

**SURVIVORS' ADJUSTMENT PROCESS TO SUICIDE IN
THE NUCLEAR FAMILY**

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STATEMENT

I, the undersigned, hereby declare that the work contained in this research assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature

Date

SUMMARY

Suicide is currently one of the leading causes of death in many countries, and is still stigmatized to some extent in some cultures. As bereavement by suicide is a very difficult loss to adjust to, this study aims at creating a better understanding of the adjustment process that survivors of suicide have to go through. The study focuses on the impact of this kind of bereavement on family members and other people touched by the loss of someone to suicide. The needs of the bereaved have to be researched so that a suitable intervention programme can be developed to lessen the severity of the aftermath for survivors of suicide. Supportive aftercare (postvention) may also help prevent further tragedies following in the wake of suicide.

The severity and stigma of suicide often contribute to the isolation of nuclear family members in their grief at a time when societal support would have been most helpful. Suicide touches the lives of people of all ages. Some may have special needs such as parents who lose a child to suicide or children whose parent has committed suicide. Better knowledge and understanding of the experiences of these survivors may guide caregivers to assist them with their bereavement and adjustment process as well as assist them in acquiring the necessary coping skills to work through the guilt, fears, anger, regrets and sorrow associated with their tragic loss.

A review of the relevant literature is presented with pertinent hypotheses to inform further research to develop a suitable intervention programme for survivors of suicide in the nuclear family. A questionnaire is also presented that may guide interviewing of people affected by suicide in the family.

OPSOMMING

Selfmoord is tans een van die leidende oorsake van sterfte in baie lande van die wêreld. Die verlies van 'n geliefde aan selfmoord is baie moeilik om te verwerk, en hierdie studie beoog om beter begrip vir hierdie proses te bewerkstellig. Daardeur kan die samelewing meer bewus word van die impak van selfmoord op die naasbestaendes van iemand wat as gevolg van selfmoord gesterf het. Die spesifieke behoeftes van die treurendes moet nagevors word sodat toepaslike intervensieprogramme uitgewerk kan word, wat kan bydra om die impak van selfmoord op naasbestaendes te help versag. Ondersteuning aan naasbestaendes na selfmoord kan die voorkoms van verdere tragedies in die gesin help voorkom.

Die geweldige impak asook die stigma van selfmoord van 'n gesinslid dra dikwels by tot isolasie van die kerngesin tydens hul rou tydperk, juis terwyl hulle dit die nodigste het. Selfmoord raak mense van alle ouderdomme, elk met hul eiesoortige behoeftes, soos ouers wie se kind selfmoord gepleeg het of kinders van wie 'n ouer gesterf het as gevolg van selfmoord. Beter kennis en begrip van die ervarings van naasbestaendes kan hulpverleners lei om bedroefdes te help met hul rouproses en aanpassing, asook hulle bystaan om die nodige hanteringsvaardighede te verwerf sodat hulle die samehangende skuldgevoelens, vrese, woede, berou en verdriet kan verwerk.

'n Oorsig van die toepaslike literatuur word aangebied met pertinente hipoteses om verdere navorsing toe te lig in die ontwikkeling van 'n toepaslike intervensieprogram vir naasbestaendes na selfmoord in die kerngesin. 'n Vraelys word aangebied wat onderhoudvoering met naasbestaendes kan lei.

DEDICATION

Dedicated to all the wounded souls...those wingless birds for whom a special place has been reserved.

We dance around in a ring and suppose,
But the Secret sits in the middle and knows
Robert Frost

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CHAPTER 1:

1.1 Introduction

Tragically, suicide is currently one of the leading causes of death in many countries worldwide. Because the actual cause of death is not always reported accurately or the real cause of accidents and overdoses is not known, suicide may pass undetected and underreported. However, family members who knew the suicide victim intimately are the people most devastated by this sad phenomenon. They sensed that something was amiss; and fear that the death may have been prevented. Where the cause of death is known as suicide they have to communicate this to society as well as live with this fact. Suicide still carries a stigma in some cultures, and therefore survivors may not have the support of their communities, as is the norm with other kinds of bereavement. Also, inwardly they have to live with this loss for the rest of their lives, sometimes carrying unspoken shame, guilt, confusion and grief (Kalish, 1985).

1.2 Overview

1.2.1 Goals of this study

For every person dying by suicide, many people related to the deceased are likely to be affected to a greater or lesser extent by this tragedy. The focus of this study is on those people that would have shared most of the developmental and personal aspects of the deceased, namely the closest family members. These people may also share the same genetic heritage, as a predisposing or as a proximity factor. Oster and Caro (1990) researched the family context of suicide and the characteristics of suicidogenic families. They identify some mutual characteristics as: deficient communication, issues of unresolved loss, dysfunctional boundaries, poor conflict resolution, and family members suffering from emotional disturbance.

By focusing on the survivors, the following goals may be accomplished:

- An *understanding* of the adjustment process that surviving family members have to go through;
- Creating an *awareness* of the devastating impact a suicidal death has on the remaining family members;
- *Lessening the severity* of the emotional aftermath following a suicide in the family;
- Aid in *prevention* of more suicides in the family after the initial tragedy;
- Introducing the *needs* of survivors of suicide so that a suitable format for support after suffering a loss by suicide can be developed, eventually creating a structured support programme based on the identified needs of survivors.

1.2.2 Need for this study

Suicide, by its very nature, is one of the most difficult bereavements to live with. To come to terms with the fact that a loved one chose to end his or her life and chose to exclude family members from this desperate decision, is a severe emotional setback (Abrams, 1995). A suicide may happen unexpectedly, leaving no opportunity for family members to even suspect that something is wrong. Such an unexpected death leaves no time for any reconciliation should relationships have been in trouble at the time of death. The unexpectedness of the death is then aggravated even further by it being a suicide. On the other hand, if the suicide had been preceded by several attempts, or by a severe breakdown in relationships due to arguments and incompatibility or unreasonable demands, then some grief work has already started to mourn the end of the relationship before the breakdown. In this case the death may not be so unexpected. However, by the time the suicide takes place the survivors may already have been deeply involved and locked into a pathological support-depend relationship with the person who dies. They may then feel extreme guilt and shame over not having been able to prevent the suicide this time (Lake, 1984).

Suicide carries with it all the aspects of any other bereavement, such as intense loss and grief, denial, isolation, anger, bargaining, depression, and a need for acceptance.

Together with this, it carries an added burden of stigma, shame, guilt and confusion as to the cause of it. And, the only person that could have offered some clarity or consolation has removed himself or herself from the family – permanently. Suicide leaves with it a sad legacy of emotional turmoil for family members to unravel by themselves. There is also the fear that such a deed may have been caused by some hereditary factors. Furthermore family members may regard suicide as a way of coping with problems, and someone in the family might fear a repeat of the tragedy. Suicide clusters, especially among adolescents, are also a real threat. Parents, school teachers and peers need to be made very aware of this phenomenon and support and prevention programme developers need to take cognisance of this (Marcus, 1996).

A forensic pathologist of Cape Town University, Dr. Denise Lourens (cited in Caelers, 1/2/2000), shares some details of her thesis on suicidal deaths. She asserts that health care workers should be empowered to deliver better care to potential suicide victims. She argues further that urgent attention is needed to set up support systems for family members bereaved by suicide. This study aims to determine the needs of these people, and to identify what coping skills could be developed further to ensure alleviation of their suffering.

Prof. Alan Flisher, Head of Emergency Psychiatry at Groote Schuur Hospital (personal communication, August 15, 2000) is of the opinion that no structured support programme for survivors of suicide is available at present, in the Cape Metropolitan area. Prof. Flisher was a guest speaker at the Nechama bereavement seminar on this particular day, presenting his paper on the pathway to adolescent suicide. Other practising psychologists in this area confirm his opinion.

Clearly, the need for such specialized support in this area is high. The generation of such a programme would be welcomed by health care professionals and survivors alike.

1.2.3 Definitions of the main constructs

Suicide: Shneidman (1984) requires the student attempting to understand suicide, to do so in his/her own understanding of the term. It would then include, for the purpose of this study, the intentional killing of oneself, knowing that the outcome of the act may prove to be fatal.

Survivors: Survivors are the people affected by the death of a loved one to suicide, also described as victim/survivors in some literature.

Nuclear Family: For the purpose of this study the nuclear family would be those persons who form part of the group of people called father, mother, children and/or siblings.

Qualitative methods: Qualitative methods “describe and analyse their subject matter using ordinary language as opposed to numbers.” (Barker, 1994, p. 72).

Grounded Theory: Grounded theory “refers to the fact that the theory emerges from and remains firmly based in the data. (Barker, 1994, p. 182).

1.3 Summary

Survivors of a suicidal death in the family have a sad legacy to bear for the rest of their existence. They have special needs that distinguish *their* coping from coping following other losses, and they often do not receive the support of their society, as would be the case with other losses. The following literature review looks at the impact of suicide on society, the needs of survivors of suicide, in particular what adjustment process is required of them, and how this can be augmented. The prevention of more suicides in the bereaved family, societal support and the generation of a support programme are also addressed.

CHAPTER 2:

2.1 Literature Review

2.1.1 Incidence of Suicide

As early as the time of Plutarch (46-119 A.D.), suicide prevention is documented in an ordinance of the magistrates of Miletus, Greece, regarding an epidemic of suicides among young women. Yet, most research on suicide has only been done in the 20th century. The results of these studies have enabled societies to generate preventative measures from the 1960's onwards (Hatton, Valente, & Rink, 1977).

Yet, statistics on suicide are underestimated because of several reasons: The stigma attached to death by suicide, the large variability in methods of committing suicide that may disguise the suicide; and the fact that unless proven, a cause of death cannot be documented as suicide. The available figures nevertheless, are a cause for concern.

In Australia, more than two thousand suicides occur in one year. If, on average, four or five family members and friends are affected for every person who commits suicide, the extrapolation thereof means that ten thousand people are bereaved by suicide in Australia - per year. In Australia, suicide and road accidents are the two leading causes of death of young people (Clark, 1995).

By and large, the distribution of suicidal deaths per capita shows a similar trend worldwide, with 11,7 per 100 000 people committing suicide per year in South Africa, and 13 per 100 000 per year in the United States of America (Caelers, 1/2/2000). Worldwide, in one day, more that 1000 people die by suicide. Converted to annual figures, this means more than 365 000 deaths by suicide per year worldwide, leaving on average 1 825 000 people per year bereaved by suicide (Clark, 1995).

However, latest figures as published by Swanepoel (2001) in *Die Burger* indicate that one million people per year commit suicide, worldwide; as reported by the World

Health Organisation. Another 10 to 20 million people attempt suicide annually. This report indicates further that discrimination and the stigma still attached to psychiatric illness create stumbling blocks to treatment.

In China, 250 000 people commit suicide in one year. However, this figure may be higher than 300 000 because official statistics might not reveal the true cause of death (New Therapist 7, p 5, May/June 2000). Although China has only one fifth of the world's population, their suicide figures represent 42 percent of all documented suicides in the world. China is also the only country in the world where female suicides outnumber male suicides. This excessively high suicide rate has led to research into this tragic phenomenon, and figures from 24 sites throughout China are being used in the study cited in this source. Officially, China is now recognizing suicide as one of their country's main health problems. Some early findings of this study are that, as in the rest of Asia, rural areas have a 3-4 times higher rate of suicide than urban areas. This is attributed to a diverse combination of stressors in the lives of people in the rural areas that impact more on young women. Some of the cultural, environmental and social factors are related to the patriarchal rural lifestyle that includes arranged marriages and heavily favouring of male offspring, resulting in ostracism and severe family conflicts. Forty percent of suicides in China, though, do not involve any of the two major factors linked to 90 percent of Western suicides, namely mental illness or alcoholism (New Therapist 7, May/June 2000).

In the United States of America, the U.S. Army has had ten times more deaths by suicide than by hostile fire, in the last ten years. During the past two years, suicide rates in the Army have risen to the highest since the 1970's. The Army has implemented a "buddy"-system similar to that of the Air Force, and are issuing booklets on prevention to help combat this tragic phenomenon (New Therapist 8, July/August 2000).

In South Africa, the National Injury Mortality Surveillance System's summary report for the year 2000 states that during that year, 18 876 people died of non-natural causes. Suicide accounted for about one tenth of these deaths, for both males and females. Alcohol was strongly associated with all types of non-natural deaths. In Cape

Town, deaths by non-natural causes increased from 1999 to 2000, from 162 to 179 per 100 000 population, mostly due to an increase in homicides and suicides. Overall, there is a peak of suicide for the age group 20-34 (Matzopoulos et al., 2000).

According to Caelers (1/2/2000), the Salt River Mortuary in Cape Town handled 3814 deaths, 157 through suicides, during 1997. Hence, if roughly 5 people per death were bereaved, then 785 people per year, in the Cape Town area alone, suffer from bereavement because of suicide. The male to female suicide ratio is 5:1, and the average age of individuals who die by suicide is 37 years. This means that the bereaved who are left behind, are mostly wives, young children, and aging parents. These people are left doubly vulnerable and bereaved from both their primary caregiver and/or breadwinner. For this reason, a study determining the needs of suicide survivors is imperative. Also, survivors of suicide have an additional issue to contend with over and above grieving the loss of a loved one – they have the agony of facing unanswered questions about the cause of their loss, because the one person that may have been able to answer their questions, chose to remove him- or herself permanently from their reach. Therefore, they will forever have their most important question unanswered – namely, why did the loved one commit suicide? According to Lucas and Seiden (1990), few survivors emerge from bereavement by suicide psychologically unscathed, and many have to live the rest of their lives affected by this horrific experience. A support programme can help lessen the emotional suffering and contribute to some form of integration of the tragedy into their lives.

Carlson (1995), who suffered the suicide of her teenage son, writes: “None of us will ever be quite the same. Our lives have changed forever, but we can use our suffering to lend sympathy and support to others who may benefit from our understanding.” (p. 49).

However, as stated in Flisher (1999), actual death by suicide reveals only a small fragment of the larger phenomenon of suicidal behaviour in its totality. According to research done among secondary school pupils in the Cape Peninsula, 19% of these scholars had thought seriously of harming themselves in the year before the study was done, in a dangerous enough way as to possibly result in their death. Aggravating

factors to suicidal threat, as found in this study, were urbanisation and attending a secondary school rather than dropping out. This may be related to several factors contributing to suicide among teenagers such as clustering through copying peers' suicide, as well as stress and pressure from the school environment. Also, secondary school students are more subject to peer pressure, and "...adolescent thinking such as a greater awareness of the self as seen by others ...could increase vulnerability to depression and suicide" (Rutter, Taylor & Hersov, 1994, p. 407). Flisher (1999) further reports that of this 19% of high school students, 8% had actually attempted suicide. This prevalence is similar to that found in other countries, presenting a widespread danger to the young people of today. This article further urges that this trend should not be seen as part of normal adolescent upheavals, and should always be regarded as a serious threat to the adolescent concerned.

2.1.2 Circumstances surrounding suicide

Lourens (1998) documents some special circumstances surrounding suicidal deaths during 1997 in the Cape Town area. It was found that of the 157 suicides presented at Salt River Mortuary during that year, the circumstances were as follows:

- Six deaths occurred while the victims (men) were in custody.
- Two victims had been under criminal investigation at the time of their suicide.
- Five men had committed suicide after either killing or trying to kill their female partner.
- Two suicide pacts had resulted in four deaths.
- Two men died as a result of complex suicide involving more than one method of attempting suicide.
- Two males died while in hospital.
- Four males died while being HIV-positive and gay.
- Forty-four victims had been known to have a psychiatric complaint.
- Twenty-six victims had been physically ill, suffering from a chronic disease.
- Seventeen victims had been struggling with financial/employment loss.
- Thirteen victims had had relational problems.

- Two suicides were drug-related.
- Thirty-two cases of alcohol abuse came to light upon conversations with the surviving family.
- Seven deaths occurred after bereavement of a loved one.
- Other reasons include a family member suffering from cancer, media influence, stress, rape, gang involvement, disciplinary investigation, family suicides, or being outcast by family.
- Of the 157 deaths, 49 were African (44 male and 5 female), 45 were Coloured (38 males and 7 females), and 63 were White (49 males and 14 females).
- Thirteen victims were under twenty years old, and sixteen victims were over fifty-nine years old. The balance of 128 victims were between twenty and fifty-nine years old, thus in their most productive years.

The following insert illustrates some of the tragic circumstances surrounding suicide, the desperation and often inevitability thereof, and the sad legacy of shame to survivors. It also reflects some of the statistical indicators of suicide:

In the Eastern Cape, the Van Stadens-bridge between Jeffrey's Bay and Port-Elizabeth has just claimed its 45th victim through death by suicide. According to Van Zyl (2001) this high bow bridge, that was an accomplishment in engineering at the time of its construction, has been named "Bridge of Death" since then – with the first jump to death within one month of its official opening in October 1971. The latest victim, a 50-year old male from Cape Town, was seen on the bridge at about 7 am. on the morning of his death. A negotiator from the Police spent several hours with him, yet just before 11 am. he jumped from the bridge. In the same article by Van Zyl, Barbara Deyzel from Port Elizabeth, former chairlady of a support group for suicide survivors, says that survivors would like to shake off the stigma associated with suicide. Survivors sometimes attend prayer- and remembrance meetings under the Van Stadens Bridge to commemorate those that they have lost through suicide.

Johns (2001) reports on the increase in attempted suicides by teenagers in Mitchell's Plain, Cape Town, and her findings state that the following circumstances contribute to teenagers wanting to take their own lives:

- -Poverty, hunger and unemployment
- -Gangsterism
- -Disintegration of family life, lack of family values and role models
- -Family violence, anger, frustration, demoralized and disempowered people
- -Teenage pregnancies
- -Lack of coping skills for parents, teachers and teenagers alike
- -Lack of counsellors or no access to guidance counsellors
- -Absent parents, alcohol abuse

In her article, Johns (2001) refers to a local community worker asking that families do a needs analysis to see where they are failing, because lack of proper parenting means that children's rights are being taken away by their own parents. This leads to children turning to gangs to find the praise and acceptance that is lacking in the home. However, once involved with a gang they need to perform horrendous tasks, such as drug smuggling and murder. Gangsters also abuse alcohol, carry guns, and are involved in fights. Many of these teenagers have also already witnessed people dying or have lost a loved one to gang-related incidents. Small wonder, Johns (2001) reports in her article, that these children consider taking their own lives. Yet, this only aggravates the horror that this neighbourhood has to endure, because this may potentially leave even more families devastated by a suicide in their midst.

The next heading titled *Special Survivor Cases* will elaborate more on the loss of a child to suicide from a parent's point of view, as well as the special needs of children who have suffered the loss of a parent through suicide.

2.1.3 Special Survivor Cases

When the suicidal death was that of a parent, the loss carries a particularly loaded conglomerate of issues that child-survivors have to work through, and this aspect needs to receive particular attention. As stated in Lewis (1999), it is very hard to explain to a child that their parent has committed suicide – in other words, willfully chose to commit such an act. However, the truth needs to be explained in as true and as gentle a manner as possible, without elaborating on detail that is not asked for. The age of the child will determine the level of the conversation, but what is always helpful is to point out that the parent who has passed away has had many problems that they could not solve in a more appropriate way. The child needs to understand that suicide is not the right option, though, and that what had happened was not their fault in any way. Children bereaved by suicide will, of course, fear for their surviving parent's well being thereafter. They may also feel rejected and abandoned at a very deep level. Many of the questions they may need to have answered, will have to remain unanswered forever because the one person who would have had the answers, is now dead. Children and their caregivers may need to receive specialized support following bereavement by suicide (Lewis, 1999).

Abrams (1995) states: "Suicide is undoubtedly one of the most difficult of all bereavements to come to terms with." (p. 43). Suicidal death leaves a sense of stigma and shame and instead of generating extra compassion from society, often rather creates a silent barrier between the bereaved and their society. This silence is further aggravated from the point of view of the bereaved, because what they have experienced is so unspeakable and carries such intense feelings of disgrace, shame and guilt, that talking about it becomes almost impossible. Survivors of suicide often feel that they could have prevented the death in some way or other; and may be very angry with themselves, as well as with the suicide victims, for committing such a horrendous act.

Children, who survive a parent's suicide, may fear the legacy thereof as well, thinking that they themselves may become victims of such a self-destructive act too. That is why information about facts surrounding the suicide is so important – to clarify the

vast complexity of dynamics preceding a choice of suicide. However, children of parents who have committed suicide may need help with their intense feelings of rejection and all the other emotions that go with that. "When a parent kills himself or herself it can leave you with deep feelings of rage, guilt, resentment, helplessness and inadequacy" (Abrams, 1995, p 43). Hence special support for these young people needs to be available.

Also, children and adolescents have the same feelings of loss and grief as adults do, but their recuperation may be hampered by their immature coping resources. This is compounded by their lack of understanding of what has happened because of the developmental phase that they find themselves at, and because of their inexperience with devastating life issues. Therefore these young bereaved people need special attention and need to be supported in a compassionate and understanding way. They have to be allowed to speak about their loss, and to work through their feelings in their own way and at their own pace. Bereaved parents need to be particularly wary of not doing double grieving by trying to do their grieving children's mourning for them, both to allow their own progress to carry on and to allow the child to come to terms with their own bereavement (Lake, 1984).

Children already have to adapt to their own constant, fast-paced development and are perpetually mourning losses of their old self, their old body or status, having to adapt to new circumstances as they grow and develop. To be confronted by a suicide in their family at their tender age, leads to a bewildering array of feelings associated to the bereavement. "The ripple effect of grief will mean that teenagers are likely to face a number of intellectual and spiritual dilemmas as well" (Zagdanski, 1994 p. 84).

For children the suddenness of a suicidal death may shatter their perception of the world as a secure and safe place. To lose a parent suddenly, alters their world drastically and dramatically, in an instant. This may be so overwhelming that the child has trouble in making sense of the proceedings that follow, even crying at the funeral may be quite impossible because of the unreal sense of it all. For a child, a world that changes so suddenly and drastically, is not a good place to be in, and leaves them feeling insecure and vulnerable (Harris, 1995). The suicide of a parent also shatters the

surviving child's beliefs about his own sense of lovability and worthiness of being loved. The child has to live for the rest of his or her life with the knowledge that his or her parent had sought death over life and had willingly left the child behind. Many childhood survivors of suicide feel that if they were loved enough, or good enough, their parent would rather have preferred to stay alive, with them – and so they live on doubting their own worthiness and inherent goodness (Harris, 1995).

When the suicide was that of a child in the nuclear family, parents and remaining siblings have an added dimension to cope with over and above other aspects of such a tragedy; and that is the loss of their hopes, dreams and expectations that they had had for that child. They may also feel that they had failed the victim, which if they had done something different the suicide would not have occurred – that in some way or another, they could be held responsible for the death. The guilt and sense of failure may be particularly acute and difficult to come to terms with (Lake, 1984). A loss of this kind may leave a large void in the lives of the remaining family members; for the parents one child less is an almost unthinkable gap in their lives and for the siblings a playmate and confidante may be lost.

Some people may also share their lives with loved ones that are chronically suicidal, and it is estimated that about half of all potentially suicidal people fall into this category (Hatton et al., 1977). These people suffer recurrent depressive episodes, and have a background of repeated suicide attempts. Interventions may avert the crisis at the time but fail to contribute any enduring improvement. A pervasive self-destructive pattern that is resistant to change, exists in their lives and substances are often abused in an attempt to alleviate their psychological anguish. Over time most of their social support systems collapse due to abuse thereof, rendering them alienated, lonely and isolated and leaving loved ones feeling powerless and regretful. Intervention for these people would then be beyond the scope of short-term crisis service (Hatton et al., 1977). Therefore, the Los Angeles Suicide Prevention Centre has formed an experimental outreach programme, to offer more of a “continuing relationship” (p.179) to high-risk suicidal people. This approach will be discussed further, under the heading of “Therapeutic Intervention.”

For widows who were bereaved by suicide, the road ahead may be particularly lonely and guilt-ridden. As Shneidman (1984) states, suicide is often a dyadic occurrence that requires the involvement of the significant other in its management. Sometimes, the wife struggles for years to hold her spouse on to life, and sometimes she may provoke him to death. For the surviving widow, this is a very tough part of her journey into the future, knowing that her contribution, no matter in what form, was significant, and that while her suicidal spouse was still alive, she played an important role in the management of his condition.

2.1.4 Theories of and recent approaches to suicide

Hatton et al. (1977) present a theoretical framework as clarification of misconceptions surrounding suicide. Hereby they are presenting what they believe, "...to be the experience that suicidal persons go through" (p. 20). When a suicidal person presents for treatment, he or she brings into that moment a complex background of circumstances that have contributed to the current suicidal state. To fully comprehend or attempt to change the subjective experience of agony, will be very difficult. However, an easier approach will be to help the client expand options on how to resolve the anguish – subsequently entering into the method and purpose of the planned suicide rather than the reasons behind it. Yet, to be of help to the suicidal person, he or she needs to be regarded within the context of how they are feeling and behaving at the time – the psychological state as experienced while contemplating suicide. This forms the basis for some theoretical frameworks of explaining suicide:

The experience of Depression, which is often accompanied by negative self-esteem, withdrawal, isolation and deprivation, may lead to an obscured vision of the world beyond the depression. Therefore, the sufferer feels trapped in the current agony of intrapsychic conflict, helplessness and immobilizing pain. The danger of suicide is high for both the periods of dark despair whilst the depression is manifest, and also for the renewed state of energy when coming out of the agony because some clients only then have enough energy to put their suicidal ideation into action.

The experience of Hopelessness and Helplessness - that feeling of a dark future in which nothing will ever work out, as well as a sense of impotence where no attempts at improving, nothing that is done will change the situation – can be regarded as the “travelling companions” of depression (Hatton et al., 1977, p. 25). By careful assessment of the suicidal individual, these powerful feelings that accompany the more overt depression may be clarified and their underlying beliefs may be addressed.

The experience of Isolation and Withdrawal may sometimes be difficult to detect because a mechanical going through of the motions of social interaction easily masks these feelings. By exploring how the client feels while attending a social function, for instance, may reveal how he or she really feels on the inside while putting up a happy front, and may indicate a sense of isolation from others as well as a desire deep down, to withdraw from contact with other people.

The experience of both Hostility and Depression may sometimes be encountered in individuals with suicidal ideation. Both need to be addressed equally by the counsellor, as independent states through which the client is attempting to communicate what he or she is experiencing. These states may also relate to how the client interacts with others and is as serious as the suicidal behaviour itself.

The experience of Ambivalence, where the client has the need to fulfill conflicting goals, may be regarded as part of the life experience of most people. However, when a suicidal client is ambivalent about whether to commit suicide or not, as many do, then utilization of this ambivalence by the counsellor, may help steer the client toward the pole of opting for a life-preserving solution to his problems instead. Ambivalence, however, lies on a continuum with content ambivalence on the less serious side and indicative of a current crisis that needs to be resolved. On the more serious side is process ambivalence, that indicates a chronically ambivalent and unstable state and that has serious implications for the outcome of attempts at therapeutic intervention because the suicidal client may vary from one moment to the next about whether to take his life or not. Clearly, ambivalence in suicidal individuals needs careful assessment to determine whether this is content or process related.

The experience of Tunnel vision reduces the suicidal client's options of how to get out of his or her agonizing state. Tunnel vision may be found not only in a person who is suicidal, but the counsellor may also be trapped in tunnel vision, through stereotyping of suicidal clients or therapies or through the absolute pressure of the situation whilst working with a suicidal client. The uniqueness of human beings requires a large measure of flexibility on the part of the therapist, and to be optimally effective counsellors need to ensure that they are emotionally well enough and philosophically broad enough to engage in consideration of a wide range of treatment options to suit individual clients. This is particularly necessary when confronted with the critical and immediate needs of the suicidal client.

Alcoholism, when combined with suicidal ideation, presents a challenge of complex nature to the therapist and may be dealt with best in a multidisciplinary team. Chronic alcoholic persons are deeply needy and in denial, and life crises that happen from time to time, may be overwhelming – presenting in suicidal ideation. However, the non-habitual drinker that uses alcohol to ease intense agony over some problem, presents a serious immediate risk of high lethality, although the prognosis is better eventually, than for habitual alcohol abusers. What is helpful for the counsellor dealing with this problem is to try and form some understanding of what lies beneath the alcohol abuse, and then subsequently to bear in mind that no matter whether the alcoholism is a cause or an effect, the underlying personality remains fragile and needy and will struggle establishing mature relationships with other adults.

The Need to Manipulate within the context of suicidal ideation has to be addressed with caution by the therapist. A client who regards suicide as the ultimate form of exercising some control over his or her life situation, needs to be understood on a deep level to be helped effectively. However, understanding what lies beneath a client's suicidal ideation does not mean that this kind of manipulative behaviour should go by unnoticed. Therefore, a helpful response will be to acknowledge the client's need to be cared for right away, but to stress that suicidal ideation is not the appropriate way to ensure that care giving will follow then proceed to help the client find safer ways of getting what he or she wants. By not addressing the client's cry for help immediately

and introducing more appropriate ways of doing so, the risk of escalating attempts at manipulative suicidal behaviour increases, with increased lethality.

The question of whether suicidal ideation arises from an Internal or External Stimulus, may never be answered fully – however, to be of help the therapist working with a suicidal client needs to address both the inner feeling state and the outer way of being in the client's milieu. For the client, insight into his or her inner conflicts needs to be applied successfully in his or her relationships with others during the course of life, to be able to feel well (Hatton et al., 1977).

Masterson (1988) describes the inner experience leading up to suicide as a devastating sense of abandonment and depression so severe that the sufferer feels as if part of him or her is cut off from that which sustains life – as some describe it, a sense... “...of being drained of blood” (p 62). Eventually, having experienced this despair long enough or often enough, the person loses hope of ever regaining that which has been seen as life-sustaining and the separation to his or her external life becomes so pronounced and painful that suicide is seen as the only way out.

However, for Masterson (1988), the experience of depression and that of anger go hand in hand. Memories of the first few years of life when the real self could not manage to emerge yet attempted to do so, leads to intensified anger that eventually can not be endured any more. Homicide may seem a solution to anger and rage too, as does suicide for depression. Yet, depression is often a rage turned inward, leading to another kind of murder – that of suicide.

The Task of the Caregiver then, will be to accompany a suicidal client of his or her painful journey of making sense of life and all its demands to such an extent that some sense of meaning, satisfaction and stability will develop from that (Hatton et al., 1977).

Another theoretical perspective is that of the French sociologist Durkheim (Kaplan & Sadock, 1998). Durkheim attempted to explain statistical patterns of suicide by dividing suicide into three social categories, namely suicide for egoistic, altruistic and

anomic reasons. Egoistic suicides, Durkheim reasoned, happen mostly among people not closely integrated into any social group, for example lonely city dwellers. Altruistic suicides are more associated with people who are excessively integrated into their society, such as the Japanese kamikaze pilots. Anomic suicides refer to suicides by people whose integration into society is too disturbed to allow for adherence to the normal customs for behaviour. They are more vulnerable to the ups and downs of that society for example a breakdown of societal standards, or a significant change in the economy, and may commit suicide when the economy slides into depression, for example.

With regard to psychological factors contributing to suicide, Freud (in Kaplan and Sadock, 1998) theorised that suicide may be preceded by an earlier, repressed wish to murder another person. Aggression is then turned inward, “against an introjected, ambivalently cathected love object” (p. 868). Menninger, in Kaplan and Sadock (1998), expanded on Freud’s theory, reasoning that suicide is homicide turned inward, either as murder or as punishment. Menninger also illustrated three aspects of hostility in the suicidal act, through three wishes: To kill, to be killed, and to die. Furthermore he described suicide as the death instinct directed at the self.

Hollis (1998) describes relationships and suicide following the break-up of relationships along Jungian concepts, by stating that initial falling in love is similar to a kind of madness, a transient psychosis. Although temporary, this madness may have tragic consequences, because many murders and suicides have been committed in a moment of blind rage or despair, where the spurned lover feels the loss of not only the beloved partner, but also the “other” part of the self that needed to be reflected by the relationship. To escape this painful loss of some part of the self, some people choose to kill themselves or lash out in anger and kill others. To explain suicide in Jungian terms then, one needs to see how a needy person was reaching for fulfillment through forming a relationship, only to lose the chance of fulfillment yet again when the relationship ends, and this loss is then too much to bear.

Shneidman (1984, p.336) theorised that contributory factors to suicide include “elements of rejection, disparity between aspiration and accomplishment, instability

and perturbation.” Shneidman elaborates upon a study about causes of suicide, stating that men who felt that they had not had the love of their father, lack an internal strength provided by parental approval that is needed to sustain long-term psychological survival.

In recent years, suicide has become a more open topic to be studied and discussed. As the taboos against suicide are fading, more research is being done and more accurate statistical data can be documented. Some theories on causation now attempt to unravel the complexity and interrelatedness of factors involved in suicidal deaths. It is now known that people choose a suicidal death for themselves because of varying psychological, sociological or other reasons or a combination of the above. These reasons may never be fully understood (Hatton et al., 1977). This eases the immense impact on the survivors somewhat, and allows some social support and some of the normal grief processes to take place.

Yet, many people still grieve silently because of their own shame, or societal taboos – compounded by the suddenness and rejection that is so much a part of suicidal death. Witz-Kotze (2000) acknowledges the immense difficulty survivors have in coming to terms with losing a family member to suicide, because of the overwhelming burden of guilt feelings they are experiencing. She emphasizes the tragedy of suicide by stating that this way of dying is so very lonely and hopelessly desperate – leaving those close to the victim with deep wounds that last forever. However, the responsibility of this choice of action cannot be carried forward to the survivors, a fact that is hard to accept. Yet, she states that every suicide attempt is a charge against society that values performance, material gain, self-centredness and a lack of caring for other people and support of them.

Contemporary theories with respect to causality of suicide focus on studies of patients who express suicidal ideation (Kaplan & Sadock, 1998). Through this, much can be learned about the fantasies of suicidal people and what they hope might be gained from this act, such as power, control, punishment and revenge. Precipitating events and intense feelings generated thereby, as well as group dynamics and overidentification with hero figures that commit suicide, are also studied. Suicidal

ideation among depressed people has also been examined in recent years, especially how suicidal attempts seem to render some control to the depression sufferer. Furthermore, studies by Beck in Kaplan and Sadock (1998) showed that a sense of hopelessness indicates suicidal risk.

With respect to physiological factors (Kaplan & Sadock, 1998), studies on genetics indicating suicidal risk prove that suicide does run in families, with as much as a four times higher risk of suicide among first-degree relatives of psychiatric patients who have committed suicide, to that of control groups. This may happen through role modelling in families, or through genetic transmission of diseases such as bipolar 1 disorder, schizophrenia, and alcohol dependence, which are all closely linked to suicide. Neurochemical links to suicide risk have also been found. The neurochemical profiles of suicidal patients with violent behaviour, poor impulse control, depressive disorders, and alcohol dependence, vary from that of control groups.

- What comes across as theories of suicide are worked through, is that suicide is preceded by varying and complex circumstances and predisposing factors. Also, suicide is committed in many different ways, following many different precipitating factors, and no one will ever know with absolute certainty how intense the victim's experience of these different variables was.

However, what may be helpful in suicide prevention is a more comprehensive review of risk factors contributing to suicide, as discussed under the next heading.

2.1.5 Assessment of suicide risk and contributory factors to suicide

Assessment of suicidality may befall any person who comes across a suicidal person somewhere in the course of human interaction. Whether the person at risk is a colleague, a loved one or a client, reasonably accurate assessment of the potential risk may result in timeous intervention and possibly save a life. Therefore, knowledge about risk factors may contribute to noticing and acting upon potentially suicidal behaviour and could be helpful to all human beings (Hatton et al., 1977).

Lourens (1998) recommends that caregivers to psychiatric patients take cognisance of the high number of suicidal deaths in this group of people. Also that some of these patients utilise prescription medication to commit suicide, and that less medication be issued at any one time, to psychiatric patients. Windows at psychiatric care institutions should be better protected, as should railway crossings. Furthermore, wardens at custodial institutions need to be vigilant to the possibility of suicide attempts of prisoners, and legislation regarding firearms need to be tightened.

Flisher (1999) illustrates a pathway to suicide among adolescents, including predisposing and precipitating factors as well as the opportunity to complete the act and previous suicidal behaviour. In his summary, he states that of these factors, the two most dangerous are the presence of psychopathology and a history of previous attempts at suicide.

Ponton (1997) reports that adolescents with suicidal ideation may respond well to antidepressant medication in conjunction with therapy, provided that they are well educated with respect to the necessity and effects of the medication. Adolescents work very hard on their developmental task of identity formation and are often struggling with feeling unsure of themselves, with being neither child nor adult. Therefore they need to be assured that medication will not alter their newfound self-knowledge or core identity, but rather free their energy to focus more on the task of selfdiscovery. Ponton also stresses that the treatment of adolescents is a complicated matter that requires the consent and co-operation of parents and/or guardians, together with the active, informed involvement of the adolescent client.

However, no one can say how effectively suicides are prevented at present; and can only utilise data currently available to generate an overview of suicidal risk factors (see next heading) in an attempt to prevent and reduce the incidence of this tragic phenomenon.

Carson and Butcher (1992) report that in the United States of America, most suicides occur in the face of severe life stress or interpersonal upsets. The majority of suicides also follows on an episode of depression, and occurs often when the person is starting

to feel better. Moreover, completed suicides happen for three times as many men as women, and suicides among teenagers are on the increase. However, many psychosocial factors are associated and many profiles are associated with an increase in the risk of suicide. From all of this, the Los Angeles Suicide Prevention Centre has accumulated information resulting in a 'Lethality Scale' for the assessment of suicide potential, as published in Carson (1992):

- Male, over fifty years old
- An increase of suicidal deaths for both genders, in the age group 15-24
- Symptoms of sleep disturbance, depression, hopelessness or alcoholism
- Stress, e.g. Loss, illness or employment issues
- Acute symptoms increase immediate potentiality, and chronic symptoms increase long-term risk
- A suicide plan increases risk
- Availability of family members reduce risk
- Prior suicidal behaviour increases risk
- Medical problems of chronic or severe nature increase risk
- Rejection by family or lack of communication with family
- Negative or punishing attitudes of significant others

All of the above are weighted and considered along with more sophisticated actuarial calculations to determine suicidal risk and to compile a treatment programme for each individual.

Flisher (1999) elaborates further on the suicidal risk among adolescents in particular, creating what he calls a suicidal pathway that includes precipitating and predisposing factors. These could be biochemical changes in the brain as well as specific psychopathology that includes substance abuse, mood- and/or conduct disorder, schizophrenia and personality traits of rigidity, impulsivity, borderline, narcissistic or schizoid traits and cognitive distortions of a dichotomous exaggerated and/or negative nature. Adolescents are also influenced by family discord, the prevalence of suicide clusters in their community, suicides by idols such as rock stars, and excessive media

coverage of suicidal behaviour such as found in soap operas that are popular among adolescents.

However, general sociocultural and religious factors also influence suicide rates. Societal norms do influence decisions about suicide, whether negatively as the Japanese kamikaze pilots, or whether positively as with aborigines in the desert of Western Australia where suicide rates are close to zero. Societal norms that include strong sanctions against suicide do in fact contribute to deterring suicidal behaviour, as do religious proscription of suicidal death such as Catholicism and the Islamic religion, but; however, this leads to suicide being stigmatised, and survivors of suicide suffering even more by being isolated from societal support when they need it most.

What is of importance for suicide prevention is the finding of a study by Slater and Depue in Carson (1992) that confirms findings by Durkheim of about a century ago, indicating that *a sense of identity with other people and a sense of involvement with others*, seems to be the greatest deterrent for suicide. Conversely, contributory to suicidal behaviour would then be isolation and alienation from other people – highlighting the added risk of more suicidal behaviour in a family bereaved by suicide.

2.1.6 Personality aspects, clinical diagnosis and suicide

In recent years, better knowledge about suicidal behaviour has led to psychological autopsies following suicidal incidents. Here, victims' psychological states prior to the suicide are unraveled with information about the victim, as supplied by close family and friends. This process has contributed to more accurate records about suicide, and improved understanding of the personal characteristics of suicide victims (Kendall & Hammen, 1995). The authors present a summary of predictors of risk for suicide that came up repeatedly in studies about suicide, but emphasise that these predictors may only hope to supply some clues to better comprehension of the phenomenon of suicide and never hope to predict who will commit suicide or to explain why a particular individual has committed suicide. Personality aspects highlighted in this list, are proneness to aggression, anger, relationship breakdown, poor stress management,

depression, dependency on substances, isolation, hopelessness, rigid cognitions, and poor functioning on occupational, social or economic level.

Lester (1972) describes some aspects of the thought processes of the suicidal individual, as researched by Neuringer from 1961 to 1964. Suicidal individuals are more prone to dichotomous thinking than the rest of the population, who have fewer extremes in their thinking patterns. Furthermore, suicidal people are more inclined to rigid thinking than other people that have partaken in the study. This means that they are not as able to generate and implement new solutions to their problems. Lester (1972) also describes investigation into the logic of suicidal individuals' thoughts, and describes studies done by Shneidman and Farberow that were done in 1957 and that prove interesting but not conclusive, offering some slight comfort to family members who have been wondering about the thought processes of the deceased. However, Shneidman (1984) points out that most for most suicidal persons, their thought processes are circumscribed (tunnel vision) and more dichotomous (either perfect, or dead).

The role of assessment and accurate diagnosis of the suicidal client is discussed in Getz, Allen, Myers and Lindner (1983). Clearly, this not only contributes to applicable intervention when clients present with suicidal ideation, but also indicates the particular difficulties that may be encountered in relation to the diagnosis in question. The three categories of clients that do present special difficulties, as discussed in this publication are schizophrenic disorders, depressive disorders, and personality disorders. Schizophrenic disorders warrant special attention because the underlying cause of suicidal ideation that will need treatment will be the illness of schizophrenia and that may involve psychotropic medication and hospitalisation. The attention of the counsellor will then have to focus on the client's particular difficulties with regard to, for example, paranoia, fear, persecutory delusions or disorientation. The structure of the interview will be different from that of other suicidal clients, with particular attention to the needs of the schizophrenic client such as avoiding sudden noise or movement and more structured questioning to avoid frustrating drifting of thoughts.

Depressive disorders may be at the root of many suicidal presentations (Getz et al., 1983). When this is assessed, it may be helpful if the counsellor focuses on alleviating the depression as well as on the presentation of suicidal ideation. This is best done by including the following elements in therapy: ensuring that the client sleeps enough, consumes adequate nourishment, engages in enough physical activity to obtain relief from psychological problems, and has enough satisfying human contact on a daily basis. All of these suggestions will be quite readily acceptable to the client, will show that the counsellor cares and understands, and will contribute to the client feeling more in control of his or her life on a basic level. This may alleviate some of the helplessness many suicidal people are experiencing so acutely. Also, some success through implementing these simple measures may render the client feeling more hopeful about his future, seeing that some of the answer to his agony is within his own control. However, severe depressive disorders warrant more extreme intervention, with possible hospitalisation, antidepressant medication, and long-term psychotherapy indicated.

Getz et al. (1983) elaborate on the diagnosis of personality disorders in relation to suicide, stating that four specific personality types warrant extra care in counselling, because of the unique problems they present, namely Paranoid, Histrionic, Antisocial and Passive-Aggressive personality disorder.

These unique problems are:

The Paranoid personality may not be willing to share the exact nature of his or her psychological state due to the suspiciousness of his nature, and so the severity of suicidal ideation may be underestimated. The therapist needs to approach the Paranoid personality with particular caution to obtain some form of insight, given the mistrustful nature and resistance to therapy, of this kind of personality.

The Histrionic personality, on the other hand, may be overly excitable and manipulative, with flights of fancy ideas that will have to be kept in check by the therapist, for therapy to be more helpful. The suicidal danger for these

clients, though, will be that they are more inclined to be manipulative and impulsive. Therefore more logical and analytical interventions will prove to keep therapy on a more helpful track.

An Antisocial personality will be inclined to try and exert sympathy from the counsellor, and also manipulate the counsellor blatantly, thereby alienating the counsellor and eliciting countertransference issues of hostility toward the client. The challenge for the therapist working with an antisocial personality will be to avoid both hostile feelings toward the client, *and* being overly sympathetic.

The Passive-aggressive personality may present the therapist with covert aggression that manifests in being late for appointments, forgetting homework, and other sabotaging acts that the client does not himself recognise as such. The challenge for the therapist will be to help the client make this connection, help him or her acquire better coping skills, and ultimately to acknowledge covert signs of aggression to ensure that the client can observe the therapist's understanding of his deep-seated anger. The danger of suicide for this kind of personality then, lies therein that for the client the ultimate passive-aggressive act will be suicidal behaviour.

Getz et al. (1983) summarise the importance of diagnosis in suicide prevention by stating that once accurately diagnosed, a client's difficulties may be better understood and treated. However, clients are so much more than their diagnoses, and a sensitive therapist would do well by keeping that in mind as well.

2.1.7 Caregiving to survivors of suicide and critical areas for the caregiver

Lourens (1998) recommends that support systems should be implemented for family members who have lost someone to suicide. The emotional needs of these families, and their bereavement counselling should receive urgent attention. Lord (1989) found that people who have experienced the suicide of a loved one, may feel particularly

lonely, guilty and isolated by the nature of their loss. They may long to have said goodbye, to have had an opportunity to make amends for whatever had been wrong, or may grieve over some comments written in a suicide note. They may agonise over why the suicide was committed, over their part in all of that and experience accompanying guilt and regrets. Most of all, the fact that it was their loved one's choice, is very hard to assimilate and they may be confused and hurt by that.

Family of the deceased need to be approached with patience, and need to be listened to in a gentle manner that is free from judgment and clichés. Valuable care would also include remembering the good times with the deceased loved one, without avoiding their memory because of the tragic nature of their deed of suicide. It would also mean being with these survivors over painful times such as anniversaries, birthdays and Christmas. Because the family also have to face the criminal justice process and some financial implications because of the suicide, they will appreciate support throughout this traumatic process, too. Ultimately, just being with someone who is in pain and showing your genuine understanding and concern is a valuable contribution to helping them to feel less alone and sad (Lord, 1989).

Hatton et al. (1977) look at the unique problems that caregivers of people in need have to deal with. To be in this position, clearly requires being sensitive and responsible and self aware enough to heed any conflicts that might arise. Working with people who have suicidal ideation may present areas of concern for both experienced and new counsellors, and a regular overview of critical areas will be helpful throughout a counsellor's career. These critical areas are:

- Quick establishing of rapport and trust
- Consulting with a colleague to maintain feeling professionally adequate
- Working through the fear of responsibility for decisions, with other therapists
- Taking care of own feelings of suicidal ideation when overwhelmed by suicidal clients, by receiving therapy yourself
- Working through own feelings of resentment toward the client, that may arise
- Avoiding subjective comparisons of what one would do in the situation the client was in, and remembering to try and see through the client's eyes

- Overcoming listening difficulties that arise from the therapist's own world, to ensure that subtle signals from the client are noticed
- Ethical and legal knowledge by both client and therapist to ensure that safety of people are addressed over and above confidentiality
- Sociocultural stereotyping and attention to statistical data must not cloud the therapist's perception of the dangerousness of an individual client's ideation.

Furthermore, as discussed in Getz et al. (1983), therapists may also suffer the loss of a client, through suicide. This event bears a severe impact, influencing both the world of work for the therapist, as well as their emotional and personal world. However, by not taking care of their own feelings about such a tragic event, therapists render themselves ineffective to support the survivors of this event, who may be in need of therapeutic help.

The same questions, angry and impotent feelings, guilt and shame, sorrow and regrets that survivors will have to come to terms with, will be the task of the therapist who is affected in this way. Then, of course the big question on the minds of both survivors and the therapist will be whether they could have prevented this tragic event. For the therapist, careful and sensitive working through of the case material with a supervisor may be helpful in coming to terms with the loss of the client.

2.1.8 Survivors of suicide

2.1.8.1 Coping skills of people that have suffered traumatic experiences

Human beings are equipped with vast potential for recuperation. The more resilient the individual and the more supportive the environment, the better the chances for a positive outcome after exposure to severe stressors. A multifaceted intervention will contribute more to the recovery of traumatized people. Parikh (1999), in his book titled "Managing Your Self," describes resistance to stress as a process of strengthening the self to prevent vulnerability. This process of strengthening is a management of the self on five dimensions: Body, mind, emotions, neurosensory

system, and consciousness; and requires that the individual develop an insight and a deeper awareness of each. Because tragedy is an external event mostly beyond our control, our only measure of impact reduction is to attempt some control over our reactions to the tragedy. Many negative emotions compound grieving after bereavement by suicide. Some of these emotions may be anguish, regret, guilt, sadness, anger, frustration and embarrassment. The suicide brings with it a finality, with no explanation, no chance of solving or altering – the only way to manage the negative emotions that cause so much pain are to alter the way to think about the suicide. Converting irrational beliefs into rational beliefs on a conscious as well as subconscious level can do this. Also, by saving emotional energy on trying to change those events that are within our control instead of wasting emotional energy in anguish over what has already happened, the self is strengthened.

2.1.8.2 The process of grief work

Grieving people experience symptoms that involve four types of reactions:

- Feelings such as sadness, guilt, anger, helplessness and self-reproach,
- Physical reactions such as hyperarousal, hollow or tight sensations in abdomen, dry mouth and tiredness
- Cognitive reactions such as confusion, forgetfulness, disbelief, poor concentration, indecisiveness
- Behavioural disturbances such as hyperactivity, crying, withdrawal, and sleep-as well as appetite changes (Lamb, 1988).

Kanel (1999) delineates the five stages of death and dying as identified by Elizabeth Kübler-Ross: Denial and isolation, anger, bargaining, depression and, finally, acceptance. Within these stages, the mourning person is completing certain tasks, such as:

- Having to accept the reality of their loss
- Fully experiencing the pain of their grief

- Having to adjust to an environment from where their loved one is absent
- Having to eventually withdraw their emotional energy so as to reinvest it into another relationship (Kanel, 1999).

The process of grief work is influenced by many factors. Some of these are, of course, the circumstances surrounding the death, but also the nature of the attachment between the bereaved person and the deceased, the religious beliefs of the grieving person, the physical and mental health of the bereaved person before their loss, as well as how the people involved have previously been able to manage crises in their lives (The Child Care Worker, 1992:5).

When the death was by suicide, the grief that follows is compounded thereby. As said above, the extent of someone's grief reactions, the process of coping in that situation and the challenges that have to be faced, are in part created by the circumstances of the death. Suicide survivors have to face a bereavement process that is regarded negatively by society, because it implies a death caused by someone's immoral or disturbed behaviour. This cultural distinction needs to be countered by interventions with families who have been bereaved by suicide, to help them come to a more positive sense of their loss and to find some meaning in that (Shapiro, 1994). This aspect also needs to be borne in mind when developing a postvention programme tailored to suit the needs of suicide survivors.

However, before elaborating upon special care for grief work involving a suicide, the needs of the bereaved in general, might provide a guideline. So, normally it would be helpful to bereaved people if:

- People do not ignore their loss. If one cannot tolerate a visit to them, write a note as support.
- Practical help is supplied – At a time of loss, everyday tasks may be overwhelming.
- People listen to them attentively. This may alleviate a lot of the anguish.

-Continued support is provided during the long months that follow the suicide. This may be particularly helpful for eventual integration of the loss.

-Individuality in grief reactions is remembered. Each person heals at their own pace and the grieving process may take more time for some people.

-Partners who have lost a spouse are most supported on a long-term basis, because their loss also implies that they may now be alone whereas before they had shared their life with their partner. They may need to have a friend that will accompany them to functions, and someone to have a conversation with from time to time (Alexander, 1993).

Grief work involving a suicide, however, does have specific requirements that need to be met in order for the survivor to integrate the tragedy in a meaningful way. Hatton et al. (1977) discuss *isolation* of the bereaved person, as a particularly difficult aspect to deal with. Even if the survivor had isolated him- or herself in an attempt to regain some strength, and then attempted to make contact with society again, they would often find that the isolation is implemented from society's side too. This leaves bereaved people feeling alone, rejected, and hurt. They have to work through their own bewildering thoughts and feelings, and find their own solutions, without the luxury of talking it through or enjoying some loving and continued support from their community. Edwin Shneidman in Hatton et al., (1977) describes postvention for survivors of suicide as: "...talk, opportunity for ventilation of feelings, interpretation of the event, reassurance, direction and even gentle confrontation" (p. 120). It offers an opportunity to express some of the deep feelings in a safe environment.

Resnik (Hatton et al., 1977) calls the above process "psychological resynthesis", with three sequential phases, namely:

-Psychologic resuscitation – a supportive visit by a counsellor on the day following the suicide.

-Resynthesis – Counsellors helping survivors learn new ways of coping with their loss, to prevent perpetuating of family pathology through grief and the eventual distortion thereof.

-Renewal – A release of grief and a freeing of the suicide for the survivor, to begin forming new contacts with others. This may start to happen from about six months onwards following the suicide, with the final counsellor contact on the first anniversary of the loss. This contact may be painful for survivors, but also reaffirms support and understanding on the side of the counsellor, for the importance and sadness of the date for them. Thereafter, the survivors carry on with the process of psychological renewal by themselves.

The above process is only the beginning of postventive intervention, hoping to ...”meaningfully assist surviving members of a family to cope with the reality of suicide” (Hatton et al., 1977, p. 122). To do this though, interveners need to be interested and compassionate and **not** associated with any facility that might cause resistance on the part of the survivors, such as the legal system. Yet, many survivors may still be so wary of the social stigma attached to their loss that they shy away from offers of help. Some suggestions of overcoming this resistance are to initiate contact with survivors within the first 24 hours, or to schedule visits to take place in the privacy of the survivors’ own homes. What may also be helpful is to have other survivors of suicide initiate the contact to contribute to credibility.

Yet, much research still needs to be done on the effects of suicide on surviving family members, as well as what the dynamics of family interaction were before the suicide, to correlate that with their response afterward. What will also be valuable is a study of healthy individuals who have survived a suicide in the family, to determine what has been helpful to them and incorporating that into the designing of a postvention programme (Hatton et al., 1977).

2.1.8.3 Current therapeutic intervention (prevention and postvention)

Prevention

For chronically suicidal persons, a more pervasive and enduring intervention than short-term crisis intervention may be called for. Because chronically suicidal people often also live alone or do not have strong ties to others, they do not have sufficient social support. To fulfill this need, the Los Angeles Suicide Prevention Centre has set up an outreach service that contacts identified chronically suicidal people at least once a week, visits them at home, has person-to-person interviews with them, and arranges group meetings. This is done on a friendship basis, and not a therapeutic relationship. This programme is based on intervention through rehabilitation and reinforcing strengths of the clients and has resulted in many people being helped through the development of new and close relationships (Hatton et al., 1977).

However, at present no specialized prevention centres are in existence in South Africa. Potentially suicidal people are treated at psychiatric care institutions. To help prevent the high incidence of suicidal deaths, Lourens (1998) has some recommendations about the needs of potential suicide victims:

- Receiving more specialized care from better trained psychiatric care workers,
- Better access control at railway stations to keep people off the railway tracks,
- Issuing medication in smaller dosages,
- Protective gun legislation.

Postvention

Postvention is a term Shneidman (1984) used to describe the process of ... "those appropriate and helpful acts that come *after* the dire event itself" (p.413). For Shneidman, postvention is roughly equivalent to tertiary prevention, or rehabilitation, or preventative intervention to repeat further suicides among those bereaved by suicide. To be bereaved by suicide or any other stigmatised, traumatic death, seems similar to suffering from a disease, and the grief work done around that is a very

difficult process. Shneidman reports results of studies done by Parkes that show recently widowed women to be more prone to die, to become physically or to become emotionally disturbed. This will be due to neglect, or a self-destructive lifestyle, or non-compliance to treatment – almost a giving-up on herself and on life. Therefore these people are more at risk than their non-bereaved peers, and will need special care.

In Boston, U.S.A., a widow- to –widow programme was used to aid survivors of “heavy deaths” resulting from the Coconut Grove nightclub fire that claimed 499 people in 1942. Similarly, the Samaritans, an organisation that is operating mostly in Great Britain, have programmes of “befriending” bereaved people to support them in their loss (Shneidman, 1984).

After extensive work around death and survivors thereof, Shneidman (1984) formulated some suggestions for postvention:

- Contact and rapport with survivors-to-be of dying patients,
- Attempt to start working with survivors of dire deaths within the first three days,
- These survivors offer very little resistance, especially if the caregiver has a neutral stance without blame or punishment,
- Wait with exploring of anger and other negative feelings toward the deceased, till somewhat later and not early on in the process,
- Be the “quiet voice of reason” for the victim/survivor, to test reality, and not feed into their conscience (p. 418).
- It is crucial to evaluate survivors medically and to look out for symptoms of mental or physical decline.

Finally, Shneidman (1984) recommends that postvention should form part of all total health care, that it could be practised by any sensitive person and not only health care professionals, and that postvention is important as prevention on suicidal behaviour in the next generation.

Robinson (1989) states that suicide changes the lives of those left behind, forever. These people all react in their own unique ways to their loss and many allow love and

understanding to mingle with tragedy, helping them move on through their grief into a different kind of life – sometimes richer and more aware, more wise, but forever tinged with the incredible sorrow of losing a loved one through suicide.

Lourens (1998) also recommends implementation of support systems for family members bereaved by suicide, because these people have particular emotional needs that are not met at present by a specialised institution in South Africa.

Shapiro (1994) states that people bereaved by suicide are viewed negatively, because the deceased may have acted in a disturbed or immoral way. Caregivers to these survivors need to address this response by society, and may have to help survivors rewrite the narrative surrounding their loss for themselves, to be able to obtain a more positive sense or even some meaning to the tragedy.

Hopefully some of the material generated by this study will contribute to a better understanding of the particular needs of suicide survivors and may be utilised in the creation of a postvention programme to help support survivors of suicide. This programme will bear in mind some principles that underlie postvention as pointed out above, and also include aspects similar to the recommendations in Hatton et al. (1977):

- Surviving family members should be allowed to accept the fact that the death was through suicide, in their own time.
- When working with parents who have lost a child through suicide, keep in mind that they are especially prone to self-blame and/or blame of the other parent, either subconsciously or consciously.
- The family has to be taught that the process of grief work is self-limiting and that even the most agonizing feelings eventually do become bearable.
- The family will have to help children grieve, by learning more about how children grieve and understand them better through that, as well as by modelling – allowing them to see the adults' grieving, but also their coping.

2.1.8.4 Empowering survivors through knowledge of suicide prevention

Hatton et al. (1977) include the personal statements of two suicidologists in their book on suicide. They pose a strong argument for suicide prevention, in spite of some societal norms that argue for own responsibility and decision-making – even about taking one's own life. Their reasons for this are that the decision for taking one's own life is often made when the individual is not well enough to come to a fair and just conclusion. This, in turn, renders a temporary nature to the decision, over and above the correctness or not thereof. Also, the fact that suicidal persons often have ambivalence about their own death is a devastating thought for those involved in suicide prevention – do people that succeed with suicide really *want* to die?

Together with all of this, concern for survivors of suicide also exists. Mourning a death by suicide is just so infinitely difficult, that to come through the process unscathed often requires specialised support and exceptional coping ability. However, a better solution by far would be to help prevent suicide in the first place. Yet, the matter is not as simple as that in every case of suicidal death, and that is why suicide is - and will always remain a very personal choice. Rather than try to prevent suicide above all else, they recommend that the focus should rather be on sharing of knowledge, experience and caring support. Hopefully this attitude will sway potential suicide victims and help explore other potential alternatives of improving the problem.

In summary then, indications are that suicide could not be prevented at all costs, or in all circumstances. However, what will be helpful is to extend a hand of support to those people who do consider taking their own lives, for as long as they need it - for as long as it takes for them to find a better alternative. An approach as gentle and caring as this could not offend or intrude upon people's rights to decide about their own fate (Hatton et al., 1977).

Given the above as a point of departure, how then do we empower survivors with knowledge in suicide prevention? Simply by sharing exactly the above information with them. By being informed, they may

conclude that suicide is as imperfect a solution to any problem as they had suspected all along. Their sense of incomprehensibility as to the cause and expected outcome surrounding suicide may be affirmed - it is often a faulty attempt at resolving some issue, and it is an ambivalent and diseased decision. Merely affirming the horror of suicide will help them realise that it is as bad as they are experiencing it. It will also be helpful for them to know that their loved one had quite possibly not really wanted to die but was in fact rather trying to escape from the pain. However, it is not the kind of solution they would want for themselves or for other grieving family members. Furthermore, by knowing that it is not always right or even feasible to prevent suicide in all circumstances, they might be relieved of the terrible burden of thinking that they should or could have prevented the suicide – which is maybe true in some instances but definitely no so all of the time.

2.1.9 Suicide and spirituality

For survivors of suicide that have strong feelings around the spiritual dynamics of such a tragedy, many questions come to mind. They may also experience the loss even more acutely, because of fears of proscription by their particular religious ties, or fears of being shunned by their congregation. Because of their hidden anguish, they may turn to literature on the topic of life after death in an attempt to find some answers to their questions, or to find some solace of trying to determine the fate of their deceased family member in the afterlife.

However, no simple answers are forthcoming, and neither does literature about life after death satisfy all people at all times. Browne (1994) distinguished between evil motives for suicide, altruistic motives for suicide and suicide because of irrational and diseased reasoning. Browne urges that the larger picture be borne in mind around understanding this very loaded issue – problems that lead to people wanting to commit suicide are only temporary, and do not warrant a permanent solution such as suicide to solve it. She states that people who have narrowly survived a suicide attempt report

that their experience of near death was not at all pleasant, and without fail all of them report this as an unhappy experience. They appreciate another chance at life. Browne also states that spiritual life cannot be killed or ended, it is only the physical life that can be ended through suicide. Therefore the mental anguish continues after the body has died. Suicide then does not end any problems, it only intensifies them. This is a very tragic thought for survivors of suicide, with respect to their deceased loved ones, but possibly a sobering thought for those survivors who do have suicidal ideation.

Moody (1988) states that research of near death experiences show that people who have attempted suicide, all return from that state with renewed purpose in life, knowing that to commit suicide is wrong, that it does not solve any problems, and that they would not like to repeat the experience. However, Moody reports further that we as humans do not understand the nature of our God, and that God in His forgiving nature will take care of those who could not do better. "What a suicidal person needs from us is not judgment but love and understanding" Moody concludes.

However, near-death experiences and the documentation thereof cannot be ignored, and knowledge of the afterlife has offered hope to many throughout the ages (Bascom, 1995). Charles Lindbergh, the aviator who undertook a transatlantic flight in 1927, reported an out-of-body experience during this flight. Later, in 1945, Carl Jung experienced a near-death experience, while suffering a serious heart attack, as recorded in his book *Memories, Dreams, Reflections*. The majority of these experiences are a pleasant revelation and a life-changing event for people who have been in this situation, but for people who have attempted suicide, however, the near-death experience is one of being trapped, of a sense that they have done something wrong, of suddenly being informed that they have a purpose in life and a task to complete. They have to return, to go and do that and to acquire more knowledge. Bascom also reports that true experiences of near-death following a suicidal attempt, seem to change these people's lives thereafter – they seem less suicidal, as if now having a better sense of purpose and meaning.

Van Praagh (1998) reports that the untimely death of people through suicide deprives them of the opportunities to have acquired the knowledge that they were still lacking.

Therefore they might have to re-experience the discomfort that they were trying to flee from by attempting suicide. He maintains that there are two kinds of suicide that are exceptions to the wrongdoing of suicide, and that is suicide through psychological illness, and suicide by some soul that had been on earth while not yet ready for the experiences that it was exposed to. People who do commit suicide may be uncomfortable thereafter, sensing the sorrow that they had brought onto their family and friends, and regretting their actions. Survivors of suicide who read this, may be sharply pained knowing that their deceased may be unhappy.

However, Van Praagh (1998) concludes by stating that each unique soul has to make certain decisions by themselves and that lessons about love and the sanctity of life have to be learnt in different ways, by each of us. "There are no right or wrong answers" (p.122). Judgment is not for us, but rather to view the experience from a spiritual perspective and trust that there is a larger meaning to all.

2.2 Summary

The literature about suicide and its impact on those bereaved thereby emphasise the enormity of such a tragedy. This is a worldwide phenomenon, taking on a variety of circumstances, and has a complex aetiology. Even thorough assessment and meticulous management of contributory factors does not ensure definite prevention of such a devastating event. The process of grief work for survivors is immense and the impact on caregivers, who lose a client through suicide or have survivors of suicide in their care, is significant as well. Suicide carries with it many issues on a social, psychological and spiritual level that may render the process even harder to bear for those bereaved by it. Suitable support may be especially welcome to help ease this burden for surviving family members, and knowledge gained above will be instrumental in generating a support programme. Chapter 3 addresses the outcome of this literature review and briefly offers some outlines for the methodology of the planned research. Information gathered through this research could be processed to formulate an intervention programme for survivors of suicide.

CHAPTER 3:

3.1 Summary of literature review

Suicide is a universal phenomenon prevalent enough to warrant more research into prevention thereof as well as postvention for survivors of suicide. The circumstances surrounding suicide vary but commonalities do exist that form the basis of a lethality scale for suicide prediction. Yet the incidence is high and the impact on survivors and caregivers who have lost someone through suicide, is significant. Sometimes the ripple effects touch lives to such an extent that more tragedies follow from that. However, many people do cope after suffering tragic losses, and many do eventually come to terms with bereavement by suicide to such an extent that they are able to enjoy a reasonable quality of life again.

At present, no structured intervention programme exists for survivors of suicide in this country. The inception of such a programme will ease the journey of adjustment following bereavement by suicide.

Robinson (1989) includes some case studies of survivors of suicide, one of a man who had lost his sister through suicide and who now works at the Los Angeles Suicide Prevention Centre. He reports that the most important support for both survivors and contemplators of suicide remains supportive, non-judgmental assistance, followed by professional help for potentially suicidal people. Furthermore, psycho-education may reduce much of the fear and misconceptions that trouble survivors, and may reduce the risk of even more suicides taking place in that family.

Members of suicide survivors' support groups report ... "they never thought it could happen to them, but it does. It happens in the nicest of families. That is why it's so frightening" (p. 55).

South Africa has equivalent statistics of suicide rates to many other countries worldwide. Yet people are bereaved through suicide in this country, at a rate of roughly 25,740 (see Incidence in Appendix A) per year, and many have to move on through the aftermath without the support that they so desperately need. This perpetuates into the next generation, eventually leaving even more thousands of people potentially vulnerable to self-destructive and/or suicidal behaviour. It is clear from the above that the generation of a postvention programme and a support group for survivors of suicide will provide much-needed assistance to this vulnerable group of people. A suitable intervention programme can be developed following more research on the experiences of survivors of suicide, and suitable processing of the information gathered.

3.2 Possibilities for future research and hypotheses that have evolved from this literature review

The above literature review poignantly illustrates how the tragic phenomenon of suicide claims a significant number of people every year. Furthermore, it affects many more people who are bereaved by suicide and who have to work through the sad legacy thereof. Research into suicide prevention or postvention for survivors may lead to intervention programmes that may reduce the incidence of suicide or alleviate some of the distress caused by suicide, and may be based on some of the hypotheses as stated below.

Future research into postvention for suicide survivors could be done by means of semi-structured interviews based on the questionnaire as in Appendix C, compiled by the writer. The Horowitz Impact of Events Scale as in Appendix D, could also be used. This scale was developed by Horowitz and partners in 1979, as delineated in Carson and Butcher (1992) as well as Rutter, Taylor and Hersov (1994). The information gathered can be analysed qualitatively, using a grounded theory approach to extract a descriptive and realistic theory that may be extremely valuable when formulating a support programme for survivors of suicide. This support programme can be based on the following hypotheses that have emerged from the literature review:

- Suicide affects people of different age groups and leaves behind survivors who may have specific requirements for coping with their grief, for example the parents of adolescents who have died by suicide.
- The loss of a member of the nuclear family to suicide results in severe adjustment difficulties for the surviving family members.
- Because of the stigmatisation of suicide, members of the nuclear family feel isolated in their grief.
- Suicide in the nuclear family is likely to induce fears and risks of further suicidal ideation in the family.
- From their own experience, survivors of suicide in the nuclear family will be able to identify coping skills and resources integral to a support programme for suicide survivors.
-
- The legacy of suicide may be passed on from generation to generation, rendering a sense of urgency to research thereof and the inception of an intervention programme.
- The suicide of a client has a significant impact on caregivers. They may require guidance in processing such a tragedy.
- Suicide leaves unanswered questions about spiritual issues that may be difficult for survivors to cope with.

These hypotheses correlate with the goals of this literature review and may lead prospective research into suicide prevention and postvention.

It could be possible though, that research of this nature may carry with it some ethical considerations that will require careful consideration. Also, participants who have suffered the loss of a loved one through suicide, may become emotional during the course of interviewing and may need extra time for containment afterward. Research of this tragic phenomenon would have to be done with caution and sensitivity so as to not traumatize participants further, but yet render them a cathartic opportunity. If done respectfully, this process may be helpful by contributing to the healing process of those bereaved by suicide.

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Appendix A:Incidence of suicide:

Underreported because of stigma attached.

Australia: 2000 per year
10 000 people affected by suicide per year

Worldwide: More than 1000 PER DAY
This translates to 365 000 per year
People bereaved by suicide per year: 1 825 000
Latest report, dated November 21, 2001: 1 000 000 deaths by suicide
per year, worldwide

South Africa: 5148 per year
25740 people affected by suicide per year

Cape Town Central: Salt River Mortuary: 157 per year.
785 people affected by suicide per year.

Ratio: 5/1 for men/ women

Average age: 37 years

Average survivors: Dependent women and children

Appendix B:

Goals of this study:

Understand the adjustment process of surviving family members

Lessening the severity of the emotional aftermath

Prevention of more suicides in the bereaved family

Creating an awareness in society of the devastating effects on family members

Introducing the needs of survivors so that a suitable format for support can be developed

Appendix C:

QUESTIONNAIRE

PLEASE TAKE YOUR TIME, AND ASK QUESTIONS AS YOU NEED TO!

Thank you for filling in this questionnaire. The content of this will be handled with the utmost of confidentiality, respect and sensitivity. You might become emotional or feel upset while busy with these questions. Please know that this is part of the process too, and that you may share your feelings about this with me if you would like to do so. This can take place while you are busy with the questions, or when we work through them afterward. I hope that sharing your experience with me will eventually contribute to the integration thereof for you.

NAME:.....

FAMILY COMPOSITION, NAMES AND AGES OF OTHER FAMILY MEMBERS:.....

.....
.....

BRIEF HISTORY OF YOUR FAMILY:.....

.....
.....
.....
.....
.....
.....
.....
.....
.....

HOW HAS SUICIDE TOUCHED YOUR LIFE?.....
.....
.....
.....
.....
.....

HOW DO YOU FEEL ABOUT WHAT HAS HAPPENED?.....
.....
.....
.....
.....

WHAT PART WAS OR STILL IS THE WORST FOR YOU?.....
.....
.....
.....

WHAT MIGHT HAVE MADE THINGS BETTER FOR YOU AT THE
TIME?.....
.....
.....
.....

HOW DO YOU THINK YOUR FAMILY MEMBERS FEEL ABOUT WHAT HAS
HAPPENED?.....
.....
.....
.....
.....

WHAT DO YOU THINK WOULD HAVE MADE THEM FEEL BETTER?.....

.....
.....
.....
.....

WHAT HAS BEEN HAPPENING IN YOUR FAMILY SINCE YOUR LOSS?.....

.....
.....
.....

WERE THERE OTHER FACTORS THAT MADE THE SUICIDE MORE
DIFFICULT TO DEAL WITH? (Some feelings, reactions, repercussions, or even
things that had been going on before your loss)

.....
.....
.....
.....

HOW DID YOUR SOCIAL SETTING REACT TO YOUR EXPERIENCE?

.....
.....
.....
.....

HOW WOULD YOU HAVE PREFERRED TO BE TREATED AT THE TIME?.....

.....
.....
.....
.....
.....
.....
.....

ASSUMING THAT THERE WAS A DIFFICULT TIME PRIOR TO THE SUICIDE, WITH THE BENEFIT OF HINDSIGHT, WHAT COULD ANYONE HAVE DONE TO HELP YOU AT THE TIME?

.....
.....
.....
.....

WHAT COPING STRATEGIES HAVE BEEN HELPFUL TO YOU AND/OR YOUR FAMILY SINCE YOUR LOSS?.....

.....
.....
.....
.....

WOULD YOU LIKE TO RECOMMEND HOW SURVIVORS OF SUICIDE SHOULD BE SUPPORTED? (SHORTLY AFTERWARDS, AS WELL AS SOME TIME AFTER).....

.....
.....
.....
.....
.....

IS THERE SOMETHING MORE ABOUT YOUR EXPERIENCE THAT YOU WOULD LIKE TO ASK, OR TELL ME ABOUT?.....

.....
.....
.....

Thank you for sharing this with me. I trust that, in time, you will find some sense of meaning through your experience, just as I have - through sharing some of your journey with you.

Appendix D:**HOROWITZ'S IMPACT OF EVENT SCALE**

Below is a list of comments made by people after stressful life events. Please check each item indicating how frequently these comments were true for you during the past seven days. If they did not occur during that time, please mark the 'not at all' column.

	Not at all (0)	Rarely experienced (1)	Sometimes experienced (3)	Often experienced (5)
1. I thought about it when I didn't mean to.				
2. I avoided letting myself get upset when I thought about it or was reminded of it.				
3. I tried to remove it from memory.				
4. I had trouble falling asleep or staying asleep.				
5. I had waves of strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from reminders of it.				
8. I felt as if it hadn't happened or it wasn't real.				
9. I tried not to talk about it.				
10. Pictures about it popped into my mind.				
11. Other things kept making me think about it.				
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.				
13. I tried not to think about it.				
14. Any reminder brought back feelings about it.				
15. My feelings about it were kind of numb.				

Note: Intrusion subset = 1, 4, 5, 6, 10, 11, 14
and avoidance subset = 2, 3, 7, 8, 9, 12, 13, 15

Source: Scott & Stradling (1992)