoral student researcher: Dorothy Ratnarajah

Phone (w) 07 4125 5788 (h) 07 4128 4358

Email: dratnarajah@bigpond.com

Supervisors:

Professor Victor Minichiello
Position: Dean of School of Health
Telephone 02 67733862
Email vminichi@pobox.une.edu.au

Dr. Myfanwy Maple
Position: Senior Lecturer School of Health
Telephone 02 67733661
Email mmaple@pobox.une.edu.au

Appendix 4A

Consent form

School of Health
Armidale, NSW 2351,
Australia

PARTICIPANT'S COPY

Consent form for participants involved in the research project

'Sagas, Suicides and Sequels'

I, ……………………………have read the information contained in the Information Sheet attached, and have had any queries satisfactorily answered. By signing this consent form, I am agreeing to be interviewed by the researcher and understand that information gathered will be published appropriately. I understand that all information provided by me will be coded so that I remain anonymous to all but the researcher. I understand that I may withdraw my participation at any time without providing a reason. If I choose to do this, I understand that all information gathered about me will be destroyed and not used in any manner. I am 18 years of age or older.

Do you consent to the interview/s being tape-recorded?

I AGREE / DO NOT AGREE to have the interviews tape-recorded (please circle).

…………………………	………………………
Signed by participant	Date
…………………………	………………………
Witnessed by researcher	Date

Appendix 4B

Consent form

School of Health
Armidale, NSW 2351,
Australia

RESEARCHER'S COPY

Consent form for participants involved in the research project

'Sagas, Suicides and Sequels'

I, ……………………………have read the information contained in the Information Sheet attached, and have had any queries satisfactorily answered. By signing this consent form, I am agreeing to be interviewed by the researcher and understand that information gathered will be published appropriately. I understand that all information provided by me will be coded so that I remain anonymous to all but the researcher. I understand that I may withdraw my participation at any time without providing a reason. If I choose to do this, I understand that all information gathered about me will be destroyed and not used in any manner. I am 18 years of age or older.

Do you consent to the interview/s being tape-recorded?

I AGREE / DO NOT AGREE to have the interviews tape-recorded (please circle).

………………………… ………………………

Signed by participant Date

………………………… ………………………

Witnessed by researcher Date

Appendix 5A

Interview Guide for Research Questions

Research project: 'Sagas, suicides and sequels'

Thank you for volunteering for this research project and for agreeing for the interview to be audio recorded. I have noted that you have signed the consent form agreeing both to the interview and that it be recorded.

Introduction

:

I really appreciate your willingness to be a participant in this research project and I am aware that the questions I will ask you may be sensitive. So before we commence, are there any questions you have for me? Are you comfortable here? Do you have any time restraints that we need to be aware of? If during the time we are together today, you need a break, please let me know.

Topic area: The circumstances of your family member's suicide.

The purpose is to ask the participant about their family member's suicide.

- **Can you tell me about your family member's suicide?**

Topic area: The Family system.

The purpose is to ask about family members and the family system and to gather enough information to be able to construct a genogram.

- **Can you tell me about your family? I would like to be able to understand how you experienced your family, including who are the members of your family. It would be very beneficial if you could tell me about previous generations, even if this information is what has been told to you by your**

parents and other family members. I would also like to have described to me later generations and especially, how members of the family related to one another.

Closing remarks:

Thank you for participating in this research study and allowing your family story to be heard and recorded. You have my contact details on the Information Sheet. I have also given you the Lifeline telephone number should you wish to speak to another counsellor about issues that may have arisen for you in this interview.

Appendix 5B

Interview Schedule

Sagas, suicides and sequels

Interview Schedule— Sagas, **Suicides and Sequels**
Introduction

(Tape recorder off)

After introductions, the participant will be informed about the study

Interviewer:
The purpose of this interview is to explore your experiences which may have impacted on your perceptions of self, how you see and feel about yourself and your family, being a family member of a person who has died by suicide.

Then the participants will be invited to ask any questions they have. After these have been answered, the participant will be told that the tape recorder is being switched on.

(Tape recorder on)

Interviewer: The tape recorder is now running.
Now I am going to ask you some questions about your willingness to take part in this interview, and then, if you agree to take part. We'll begin the interview.

- Do you understand that you are being taped, and that the information on this tape recording will be used for research which may be published, and that if publication does occur, your name will not be used?
- Do you agree that you have read the letter which invited you to participate in this research, that you understand the nature of this research, and that all of your questions about the research have been asked and been answered?
- Do you understand that, if you tell me about an illegal act or specific incidence of violence in such a way that an offender can be identified, I may be obliged to report this to the authorities?
- Do you understand that you are free to withdraw from the research at any time, which includes your right to stop or pause this interview?
- Do you have any questions before we begin the interview?

Interview

The questions to be asked will be those previously approved on the Ethics Committee application—*Approval Number HE06/159 Valid to 31/10/2009*

After the questions on the interview guide have been explored:

That finished the interview. How are you feeling after talking about these issues?

Is there anything you would like to add?

Ending the interview

The participant will be thanked, and asked if she or he has any questions.

Any participants who have become upset or uncomfortable will be reminded of the Lifeline telephone number, and of the availability of counselling through Lifeline.

Appendix 6

Letter of appreciation for participants

School of Health
Armidale, NSW 2351,
Australia

6 Corfield Street
Point Vernon, Qld 4655
07 4128 4358
dratnarajah@bigpond,.com

5th March, 2007

Name and address of participant

Dear participant,

Here is the transcript of the interview. Before you begin to read it, please be aware that you may find that it is distressing for you to read in print your own story. So please do not read it unless you have support there with you.

I have also sent to you, as promised, the last 22 pages of my previous thesis where I list my recommendations for support for the families bereaved by suicide.

The transcript of your interview is sent back to the participants for two reasons, the first is so that you can check it, if you wish to read it, to make sure it is correct, that there haven't been errors made in the transcribing of the recording. But the more important reason it is sent back is because it is your story, and you may want to keep it for your children and grandchildren to read many years in the future.

You will notice that each segment of conversation is numbered in the left hand column. If you find anything that you would like changed, please drop me a line, just indicating what line and how you want it changed. As you will see, you are referred to as 'Synonym' all the way through the document and you may like to think about changing the names of your mother and Aunts. Just tell me what names to use in substitution and I will change them.

Thank you again for contributing this story, as I said to you over the telephone, that it has much of interest and is a story rich in information.
Warm RegardsDorothy Ratnarajah

Appendix 7

Family history of abuse suffered

Table 7.1

Family history of abuse suffered by deceased family member or by participant

Participant	Victim of abuse (if not participant)	Reported abuse or emotional pain
Lyn	Husband Danny Lyn	Danny—adopted as a baby—no information about natural parents. Shaming and put-downs by adoptive father. Lyn—harassment and verbal abuse after Danny's death by father-in-law. Lyn, sister verbal abuse after Danny's death.
Janelle		Janelle's husband Gary was planning to kill her prior to his suicide. Janelle blamed by mother-in-law for Gary's suicide.
Emma	Husband Arun	Arun abandoned by his natural father, placed in neglecting boarding schools in Asia, sent back to Australia to relatives who were strangers for schooling, racial discrimination.
Darryl		Mother died when Darryl was 6 years old. Step-mother *'wicked step-mother from hell'*.
Jerome	Partner Sean	Adopted as a baby—no information about natural parents. Shaming at school because of same-sex orientation.
Wilson	Daughter Holly	Sexual abuse by mother's boyfriend. Exposure to drug culture in mother's home. Access to father denied by mother through much of Holly's childhood.
Delma		Extensive domestic violence suffered at the hands of alcoholic husband.
Angie	Son, Joshua	Abandoned by natural father. Verbal abuse and victimisation at school because of appearance. Negative experiences with police because of behaviour caused through mental illness.
Olivia	Son, Chris	Physical and suspected sexual abuse by older boys when Chris was a child. Abandonment by father.
Hazel	Son, Warren	Sexually abused by priest.

	Hazel	Hazel separated from parents in childhood to be raised by relatives. Hazel's first marriage was to an '*alcoholic wife-beater'*—Warren's father, who then abandoned Hazel and Warren. Hazel suspects that Warren's father sexually abused Warren when a teenager. Hazel's son separated from Hazel by Hazel's mother.
Laura		Laura's aunt verbally abused Laura and refused to allow Laura contact with her mother.
Kim	Kim's mother	Kim's mother suffered in her childhood from a mentally ill, uncaring mother. Kim's mother's mental illness. Kim at age 22, the prime carer.
May		May carer of young siblings because of mother's illness and disability.
Delia	Delia and younger brother Delia's mother	Mother who was cold, uncommunicative, controlling, and '*could be very cruel'*. She was a member of Jehovah's Witness Church. Delia and brother abused by members of the Jehovah's Witness Church after father's suicide and made to destroy his belongings. Told that their father would go to hell. Delia's mother was raised in a very violent home and '*had a hideous upbringing'*.
Monica	Monica and siblings	Mother was rigid and had no connection with children. Monica believes her brothers suffered abuse in their Catholic schools.
Elizabeth	Elizabeth and sister Roberta	Severe childhood physical abuse by father. Father's jailing resulted in children being placed in orphanage. Deprivation. Elizabeth and Roberta both suffered domestic violence when married.
Sally	Sally and her two brothers	Authoritarian, shaming and physically punishing father.
Philip	Mother-in-law, Delma	Severe domestic violence by alcoholic husband.

Appendix 8

Relative who died by suicide: method and location**Table 8.2**

Relative who died by suicide: method and location

Participant Age of participant at interview	Relative who died by suicide Age at death	Method of suicide
Lyn 20s	Husband Danny 30s	Hanging in a regional motel after taking all of Lyn's postnatal depression medication
Janelle 40s	Husband Gary 40s	Carbon-monoxide poison on a family property
Emma 40s	Husband Arun 50	Hanging in the garage in the family home
Darryl 50s	Wife Josie 40s	Overdosing on anti-depressant and pain medication in her bedroom
Jerome 40s	Partner Sean 20	Overdosing on Jerome's insomnia medication, dying in bed, beside Jerome
Wilson 50s	Daughter Holly 17	Hanging at mother's home
Delma 70s	Son Colin 33	Gun shot in mother's home
Angie 60s	Son Joshua 29	Intentional heroin overdose in his own flat
Olivia 70s	Son Chris 21	Gun shot in father's home
Hazel 50s	Son Warren 32 Partner Larry 40s	Warren, hanging in grandparent's garage. Larry, hanging at relative's home
Laura 24	Mother 50s	Throwing herself under a train near her sister's home
Kim 50s	Mother 56	Suffocation, tying plastic bag over her head after taking all her medication, dying in her own bed
May 20	Mother Josie 40s	Overdosing on anti-depressant and pain medication in her own bed
Delia 20s	Father 38	Cyanide in a glass of milk in his laboratory at work
Monica 50s	Two brothers Tom & Ben 34 38	Both gun shot, one in his home, the other brother in a detoxification clinic
Elizabeth 60s	Sister Roberta 39	Drove car off cliff in Spain on way home after visiting a convent

Sally 40s	Brother John 36	Killed by a train, lay down in a tunnel
Philip 40s	Brother-in-law Colin 33	Gun shot in mother-in-law's home

Appendix 9

Disorders of suicide-deceased relative and background family

Table 9.1
Disorders of suicide-deceased relative and background family

Relative who died by suicide—	Contributing disorder/issues as reported by participant
Lyn's husband Danny .	First marriage unhappy, serially unfaithful wife. Unresolved grief re adoptive mother's cancer death when Danny young teenager. Abusive and controlling adoptive father. Adopted at birth, no record of birth parents.
Janelle's husband Gary	Narcissistic, depressed. Risk-taker with own life. Planning Janelle's murder. Distant reclusive father. Spoiled by adoring mother and grandmother. Gary's brothers' children all have mental illnesses or disabilities, one child institutionalised. Janelle & Gary's oldest son Vance hospitalised after suicide attempt. Son Vance is depressed, daughter is depressed.
Emma's husband Arun .	Depressed, perfectionist, prior suicide attempt, low self-esteem. Abandoned by father and paternal family. Separated from mother for extensive periods in childhood and adolescence. Some history of abuse in childhood. Raised in Asia, then sent back to Australia in childhood to unknown maternal relatives. Felt different because Arun part Asian. Not accepted in either Australia or Asia.
Darryl's wife Josie	Depressed, previous suicide attempts. Invalided through work-place injury and resultant intractable pain. Mentally and physically disabled younger brother. Pressure from mother to assist in care of younger brother. Josie torn between duty to her husband and children and

	duty to help her mother with disabled brother.
Jerome's partner Sean	Depression following discrimination at school because of sexual orientation. Seeking an identity, insecure. Adopted at birth, no record of birth parents. Loss of relationship with adoptive parents following Sean entering a same-sex relationship.
Wilson's daughter Holly	Sexually abused by mother's boyfriend, mother minimised this. Evidence of drug use, low self-esteem. Holly's mother disappeared with Holly and her younger brother when Wilson was recovering from a work injury. Children kept hidden and repeatedly shifted so Wilson could not have contact with them when Holly and her brother were young. Mother and her friend had a drug lifestyle.
Delma's son Colin	Depression, inability to maintain relationships. Father violent alcoholic. Mother suffered extreme domestic violence over a long period of time. Colin witnessed this. Mother hospitalised with breakdown after severe domestic violence. Children left in neglecting fathers' care until mother's return. Lost contact with Colin's son and daughter.
Angie's son Joshua	Bipolar disorder, depressed, addicted to heroin. Childhood severe illness and long-term hospitalisation. Medications resulted in short, obese body. Low self-esteem. Frequent trouble with law. Joshua's father and other paternal relatives' bipolar disorder and evidence of other suicidal deaths. Joshua's parents separated when Joshua was a baby. Father abandoned Joshua.
Olivia's son Chris	Abused in childhood by older boys. Guilt re revenge exacted on perpetrators when Chris was seventeen years old. Prior suicide attempts. Parents separated when Chris was a very young child. Father absent through most of childhood and adolescence, little contact with Chris and sister.
(1) Hazel's partner Larry. (2)Hazel's son Warren	(1) There was no early history known to Hazel about Larry's life, nor were any reasons found for the suicide. (2) Abused by priest when a schoolboy. Brain damaged following a car accident. Alcoholic, separated from wife and children. Depressed, several prior suicide attempts. Separated from mother as a very young child. Yet mother kept her other three sons. Raised by maternal grandparents, grandmother kept Warren away from

	Hazel and discouraged all contact. Warren told by grandmother Hazel abandoned him and did not want him. Warren told grandmother of the sexual abuse by priest, grandmother did not believe him and did not tell Hazel. Wife left taking children as Warren became an alcoholic.
Laura's mother	Depressed following separation from Laura's father. Living with controlling, abusive sister at time of death. Maternal aunt hated Laura and her father. Discouraged any contact between Laura and her mother. Laura's older brother, drug addict, in corrective custody, earlier suicide attempt. Fractures in both paternal and maternal families.
Kim's mother	Bipolar disorder, repeated hospitalisation. Diagnosed mental disorders in both maternal grandparents' families. A past generation maternal family member institutionalised for life.
May's mother Josie	Depressed, invalided through work-place injury and intractable pain. Josie's brother intellectually and physically disabled. Josie's mother demanding for assistance with Josie's brother. May's two older brothers both drug addicted and depressed. May's two younger sisters in abusive same-sex relationships and one has attempted suicide.
Delia's father	Unhappily married, wife distancing children from father. Severely depressed, refused to take anti-depressant medication. Delia's mother experienced physical and sexual abuse in childhood, became very uncommunicative and controlling. Joined Jehovah's Witness Church. Told husband and children that Delia's father would go to hell if he did not join the church. Actively discouraged children from speaking with father who became isolated. Father's mother, history of depression.
Monica's two brothers Tom & Ben	Both brothers severe alcoholics, depressed. Monica's mother rigid and had no connection to children. Monica's daughter history of drug use, alcohol abuse and past suicide attempts. Another brother depressed and unable to maintain relationships.
Elizabeth's sister Roberta	Severe depression; hospitalised after several prior suicide attempts. Roberta's husband abusive. Both Elizabeth and Roberta severely beaten by father

	during childhood. Father jailed for theft and fraud. Roberta and Elizabeth spent time in an orphanage when very young when father jailed. Father disowned by his family. Elizabeth, mental breakdown.
Sally's brother John .	Heroin addicted, unable to maintain relationships. Bipolar disorder, depression. Father severe disciplinarian, controlled children through shaming. Tim, John's younger brother, heroin addicted, depressed, unable to maintain relationships.
Philip's brother-in-law Colin	Depressed, unable to maintain relationships. Witnessed extreme domestic violence from his father to his mother. Father violent alcoholic, Colin and his older brother neglected by father when they were in his care as children, when their mother was hospitalised. Colin adored his father and longed for a relationship with him all his life.