Suicide complex:
a narrative and theatrical inquiry
on suicide survivors

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Summary

This thesis is about the experiences of those who have lost their loved ones through suicide (called “suicide survivors”). Focusing on how they live their lives after the suicide and the unique features of their journeys, a methodology combining narrative and dramatic (applied theatre approach) is employed, including presenting the findings with narrative analysis. Jungian psychology serves as the theoretical basis for analysis and interpretation. With the aid of Papadopoulos’ ‘Trauma Grid’ (TG) (Papadopoulos, 2007), the contributing factors to their experiences are explored, which include negative impacts, positive outcomes, and resilience. The central research question addresses the following:

- ✧ What are the unique features of suicide survivors’ journeys and experiences? What contributes to the negative impacts, the positive and the unchanged?
- ✧ How can a combination of Jungian psychology and Papadopoulos’ TG provide a theoretical framework to put the survivors’ experiences in a unique perspective?
- ✧ How can the methodological principles of narrative and theatrical provide a platform for suicide survivors to tell stories which are true to their experiences? In what way do narrative and theatrical approaches provide an effective vehicle suitable for this type of bereavement?

After gathering data and analysing the findings, the researcher has proposed a hypothesis of suicide complex that is responsible for the complexity of suicide. Suicide is a total problem, covering biological, psychological, sociological, and cultural factors. Although this complex explains the elevated suicidal risk for survivors, it also sheds light on the transmitting effect among the general public indirectly. To tackle the issue of reducing the suicide of survivors, the community and society need to collaborate together, helping survivors transform the tragic loss to positive growth.

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Acknowledgements

To be able to finish this PhD is a miracle. It is karmic as well.

I lost my dear son, Zero, on 24 June 2003, while he was merely 12 years old. It has been a struggle for me to understand his suicide and to live with it. Initially I was hoping to work through this experience by doing this research; in the end I found that I was done to by this experience and research rather than me doing it. Being propelled by karma, I would not have been able to finish this project without the tremendous support – in practical, financial, and emotional terms – from my parents, my first son Swift, and my siblings. They deserve the first thanks.

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friends in Taiwan who have gone through the pain with me. Finally, to all the sentient beings who make the continuation and development of my life possible after the loss to suicide.

Introduction

This thesis is about the experiences of those who have lost their loved ones through suicide (for the purposes of this thesis this population will be called suicide survivors; the definition of how this term will be employed will be presented later in this introduction). The inspiration for me embarking upon this research stemmed from a personal loss. Twelve years ago I lost my second son to suicide. This incident changed my life completely (and has continued changing it in many ways). I could not understand how a person could just leave the world that we are in. I could also not comprehend why a person would choose to do so. Of course, I know it is about pain, but are we not all enduring some form of pain? And what are we left with after that person has gone prematurely? I began emerging from the acute stress caused by the loss of my son after about five years. It was at this time that I started wondering how other survivors live their lives. How have they been struggling? How could they face the loss for the rest of their lives? Those questions led me to this PhD study.

I conducted my studies at the Centre for Psychoanalytic Studies, which was based in the sociology department of university of Essex. Doing this psychoanalytic research within a sociology department has tapped into the tension between personal and academic, subjective and objective, feelings and science. Following the precedent set by Robert D. Romanyshyn who wrote graciously with the soul in mind in *The Wounded Researcher* (Romanyshyn, 2007, Romanyshyn, 28 May, 2014), I have tried to do research with “woundedness” in mind. Survivors are wounded, and wounded badly. The “woundedness” here

denotes the destiny that is shared by the group of people who lost their loved ones through suicide. Instead of calling myself “the researcher”, I will use personal pronouns including “I” to refer to myself (hence why I have called it “my” research) to indicate that this is a bold position-taking. This act is essential since the use of my personal experience is the core of my research and of my journey as a survivor-as-researcher. In what follows, aspects of this journey will show up in some autobiographical moments, and the traces of balancing the tension between myself as survivor and as objective researcher are more than obvious. The main focus of this research is more on the academic and objective qualities (particularly in the utilization of theories), and these theories will be supplemented by elements of the personal and subjective (especially in the mood and attitude). Striving for the latter has not gotten in the way of the former and the former has not disguised the latter, even though the personal and subjective have occupied little space in the text.

This thesis explores how survivors live their lives after the suicide of a loved one and the unique features of their journeys. I have employed a methodology that combines narrative and dramatic methods. Jungian psychology serves as the theoretical basis for analysis and interpretation. With the aid of the Renos Papadopoulos’ ‘Trauma Grid’ (TG) (Papadopoulos, 2007), I have explored the factors that contribute to survivors’ various responses to trauma, including negative impacts, positive outcomes, and the development of resilience. The central research question addresses the following:

- ✧ What are the unique features of suicide survivors’ journeys and experiences? What factors contribute to the negative repercussions and the positive transformations that the survivors experience? What contributes to the aspects that remain unaltered?
- ✧ How can a combination of Jungian psychology and the Papadopoulos’ TG provide a theoretical framework to put the survivors’ experiences in a unique perspective?
- ✧ How can the methodological principles of narrative and dramatic expression provide a platform for suicide survivors to tell stories which are true to their

> experiences? In what way do narrative and dramatic approaches provide an effective vehicle suitable for this type of bereavement?

In this thesis, those who lost their loved ones through suicide are called “suicide survivors”. A suicide survivor is:

> someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person. (Jordan and McIntosh, 2011b: 7)

However, the term “suicide survivor” is problematic because it can be misunderstood as referring to someone who has attempted suicide and survived the attempt. Nevertheless, it is broadly used in suicidology and the survivor community in the United States and the UK to describe someone who is bereaved after the suicide of another person (Jordan and McIntosh, 2011b, Wertheimer, 1991). For those who have attempted suicide and are still alive, the term “suicide attempt survivors” is suggested by the American Association of Suicidology and a division of the association that addresses the specific needs of suicide attempt survivors was set up in 2014 (Madpix-Films, 2014).

For each suicide, at least six survivors (Williams, 1997), or ten (Peters, 2006), or twenty-four (Pompili et al., 2008) will be impacted; and as many as one hundred would seriously contemplate killing themselves (Litman, 1994: 189). The parameters of who qualifies as a survivor have been extended to include health professionals (such as doctors, nurses, social workers and therapists) (AAS) and those who are distressed after the suicide (such as the police). They have been included regardless of their kinship relationship or psychological relationship with the deceased due to their professional involvement prior to and after the suicide (Jordan and McIntosh, 2011b). Myfanwy Maple proposed a continuum of survivorship for those who are ‘exposed’, ‘affected’, ‘bereaved short term’, and ‘bereaved long term’ (Maple, 2013).

By means of the wider inclusion of survivors in this research, the number of survivors is increased. Granting the broadest extension of this argument, there are more survivors than are immediately obvious. In a word, we are all survivors, directly or indirectly, explicitly or implicitly. We are all born survivors[1]. This is not to exaggerate the shocking effect of suicide, but to shed more light on how a wider community might be influenced by suicide. Survivors did not "exist" until suicide became a mental health issue (Colt, 1987); and their well-being is just beginning to attract minimal attention (Ellenbogen and Gratton, 2001, McMenamy et al., 2008).

Before giving the outlines of each chapter, I will clarify some controversial terminologies. First, the expression of "successful" or "failed" suicide was replaced by "suicide" or "attempted" suicide (Stengel, 1969). The relationship between the acts of "committing" (i.e. successful) and "attempting" (i.e. failing) suicide is a complex one. For example, one may deny one's intention to kill oneself after having been rescued, and many suicidal attempters and those who do kill themselves might not have a clear and absolute determination to end life.[2]

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1 This conclusive statement is from my subjective experience of the loss through suicide. In the other trauma discourse, I found a similar ethos in Lifton who said that 'we are all survivors of Hiroshima'. Cited in LIFTON, R. J. 1968. Death in Life: The Survivors of Hiroshima, London, Weidenfeld and Nicolson. P. 479. Lifton also said, 'all Americans are survivors of the Vietnam holocaust and are faced with the task of recognising and bringing significance to their death immersion'. In LIFTON, R. J. 1973. Home from the War: Vietnam Veterans: Neither Victims nor Executioners, New York, Simon & Schuster. P. 305. Both references are cited in LUCKHURST, R. 2008. The Trauma Question, London, Routledge. P.63, 64.

2 Another behaviour that is described as "attempt" is self-harm. Deliberate self-harm refers to any intentional act of self-injury or self-poisoning (i.e. overdose), irrespective of the obvious intention or motivation. Although it will not be discussed in this thesis, deliberate self-harm is a positive indication of the risk of future suicide. Hawton and colleagues adopted a community-based approach to investigate self-harm in adolescents through schools. Their approach is to counteract the drawback of the clinical approach whose results are inaccurate, because some young people might have self harmed without getting the help through the clinical route. They wrote that the risk of suicide in deliberate self-harm patients during the year after hospital presentation is 50-100 times higher than that in the general population. See HAWTON, K., RODHAM, K. & WITH EVANS, E. 2006. By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents, London, Jessica Kingsley. P. 12.

However, it is also suggested that "self-harm" is differentiated from "suicide attempt" depending on the evidence of suicidal intent. See O'CONNOR, R. C., PLATT, S. & GORDON, J. 2011. Introduction. In: O'CONNOR, R. C., PLATT, S. &

However, the term “commit suicide” is discarded in this thesis because its usage has the connotation of committing a crime (unless it is used in a quotation), which results from the historical residue of seeing suicide as an offence (Szasz, 1989: 441).

Second, the term “suicide” used in this thesis refers to both the one who kills him/herself and to the act of killing oneself; whether it refers to the person or the act will be made clear by the context. Third, to honour the traditional usage of suicidology, the person who kills him/herself will be referred to as the ‘victim’, whereas the people who are left behind will be called ‘survivors’ (Wertheimer, 1991, Jordan and McIntosh, 2011b). This use of the word survivor is a choice of ‘therapeutic empowerment’ (Luckhurst, 2008: 62) as Charles Figley suggested: ‘the victim has been immobilized and discouraged by the event, the survivor has overcome the traumatic memories and become mobile’ (Figley, 1985: 399). Lastly, the question of whether suicide is rational or not and the issue of assisted-suicide will not be investigated in this paper, because they are not the focal points of the thesis.

In the context of this thesis, the term “survivors” is used to refer to “suicide survivors”; it will be indicated if other types of survivors are referred to. All italics in the cited texts are original unless specified otherwise. “S/he” and “him/her” are used as an economical way of including both sexes. A single quotation mark (‘) denotes a direct quotation from a text. A double quotation mark (“) is used to denote a phrase, dialogue or colloquialism. In the following paragraphs I will introduce the structure of this thesis. It is comprised of three parts, which are made up of ten chapters and is concluded with a personal epilogue.

GORDON, J. (eds.) International Handbook of Suicide Prevention: Research, Policy and Practice. Oxford: Wiley-Blackwell. P. 2.

Part one includes the first three chapters. These chapters explore the issues of suicide and survivors. Chapter One investigates the history and theories of why people kill themselves. The history is confined to the western context because it is where most of the research is to be found, and the scope of theories investigated will be from psychology, sociology, and archetypal dynamics. General statistics of suicide rate, quantitative data or chemicals in the brain will not be discussed because they only generate relative ideas without really understanding the dynamics in the suicide's psyche (Hillman, 1973/2011, Menninger, 1938). As James Hillman is an important Jungian analyst, his attitude on suicide cannot be ignored, I will present a critique at Chapter Four on Analytical Psychology.

Chapter Two begins with an overview of contemporary research on loss, grief and bereavement, since it is the majority of studies on survivors have been undertaken. After a brief discussion of life after death, the focus will shift to an examination of common themes of survivors' emotional reactions, psychological turmoil, and the changes they undergo. These themes have been organized into the categories of: stigmatization, shame and guilt; the life-long mourning journey; the influence of suicide on the survivor's well-being; social isolation, the conspiracy of silence, distorted communication; identification with suicide; meaning seeking; and the potential for transformation after adversity. Chapter Two concludes with research that investigates the potential for positive growth and other possible outcomes that may occur after the experience of adversity and a section on the Trauma Grid.

Chapter Three looks into the therapeutic approaches in relation to survivors. Three layers of suicide prevention are introduced: 'primary' prevention (involving the family, community and society); 'secondary' prevention (involving intervention/treatment of suicidal persons); and 'tertiary' prevention or 'postvention' (referring to the work with survivors of suicide) (Stillion and McDowell,

1996: 199). In addition, three specific interventions for survivors are discussed: group work, psychological autopsy, and the narrative approach. The narrative approach contains two applications: one focuses on the trauma and its treatment, in which two tenets of trauma discourse are discussed: personal trauma (Parry and Doan, 1994: 9, Gilmore, 2001) and social trauma (Caruth, 1995, Felman and Laub, 1992). Another focuses on community building and empowerment through sharing stories. For the orientation that is concerned with therapeutic community building and empowering storytelling, illness narratives and life stories are the genres chosen as a means of exploring how narratives are used in therapeutic contexts.

The three chapters that make up Part One cover the discipline of suicidology. The chapters that consist of Part Two are concerned with the theoretical frameworks embedded in the thesis. These frameworks are: the discipline of Analytical Psychology, Narrative Inquiry, and Applied Theatre.

Chapter Four, Analytical Psychology, focuses on Jung's theory of Complex and Archetype. The theory of archetype has caused confusion and researchers have debated about the out-datedness of the classical Jungian model (i.e. archetype as innate) and proposed a developmental/emergent model. They have done so by adopting the studies that were unavailable to Jung's time. The theoretical exploration of complex/archetype is employed in order to pave the way for the formulation of a hypothesis of the existence of a "suicide complex" (SC). This theory posits that a complex can be observed in the form of a constellation of neuroses in the survivor's psyche and the presence of this constellation may result in the survivors' suicidality. This complex may also be constellated in the psyches of the general public indirectly after a suicide happened because of the expanding populations of survivors. I will use the data obtained from the empirical

work and analysis to further prove my theory of SC in Chapter Nine. This chapter ends with a section critiquing Hillman's attitude to suicide.

The theories for Narrative Inquiry (NI) are explored in Chapter Five. First, I will investigate NI as a qualitative research method. The conceptual roots of NI were situated in a Deweyan ontology of experience. This chapter ends with an outline of methods of narrative analysis and the experimental development in qualitative research.

Chapter Six is about Applied Theatre (AT), beginning with the history of its development which shared the same root of dramatherapy and psychodrama. Then I discussed its pedagogical, social, and political functions and some key terms (community, identity and identification, space, and intervention). AT also overlaps with the discipline of performance, therefore, this chaper ends with the performance and personal narrative, and the element of performative.

Part Three covers Chapters Seven to Nine. This part is about my work – the opus. This work includes: empirical stage of the research, analysis of data and a discussion of the analysis. The research design and method are the main focuses of Chapter Seven. In this chapter, the components of the empirical research that took place are outlined and explained. This work consisted of an initial interview with potential participants, followed by an intervention in the form of an applied theatre group, and a post-intervention interview with the group participants. In the sections that follow, I discussed the selection of participants, the rationales behind the research design, and ethical issues. This chapter ends with the rationale behind choosing narrative analysis and data presentation.

Analysis of the data is the main content of Chapter Eight and the contributing factors to various responses to losing someone to suicide are identified according to the TG. The factors that were identified as contributing to negative outcomes are: individual vulnerability and environmental deficiencies before the suicide and

after; the barriers that prevent survivors receiving support from others; and external pressures preventing the grieving process. The elements contributing to one's 'neutral' responses (i.e. resilience) are: making good use of the availability of existing support and financial security; seeking available resources; and developing and maintaining effective coping strategies. The circumstances that contribute to positive outcomes include: the determination to outgrow the pain; recognising the insufficiency of the utilitarian or operative attitude toward life, and as a result seeking changes; and finally, saying "yes" to the future. This chapter ends with a discussion of the analysis.

Chapter Nine begins with the evaluation of the participatory and empowerment elements in my empirical work. The discussion is then focused on further exploration of the constitutive elements and applications of the TG to the researched population, and the application of the applied theatre method to the research on survivors. Furthermore, by applying Jung's theory of complex/archetype, a suicide complex (SC) (i.e. the survivor's impulse to kill him/herself is constellated in the psyche, and the general public is influenced indirectly) is proposed and analyzed. This hypothesis – that suicide is an indication of a deep psychic problem, not just a mental one – is one of the main contributions that is offered by this thesis. The hypothesis of SC helps to explain why suicide is controversial: suicide is a total problem that has roots in the psychological, sociological and cultural levels, although it is mainly manifested at the behavioural level. Some of the impulse is embedded in the unconscious, waiting to emerge after the frustration of one's essential needs. A detailed analysis of this complex will be presented at the end of this chapter.

The Conclusion starts with the issues of reflection and reflexivity. As the survivors participated in my research, they took the deceased with them into the

sessions; they were among us and they deserved a place. The identification that existed between survivors and me as a researcher is full of complexity. The way I experienced the project and the way the research influenced my relationship with loss became an important issue. Therefore, three pivots that are embedded in the reflective and reflexive processes are investigated: the essentialist stance and the place of the Other; identity and identification between survivors and me as the researcher, including my self identity; and the ethics surrounding subjectivism in this research. This chapter ends with my self-analysis, the limitations of the study, and suggestions for future research.

The ending of this thesis does not end the journey; like it or not, the journey continues. Instead, I embark on a different level of surviving the loss and living with the loss. It becomes part of me and I have a better relationship with it – with more laughter, acceptance and realization.

PART ONE

SUICIDE AND SURVIVORS

1. Suicide: the History and Aetiology

According to the World Health Organization, over 800,000 people die by suicide every year. Suicide occurs throughout the lifespan and was the second leading cause of death among 15-29 year olds globally in 2012. Death by suicide accounted for 1.4% of all deaths worldwide, and was rated the 15th leading cause of death in 2012 (WHO). In the UK, according to *Suicide Statistics Report 2014* published by Samaritans, the male suicide rate is approximately three and half times higher than that of females for the UK as a whole. In Scotland, the male suicide rate is roughly three times higher than that of females (Scowcroft, 2014). In U.S.A., more than 36,000 people die by suicide every year. Male suicide rate is four times than that of females, although females attempt suicide is three times more frequently than males (AAS).

Suicide is a global phenomenon, and the International Association for Suicide Prevention has indicated on its website that the populations at risk abound. They include: addicts, bullied, young adults, older people, HIV/AIDS, LGBT, minorities, helping profession … (IASP). The risks for each population deserve to be researched. For example, according to the *Lesbian, Gay, Bisexual and Transgender Resource Sheet* published by the American Association of Suicidology, gay men were six times higher than heterosexual males to attempt

suicide, and lesbians were two times more likely than heterosexual females to attempt[3].

I am aware that the choice of what to present in this chapter can give the impression of treating suicide as a homogenous subject; however, the exploration of risk factors for different groups is not the focus of my thesis, and the purpose of raising the issues of suicide is to open the tapestry of what happened after suicide, therefore, I will focus on the history and a few well-established theories of why people kill themselves. As it is unrealistic to put all the history and theories in a chapter, therefore, the history explored in this thesis is confined to the western context, because this is where most of the research is to be found[4], and the scope

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3 However, there is no empirical data regarding the number of completed suicides within the LGBT community yet. See AAS. Lesbian, Gay, Bisexual and Transgendered Resource Sheet [Online]. Available: http://www.suicidology.org/Portals/14/docs/Resources/LGBT%20Resources/LGBTresource-sheet.pdf [Accessed 24 Apr. 2015]. The risk factors to suicide for the LGBT community different from those of other population are resulting from the sexual orientation and gender identity. They experience more social stigma, prejudice and discriminations (including individual and institutional). See HAAS, A. P., ELIASON, M., MAYS, V. M., MATHY, R. M., COCHRAN, S. D., D'AUGELLI, A. R., SILVERMAN, M. M., FISHER, P. W., HUGHES, T., ROSARIO, M., RUSSELL, S. T., MALLEY, E., REED, J., LITTS, D. A., HALLER, E., SELL, R. L., REMAFEDI, G., BRADFORD, J., BEAUTRAIS, A. L., BROWN, G. K., DIAMOND, G. M., FRIEDMAN, M. S., GAROFALO, R., TURNER, M. S., HOLLIBAUGH, A. & CLAYTON, P. J. 2011. Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations. Journal of Homosexuality, 58, 10-51.

4 For cultural differences, for instance, suicide in China (especially by young women) can be a subtle way for victims to take revenge against the power of social injustice, see BAUDELOT, C. & ESTABLET, R. 2008. Suicide: The Hidden Side of Modernity, Cambridge, Polity Press.

In some East African tribes, suicide was seen as a sign of the wrath of the ancestors who had to be appeased by sacrifices, see STENGEL, E. 1969. Suicide and attempted suicide, 2nd edition., Middlesex, Penguin.

For two types of altruistic suicide in ancient India: mass suicide by the women when their men faced defeat (Jauhar) and self-immolation of widows (Sati), see VIJAYAKUMAR, L. 2004. Altruistic Suicide in India. Archives of Suicide Research, 8, 73-80.

For the socio-political contexts of self-immolations in Vietnam and South Korea, see PARK, B. C. B. 2004. Sociopolitical Contexts of Self-Immolations in Vietnam and South Korea. Archives of Suicide Research 8, 81-98.

For the Japanese custom of hara-kiri (ritual self-disembowelling), an aestheticization of honourable death (kakugo no jisatsu), and "overwork suicide" (karô jisatsu), see KITANAKA, J. 2009. Questioning the Suicide of Resolve: Medico-legal Disputes Regarding "Overwork Suicide" in Twentieth-Century Japan. In: WRIGHT, D. & WEAVER, J. (eds.) Histories of Suicide: International Perspectives on Self-Destruction in the Modern World. Toronto: University of Toronto.

of the theories investigated will cover psychology, sociology, and archetypal dynamics. The division of the disciplines in this chapter is only for polemical clarity, for it is averred that suicide is a multi-disciplinary phenomenon (Raingruber, 2003, Blaauw and Kraaij, 1997).

Sketches of Suicide from Historical Contexts

In the *Bible*, we can find numerous examples of characters struggling between the pulls of life and death. Job's despair is a good example:

> Why is light given to those in misery, and life to the bitter of soul, to those who long for death that does not come, who search for it more than for hidden treasure, who are filled with gladness and rejoice when they reach the grave? (Job 3: 20-2)

Rebekah in *Genesis* (25: 22) cried: 'If this is the way it is, why should I go on living?' Moses in *Numbers* (11: 15): 'Please kill me right now. … Do not make me see any more calamity'. Elijah: 'Take my life away, for I am no better than my forefathers' (1 *Kings* 19:4) (the three quotations are cited in Awake!, 2014: 7). In the early years of the Church, suicide was seen as a neutral phenomenon. It had not been explicitly condemned in either the Old or the New Testaments[5], and none of the four suicides recorded in the Old Testament – those of Samson, Saul, Abimelech and Achitophel – were

5 For the opposite point of view and the different positions between Judeo-Christianity, Judaism and Catholicism, see BARRY, R. F. 1999. The Catholic Condemnation of Rational Suicide. In: WERTH, J. L. (ed.) Contemporary Perspectives on Rational Suicide. London: Brunner/Mazel.

criticized in the text[6] (Alvarez, 1971: 69). Thus, it was not until the sixth Century AD that the Church formally legislated against suicide.

According to A. Alvarez, in ancient times some warrior societies worshipped the gods of violence. A trait that was highly valued by these societies was bravery and suicide was seen as a brave act and therefore virtuous. For instance, those who died in battle could enter the banquet in the paradise held by the god of the Vikings, Odin; the next ranking guests were the suicides. They killed themselves to avoid a shameful natural death and to avoid being banished from eternal paradise. By seeing death as comparatively unimportant, suicide could become more of 'a matter of pleasure than of principle'; it is a 'frivolous act' (Alvarez, 1971: 74).

Alvarez observed that the motivations for suicide among the ancient Greeks were grief, patriotic principle or the avoidance of dishonour. Their philosophical argument regarding suicide was rather detached and balanced with a 'calm, though slightly excessive, reasonableness' (Alvarez, 1971: 79). On the other hand, from Plato's *Phaedo*, we can see that Socrates believed that man was the property of the gods, and the gods would be angered by the act of suicide. Plato (428-348 B.C.) wrote in *Laws* that the person who died by suicide:

> must be buried individually, with no one to share their grave. ... [they must] be buried in disgrace on the boundaries of the twelve territorial divisions, in deserted places that have no name. The graves must not be identifiable, either by headstone or title. (Plato, 1975 873d: 347)

In contradiction to this practice, Plato suggested that if life became unbearable, suicide could be a rational and justifiable choice. Aristotle

6 Another reference pointed out that there were eight suicides in the Old Testament and one in the New Testament; none of them were condemned. Cited in PETERS, J. 2010. Cultural Dimensions. In: LINN-GUST, M. & PETERS, J. (eds.) A Winding Road: A Handbook for Those Supporting the Suicide Bereaved. New Mexico: Chellehead Works. P. 61.

(384-322 B.C.), on the other hand, wrote that suicide was 'an offence against the State'. In *The Nicomachean Ethics,* he wrote:

> The law does not allow a man to kill himself. … [The suicide is] contrary to the law, he is acting unjustly. ... contrary to the right principle, what the law does not allow; therefore he is acting unjustly. But towards whom? Surely not himself, but the state;…. It is for this reason that the state imposes a penalty and a kind of dishonour is attached to a man who has taken his own life, on the ground that he is guilty of an offence against the state. (Aristotle, 1976: 200-01)

The change of thought in Greek society indicates the inevitable complex relationship between suicide and the authority. The Stoics accepted suicide as a reasonable and desirable means of death. They were as indifferent to death as they were to life (Donnelly, 1998: 35-9). The famous Stoic philosopher Seneca (4 B.C. – A.D. 65) rejected the 'paternalist-statist argument' against suicide and even recommended it (Szasz, 1999: 11). For the Epicureans whose guiding principle was pleasure, anything that produced pain was seen as evil. When life lost dignity, death became a rational choice that conformed to a rational attitude. In Athens, where hemlock was used as a means of suicide, official permission for suicide could be granted by the authorities. Durkheim quoted from *Libanius*:

> Whoever no longer wishes to live shall state his reasons to the Senate, and after having received permission shall abandon life. If your existence is hateful to you, die; if you are overwhelmed by fate, drink the hemlock. If you are bowed with grief, abandon life. Let the unhappy man recount his misfortune, let the magistrate supply him with the remedy, and his wretchedness will come to an end. (Durkheim, 1952/1963/1966: 330)

As noted by Alvarez, the Romans advanced the idea of suicide as an act which could be carried out with the greatest dignity and bravery[7] (Alvarez, 1971: 82). They did not look on suicide with fear or revulsion, but as a rational choice,

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7 Hill suggested that suicide was rather 'performed' in the presence of family and friends; it was more 'politically' gestured. Cited in MARSH, I. 2010. Suicide: Foucault, History and Truth, Cambridge, Cambridge University Press. P. 83.

validating the way they wished to live their lives. For the Romans, to live nobly would mean to die nobly and at the right time. If suicide was punished, it was not because it was a crime but irrational; and anyone except slaves and criminals was allowed to kill him/herself. This attitude was reinforced by Roman law. If criminals killed themselves to avoid trial, the relatives might be unable to inherit the assets; and slaves were considered the property of their owner. Thus, suicide on the part of a criminal or a slave was forbidden for economic concerns rather than moral or religious ones; that is, against the monetary investments or the treasury of the State.

Citing the linguistic analysis of suicide made by David Daube and Anton van Hooff, Ian Marsh argued that suicide 'did not exist as a concept in either ancient Greece or Rome', because there were more than 300 ancient Greek and Latin words or expressions that describe various forms of self-accomplished death, e.g. 'voluntary death', 'to strive after death', etc. The word "suicide" is used firstly by Sir Thomas Browne in his *Religio Medici* (1642) (Marsh, 2010: 79, 90). In the period of Christian Europe, the history of suicide was described as 'the history of official outrage and unofficial despair' (Alvarez, 1971: 64). In its early development, Christianity seemed to regard suicide with indifference, for this earthly life was seen as shadowy, unredeemable and sinful. To kill oneself to enter God's eternal glory became an irresistible temptation, and the Church could therefore be seen as encouraging suicide (Constantelos, 2004). This attitude persisted until St. Augustine advocated that life was the gift of God; if one killed him/herself, it meant s/he did not accept the divine will. This interpretation was based on the sixth commandment: "Thou shalt not kill". St. Augustine wrote:

> Whoever kills himself is a murderer, for the commandment "Thou shalt not kill" implies a general prohibition of killing human beings, "neither another, nor yourself". (cited in Szasz, 1999: 1)

Having one's own blood on one's own hands became a terrible sin because there was no chance to repent.

One of the first cases of suicide being formally condemned occurred in Hereford in 673 A.D.[8] In 533 A.D., the Council of Orleans denied funeral services to those who killed themselves and accused them of a crime at the same time. Suicide during these times was condemned as a crime and considered worse than other crimes, since all other people considered criminals were allowed a proper religious burial. In 562 A.D., the Council of Braga banned funeral rites for all suicides regardless of their social status. In A.D. 693 the Council of Toledo ordained that even the suicide attempter would face the fate of being excommunicated. A suicide was considered to be the lowest form of criminal.

Citing the Elizabethan lawyer Fulbecke[9] words from Glanville Williams' *The Sanctity of Life and the Criminal Law* (1957), Alvarez wrote that in early modern England the person who died by suicide 'is drawn by a horse to the place of the punishment and shame, where he is hanged on a gibbet, and none may take the body down but by the authority of a magistrate'. Another legal figure, Blackstone, wrote that the suicide was buried 'in the highway, with a stake driven through the body', thus being treated like a vampire. According to Alvarez, the last record we can find of the 'degradation' of the corpse of a suicide in England was in 1823. A man called Griffiths was buried at the crossroads of Grosvenor Place and the King's Road, Chelsea (Alvarez 1971: 64).

Mark Williams interpreted the historical attitudes to suicide as 'a journey from the darkness of ignorance and belief in the supernatural to the light of a

8 The following historical records are referenced from ALVAREZ, A. 1971. The Savage God: A Study of Suicide, Middlesex, Penguin Books. P. 89.

9 Alvarez's text did not provide the full name of Fulbecke; nor the next legal figure, Blackstone.

modern and tolerant era' (Williams, 1997: 17). The primitive fear of suicide was 'a horror of blood evilly spilt and unappeased' (Alvarez, 1971: 68). Arising out of the development of modernity[10] and capitalism, two main discourses of suicide have been competing with each other: the psychological and the sociological (Alvarez, 1971, Giddens, 1971b, Williams, 1997). These two competing theories of suicide are the humanizing developments of the discourse on insanity that stems from the beginning of modernity. Since then, perceptions of suicide have bypassed the domains of philosophy and theology. Suicide is no longer viewed as a sin (Murray, 1998) or a crime (Alvarez, 1971, Marsh, 2010) or a punishment[11]. According to the psychological approach it is understood to result from psychical malfunctions; while in the realm of the sociological, it is understood to be a societal problem.

Before reviewing the different approaches to understanding the aetiology of suicide, it is pertinent to explore the connection of suicide with madness during the period between the Sixteenth and the Eighteenth Centuries. This discussion is

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10 Modernity in the broad sense refers to a change of living style and cultural practice initiated by the Renaissance, including the end of feudalism and the rise of capitalism, with a stress on the market and individualism. The narrow sense refers to the changes resulting from the agricultural and industrial revolutions of the early 1800s. See ARMSTRONG, T. 2005. Modernism: A Cultural History, Cambridge, Polity Press. BAUDELOT, C. & ESTABLET, R. 2008. Suicide: The Hidden Side of Modernity, Cambridge, Polity Press.

Sometimes "modern" simply means "comtemporary" and they are interchangeable. When it comes to "modernism" and "modernist" in the thesis, they refer to a new way of thinking, social life and cultural practices during the narrow sense of modernity. However, the division of historical development is not straightforward and often overlapping.

11 Death is described implicitly as a punishment, in Schubert's Death and the Maiden verses: 'Give me thy hand, thou fair and gentle creature/I am a friend and come not to punish thee'. Cited in STORR, A. 1972. The Dynamics of Creation, Middlesex, Penguin Books. P. 63.

Suicide can be seen as a punishment of the self, see HAMILTON, R. 2004. Irreversible: Unbearable Feelings. British Journal of Psychotherapy, 20, 281-293.

Suicide as a punishment for others, see FUTTERMAN, S. 1965. Suicide: Psychoanalytic Point of View. In: FARBEROW, N. L. & SHNEIDMAN, E. S. (eds.) The Cry for Help. New York: McGraw-Hill Book Company. P. 178.

based on the following considerations: (1) the madness discourse relieved the suicide from succumbing to the social dominance of philosophy and theology; (2) during this time the practice of using scientific method to examine the biological and psychological factors in the suicidal mind was originated; (3) the link made between suicide and madness during this time was the precursor of seeing suicide as a mental problem, which has since become a popular and recognized perspective. By linking the madness discourse with suicide, the door to examining the suicidal mind in medicine (including psychiatry and psychology) had been opened. To assign suicide 'a separate diagnosis', 'separate identity', or 'separate diagnostic entity' other than mental illness has been called for by psychiatrists (Oquendo, cited in md-fm.com, 2013).

Suicide is a controversial issue (Battin and Mayo, 1980, Battin, 1982, Weaver and Wright, 2009, Prado, 2011, Beauchamp and Veatch, 1996, Hillyard and Dombrink, 2001), and its aetiology is hard to grasp (Baechler, 1979, Szasz, 1999, Silverman, 2011). No one single theory can fully explain suicide and many theories contradict one another (Giddens, 1971b, Farberow and Shneidman, 1965). There are many 'grey areas' to clarify before it can be researched in a meaningful way (Fincham et al., 2011: 33). After outlining the madness discourse, I will then give the main arguments of each theory (psychological, sociological and archetypal), and some available critiques of each approach will be provided.

The Link with Insanity since Modernity

The beginnings of the modern study of suicide date back to the Seventeenth Century (Giddens, 1971a: ix), and the connection between suicide and madness has dominated the discourse (Giddens, 1971c). William Ramesey in *The Gentlemen's Companion* (1672) suggested that the victim of suicide was also a victim of mental illness. He wrote that suicides:

> should rather be objects of our greatest pity than condemnation as murderers, damned creatures and the like. For, 'tis possible even for God's elect having their Judgements and Reasons depraved by madness, deep melancholy, or somehow otherwise affected by Diseases of some sorts, to be their own executioners. Wherefore let's be slow to censure in such cases. (cited in Williams, 1997: 12)

The earliest English reference connecting suicide to clinical depression is found in *The Anatomy of Melancholy* (1621) by Robert Burton (1577-1640). Burton used the term 'melancholy' to denote an affective state that occurs in the body and mind as the result of humoral imbalance[12]. The person who killed him/herself was considered *non compos mentis* (not of sound mind), and s/he was not therefore responsible. This line of thought changed the perception of self-killing from '*a deliberately felony into a purposeless accident*' (Szasz, 1999: 31). In 1672, Gideon Harvey, the physician to King Charles II, published a treatise called *Morbus Anglicus*, a term used to refer to 'hypochondriacal melancholy' as a specific disease and paving the way for the medical theory which holds that the English are particularly susceptible to melancholy.

In 1733, George Cheyne published *The English Malady*, stating that the English temperament was linked with melancholy, and that melancholia had become an excuse for self-murdering. In the early Nineteenth Century, a

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12 The Greek physician Hippocrates (460-370 BC) found that personality and behaviours were the manifestations of four bodily liquids: black bile, phlegm, blood, and yellow bile. Too much of black bile caused one to be melancholic, delusional, manic; too much of phlegm, phlegmatic, easygoing, calm; too much blood, sanguine, confident, hopeful; too much of yellow bile, choleric, angry, irritable. Hippocrates probably was the first clinician to suggest the connection between brain function and mental health; he could also be the first person to suggest the link between brain function and suicide. He wrote in On Sacred Disease,

'... the source of our pleasure, merriment, laughter and amusement, as of our grief, pain, anxiety and tears, is none other than the brain. … It is the brain too which is the seat of madness and delirium, of the fears and frights which assail us ...'. See HIPPOCRATES 1950. The Medical Works of Hippocrates, Oxford, Blackwell Scientific Publications, ibid. (18) P. 190.

Another figure, Empedocles in around 450 BC connected humoral theory with cosmic elements (earth, water, air, fire); each element has two properties (cold/warm, dry/moist). Cited in COHEN, D. B. 1994. Out of the Blue : Depression and Human Nature, New York, W.W. Norton. P. 246.

discernable shift occurred, from a narrow understanding that linked mental illness with suicide to seeing suicide as clear evidence of insanity (Marsh, 2010: 93). Since the development in the Twentieth Century of psychiatry and the "scientific" method to explore the mind, there is ample evidence showing the positive relationship between suicide and mental illness (Robins et al., 1959/1996, Stengel, 1969: 59-60)[13]. During this period, a greater understanding was garnered of the connection between a family history of suicide and a person attempting suicide (Cain, 1972b, Segal, 2009, Cohen, 1994). Another shift in the understanding of suicide is a result of advances in the study of neuroscience, from which an understanding of suicide being caused as a result of biological malfunction and a biochemical imbalance in the brain has developed (Lann et al., 1989).

The biochemical, genetic, and heritable factors seem persuasive with the support of scientific evidence (e.g. the fluctuation of hormones, or brain scans, or an overview of family trees), and indicative that mental problems can be treated with drugs; hence, in this train of thought, suicide is treatable by purely medical intervention. We cannot deny the merits of clinical treatment for acute suicidal patients, yet this line of argument seems to have confused symptoms with causes. When a person is inflicted with a clinical mental disorder that results in the killing of him/herself, there will be psychological issues behind this act (see the following psychological explanations). When a family has suffered multiple suicides, there will be hidden systematic malfunction issues (see the following sociological

13 The opposite views are also ample, that many suicidal patients do not show the clinical symptoms of depression; nor is each depressed patient suicidal. See HENDIN, H. 1965. Suicide: Psychoanalytic Point of View. In: FARBEROW, N. L. & SHNEIDMAN, E. S. (eds.) The Cry for Help. New York: McGraw-Hill Book Company. P. 185. MENNINGER, K. A. 1938. Man against Himself, New York, Harcourt, Brace & World, Inc. SHNEIDMAN, E. S. 1993. Suicide as Psychache : A Clinical Approach to Self-destructive Behavior, Northvale, N.J., J. Aronson.

discourses). The fact that suicide has been an option for mankind indicates the fragility of our human destiny (see the archetypal aspects). As I believe that the aetiology of suicide resides at a deeper level and is a multifaceted phenomenon, the different approaches to understanding the causes of it will next be looked at.

Psychological Explanations for Suicide

Some of the well-established psychological theories for suicide will be discussed under the themes of: psychodynamic explanations; suicide as psychache; a cry for help or a cry of pain; perceived burdensomeness and failed belongingness. There are multiple emotional issues behind suicide and those theories provide the lens through which emotions are investigated (e.g. anger, aggression, revenge in psychodynamics; pain in psychache).

Psychodynamic Explanations

Psychodynamic theories advocated by psychoanalysts were once considered the key to unlock in the secret of human's dark impulses (Maltsberger and Goldblatt, 1996). In 1910, a symposium on suicide was held in Vienna in the hope that it would shed more light on the subject (Friedman, [1910]1967). In the growing trend of applying psychoanalytic theories to the interpretation of suicide in the earlier Twentieth Century, Freud was the original thinker. In *Mourning and Melancholia* (1917), he differentiated the normal mourning experience from pathological melancholy. In the normal mourning process, Freud suggested, the mourner is able to withdraw the libido from the lost object; s/he will not lose his/her self-regard or ego functions. For a melancholic, the loss of an object with whom he identified or internalized is too great to tolerate; the life is not worthy of living after the loss.

> [F]eatures of melancholia are a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment. (Freud, 1917: 244)

In mourning, it is 'the world which has become poor and empty; in melancholia it is the ego itself' (Freud, 1917: 246). Here the destruction is directed toward the ego itself; the libido is 'disappointed' (Freud, 1910: 232) and the self-reproaches are shifted away from a loved object to the patient's own ego. The melancholic blames him/herself; his/her libido is withdrawn from the ego and is not free to develop a new relationship because of the narcissistic identification with the original object. The melancholic torments and blames him/herself, even wishing to destroy him/herself. Freud continued:

> If the love for the [lost] object … takes refuge in narcissistic identification, then the hate comes into operation on this substitutive object, abusing it, debasing it, making it suffer and deriving sadistic satisfaction from its suffering. The self-tormenting in melancholia [is] a satisfaction of trends of sadism and hate which relate to an object, and which have been turned round upon the subject's own self … (Freud, 1917: 251)

This can be interpreted as the ego thinking itself inferior to the lost object and does not deserving to be alive since the better one has gone. Or the ego hates itself for not being dead and gone with the loved ones. Besides narcissism, Freud relates another dynamic – ambivalence between love and hate, resulting in regression to the stage of sadism and further, to suicide.

> It is this sadism alone that solves the riddle of the tendency to suicide which makes melancholia so … dangerous … The ego can kill itself … if it can treat itself as an object – if it is able to direct against itself the hostility which related to an object and which represents the ego's original reaction to objects in the external world. (Freud, 1917: 252)

Here Freud may have implied that the ego objectified itself as an object and identified this objectified ego as something that needs to be destroyed in an infantile regression. Suicide could be as a punishment for one's once wishful thinking for someone's death. In *Totem and Taboo* (1913), Freud conjectured,

‘we find that impulses to suicide in a neurotic turn out regularly to be self-punishments for wishes for someone else’s death’ (Freud, 1913: 154, note 1). Freud, in his analysis with a woman about her homosexuality, explained that suicide contains two forces – the fulfilment of a self-punishment and the fulfilment of a wish.

> No one finds the mental energy required to kill himself unless, in the first place, in doing so he is at the same time killing an object with whom he has identified himself, and in the second place, is turning against himself a death-wish which had been directed against someone else. (Freud, 1920c: 162)

It was interpreted that the patient attempted to kill herself as punishment for her wishing one of her parents to be dead; or the death symbolized the wish to re-unite with the beloved parent. Freud went on to say that the unravelling of the unconscious death wishes should not surprise us: ‘the unconscious of all human beings is full enough of such death wishes against even those they love’. Implicit in this bold statement is that we do not need to have any reasons to kill ourselves; the impulse to suicide is embedded in everyone’s psyche; it is a given.

According to Robert E. Litman, up until 1910, Freud’s formulations on suicide were framed in his libido theory; after 1920, they were interpreted with his death-instinct theory (Litman, 1970/1996)[14]. The term ‘death instinct’ first appeared in an analysis of phobia; at that time, it was equivalent to an aggressive or destructive force (Freud, 1909: 140, note 2). In *Beyond the Pleasure Principle*, he dichotomized Eros (life instinct) and Thanatos (death instinct) (Freud, 1920a). In *The Ego and the Id* (1923), Freud not only hypothesized that the death instinct

14 Herbert Hendin pointed out, in Mourning and Melancholia, all aggression was interpreted as having a sexual origin; the paper is ‘filled with complicated and undemonstrable discussion of what amounts to retroflexed anger’. Only years later did Freud confess to having overlooked the ‘universality of non-erotic aggression’ in Civilization and Its Discontents (1930). See HENDIN, H. 1971. The Psychodynamics of Suicide. In: GIDDENS, A. (ed.) The Sociology of Suicide: A Selection of Readings. London: Frank Cass & Co. Ltd. P. 320-321.

would drive oneself to an ‘inanimate state’, he also conjectured that the dynamic between the life instinct and death instinct is interactive and dialectical.

> [W]e put forward the hypothesis of a death instinct, the task of which is to lead organic life back into the inanimate state; on the other hand, we supposed that Eros, by bringing about a more and more far-reaching combination of the particles into which living substance is dispersed, aims at complicating life and at the same time, of course, at preserving it. Acting in this way, both the instincts would be conservative in the strictest sense of the word, since both would be endeavouring to re-establish a state of things that was disturbed by the emergence of life. The emergence of life would thus be the cause of the continuance of life and also at the same time of the striving towards death; and life itself would be a conflict and compromise between these two trends. (Freud, 1923: 39-40)

The death instinct that explains the punishment by a domineering super-ego is sufficient to drive one to suicide[15].

> We find that the excessively strong super-ego which has obtained a hold upon consciousness rages against the ego with merciless violence, as if it had taken possession of the whole of the sadism available in the person concerned. … [T]he destructive component had entrenched itself in the super-ego and turned against the ego. What is now holding sway in the super-ego is, as it were, a pure culture of the death instinct, and in fact it often enough succeeds in driving the ego into death. (Freud, 1923: 53)

At the collective level, Freud used the death instinct to explain the symptoms of civilization (Freud, 1930) and war (Freud, 1933). What Freud offered us is an understanding of the inner dynamics that operate in a suicidal mind. He provided us with a “rational” language to peek into the dark shade of the psyche which he called the ‘unconscious’. His theory illustrated a humanising picture and normalized the “abnormal” in us, arguing that it is anger, hatred, and aggression that kills people, not something mystical or supernatural.

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15 In this article, Freud suggested the mechanism of super-ego driving one to suicide would only be applicable to melancholics and not to obsessional neurotics. The obsessional neurotic could turn the aggression outward against an object, hence protecting him/herself from self-infliction. However, it is contestable how much this position can be upheld, since nowadays the empirical research on suicide has covered the pathology and murderer’s suicide. See BARRACLOUGH, B. & HARRIS, E. C. 2002. Suicide preceded by murder: the epidemiology of homicide–suicide in England and Wales 1988–92. Psychological Medicine, 32, 577-584, LOGAN, J., HILL, H. A., BLACK, M. L., CROSBY, A. E., KARCH, D. L., BARNES, J. D. & LUBELL, K. M. 2008. Characteristics of Perpetrators in Homicide-Followed-by-Suicide Incidents: National Violent Death Reporting System-17 US States, 2003-2005. American Journal of Epidemiology, 168, 1056-1064.

As I conjectured, at the individual level, Freud suggested that an impulse to suicide is embedded in everyone's psyche. This stance is very similar to a hypothesis that I am going to propose later in the thesis (i.e. the suicide complex (SC)) by using Jung's theories of complexes and archetypes. SC is defined in this thesis as a complex constellated in the survivors' psyches directly and in those of the general public indirectly after a suicide has occurred. Here it may be pertinent to indicate that what is different from Freud is that SC also emphasizes the influence of the environment in addition to the internal dynamics. I will give a complete definition in Chapter Nine.

Karl A. Menninger built upon Freud's observations and suggested that every suicide had three forces: 'the wish to kill', 'the wish to be killed' and 'the wish to die'[16] (cited in Leenaars, 1993). The wish to kill was directly from the death instinct, the wish to be killed was from the super-ego's need for punishment which is masochistic, and the wish to die was from the desire to return to the womb (Menninger, 1938, Menninger, 1933/1996). Based on these three forces, Stengel suggested that two further aspects need to be added to the list: 'the appeal' and 'the ordeal function', which are derived from 'the urge of self-preservation' (Stengel, 1969: 126).

Herbert Hendin derived the psychodynamic interpretation of suicide from affective and cognitive aspects in young people. The affective states such as rage, hopelessness, despair, and guilt were observed among young patients who killed themselves. The cognitive and unconscious meanings, such as death as reunion,

16 Menninger in an interview added, 'I think there is one more unconscious motive to add to the triad. I think some love gets into suicide motivation'. See MENNINGER, K. A. 1989. Afterword: Reflection on Suicide. In: JACOBS, D. & BROWN, H. N. (eds.) Suicide: Understanding and Responding: Harvard Medical School Perspectives. Madison: International Universities Press, Inc. P. 484. It refers to 'pathological' love. Cited in LEENAARS, A. A. 1993. Unconscious Processes. In: LEENAARS, A. A. (ed.) Suicidology: Essays in Honor of Edwin S. Shneidman. London: Jason Aronson. P. 135.

as rebirth, as retaliatory abandonment, as revenge, as self-punishment or atonements were found to be significant (Hendin, 1991/1996).

Anthony Giddens commented that the weakness of Freud's theory (particularly on depression) is the equation of depression and suicide (Giddens, 1971d: 101). Alvarez suggested that psychoanalysts did not say enough about what it means to be suicidal and about the feelings involved. He wrote that the real motives that push one to kill oneself are in the 'internal world, devious, contradictory, labyrinthine' and which are invisible forces (Alvarez, 1971: 123). To link suicide with the hostility directed toward the introjected love object is a misunderstanding, Thomas Joiner argued. For him, some psychoanalytic views of suicide are 'obfuscatory and contradictory' (Joiner, 2010: 44). The mechanism of 'aggression turned inward' only happened to relatively few people (i.e. there are more cases where people turn their aggression outward), and it ignored the fact that many people made their suicides easier for the loved ones to handle afterwards (e.g. by going to a faraway place to avoid shocking the relatives). The challenge of using psychoanalytic theory to probe the questions of suicide is to judge whether aggression is innate or reactive or both (Perelberg, 2009)[17]. A

17 Erich Fromm in The Anatomy of Human Destructiveness (1973) (the numbers in the following parentheses are the page numbers) examined human destructive behaviour from studies of neurophysiology, behaviour, palaeontology, anthropology and psychology (particularly in psychoanalysis). He suggested we differentiate 'two entirely different kinds of aggression': one is 'defensive, "benign,"' 'phylogenetically programmed impulse' when species' survival (including animals and human) is threatened. This line of aggression is 'adaptive'. Another kind of aggression is '"malignant, is shown only in human behaviours and absent in most mammals (24). He did not believe the 'theory of an innate aggressiveness' which for him is an 'ideology' used to blame the fear of human's destruction (22). To distinguish between 'benign-defensive and malignant-destructive aggression, he suggested to differentiate between 'instinct and character', between 'drives rooted in man's physiological needs (organic drives) and those specifically human passions rooted in his character ("character-rooted, or human passion"). The former is the answer to man's 'physiological needs', whereas the latter, to 'existential' needs (26). For Fromm, the significance of the concept of character is that it overcomes the old dichotomy between instinct and environment (122). The character is 'the specific structure in which human energy is organized in the pursuit of man's goals; it motivates behaviour according to its dominant goals; a person acts "instinctively", … in accordance with his character'. He continued the paragraph by using Heraclitus's term - 'character is man's fate' (337)- to express his point. See FROMM, E. 1973. The Anatomy of Human Destructiveness, Middlesex, Penguin.

similar struggle can be observed in Analytical Psychology, where it is debated whether suicide is an archetype or complex (see the following section of archetypal aspects).

Suicide As Psychache

Edwin S. Shneidman argued that every suicide is 'purposive' and responds to certain psychological needs (Shneidman, 1993: 3). The key factor in suicide is psychological pain which he called 'psychache'. He conceptualized suicide as 'a state of being, a human malaise', rather than a disease; and one's suicide is often 'transient, ambivalent, and dyadic' (Shneidman, 1993: 9, 145). For Shneidman, suicide is not a psychiatric disorder, although it shares many symptoms of depression; rather, it is a nervous dysfunction (Shneidman, 1981/1996: 637). Shneidman is an important figure in the field of suicide preventions as he is the founding figure of the discipline of suicidology. He represented the early attempt to use psychological languages to explain the suicidal mind and hence demystified the irrationality of the unconscious.

Schneidman explicated two concepts to gauge one's suicide risk: lethality and perturbation. Lethality means how risky and dangerous someone is (e.g. one who owns guns), and perturbation means how disturbed, frustrated, and painful someone is. By assessing a person's lethality (e.g. how at risk s/he is) and perturbation (e.g. how disturbed s/he is), one can detect the risk level in a suicidal person. By reducing elevated perturbation, lethality can concomitantly be reduced.

Schneidman also adopted Murray's theory of psychological needs in *Explorations in Personality* (1938) and identified the link of suicide with one's psychological needs. For him there are two types of needs: the first one is

called the ‘modal’ needs that define one’s personality in the daily intrapsychic and interpersonal functions. This type of needs focuses on one’s functions and will not compromise one’s sense of being. The second type is called the ‘vital’ needs: ‘vital’ means the frustration of which the individual cannot tolerate (for instance, one’s experience of thwarted love, ruptured relationships, assaulted self-image, fractured control, and anger related to frustrated dominance). The fulfilment of the vital needs has to do with one’s well-being; it is like one cannot live without water or air. Although these two categories of needs are psychologically consistent, it is often the loss of the ‘vital’ needs that pushes one to the dark space resulting in suicide.

Israel Orbach analyzed the unbearable emotions and painful feelings of the suicidal population (Orbach, 2003). The common factors include ‘intense negative emotions, loss of self, surfeit of the negative’. Psychache is the mental pain that a suicidal person experiences (Shneidman, 1993/1996, Shneidman, 1993). This mental pain, caused by the loss of meaning, is profoundly related to suicide (Orbach et al., 2003).

A Cry For Help; A Cry Of Pain

Shneidman and his colleagues suggested that suicide is ‘a cry for help’ (Farberow and Shneidman, 1965, Shneidman and Mandelkorn, 1970). Stengel wrote that suicide attempts act ‘as alarm signals and have the effect of an appeal for help, even though no such appeal may have been consciously intended’ (Stengel, 1969: 113). However, how much of one’s conscious intention it is to make an appeal is hard to know and measure, for both intentions – the wish to die and the wish to be saved -- might co-exist. The suicidal mind is occupied by ambivalence, with equal

forces pulling from both sides of life and death (Williams, 1997: 151, Stengel, 1969: 117, Shneidman, 1993: 21, Joiner, 2010: 64).

In his book, *Cry of Pain: Understanding Suicide and Self-Harm*, Mark Williams suggests that the key to understanding suicidal behaviour is to view it as 'a cry of pain' instead of 'a cry for help'. By using the trapped animal's crying with pain as a metaphor, Williams wrote that suicide is 'elicited by the pain of a situation with which the person cannot cope – a cry of pain first, and only then a cry for help' (Williams 1997: xii-xiii). By considering both psychiatric illness and social facts, Williams highlighted the idea of 'entrapment' as a way of understanding suicide. People felt 'entrapped' by their symptoms. This subsequently engendered 'hopelessness'[18], which is a key factor in suicide (Williams, 1997: 64-5).

Perceived Burdensomeness; Failed Belongingness; Lethal Self-Injury

Joiner, in *Why People Die by Suicide*, adopted Shneidman's categories of psychological needs (such as thwarted love, ruptured relationships, assaulted self-image, fractured control, and anger related to frustrated dominance) and summarized them into two factors: 'thwarted belongingness' and 'perceived burdensomeness'. These two factors show social isolation as a significant factor in the desire to die. However, there is also a third factor contributing to suicide: 'the ability to enact lethal self-injury' (e.g. one is used to the physical pain) (Joiner, 2005: 96, 46).

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18 Prior attempted suicide and hopelessness are the most obvious clinical predictors of future completed suicide. See BECK, A. T., BROWN, G., BERCHICK, R. J., STEWART, B. L. & STEER, R. A. 2006. Relationship Between Hopelessness and Ultimate Suicide: A Replication With Psychiatric Outpatients. FOCUS: The Journal of Lifelong Learning in Psychiatry, 4, 291-296, BECK, A. T., STEER, R., KOVACS, M. & GARRISON, B. 1985. Hopelessness and Eventual Suicide: a 10-year Prospective Study of Patients Hospitalized with Suicidal Ideation. American Journal of Psychiatry, 142, 559-563, HOLMSTRAND, C., ANDERS, N. U. & TRA¨SKMAN-BENDZ, L. 2006. Risk factors of future suicide in suicide attempters : A comparison between suicides and matched survivors. Nord J Psychiatry, 60, 162-167.

By elaborating his model and comparing it with other contemporary research, Joiner suggested that 'perceived burdensomeness' and 'failed belongingness' lead one to initiate the first suicidal act, whereas the accumulated experiences or skills that follow this make multiple suicide attempts easier. The experience of multiple attempts leads one to require the ability to enact lethal self-injury and to become used to pain and provocation. This is similar to the concept of the 'thermal pain threshold' used by Israel Orbach and colleagues, who suggested that suicidal people tend to have higher than average thermal pain thresholds and higher tolerance of general physical pain (Orbach et al., 1997, Orbach et al., 1996).

Sociological Discourse for Suicide

Thomas Masaryk (1850-1937), a professor in the University of Prague and the first president of Czechoslovakia, published an essay called *Suicide as a Social Mass Phenomenon of Modern Civilization* in 1878. He believed that suicide did not occur in primitive societies; it was modern civilization and the decline of religion that contributed to the increase in suicide rates. He came to this conclusion before Durkheim and he recognised the role of sociological factors in the investigation of suicide (Stengel, 1969: 48, Baechler, 1979: 5).

Emile Durkheim (1858-1917) is generally considered the predecessor of those who adopted sociological approaches to the research of suicide. His book *Suicide* was published in 1897 and translated into English in 1951. He developed his theory based on the interpretation of statistical data from *Il Suicidio* by Enrico Agostino Morselli (1852-1929) (Morselli, 1881, Morselli, 1903/1971). Durkheim dismissed the psychological causes of suicide, linking suicide to socially unfavourable conditions, and differentiating three types of suicide: 'egoistic',

‘altruistic’, and ‘anomic’. The first two are concerned with how the individual is integrated into his society, and whether it is either too little or too much. ‘Anomic’ suicide would result from a drastic or sudden change in one’s social position with which one is unable to cope. By investigating many statistical surveys, Durkheim concluded that suicide is not correlated with biological or cosmic phenomena; rather, it has more to do with social factors, such as family, politics, economy, and religion. He suggested that each social community has its own specific tendency to suicide, which depends upon social causes and is itself a collective phenomenon.

> [T]he social suicide-rate can be explained only sociologically. At any given moment the moral constitution of society establishes the contingent of voluntary death. … The victim’s acts which at first seem to express only his personal temperament are really the supplement and prolongation of a social condition which they express externally. … Each social group really has a collective inclination for the act, quite its own, and the source of all individual inclination, rather than their result. It is made up of the currents of egoism, altruism or anomy running through the society with the tendencies to languorous melancholy, active renunciation or exasperated weariness derivative from these currents. These tendencies of the whole social body, by affecting individuals, cause them to commit suicide. (Durkheim, 1952/1963/1966: 299-300)

He examined psychological factors that might influence suicide rates and found that they had no dominant effects. He came to the conclusion that individual traits could not explain the social suicide rate, and the factors that lead to suicide are almost infinite. Durkheim argued against the psychiatric approach to suicide. He wrote that suicides are either ‘devoid of any motive’ or caused by ‘purely imaginary motives’, but many voluntary deaths could not be categorized into either type. ‘Not every suicide can therefore be considered insane, without doing violence to language’ (Durkheim, 1952/1963/1966: 66). Durkheim claimed that each society had its own collective orientation towards suicide, i.e. some suicides

could be expected in some types of society[19]. If the suicide rate increased drastically, it may indicate that some parts of the society were breaking down.

Anthony Giddens praised Durkheim's *Suicide* as having 'marked a decisive advance' in using 'a coherent sociological theory' to explore the phenomenon (Giddens, 1971c: 38). Durkheim's work had rekindled the heated debate about whether psychiatric causes or sociological factors were the aetiology of suicide, especially in the period between the two World Wars in France. Post-Durkheimian sociological theories of suicide have been edited systematically and included in his edited book, *The Sociology of Suicide: A Selection of Readings* (Giddens, 1971b). Jack P. Gibbs and Walter T. Martin criticized Durkheim's work for not having a precise definition of 'social integration' and for failing to be a testable theory. Instead, they used the concept of status to examine one's integration in society. Status is related to one's roles: the more roles one can identify with, the higher status and integration one could have (Gibbs and Martin, 1964). Another critique was made by Jack Douglas, who explored the social meaning of suicide (Douglas, 1967). What is significant in Douglas' critique is that the method Durkheim used did not help us to understand the meaning of suicide.

Based on Durkheim's analysis of suicide, Christian Baudelot and Roger Establet examined in detail the variables Durkheim advocated. They pointed out that his sociological research into the relationship between social changes and the suicide rate is meaningful, but it can only be certain about concomitant variations, not the real causes of suicide. They looked into the geographical differences within some western countries, revising Durkheim's conclusion of poverty as a

19 Some researches extended the concept of altruistic suicide, differentiating it from martyrdom. See CONSTANTELOS, D. J. 2004. Altruistic Suicide or Altruistic Martyrdom? Christian Greek Orthodox Neomartyrs: A Case Study. Archives of Suicide Research, 8, 57-71. For the reflecting upon the phenomena of suicide bombing and terrorism, see ORBACH, I. Ibid.Terror Suicide: How is it Possible? , 115-130, LEENAARS, A. A. Ibid.Altruistic Suicide: A Few Reflections. 1-7.

protective factor. They suggested the relationship between growing wealth and suicide is clearly observed in the Nineteenth Century, but is not so straightforward in the Twentieth Century (Baudelot and Establet, 2008: 23). They humorously indicated that the investigation of society does not help us to understand suicide; it is rather that suicide sheds light on society, and we need to 'look at society in a different way' (Baudelot and Establet, 2008: 195).

According to Luigi Tomasi, Durkheim's analysis of the social and institutional influences on the suicide rate did not locate the real causes of suicide. The development of sociology and the discipline's subsequent inquiries into suicide led to the replacement of analysis that was concerned with the quantification of individual elements and the dimensions of morphological factors, with qualitative analysis and assessment from 'the angle of social differentiation' (Tomasi, 2000: 13). Yet, there is a discrepancy between the verdict of suicide and the real motives of the deceased. Since modern individualistic society emerged from a communitarian and agrarian society, an objective assessment of Durkheim's theory needs to involve reflections on 'urbanization, industrialization and secularization' (Tomasi, 2000: 19). Although two related issues regarding suicide – 'rate and liability' – are observed from Durkheim's study (Cohen, 1994: 120), Alvarez suggested that the sociological theories are too simple and narrow to give us a full picture of the issue (Alvarez, 1971: 117-21). Marsh maintained that no coherent and plausible rationale for social intervention is available; psychiatry continues to be the dominant practice of suicide prevention (Marsh, 2010: 184).

Although Durkheim's theory has attracted on-going criticism, his sociological approach to suicide is recognized to be of historical significance (Lester, 1994, Pickering et al., 2000), and some fruitful results can be observed from the cross-fertilization of his theories with others. For example, Joiner compared 'low

belongingness' with the 'egoistic' type of suicide that Durkheim identified. The 'perceived burdensomeness' of which Durkheim wrote might lead to 'altruistic' suicides because of excessive societal integration in which people are willing to self-sacrifice for the larger goal[20] (Joiner, 2005: 33-4).

The above sections on the psychological and sociological factors of suicide have offered us a basic understanding of suicide. There would never be a single influencing factor for one's suicide, and even the psychological factors are overlapping. For instance, the suicidal person would feel the pain of the unresolvable dilemma in his/her life; s/he would feel hopeless enough to choose seemingly the only option for the dilemma; s/he would also feel empty for not being able to relate to people and the world in a meaningful way; … the list can go on. The causes of suicide may also be made up of social factors; for instance, if a man losses his job and finds himself unable to support his family, he may feel the loss of purpose and the identity that came along with being the familial provider, which may result in depression; subsequently the loss of status and power may be too great to deal with if there is a structural lack of available social services. The psychological and social factors will influence each other and both eventually contribute to the motivation for suicide. The next section will explore the archetypal aspects of suicide.

Archetypal Aspects of Suicide

The founder of analytical psychology, Carl Gustav Jung (1875-1961), did not systematically explore the issue of suicide. He touched upon this issue only during his 'psychiatric period' – the time in his career when he developed the theory of

20 Joiner's thinking is also compatible with Shneidman's theory. He wrote, 'perceived burdensomeness combined with failed belongingness constitutes psychache'. See JOINER, T. E. 2005. Why People Die by Suicide, Cambridge, Mass., Harvard University Press. P. 37.

complexes through the Word Association Test (Papadopoulos, 1991: 60). In *Memories, Dreams, and Reflections*, Jung wrote about his 'unconscious suicidal urge' which occurred in his early years (Jung, 1963/1977: 24). In his collected works, the closest he comes to the topic is in The *Soul and Death* (1934), but here he was expressing his attitude towards life and death, not to suicide. His basic attitude is that in some circumstances, it is inevitable that one would kill him/herself. He stated, 'I never hinder people. When somebody says, "I am going to commit suicide if-", I say, "If that is your intention, I have no objection"' (Jung, 1976: par. 207).

This section on archetypal perspectives will examine suicide in a deeper sense as: (1) suicide is the result of the interactions of a person's (maybe pathological) characteristics and the failure of the environment to meet their needs; (2) suicide can be seen as a symbol for the soul's call for transformation. In the first category, a few Jungian and post-Jungian (Samuels, 1985) psychologists use the theories of complex and archetype to illustrate the aetiology of destructive behaviours. Complex and archetype theories are two of Jung's significant psychological theories, which will be examined in Chapter Four. Here, it is enough to indicate that complexes refer to the issues in one's psyche, whereas archetypes are those in the collective psyche. The Jungian and post-Jungian exploration of suicide and destructive behaviours is either based on the negative affects that are taking place in a person's psyche (complex) or on a deeper level of inner living mechanisms (archetype), or on both.

L. Stein used biochemical analogies to explain the relationship between archetype and self[21]. He distinguished between 'discrete' archetypes and the 'abstract aggregates' (such as anima, animus, and shadow). A discrete archetype has only one 'assignment' or function; for instance, the self exists in order to maintain the wellbeing of the individual (Stein, 1967: 102). The biological system defends against the part of itself that is felt 'wrong' by killing or destroying the intruding content. Similarly, the 'psychosomatic self' can defend itself against 'not-self'. Stein pointed out that not every act of self destruction is the result of aggression turning inward, but the self defends against not-self as a 'foreign graft', 'irrespective of the existence of intervention of the ego' (Stein, 1967: 101).

Charles T. Stewart (CTS) explored the necessary conditions for normal emotional development and optimal affective outcomes as well as those for killing oneself and/or others (Stewart, 2008). In this context, pathological development is caused by the thwarting of the life instincts – Interest and Joy. Here CTS adopted 'the archetypal affect system' that L. H. Stewart (LHS) has developed. The latter theory is based on Jung's theory of complex and the idea of an *a priori* self and affectivity, combined with Silvan Tomkins' theory of innate affects as the primary motivational system in human beings[22]; and Charles Darwin's research on the expression of emotions in man and animals[23]. LHS wrote: 'The archetypal affect system is an inherited regulatory system of the psyche which functions as an unconscious, energic, orienting and apprehension-response system which has

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21 In this article, Stein used "self" instead of "Self" even in the passages where he clearly referred to archetype, where "Self" is more appropriate. Sometimes, the description of the self is not so different from that of the ego even though he made the distinction. It is only clear to me if the self he referred to is bigger than the ego, but unclear if he meant the self as "the archetype of archetypes". In this paragraph, I followed his usage of "self".

22 Tomkins identified Interest, Enjoyment, Surprise as positive affects; Distress, Fear, Anger, Shame, Dissmell, Disgust as negative ones.

23 Darwin identified Joy, Surprise, Fear, Sadness, Anger, Contempt, and Shame as innate emotions.

evolved to replace an earlier system of programmed instinct' (cited in Stewart, 2008: 8). According to CTS, the four necessary conditions for people to kill themselves and/or others are: 'social isolation', 'dissociation of the personality', 'unbearable affect', and 'possession by (negative) affects' (Stewart, 2008: 40).

In *Evolutionary Psychiatry* (1996), Anthony Stevens and John Price offer an evolutionary perspective on psychopathology. The theory of archetype is extended to explain psychiatric aetiology and to illustrate the phylogenetic dimension of psychopathology. As one form of psychopathology, suicide could be seen as '*an ancient adaptive response…[which] has become maladaptive to the detriment of the patient's emotional and social life*' (Stevens and Price, 1996: 229). This is an internal theory of pathology. Stevens also pointed out that the pathology could result from 'environmental insults of deficiencies' (Stevens, 2006: 86), namely when '*the environment fails, either partially or totally, to meet one (or more) archetypal need(s) in the developing individual*' (Stevens and Price, 1996: 34). The frustration or unfulfilment of archetypal intent can happen at any developmental stage. 'Archetypal strategies malfunction', when the environment and the ensuing development of oneself are not in accord with the constellated archetype; when this occurs it can have a very negative impact upon our lives. For instance, when a baby is neglected or abandoned, the care, nurture and love s/he needs from the mother (what Stevens and Price called 'archetypal needs') are not fulfilled, the constellated mother-child archetype does not function properly and causes a disruption in the development of a whole person.

Although suicide is a phenomenon beyond the developmental stages, it can complicate the developmental stage and frustrate the fulfilment of developmental tasks. For instance, when a child has lost his/her mother to suicide, the grieving

process disrupts the developmental needs. This is evident if we compare that loss with that of an adult who has lost his/her mother when s/he is mature. For Brian Skea, suicide is the result of ‘an inner conjunction gone wrong’. What he meant by being ‘gone wrong’ is when the shadow wins over the light.

> [T]he destructive and disintegrative energies of the Self have in the end outweighed the Self’s creative and integrative energies, resulting not in a greater integrity or a creative transformation, but in chaos, death or dismemberment, whether literally or psychologically. (Skea, 2003: 337)

Dr. Gregory Zilboorg (1890-1959) pointed out one ritualistic element of suicide. The identification with the dead and wanting to join the dead has been the ‘archaic’ force that drives people to suicide (Zilboorg, 1936/1996: 58). He paralleled some ethnological data with clinical findings, suggesting that suicide should be considered a form of ‘instinctual’ manifestation, not only the illness of society or of mental problems (Zilboorg, 1937/1996: 81). The behaviours of oral aggression, spite, and identification with the deceased are rather men’s reactions to developmental conflicts which are universal; the forces are ‘rooted deeply from both the ontogenetic and the phylogenetic point of view’ (Zilboorg, 1936/1996: 54). His thinking was closely linked with the development of the theory of archetype.

James Hillman is the theorist who is the well-known representative to interpret suicide as a symbol of the soul’s call for transformation. He viewed suicide as a symbol that comes from one's interior – the soul. Hillman argued against the perspectives on suicide derived from Sociology, Law, Theology, and Medicine, which for him disregard the soul's need for change and transformation. The suicide impulse is 'a transformation drive' (Hillman, 1973/2011: 68). For Hillman, the soul cannot be precisely defined, nor be understood in the scientific realm. It is not a concept, but a symbol.

> The soul has been imaged as the inner man, and as the inner sister or spouse, the place or voice of God within, as a cosmic force in which all humans, even all things living, participate, as having been given by God and thus divine, as conscience, as a multiplicity and as a unity in diversity, as a harmony, as a fluid, as fire, as dynamic energy, and so on. (Hillman, 1973/2011: 45)

From the point of view of archetypal psychology[24], suicide is 'one of the human possibilities'; the meaning of suicide could be understood only from 'inside' our psyche. In contrast to 'case history' (e.g. taking a medical attitude and focusing on biography or outer events), the 'soul history' aims at exploring one's complexes for archetypal meanings. In Hillman's words, what is important is to be open 'in the reawakening of emotion, fantasy, and dream, in a sense of mythological destiny penetrated by the transpersonal, and by spontaneous acausal time' (Hillman, 1973/2011: 41, 79). Through experiencing death by suicide (not necessarily in a concrete way), one moves beyond suffocating mundanity and habitual rigidity; one experiences the reality of one's psyche.

Not everyone agrees with Hillman's theory. Since the focus of this chapter is to investigate various theories on suicide in a general sense, I will instead present my critique of Hillman's attitude on suicide in Chapter Four, since it is the chapter devoted to Analytical Psychology. The archetypal theory behind suicide is the main focus of this thesis. In Chapter Nine, I will discuss my hypothesis on the existence of a suicide complex that constellates in the psyches of survivors interpreted from the analysis of data I collected. This complex can explain why survivors are suicidal at times after the loss of their loved ones and why their

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24 According to Andrew Samuels' research, the developments of Jungian psychology after Jung can be categorized into three schools: 'the classical school, 'the developmental school', and 'the archetypal school', based on different theoretical emphases and clinical practices. James Hillman is the representative of the archetypal school which focuses on images, symbols, and soul. See SAMUELS, A. 1983a. The emergence of schools of post-Jungian analytical psychology. The Journal of Analytical Psychology, 28, 345-362, SAMUELS, A. 1985. Jung and the Post-Jungians, London, Tavistock/Routledge. HILLMAN, J. 1993. Archetypal Psychology - A Brief Account Together with a Complete Checklist of Works, Dallas, TX, Spring.

suicidal risk is elevated. By using Jungian theories to argue the aetiology of suicide, I hope to express that suicide is a psychical illness (not just mental illness or psychiatric disorder) for the individual and for mankind at large.

2. Suicide Survivors

In the previous chapter, Western history and some approaches of understanding suicide were discussed under the themes of insanity, psychology, sociology and archetype. Suicide had been colonized by the church (Murray, 1998), by the state (Alcoz, 2007), and now by medicine (Dripps et al., 1959, Murphy et al., 1999). The overview of the different ways that suicide has been researched by various disciplines offered in Chapter One can help us to understand the trajectory that survivors may be subjected to after losing a loved one. From ancient times[25], survivors have been left alone to deal with the aftermath of suicide; they have not been under any care or obtained any attention until the 1960s when the discipline of suicidology discovered this hidden population (McIntosh, 2003, Cutcliffe and Ball, 2009).

In this chapter, the experiences of suicide survivors will be explored. I will begin with the contemporary research on bereavement, where the majority of the studies of survivors is situated. After a brief discussion on life after death, some common themes of survivors' emotional reactions, psychological turmoil and changes will be identified. The heavy, negative emotions (e.g. shame, guilt) indicate the loss is archetypal as Jung has reminded us of the relationship between affect/emotion and archetype (Jung, 1975) (further discussion on

25 The survivors do not "exist" even though people killed themselves from the time of the Greeks. This phenomenon can be observed in Greek tragedy. The tragedy described the incident of suicide (e.g. Oedipus The King, or Antigone), but what happened to survivors has never been the theme of the drama.

archetype will be presented on Chapter Four). The chapter will end with the theories of positive growth after adversity, which is compensatory to the trauma discourse of loss, and with a section focusing on the Trauma Grid (Papadopoulos 2007).

Loss, Grief and Bereavement

Studies about survivors are mainly located under the theme of loss and bereavement. Bereavement refers to 'the physiological, psychological, behavioral, and social response patterns' after loss (Hauser, 1987: 58). According to Marilyn J. Hauser, it comprises two components: grief and mourning. Grief refers to the affects, feelings, and emotions, one's experience after a loss (Worden, 2002: 23), or the reaction to loss (Parkes, 1996: 7). Mourning refers to social customs and rituals which help the bereaved person grieve. This process or journey can be viewed in stages (Kübler-Ross, 1970), phases (Parkes, 1996), tasks (Doka, 1995) or models (Rubin, 1996).

Elisabeth Kübler-Ross, in her pioneering work *On Death and Dying* (1970), outlined five stages of loss: 'denial and isolation', 'anger', 'bargaining', 'depression' and 'acceptance'. In 2005, *On Grief and Grieving* was published, which focuses on the anticipatory grief experienced by the whole family when one of their members is seriously ill. In this book, suicide was included in the chapter entitled *Specific Circumstances*. It suggested that, for survivors to work through their grief and guilt, they need to understand that they are not - in fact, no one is - responsible for the loved one's suicide. 'There are no models for it [suicide], and the loss can become multi-generational' (Kübler-Ross and Kessler, 2005: 188). A sixth stage, the stage of 'being angry at God', can be seen as a derivative of the anger stage and David Kessler called it the stage of 'meaningfulness' or 'renewed

meaning' (ibid: xvi, 225). As correctly pointed out by Kübler-Ross and Kessler, this stage is highly relevant to survivors' responses.

Colin Murray Parkes outlined the four phases of encountering loss: 'numbness', 'pining', 'disorganization and despair', and 'recovery'. He categorized different possible outcomes of bereavement as: 'the trauma response' (which includes alarm reaction, anger, guilt, Post Traumatic Stress Disorder (PTSD)), 'the grief response' (an urge to search for or relocate the lost person, identification with the deceased, and pathological variants of grief), and 'the psychosocial transition'[26] (Parkes, 1996: 200-6).

There are a number of different approaches to finding ways of coping with loss. Grief therapy expert, J. W. Worden, suggested focusing on the tasks to be accomplished: helping survivors to reality test the guilt and blame, correct denial and distortions, explore fantasies of the future, work with anger, reality test the sense of abandonment and help them in their quest to find meaning in the death (Worden, 2002: 122-5). The Harvard Mental Health Letter suggested: to normalize the grief, ease guilt, respect differences, encourage openness, plan ahead and make connections (HMHL, 2009 Nov.: 4-5).

For Simon Shimshon Rubin, the focus on the survivor's functions and effectiveness after loss tends to ignore the possible connection between the survivors and the deceased. 'The quality of the recollected and remembered relationship to the deceased' is 'a significant and independent feature of the outcome to mourning and loss' (Rubin, 1996: 221). To bridge the gap, he

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26 Psychosocial transitions refer to some threatening life-change events, which may change one's 'assumptive world' (i.e. everything that we accept as true based on our previous experiences); the implications are long lasting and the events happen in a short period of time, so there is little space for preparation for them. This perspective suggested that loss could be evaluated from the scope and magnitude of life-change experiences, rather than an individual's inability to adapt after the loss. See PARKES, C. M. 1993. Bereavement as a psychosocial Transition: Processes of Adaptation to Change. In: DICKENSON, D. & JOHNSON, M. (eds.) Death, Dying & Bereavement. London: SAGE Publication. P. 242.

developed a ‘Two-Track Model of Bereavement’ to assess the mourner’s functions after loss and the ongoing relationship with the deceased. He suggested the relationship with the deceased should be ‘fluid’ and ‘coexist as an adjunct to the ongoing relationships with the living’ (ibid). His model could be applied effectively to detect the real trajectory of the bereavement process (e.g. one does not manifest symptoms while grief is continuing), and how the deceased influences the bereaved (e.g. whether the memories of the deceased create a sense of well-being or not). Similarly, a dual-process model of coping with bereavement looks at two aspects of development: the ‘loss’ and the ‘restoration’ (Stroebe and Schut, 1999). By oscillating between various coping strategies, especially between loss-oriented and restoration-oriented processes (Stroebe et al., 2005), the survivors are encouraged to explore effective coping methods (Caserta and Lund, 2007).

The mainstream discourse on grief until 1990 has established ‘disengaging’ as a goal of grief, and a continued attachment to the dead was considered unresolved grief and a symptom of pathology (Silverman and Klass, 1996: 4). This attitude was a ‘modernist’ one (Stroebe et al., 1996: 32), which began with Freud’s definition of mourning; hence, to have ‘continuing bonds’ with the deceased as a normal part of the bereavement reaction has been denied[27]. In the Romantic Age, grief occurred because of a ‘broken heart’, and it was not rare to see the bereaved keeping the bonds with the deceased. In other cultures, such as Japan, some

27 Here Silverman and Klass mentioned that Freud developed his theory of mourning based on the loss from the Oedipal Complex rather than for grief after a significant death. Freud’s personal experience of grief (from the loss of his daughter and his grandson) was not integrated into his psychoanalytic thought. The later psychoanalysts developed the concept of internalization to explain how grief works in one’s mind. They examined the differences between identification and introjection used by Abraham, Schafer, Volkan, and Fenichel, whose views on grief advocated letting go of the deceased as the successful completion of grief.

Native American tribes, and Muslim communities in Bali and Egypt, there existed no evidence of 'proper grieving' (Stroebe et al., 1996: 36-7)[28].

Instead of emphasizing completion, letting-go, and detachment, Phyllis Silverman and Dennis Klass examined the processes of 'negotiating and renegotiating the meaning of the loss over time', seeing bereavement in 'a social context of which the deceased is a part' (Silverman and Klass, 1996: 19). They argued that the early research emphasized the letting-go by ignoring a small amount of evidence showing the function of 'continuing bonds'.

> The process does not end, but in different ways bereavement affects the mourner for the rest of his or her life. People are changed by the experience; they do not get over it, and part of the change is a transformed but continuing relationship with the deceased. (Silverman and Klass, 1996: 19)

Silverman and Klass found support from Pincus, who suggested the incorporation of the identified aspects of the deceased into a new sense of self that evolved in the journey of adaptation to the loss[29]. Nigel Field and colleagues employed an attachment theory perspective and suggested revising the bond to the deceased (Field and Wogrin, 2011). By reorganizing or relocating the relationship, the deceased could exist as the internal object and serve as a holding figure (Field, 2006a, Field, 2006b, Field et al., 2005). Silverman and Klass also found support from Tahka's theory that differentiated the internalization of the deceased object between 'pre' and 'post' structure. At the prestructural aspect, internalizations of the object are experienced as anxiety or pathology '[s]ince the self and the object

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28 The authors suggested three possibilities to understand grief and bereavement in contemporary society: by paying attention to 'conceptual integration', be open to 'culturally embedded practices', and be aware of the 'expansion of responsibility'. See STROEBE, M., GERGEN, M., GERGEN, K. & STROEBE, W. 1996. Broken Hearts or Broken Bonds. In: KLASS, D., SILVERMAN, P. R. & NICKMAN, S. L. (eds.) Continuing Bonds: New Understandings of Grief. London: Routledge Taylor & Francis Group. P. 41-2.

29 Pincus wrote: 'The bereaved can draw on memories, happy or unhappy, and share these with others, making it possible to talk, think and feel about the dead person'. Cited in SILVERMAN, P. R. & KLASS, D. Ibid.Introduction: What's the Problem? P. 9.

presuppose each other … even a temporary loss of the object becomes a threat to the existence of the self' (cited in Silverman and Klass, 1996: 9). Once the feelings and experiences have been worked through and become conscious (poststructurally), 'remembrance formation' – the process of turning experiences to memories – is on the way[30].

Life after Death

What kind of death is suicide for survivors? First, it is a 'dyadic' death. In *On The Nature of Suicide* (1969) Shneidman emphasized the role of the significant other in the suicidal dyad, viewing the suicidal crisis as a 'dyadic crisis'. Citing Arnold Toynbee:

> There are always two parties to a death; the person who dies and the survivors who are bereaved ... [T]he sting of death is less sharp for the person who dies than it is for the bereaved survivor. … There are two parties to the suffering that death inflicts; and in the apportionment of this suffering, the survivor takes the brunt. (cited in Shneidman, 1972: ix)

What a bitterness it is to see the survivors grapple with their own lives while the deceased has gone forever. 'The algebra of death's suffering is a complicated equation', Shneidman wrote, and the anguish of the suicide survivor's bereavement is 'sharp, prolonged and inimical' (Shneidman, 1972: x). The survivors face a 'triple loss': 'death, rejection, and disillusionment' (Lindemann and Greer, 1972: 66).

Second, suicide is considered a 'bad' death (Howarth, 2007: 155). Glennys Howarth investigated the sociology on death and dying and indicated that a

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30 Remembrance formation is neither identification nor introjection, wrote Tahka; it 'represents an entirely different form of internalization: building and integrating the representation of the lost object into a remembrance of him as he was really experienced during a common period of life. … In contrast to fantasy objects possessing various wish-fulfilling functions, it includes the awareness that nothing more can be expected from it and therefore, in its fully established forms it has chances for becoming the most realistic of all existing object representations'. Cited in ibid. P. 9.

‘sudden’ death such as suicide shortens the life of the deceased and ‘damages the self-identity of survivors’ (ibid, 169). Without a clear and accepted guideline of burial and ritual, survivors struggle with how to integrate the death and come to terms with it. Before elaborating upon this issue, I would need to consider the debates about whether death is feared/denied (or not) in our contemporary society.

Tony Howarth has outlined the changing trajectory of death in traditional, modern and postmodern societies (Howarth, 2007: 16-25). He presented that the thesis of the ‘denial of death’ emerged in the 1950s and 60s which was promoted by psychologists. According to Howarth, this concept of denial (hence death-denial) can be traced back to Freud’s work on primitive defence mechanisms. Ernest Becker advocated that whole societies have adopted a maladaptive reaction to mortality (Becker, 1973). The denial tenet has been supported in academic studies, such as Gorer’s studies on mourning rituals which have atrophied in modernity. Ariès’s research on the historical management of death also contributed to this thought (cited in Seale, 1998: 53). However, this tenet has been challenged from two angles. Talcott Parsons and Victor Lidz have argued that death as a current social practice is suitable to our ‘cultural patterns of activism’ (‘instrumental activism’), and Allan Kellehear criticized the ‘indiscriminate manner’ that the theory of denial is applied (cited in Howarth, 2007: 31-5).

Clive Seale looked into the analyses conducted in macro-structural scales on traditional societies and modern industrialized societies and argued that ‘social organization for death in late modernity is remarkably active, realistic and death accepting’. Hence, he differentiated the psychological denial of death and the sociological one, suggesting that death is ‘hidd[en] away’ or sequestrate[ed]’ (rather than “denied”) in modern times (Seale, 1998: 3). Sarah Tarlow adopted an

archaeological stance to examine the historical development of death practice (such as commemoration and remembrance). She suggested that our attitudes to death may not have changed much since 1800; for her, what manifested a seemingly ‘dramatic transformation’ in contemporary societies may be more about ‘a crisis of expression than a fundamental change in attitude’ (Tarlow, 1999: 151).

Mario Erasmo contrasted the modern death practice (including funerals, disposal of the corpse and commemoration) with the ancients (mainly Greek and Roman) (Erasmo, 2012). In this study, Erasmo indicated the ‘enduring need for the living to perpetuate the identity and memory of the dead’ – the ‘social relationships with the dead’ (ibid: 140, 142) are prominent. In the British Christian faith (and the wider Christian sectors), the annihilation of the construct of purgatory since the Reformation has left the bereaved in a powerless position (Tarlow, 1999: 86-7).

If the general public has difficulty to come to terms with death, for survivors, the lack of suitable rituals has resulted in the third characteristic of what suicide death is for them. Suicide survivors in American culture, James Henslin wrote, are faced with the problem of meaning and interpretation because there are no clear categories to interpret suicide (Henslin, 1972). They are left with difficult feelings and ambivalent attitudes to prepare themselves to embark on the final journey of, and with, the deceased. According to Bill Young and Danai Papadatou, the connection between suicide and sin or moral stigma can still be observed among Catholics, Orthodox Christians, Protestants and Jews (Young and Papadatou, 1997). The major faith systems have provided rituals for the people to rely upon (Parkes et al., 1997), but suicidal death is still considered exceptional In Judaism, for example. It would be up to the discretion of a rabbi to decide whether the

suicidal death is intentional or uncontrollable[31] in order for a “proper” burial to be considered (Levine, 1997). As long as suicide is categorised as an unnatural or “bad” death, the difficulty to have a sense of satisfactory burial and proper commemoration for survivors will remain.

Radcliffe-Brown emphasized how a person's death constitutes ‘a partial destruction of the social cohesion’ until a new equilibrium is established (cited in Palgi and Abramovitch, 1984: 390). In addition to psychological struggles, another layer of difficulty is to do with the social body of the deceased. Social body refers to the ‘accumulation of social meanings and functions which were embodied in that person’ (Tarlow, 1999: 95, by adopting Llewellyn). Although the concept of social body is derived from the death of a prestigious figure (e.g. as the salutation ‘The King is dead; long live the King’ showed), the social influence of the dead can be observed in survivors (Hallam et al., 1999). For this problem, anthropological studies such as the theories of Arnold van Gennep and Victor Turner can shed some light on the no-man’s land in which survivors are stuck.

Van Gennep’s theory of rites of passage involved three stages: first by being separated from one status, following by a liminal state, then by being reincorporated into a new status (Van Gennep, 1960/1977). When applying this model to the dead, first the dead is separated from the world, s/he embarks on an unknown journey, and is then incorporated into the ancestor’s lineage. For the living, first they lose the deceased, and then they detach from social engagements and embark on a grieving process, and are then integrated to the community/society once again. Victor Turner emphasized the notion of liminality

31 I hope I have shown in the Introduction and Chapter One that, whether a suicide is intentional or not is a complicated, sometimes conflicting, phenomenon. The definition used by medical and legal systems to prove a suicide is suicide is more for ‘practical’ concerns than based on ontological understandings. See HOWARTH, G. 2007. Death and Dying: A Sociological Introduction, Cambridge, Polity. P. 164 [by adopting Giddens].

to incorporate any ‘transition’ in rituals and life (Turner, 1969, also see Metcalf and Huntington, 1991: 29-33). It is in the liminal space after death that survivors are stuck, which is to do with the deceased’ body/corpse.

The deceased’s body has been a crucial part in any cultural practices of death (Erasmo, 2012, Metcalf and Huntington, 1991, McManus, 2013, Seale, 1998). The body that has died by suicide is not only damaged, but is also under the control of the medical and legal system (e.g. coroner system); survivors will have a hard time to separate from, and accept, the brokenness of the “natural” body of the deceased to start with. After the funeral (in whatever forms), the struggling of identifying the ‘social body’ of the dead will be awaiting them.

As shown in Chapter One, suicide has gone through various discursive practices; from being caused by the devil, to resulting from mental illness, and further to being ‘a category of risk’ (McManus, cited in McManus, 2013: 19). For survivors, it is hard to re-establish and recognize the deceased’s social body, and hence to put it in a proper place. Whether, how and when, the suicide would be accepted to the ancestry is unknown; namely, it is impossible to resurrect the suicide’s social body.

Howarth has elaborated two dominant ways to conceptualize the relationship between the living and the dead: one is a belief that the relationship between life and death is a dualistic opposition, another is to see the relationship as continuous where life merges into death (Howarth, 2007: 215-6). As shown earlier, the theory of continuing bonds has been gaining importance, but it still leaves survivors in a difficult situation: the bonding is one-way, for the deceased can never mirror back the love. Survivors are therefore locked in a vacuum space, hearing their anguish and lament echoing back. In their minds, the broken/damaged body of the deceased looms large; the wounds incessantly

narrate a death premature, a connection severed, and an identity dislocated. At the end, it would be up to the survivor's good will to bury the suicide in peace. But when and how survivors can reach this stage is unclear, this dilemma still needs to be explored.

How Survivors Experience Loss to Suicide

> The idea that a person chooses to die creates in us a profound sense of unease. Suicide challenges some of our most deeply held beliefs. It defies the cherished notion that all human life is sacred; it challenges the value of life itself, and places a question mark over the taboos against the taking of life. The suicide of another person forces us to question the value and meaning not only of life in general but of our own individual lives. (Wertheimer, 1991: 1)

It is not uncommon to see a look of shock and disbelief on people's faces when they first hear of a suicide. Survivors are forced to face the devastating disaster of losing someone to suicide, and are left with a mixture of powerful and chaotic feelings that include: shame, guilt, confusion, anger, fear, isolation, rejection, abandonment and stigmatization. As mentioned earlier, these strong effects indicate that the suicidal loss is archetypal; it turns one's life 'inside out' and the changes are experienced viscerally and irrevocably (Alexander, 1987: 110). The pioneer of the suicide prevention movement in the U.S.A., Edwin Shneidman, vividly expressed the survivors' agony:

> Suicide is a personal and interpersonal disaster. ... [T]he person who commits suicide puts his psychological skeleton in the survivor's emotional closet – he sentences the survivor to deal with many negative feelings and, more, to become obsessed with thoughts regarding his own actual or possible role in having precipitated the suicidal act or having failed to abort it. It can be a heavy load. (Shneidman, 1972: x)

It is not only a heavy load, but also an almost impossible journey. The survivors are "endowed" with a life-long task, for better or worse. Although each suicide may have his/her legitimate reason to leave this world prematurely, no matter if it is

depression (Cohen, 1994), insanity (Watt, 2004), heredity (Wenz, 1980), psychache (Shneidman, 1993), aggression turned inward (Menninger, 1938, Freud, 1917), a cry for help (Farberow and Shneidman, 1965) or for pain (Williams, 1997), copycat behaviour (Brent et al., 1993), societal anomies or too much or too little of personal integration with collective expectations (Durkheim, 1952/1963/1966), no survivor has ever asked to be touched this way.

Suicide, a 'normless event' (Wertheimer 1991: 136), breaks through the survivor's shield of existence, making a fatal statement on the limit of a relationship. Suicide is 'personally and socially disorganizing', and could be seen as a 'murder on the survivors' (Cohen, 1994: 112). Such a death never occurs in isolation, but always has 'knock-on consequences' (Williams, 1997: 111).

> Suicide has a dramatic ripple effect; the lives of relatives and friends are seriously damaged, in the form of emotional and mental disturbances, failure in life tasks, and repetition of suicide and other self-destructive behaviour. (Brock and Barnard, cited in Fairbairn, 1995: 194)

As Williams maintained, suicide survivors have to cope with their own grief against the background of searching for answers to "why" and "what if" questions. No satisfactory answers to these questions can be found. On top of that, the 'conspiracy of silence' discourages survivors from revealing the truth, opening up to others about their wounds, or acknowledging the journey of recovery. Survivors are left alone to deal with their pain in the dark (Williams 1997: 224). Although life and death are part and parcel of the life cycle, the premature death that results from suicide is an event that never leaves the survivors in peace. When their loved ones kill themselves, survivors are shown the door to doing the same, which means survivors could follow suit – they embody the highest risk of killing themselves.

> [W]henever a loved and admired person commits a forbidden act, one which we ourselves have avoided with some effort and more or less awareness of pain and sacrifice, our defences against that act are lowered and we are in

> greater danger of yielding to the temptation to perform it. (Lindemann and Greer, 1972: 69)

Albert C. Cain listed the complex reactions suicide survivors might experience after the loss of a loved one: ‘reality distortion’, ‘tortured object-relations’, ‘guilt’, ‘disturbed self-perception’, ‘impotent rage’, ‘identification with the suicide’, ‘depression and self-destructiveness’, ‘search[ing] for meaning’, and ‘incomplete mourning’. These psychological changes, some of which might be pathological, do not result from an ‘interpersonal vacuum’ (Cain, 1972a: 13-5). Norman Farberow outlined the following themes: the search to understand why, guilt, stigma, identification with the suicide and anger (Farberow, 1993). The surviving journey, however secretive, is also interactional and reciprocally constructed by individuals and society as a whole.

In the following section, I will examine the survivors’ experiences under the themes of: (1) stigmatization, shame and guilt; (2) the experience of a life-long mourning journey; (3) the negative influence on well-being the survivor undergoes; (4) social isolation, the conspiracy of silence, and distorted communication; (5) an identification with suicide; (6) meaning seeking; and (7) the possibility of personal transformation. The potentiality of transformation echoes the theory of positive growth after adversity. This is not to eulogize the pain or deny the intensity of the experiences, but to point out a perspective that may plausibly be gained after digesting and processing a traumatic loss from suicide.

Stigmatization, Shame And Guilt

Suicide is seen as ‘stigmatized’ death by the public (Worden, 2002: 41). As Cain identified, our society has a low tolerance toward suicide:

> [Our] society whose attitudes toward suicide are basically punitive; a society which affords virtually no institutions or mechanisms for relieving the unique burdens bequeathed the suicide’s bereaved. And ultimately a social milieu is portrayed which surrounds suicide and its survivors with the mark of *stigma*; stigma whose familiar accompaniments of shame, disgrace, social

> avoidance, and cloaked communication (if not forthright malignant blaming and ostracism) multiply the intrinsically formidable tasks of mourning and coping with the suicide death of a family member. (Cain 1972: 15)

Since shame and guilt are common feelings that dominate the survivor's mind, the stigma attached to suicide may have created vicious effects in his/her journey (Colt, 1987). Erving Goffman described how people feel stigmatized by perceiving themselves as being very different from the rest of society (cited in Wertheimer, 1991: 175). To build upon this idea, survivors may feel stigmatized not only because they feel different, but also they may experience feelings of being 'inferior' (Farberow, 1993: 338). The taboo and the resulting social stigma that surround suicide should not be underestimated, because they influence the well-being of the family and the wider community (Curphey, 1965, Shneidman et al., 1965a, Grad et al., 2004).

The origin of the stigma of suicide can be traced back to the condemning attitude of the Church (Grad et al., 2004). According to Robert Litman, suicide is considered 'a grave social wrong by the prevailing religious, legal, social, and medical ethics' (Litman 1965, cited in Jacobs and Klein, 1993: 216). As Iris Bolton described that suicide is a 'disgrace', a stigma of 'iniquity' (Bolton, 2005: 15), survivors may feel that they have been insulted openly by the deceased, who they may feel made a 'public declaration' that s/he prefers death to them (Smith, cited in Wertheimer, 1991: 145). Survivors grapple with a tremendous amount of shame. This shame may have its origins in feelings of having been rejected, failed, and abandoned by the deceased. Bolton, a bereaved mother, described herself as 'foul' and that she must be 'foul' for her son to prefer death to living with her and the family (Bolton, 2005: 11).

> The deliberateness of this act [suicide] fuels intense feelings of rejection, abandonment, and desertion in those left behind. This can contribute to a profound shattering of your self-esteem, with strong feelings of unworthiness, inadequacy, and failure. (Rando, 1991: 111-2)

However, research conducted by Kjell E. Rudestam has speculated that the stigmatizing of suicide may be more of an 'intrapsychic process' in the survivors' perceptions of how they are perceived by the public (Rudestam, 1987: 33). Some research suggested that the stigma surrounding suicide has been caused by the difference in the treatment of suicide bereavement from other types of bereavement.

> [T]he *mode of death plays only a marginal role in adaptation to bereavement*. The "crisis atmosphere" which some authors in the field continue to create around suicide bereavement may be more stigmatizing to suicide survivors than anything else. (Cleiren et al., 1994: 33)

Because of the negative effect of the stigma that is attached to suicide, social support offered to survivors may be less than adequate (Grad et al., 2004, Kübler-Ross and Kessler, 2005, Wertheimer, 1991)[32].

Similarly, survivors experienced guilt more often than those who survive death from other causes (Worden, 2002: 120). This guilt can exist between generations – for example, between children and the surviving adult (Cain and Fast, 1966). Out of intense guilt – in fact, it is 'illegitimate guilt' (Rando, 1991: 34) as it is out of proportion -- survivors may feel they need to be punished. This, in turn, may lead them to engage in self-destructive behaviours which ultimately can

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32 A study showed that 72% of the participants wished to have received formal and professional help, whereas only 47% expressed that they had received such help. 16% wished to have had informal assistance (e.g. help from friends or family), whereas 41% had obtained such support, and only 12% received both types of support. The researchers suggested raising public awareness of the needs of survivors tackling the problem of stigmatization of suicide, creating easier assessing channels for both professional and community help, and increasing the availability of culturally appropriate services. See PROVINI, C. & EVERETT, J. R. 2000. Adults mourning suicide: self-reported concerns about bereavement, needs for assistance, and help-seeking behavior. *Death Studies,* 24**,** 1-19.

A study conducted in Norway examining the support from the local authorities for survivors after suicide of their children shows that, even though the supports survivors need are well recognised by the professionals, local authorities lack the expertise to fulfil these expected needs, see DYREGROV, K. 2002. Assistance from local authorities versus survivors' needs for support after suicide. Ibid.26, 647-668.

The gaps between what survivors need and the available supports reaffirm that long-term support is significant in reducing the risk of complicated bereavement, see MURPHY, S. A. 2000. The use of research findings in bereavement programs: a case study. Ibid.24, 585-602.

result in punishment by society (Worden 2002: 120). Another form of guilt, 'survivor guilt', mentioned by William Niederland (cited in Warren, 1972: 119), could burden the survivor. This form of guilt is especially prevalent in situations where two people attempt to kill themselves together and one of them survives. 'Separation guilt', a term employed by T. L. Dorpat, occurs in psychotic and borderline patients who link parental suicide with their desire for independence and autonomy (Dorpat, 1972)[33].

Some survivors can see that the cause of suicide is outside of their control and are therefore able to protect their sense of themselves, while some may perceive themselves as having caused the suicide in some way. However, the "responsibility" for suicide lies with the victim, rather than the survivors. 'The failure to choose life is the failure of the deceased, not of the survivors' (Dunne and Dunne-Martin, 1987: xvi).

Life-Long Mourning Journey

> [S]uicide bereavement occurs within the context of a combined interpersonal and social landscape that oscillates between appraisal of the suicide act and engaging in the task of day-to-day living. (Begley and Quayle, 2007: 32)

Any suicide has a 'lifetime' effect (Peters, 2006: 82). A survivor, John Peters, described the journey to recovery as a 'winding road' (Linn-Gust and Peters, 2010). The loss of the beloved to suicide is 'nonfinite loss'; survivors will feel the eternal presence of the loss so that continued adaptation and accommodation are needed (Schultz and Harris, 2011). And survivors grieve in their own way; an 'individual's grief is as unique as his/her fingerprints' (Clark and Goldney, 2000), and no style of coping or timetable is preferable. There is a need to reaffirm the

33 According to Dorpat, separation guilt results from one's developmental failure during the phase of self-object differentiation. The pre-oedipal origin of separation guilt, intensified by the parental suicide, would result in a large-scale inhibition of development towards independence and of the necessary differentiation of one's self and object representations.

individuality of responses and recognise the complexity of the grief journey (Doka, 1995).

Research has shown that grief in suicide bereavement may be more intense and last longer than grief from other types of losses (Farberow et al., 1992a, Farberow et al., 1992b, Cain, 1972a). Grief after a suicide is often 'complex and likely to be incomplete' (Dunne, 1987: 203). The survivors' grief reactions can be exacerbated by inappropriate responses from the community to the suicide (Knieper, 1999). So far, research data offers very little guidance for answering the question "is suicide bereavement different from other modes of death?" as well as for developing and evaluating empirically clinical interventions for survivors (Jordan and McMenamy, 2004). It is very common to hear survivors say that the suicide has changed their lives totally (Begley and Quayle, 2007, Smith, 2011, Myers and Fine, 2007). Carla Fine, a survivor, advocated for more of a dialogue between survivors and clinicians in order to understand suicide, and wrote:

> For most survivors, suicide is something we know nothing about until someone we care for ends his or her life. Suicide is not in our vocabulary and we have no time to prepare for it. From the minute [the suicide occurred], our lives are split apart, creating a frozen "before" and a permanent "after". (Myers and Fine, 2007: 121)

A father who lost his son to suicide expressed that: 'The truth is that it will never be over, but then, it is not supposed to be over. The truth is that it will never be over, but my growth and gaining strength will make it acceptable' (Bolton, 1987: 90). After losing her mother to suicide, Victoria Alexander felt that her mother's life and death 'are too important' in her life and 'will always be part of' her. The journey of mourning will go on as long as life continues: 'I'll never be finished with my mother's suicide, anymore than I could ever be finished with her' (Alexander, 1987: 116).

Influence On Psychological Well-being

Survivors may be blamed for what happened, the blame is very 'destructive', and the experience of loss to suicide 'damaging' (Silverman, 2010). The grief process can be complex and traumatic and may result in PTSD (Aguirre and Slater, 2010, HMHL, 2009 Nov., Holmstrand et al., 2006). Losing someone to suicide is considered the 'most difficult bereavement crisis' for survivors (McGee in Worden 2002: 119). The experience of surviving suicide has been described as 'a personal Holocaust' (Wertheimer 1991: 13), and the pain of the loss can be experienced both physically and emotionally. Alison Wertheimer pointed out that several survivors she interviewed had suffered from severe chest pains, which could be the result of intensive crying and feeling the heart broken. Some may develop "complicated grief", putting them at risk of experiencing long-term health problems (Mitchell et al., 2004, Worden, 2002, Parkes, 1996, Cain and Fast, 1966).

Complicated grief was identified as a distinct subcategory of bereavement, which is separate from normal grief and other psychiatric problems (e.g. bereavement-related depression, and anxiety disorders). The diagnostic criteria for complicated grief include: the bereavement was caused by death; the intrusive and distressing symptoms include yearning, longing for, and searching; individuals show four or more persistent symptoms of traumatisation (e.g. avoidance of reminders of the deceased, purposelessness, numbness, detachment, feeling empty and/or meaningless, etc.) (Roten, 2007).

Mitchell and colleagues formulated an instrumental tool, *The Inventory of Complicated Grief,* in order to measure and investigate the relationship between one's kinship to suicide and complicated grief reactions (Mitchell et al., 2004, Mitchell et al., 2005). They pointed out that a high level of complicated grief symptoms is a risk factor for physical health problems and suicidal ideation, especially when the survivors were closely related to the deceased. They

suggested that when assessing complicated grief needs, it is important to consider the familial and/or social relationship between the bereaved and the deceased. The extent of the survivors' emotional attachment to the deceased is another important factor.

However, a conflicting picture of survivors' adjustment to life after loss is presented by Dyregrov and colleagues. They compared suicide survivors with other forms of sudden loss, such as the unexpected death of a child (like an accident or sudden infant death syndrome), and found no evidence to suggest that suicide survivors have more difficulties in adapting to their loss. The various forms of grief reactions have more in common than they differ (Dyregrov et al., 2003). Another study examined the relationship between the exposure of adolescents to the suicide of a peer and subsequent suicide risk. The results did not support the hypothesized differences between the exposed and unexposed on measures of suicide risk or depressive symptomatology (Watkins and Gutierrez, 2003).

The issue of whether suicide survivors experience more difficulties than the other survivors of loss takes the focus away from more pertinent questions. I would say that the conflicting findings on the topic indicate that there is a need to explore what contributes to their different reactions in greater depth.

Social Isolation, Conspiracy Of Silence, And Distorted Communication

Research showed that survivors suffer from social rejection and alienation (Silverman et al., 1995), remain isolated socially (Rando 1991: 113) and do not get enough support (Kübler-Ross 2005). Dyregrov and colleagues conducted a study comparing how a child's death by suicide impacted the child's parents in comparison with the loss of a child to sudden infant death syndrome and accidents. Social isolation was found to be the strongest predictor of psychosocial

distress among parental survivors, and guilt and self-blame contributed to this isolation (Dyregrov et al., 2003). In a study of survivors ten years after losing someone to suicide, it was observed that survivors had a notable lack of social relationships (Saarinena et al., 2002). Pirjo Irmeli Sarrinen and colleagues conducted research looking into survivors' mental health and social isolation: survivors were found to have fewer friends, living in a constrained economic situation, and their general health was poor. Although it is possible that the surviving family members themselves had been in an unhealthy dynamic before the time of the suicide, the bereavement caused by suicide may limit their ability to cope with other difficulties, even ten years later (Saarinena et al., 2002).

Survivors find it hard to talk about the suicide (Grad et al., 2004), and this reticence to talk about their personal tragedy creates an ambiguous dynamic that entangles survivors' friends and their greater social community. It is unclear '*whose* reluctance to discuss the event is more responsible for the eventual silence' (Rudestam, 1987: 33). Overall, it can be said that suicide is 'a wedge that comes between' the family, the community and support network preventing effective understanding (Linn-Gust, 2010: 42). Secondary survivors (i.e. those who are not in direct kinship to the suicide victim) may not understand the silence and may only sense an 'oppressed' atmosphere within the family of the person who has died by suicide. The shame, blame, and secrecy are a 'tremendous load to carry' for survivors, and very often they carry it alone (Silverman, 2010).

Marilyn J. Hauser noted that western societies have, in principle, failed to develop guidelines for suicide bereavement (Hauser, 1987). Silence can be a way for survivors to cope with feelings of blame or guilt that are either directed at themselves or at others. Lukas and Seiden explain that:

> family members do not want to expose the guilt and blame they feel; the blame they feel towards other family members, the guilt they feel about themselves. … The silence is an attempt to keep the cap on terrible

> accusations … towards others and towards oneself. (1987, cited in Wertheimer, 1991: 112)

Unhealthy isolation and silence may create an unhealthy communication pattern. This pattern may lead to communication being distorted between the surviving adults and their children (Cain and Fast, 1966). One study showed that about 44 percent of suicide survivors had lied to others (Range and Calhoun, cited in Joiner, 2005: 6). In thirty-nine cases of suicide in Ohio, it was revealed that about half the respondents were reluctant to discuss the suicide with friends and other people, and nearly a third confessed that they had lied to others about the real cause (Rudestam, cited in Rudestam, 1987: 32). It is also possible that some survivors deny the existence of the suicide, because of a fear of facing possible responsibility for causing the suicide (Lester, 2004). However, for the family facing repetitive stresses from a member who is pathological (e.g. one who is an alcoholic or chronically depressed), it is likely that the warning communications are ignored. Some family members might have experienced hostile and even murderous impulses towards the suicidal person. Such complex dynamics make it really difficult to reconcile, accept, acknowledge and work through emotional residues after the suicide.

Identification With Suicide

Suicide is contagious (Range et al., 1988). Research has shown an increased risk of suicide among bereaved people (Lu et al., 2011, Shneidman, 1972, Farberow and Shneidman, 1965, Kaprio et al., 1987), and this risk is the most alarming factor. A study showed twenty-two percent of the subjects reported feeling suicidal in the first four weeks after the death of a friend, partner or family member (Farberow, 1994). For some, it may be seen as a way to reunite with the deceased or as an end to feelings of alienation and misery (Parkes 1996: 56). It may also be because of the guilt and self-blame regarding the loved one's suicide

that fifty percent of the subjects in a research study were reported to have considered suicide for themselves (Battle, cited in Farberow, 1994: 173).

The risk is highest during the first week of bereavement when women are ten times more likely to die by suicide and men sixty-six times more likely (Kaprio et al., 1987). Bereaved adults experiencing complicated grief manifest the highest risk for suicide (Latham and Prigerson, 2004). Traumatic grief was associated with a 5.08 times greater likelihood of suicidal ideation, most especially among young adults (Prigerson et al., 1999). The first year after exposure to suicide is also a crucial time for suicidal ideations and behaviours. Those who knew the deceased within the last year were found to be 1.6 times more likely to have suicidal ideation, 2.9 times to have suicidal plans, and 3.7 times to have made a suicide attempt (Crosby and Sacks, 2002).

Clear evidence shows that exposure to suicide increases the risk of suicidal behaviour and death by suicide (de Leo and Heller, 2008). The increased risk of death by suicide among people who have lost a close kinship member to suicide was also documented, although the risk may be co-morbid with other pathological factors (Qin and Mortensen, 2003, Qin et al., 2003, Agerbo et al., 2002, Agerbo, 2003). Even those who are exposed to the suicide of non-family members are more likely to have suicidal inclinations than they would have previously (de Leo and Heller, 2008). As mentioned in Chapter One, a family history of suicide was found to be a risk factor for people attempting suicide, and this is true regardless of the psychiatric diagnosis of the attempter (Trémeau et al., 2005). Losing a parent to suicide was associated significantly with the elevated risks of suicidal ideation and suicide attempts among the offspring (Goodwin et al., 2004).

After witnessing the suicide of a loved one, the survivors are shown the way to do the same thing (Cain, 1972a, Farberow, 1993). Suicide becomes an option for survivors as Edward Dunne noted:

> Survivors have had the “veil” of death lifted and are forced to confront existential reality. They usually know or believe they know what led to the suicide. … [T]hey view the suicide as a way to handle a difficult interpersonal, financial, or legal problem or situation. What’s more, the closeness of the survivor’s relationship to the deceased promotes an openness to options suggested by the deceased. This openness is even more pronounced when the suicide victim was a spouse, a parent, or an older sibling, or some other admired figure. (Dunne, 1987: 204)

For Bolton, after losing her son, suicide:

> personifies the ultimate noncomformist. He is also a seducer. If his demise seems to prove that death is more to be desired than life, then it is assumed that many other troubled souls will be encouraged to follow his example. (Bolton, 2005: 13)

The findings on survivors’ identification with suicide is one of the arguments that lies behind the hypothesis of a suicide complex that this thesis puts forward and which will be further explored in Chapter Nine.

Meaning Seeking

‘Man cannot stand a meaningless life’ (Jung and Freeman, 1959). When one experiences the disruption of life, or the loss of a loved one, it is inevitable to search for meanings. Worden wrote: ‘There is a need to search for an answer to why the loved one has taken his or her life and, in particular, to determine the state of mind of the deceased before the death’ (Worden 2002: 124). After a life-altering loss, the meaning-searching of the bereaved can range from ‘the practical’ (e.g. *How* did s/he die?), via the ‘relational’ (e.g. *Who* am I? Am I still a wife after the loss of my husband?), to the ‘spiritual or existential’ (e.g. *Why* did God permit this to happen?) (Neimeyer and Sands, 2011: 11). Cain pointed out that there are ‘endless repetitions and reconstructions of different versions of the events preceding the suicide and a groping quest for the “meaning” of the suicide’ (Cain 1972: 14). This quest may come out of the need to deny the suicide, or prove it was not suicide, or at least to understand it in order to ‘tolerate[sic]’ it (Farberow, 1993: 338).

The searching process begins as a way of trying to make sense of the death and as a part of the struggle to put the broken pieces of life together (Alexander, 1987). Clark and Goldney charted the trajectory of meaning-making among survivors. In the acute state of loss, some survivors could not sense any meaning; for some, this changed over time and they went on a healing journey and found some meaning, while others remained bitter and devastated (cited in Worden, 2002: 124). A study investigating a constructivist model of grief confirmed that sense-making, or the ability to construct a coherent narrative and understanding of the loss experience, has a positive effect on mediating the relationship between violent death and complicated grief symptomatology (Currier et al., 2006).

In a phenomenological study of eight adults bereaved by suicides, questions emerged around the themes of making sense of the suicide and the sense of 'purposefulness' in survivors' lives (Begley and Quayle, 2007). In the first twelve months after the suicide, survivors tried to control the impact of the suicide. By ruminating about the demeanour of the deceased prior to suicide and some potential events that led up to it, survivors questioned their prior relationship with the deceased and how much they contributed to the death. Making sense of the suicide is 'a complex process' and it is not a linear development.

> The picture that emerged from participants was that meaning-making occurred in the context of seeking out the story of death, then matching prior beliefs about the person to a possible cause of death while protecting their sense of self in the process. It was done slowly. Meaning-making occurred in the context of putting the suicide aside and living through daily routines of work. (Begley and Quayle, 2007: 30)

According to Mary Begley and Ethel Quayle, when survivors started to search for meaning, difficulties arose from social and interpersonal interactions. Survivors felt that the others were uneasy around them and people failed to understand their difficulties in communication. The participants in this study chose to avoid social interaction in order to minimise their overwhelming emotions. Even if survivors

were able to find a purpose in the suicide death, they did not express that they 'had moved on from the suicide'. The majority of the participants were 'deliberately living in the shadow of the suicide at least five years after its occurrence' (Begley and Quayle, 2007: 32). They felt the death had changed their lives, and their perceptions of life had changed. In the long term, survivors are willing to engage in new activities, especially in helping others.

By becoming involved in research about suicide or engaging in suicide prevention, survivors can create meaning for themselves. Dyregrov and colleagues conducted a study to see how survivors' participation in bereavement research influenced their well-being (Dyregrov et al., 2011). It showed that by engaging with research projects, some survivors found meaning by giving back their experiences. It showed that the interview can facilitate a process of re-defining meanings and increasing awareness of the bereavement journey.

> [T]he interviewees used the interview to perform a complex reconstructive task, striving to piece together the shattered biographies of the deceased and themselves. With traumatic loss, a sense of meaning may be shattered; however, with meaning reconstruction, there is the possibility for new adaptations and new behaviors. (Dyregrov et al., 2011: 702)

This study showed that objective factors such as gender, the interviewee's relationship to the deceased, the method of suicide, and the amount of time that had lapsed after the loss did not influence their experience of meaning-seeking. However, when survivors take part in suicide prevention programs there is a risk that they may be doing so because of an unconscious need to 'aton[e] for' their perceived failure in preventing the suicide of the loved one that they have lost (Lester, 2004: 79).

Potential For Transformation

There are research studies exploring the positive growth after experiencing grief and loss. This positive response to grief and loss has been identified as post-traumatic growth (PTG) (sometimes called personal growth or positive

growth, PG) (Calhoun and Tedeschi, 2006). Although there is a subtle difference for each term, in this section I use them interchangeably. PTG is a concept developed by Lawrence G. Calhoun and Richard G. Tedeschi, who argued that grief and trauma present some survivors with a potential for transformation; there are some changes occurring in survivors that enable them to transform their post-traumatic stresses into post-traumatic growth.

The personality of the bereaved contributes to the potential for positive growth outcomes. The optimistic attitude of some bereaved mothers, along with their capacity to reframe the loss in a positive way, as well as seek and engage with support, are identified as significant factors (Riley et al., 2007). Feigelman and Jordan examined the growth experiences of parents after the loss of a child to suicide by using the Hogan Grief Reaction Checklist (HGRC). The list consists of a variety of scales measuring significant elements in the grieving process, and among them is a subscale for personal growth, a development that is estimated to emerge at a later point in the grieving process. They found that PG is positively linked with the length of time that had passed after the subject's loss. About two-thirds of the surviving parents who have shown the characteristics of PG had been grieving for their loss for five or more years (i.e. long-term survivors scored higher than the newly bereaved). These findings strongly suggest that PG is a significant factor resulting in the healing process after suicide loss and is negatively related to suicidality, abnormal grief reactions and mental health problems (Feigelman et al., 2009).

Angela Smith and her colleagues used Interpretative Phenomenological Analysis to explore the experiences of PTG in adults bereaved by suicide. They suggested that the positive outcomes of surviving a loss to suicide are contingent on the 'process of time'; and it is impossible to give a time frame for survivors to determine when growth may begin, for it is rather a fluid journey which is very

dynamic in nature. However, for the survivors with whom Smith and her fellow researchers studied, the idea of PG seemed ‘unmentionable’ (Smith, 2011: 425); the survivors were reluctant to mention that they obtained positive feelings from the traumatic loss. The authors also reminded the readers that the experiences of growth do not preclude distress; these experiences can co-exist.

Despite their struggle, survivors wish to outgrow their pain. From those studies, some circumstances leading to PG can be identified. Having access to social support and genuine interpersonal communication are key factors in assisting survivors to obtain positive outcomes (Dyregrov and Dyregrov, 2008, Smith, 2011, Grad et al., 2004).

The social support is a significant factor in aiding survivors in the reconstruction of their experiences and lives, as well as facilitating the finding of new meanings and ‘rediscovering hope for the future’ (Hogan and Schmidt, 2002: 629).

> Social support was shown to enhance the bereft’s ability to ameliorate grief, which in turn provided the opportunity for them to make the transition toward personal growth. … [T]hat the bereft’s ability to talk openly and honestly about their grief is dependent upon the supporting person being willing to take the time to listen and to listen non-judgmentally. The act of talking about grief is often viewed as facilitating the healing process. … [T]he onus is on the support person to provide the context for healing to occur by being fully present and accepting of the bereft’s story of suffering, transformation and growth. Professionals should support the bereft’s search for meaning and purpose as they reconstruct their sense of self and worldview following significant loss. (Hogan and Schmidt, 2002: 630)

From the suicide prevention work done in Norway, ‘openness’ was identified as an important remedy for the ‘social helplessness’ that some survivors experienced (Grad et al., 2004: 135-6). Social helplessness is defined as a social institution’s difficulty ‘in responding to and supporting’ survivors in a way that is helpful to them. By being open to talking about the suicide and the accompanying struggles and grief, a greater acceptance and understanding can be achieved. Openness can be an empowering stance for survivors and for social networks as well.

Similar to Smith's research, another study by David Miers and colleagues has identified the forms of assistance that survivors wish for: namely, being heard and receiving a response; advice from other survivors, aid in finding direction; support in viewing the deceased; help in remembering the deceased; and opportunities to give back to the community at large (Miers et al., 2012). Although this phenomenological study is focused on families losing their teenager, its findings can be applied to any kinship.

The Theories of Positive Growth after Adversity

After having reviewed the impact suicide has upon survivors in the previous sections, this section will explore the theories of positive growth after adversity. There is a long tradition in the psychoanalytic discipline that interprets the process of going through a traumatic experience as one that 'gifts the patient heightened, even supernatural powers' (Luckhurst, 2008: 64). Although research on the positive outcomes from traumatic events is relatively new, the potential for transformation arising from extreme difficulties and challenges is a phenomenon that is not new to us. Victor Frankl, a man who survived living in a concentration camp during the Second World War, talked about the importance of meaning-making, in and alleviating, the suffering (Frankl, 1963). Carl Jung lived through his break-down after his split with Freud; after emerging from the trauma, he formulated the theory of positive functions of symptoms. For him, pathology is one's self striving to redress some imbalances in one's psychology rather than being merely one's disease (Jung, 1931a, Jung, 1945).

As mentioned earlier, the formation of positive response to grief, loss and/or trauma has been identified by researchers and this stance serves as a counterbalance to the prevailing pathological discourse (e.g. PTSD, complicated

grief) (Joseph and Linley, 2008). Another concept that closely relates to PTG is resilience. Resilience is a trait that reflects one's ability to adapt to stressful events in life (Bonanno et al., 2001, Cohler, 1991, Luthar et al., 2000). It is defined as 'a dynamic process encompassing positive adaption within the context of significant adversity' (Luthar et al., 2000: 543). In the 1970s, the healthy development of children in negative environments was identified by researchers as "resilient" (Martinez-Torteya et al., 2009, Luthar, 1991, Lengua, 2002, Kim-Cohen et al., 2004). The theory of resilience has subsequently been developed to counter 'the default assumptions of the trauma model' (Luckhurst, 2008: 210).

From the perspective of the trauma model, signs of resilience could be misunderstood as 'rare or pathological' (Bonanno, 2004). Resilience is not the same as recovery, although it is 'common', and can travel 'multiple' and 'unexpected' routes to reach fruition. George Bonanno iterated that many people when 'exposed to violent or life-threatening events will show a genuine resilience that should not be interfered with or undermined by clinical intervention' (Bonanno, 2004: 22).

In the context of bereavement, it is one's capacity to maintain continuity of identity before the loss and over the post-loss bereavement period that shows evidence of resilience. In this situation, the emphasis is particularly on the relationship between resilience and continuity in terms of one's social identity (Bonanno et al., 2001). The linking of resilience with continuity resonates with the idea of preserving continuing bonds with the deceased (Stroebe et al., 2010, Stroebe et al., 2001b). In Bertram J. Cohler's article, resilience was reviewed in the context of a person's life story and relied on one's construction of 'a good or followable life-story' (Cohler, 1991: 183). The narrative of resilience is synonymous with effective coping after adversity.

According to Papadopoulos, in the face of adversity, resilience may manifest itself in five possible distinct and inter-related ways (Papadopoulos, in press). The five categories are: ‘stability’ (which can be understood as an emphasis on retaining existing positive functions, qualities, and characteristics that were present before the exposure to adversity); ‘agility’ (or returning speedily to one's previous equilibrium); ‘tolerance’ (which, in this case, is the tolerating of the various forms of instability created by changes while also minimising the harmful effects of this instability); ‘flexibility’ (i.e. adapting to the new changes, contexts, realities, pressures, challenges, and opportunities that adversity activates); and ‘transformation’ (in other words, developing new ways of being). Here Papadopoulos maps out a substantial tapestry of resilience in human psyche.

Trauma Grid

The Trauma Grid (TG) is an important model that was a major influence on my research design and methods for the empirical part of this research (see Chapter Seven). Developed by Papadopoulos, the TG explores the negative, the ‘neutral’, and the positive responses a person may experience after encountering adversity (Papadopoulos, 2007). The negative outcomes of trauma may include: ‘ordinary human suffering’, ‘distressful psychological reaction’, and ‘psychiatric disorder’. Papadopoulos called the ‘neutral’ response ‘resilience’. Here, the ‘neutral’ response is always written in inverted commas to emphasize the qualities of the person that do not change. The resilient qualities remain unchanged after encountering the adversity, although it is possible that they are lost temporarily. The positive outcome of a distressing situation is called ‘Adversity-Activated Development’ (AAD). This refers to positive growth and developments that are a direct result of being exposed to adversity. AAD includes the development of new

characteristics that did not exist prior to the encounter with adversity (Fig. 1, see below).

The TG is a framework that aims to examine the total range of effects that one experiences after encountering adversity. Papadopoulos argued that the medical theory of trauma identifies only the pathological reaction one has in response to adversity and this has the effect of polarizing the victim and over-simplifying the problems. For Papadopoulos, the TG is an antidote to this treatment of trauma (Papadopoulos, 2007). This innovative model came from his work with refugees and other survivors of political violence and disasters in various countries. He brought to our attention the general confusion that comes from assuming that traumatic events inevitably lead to the development of traumatic symptoms. This prevalent misunderstanding may diminish the survivors' capacity to live with adversity without medical intervention.

What makes AAD unique is that it shows that it is possible for positive outcomes to develop as a direct result of a person having been exposed to adversity. It highlights the existence of new strengths that did not exist prior to the adversity, and it expands the differentiation of non-pathological outcomes following calamity. When a person is coping with adversity, the course one takes is rarely a linear progression (i.e. from the negative to the positive). AAD is acquired because traumatic incidents force a person to face their personal limits. It often pushes them over the edge of their world, they feel their life has reached an end and they do not know how to go on. Paradoxically, an encounter with adversity can open a potential space for change.

The TG model provides therapists and care workers with a comprehensive and systematic way of identifying the coping strategies of refugees in the contexts of individual, family, community, and society/culture. It has been used to explore the dynamics of traumatic encounters and the possibility of bringing about

integration of the psyche from a Jungian standpoint (Papadopoulos, 2011, Waldron, 2008). It has also become an important model for assessing the mental health and wellbeing of refugees in America (Murray et al., 2010) and in Pacific Rim countries (Davidson et al., 2008). It can be considered as significant as the theories of PTSD and PTG and has been integrated into post-war contexts and even a war trauma counsellor training programme (Badri et al., 2013, Somasundaram and Sivayokan, 2013).

According to Papadopoulos, there are some differences between AAD and PTG (Papadopoulos, 2007: 307).

1. The anchoring point for PTG is trauma; it implies that those who develop PTG must have been traumatized. The anchoring point for AAD is adversity rather than trauma. There is a subtle difference between being traumatized and being exposed to adversity.
2. The “post” in PTG not only echoes the ‘post’ in PTSD, it also implies a stopping point in time when the experience of trauma turns into an experience of growth. The AAD concept suggests that the adversity may still go on after one’s initial encounter with trauma, and the positive responses may have entered into one’s life during the period of adversity, not necessarily afterwards.
3. The term “growth” may have a ‘negative connotation’, as the ‘‘morbid formation’ in cancer, whereas “development” is more ‘neutral’, accommodating a wider variation of positive responses.

	Negative effects			‘neutral’ effects	Positive effects
	Psychiatric disorder, PTSD	Distressful psychological reaction	Ordinary human suffering	Resilience	ADVERSITY-ACTIVATED DEVELOPMENT (AAD)
Individual					
Family					
Community					
Society/culture					

Figure 1 The ‘Trauma Grid’ (Papadopoulos, 2007)

Before adopting the TG as part of my methodology, a critical examination indicates some pitfalls that I need to be aware of: (1) by replacing “trauma” with “adversity”, it humanizes the sufferings that impact the survivors and raises the experiences to an existential level. However, it may implicitly deny the ubiquitous power of the traumatic loss that many suicide survivors are living with. It requires the sensitivity and care of the helping professions to attend to survivors’ needs; (2) although the diagram makes it clear there are various responses among different parties (i.e. from individual to society/culture), the impacts/developments on various levels are circular rather than linear. The diagram loses the qualities of mutuality, reciprocity, and the depth of the grey area that any traumatic encounter generates; (3) it ignores the personality or pathology that an individual may have formed before the encounter. Without addressing the individual’s idiosyncrasies, the societal/cultural system may be forced to take on more responsibility than it should. Notwithstanding these speculative critiques of the TG model, its merits cannot be dismissed as will be shown later in the research design and methods (Chapter Seven), I designed the interview questions according to the TG and facilitated the groups’ discussion along this framework, hoping to generate a collective awareness of what impacts survivors have been living with. By sharing the researcher’s tool with the participants (i.e. by distributing the TG model to the researched), this project is a collaborative one in essence and the approach is empowering. More analysis and reflection on the researcher’s position will be presented in the later chapters.

3. Therapeutic Approaches

In the last chapter, we reviewed the theories of loss, grief and bereavement, and life after death. It was indicated that the 'letting-go' approach is insufficient for survivors' long-term bereavement. The theory of a 'continuing bond' may be more appropriate due to the survivor's need to feel a sense of continued connection with the deceased after the shocking incident of suicide, although it may still leave survivors in an eternal grieving state. The loss is an archetypal one, manifesting itself in quanta of negative affects. The elaboration of experiential themes that affected survivors helps us to understand deeply, and in a systematic way, their struggles and challenges. This understanding serves as a point of reference as well as background knowledge for us to discuss the analysis of the survivors' overall outcomes later in Chapter Eight.

In this chapter, I will focus on therapeutic approaches that have been developed to help survivors. First, three layers of suicide prevention are introduced: 'primary' prevention (involving the family, the community and society); 'secondary' prevention (involving the intervention and treatment of suicidal persons); and 'tertiary' prevention or 'postvention' (referring to the work with survivors of suicide) (Stillion and McDowell, 1996: 199). The first two levels focus on the potential for suicide and ways of discouraging people from becoming victims of suicide; while survivors' vulnerability is addressed by the third level of prevention. The mapping of the levels can give us an overall picture of what will need to be considered in terms of suicide prevention, and the division is rather fluid and overlapping. I will then turn to three specific interventions for survivors:

group work, psychological autopsy, and the narrative approach. The narrative approach will include narrative therapy and narratives used in therapeutic contexts.

Levels of Suicide Prevention

When a suicide occurs, three types of support need to be offered to the family immediately. The first being the accurate and honest reporting of the cause of death from the very beginning; this prevents confusion and future difficulties in processing the loss. Second, space and time to see the body should be provided. The family may feel angry and deprived if this opportunity is denied. The act of seeing the body would prevent the fantasies of misidentification, or other difficulties in accepting the suicide. Third, a funeral should be held for the deceased and the survivors (Clark and Goldney, 2000). As mentioned previously, survivors have been historically overlooked by the mental health profession, and it was only in the 1960s that this started to change (Colt, 1987). Survivors came to the forefront unexpectedly after the execution of the psychological autopsies done by the Los Angeles Suicide Prevention Center (LASPC) in order to understand the causes of some ambiguous deaths by suicide[34].

In 1966, the American government set up a National Center for Studies of Suicide Prevention within the National Institute of Mental Health. The Center

34 LASPC was set up in 1958, and the team investigated why the deceased killed themselves by interviewing the family members and friends. They found widespread resistance to reveal, the denial of evidence, and mental health problems among survivors; unexpectedly they also discovered that survivors had a great need to talk about their experiences. Hence, concern for specific groups, such as survivors, youth, and AIDS victims emerged in the 1980s; a "Survivors after Suicide" group was formed based on a crisis intervention model. See FARBEROW, N. L., HEILIG, S. M. & PARAD, H. J. 1994. The Suicide Prevention Center: Concepts and Clinical Functions. In: SHNEIDMAN, E. S., FARBEROW, N. L. & LITMAN, R. E. (eds.) The Psychology of Suicide: A Clinician's Guide to Evaluation and Treatment. Revised Ed. ed. London: Jason Aronson Inc.

aimed at generating active suicide prevention programs across the country. In 1968, the American Association of Suicidology (AAS) was developed. Edwin Shneidman, the founder of the AAS, is considered the current foremost advocate for suicide prevention. Scneidman advocated 'A comprehensive suicide-prevention program should attend to the psychological needs of the stigmatized survivors, especially children who survive parent who has committed suicide'. This effort was called "postvention". Since then, the intervention effort has been officially expanded to include survivors of suicide (cited in Colt, 1987: 14-5). Shneidman soon coined the term "suicidology" to refer to suicide studies that have been established and well-accepted as an academic and clinical discipline.

Shneidman used 'prevention', 'intervention', and 'postvention' to describe the three stages of suicide intervention. He advocated that 'postvention is prevention for the next decade and for the next generation' (Shneidman, 1969: 20-2). For him, suicide prevention is not a 'solo practice', but involves multiple networks and resources; to prevent survivor suicide, a '*Therapeutic Council*' is needed (Shneidman, 1993: 141, 150). Since this thesis is about survivors, the focus will be more on the third layer of prevention – postvention.

Primary Intervention

Primary intervention looks at suicide prevention at the levels of family, community and society. For instance, in suicide prevention at the family level, family members can remove guns or other lethal means from the home. In the community, the residents can set up a prevention centre which can make a substantial difference in reducing the suicidal loss of their members (Farberow, 1967). Edwin Shneidman and Philip Mandelkorn suggested that each community should create and 'tailor' a suicide prevention program to suit its own needs. It is ideal for each community prevention centre to be

staffed with at least one or two mental health professionals or social workers and a group of volunteers. The volunteers should be '*carefully selected',* '*rigorously trained',* and have basic assessment knowledge. Crisis help-lines can be very helpful, because the format allows for the suicidal person to remain anonymous. The suicide prevention worker receiving the phone-call deals with life and death issues and could become the caller's 'lifeline' (Shneidman and Mandelkorn, 1970: 140, 136). The prevention goals in the primary level are, as Shneidman and colleagues advocated: 'clinical' (i.e. focused on saving the life of the person considering suicide), 'community' based (i.e. the integration with other agencies in the community), and 'research' driven (i.e. to test various hypotheses regarding suicidal phenomena (Shneidman et al., 1965b: 7).

In the UK, as set forth in the paper *The Health of the Nation* (1992), mental health management was identified as a key factor in reducing the suicide rate, along with reducing morbidity and mortality caused by mental illness. The government aimed to reduce the overall suicide rate by at least fifteen percent, as well as reducing the lifetime rate of suicide in people with serious mental health issues by at least one-third by the year 2000 (Bottomley, 1994). The primary care system was identified as an important factor in enacting these reductions, especially GPs who assess the risk to patients. The Defeat Depression Campaign organized by the Royal College of Psychiatrists and the Royal College of General Practitioners conducted an education program for GPs and other health professionals. This program provided an overview of different topics on suicide and relevant risk factors, taking into account such potential causes as the psychiatric history, social and physical health problems (including unemployment and financial problems, family breakdown and divorce, and physical illness), and people

being in high-risk occupations (e.g. medical practitioners, pharmacists, farmers). It also indicates prison as a site for suicides and the availability of particular means for suicide. Media influences were further identified as significant factors of suicide (Hawton, 1994). The treatment of mental disorder, restricted access to methods (e.g. detoxification of domestic gas), and an awareness of social and media influences were highlighted as primary prevention methods (Shaffer, 1994).

Secondary Prevention

Secondary prevention involves intervention/treatment of suicidal persons. These procedures incorporate the significant others in the intervention process, and efforts are extended that range from crisis management to diminishing the level of acute lethality. It also involves cooperation between different agencies and communities such as the police, school, and social agencies, with the aim of executing effective referrals and to involve more input from clinical suicidologists.

Postvention

The term “postvention”, coined by Shneidman, refers to measures taken after a suicidal event. It can mean working with a suicide attempter after a suicide attempt, but in the context of this thesis, the main focus of this layer is on the survivors (Shneidman, 1969). Postvention is not limited to the initial stage of loss, but is more often directed towards the day-to- day struggle of living with grief for over a year or more. It is ‘an ongoing therapy’, sharing some of the characteristics of psychotherapy, such as abreaction, interpretation, reassurance, discussion, and gentle confrontation. It provides a space for the expression of negative feelings such as anger, shame, and guilt (Shneidman, 1993: 167).

A successful example of this is the proactive postvention service that was established in Australia – the StandBy Response Service (Fisher, 2010). StandBy

was developed by United Synergies Limited, a Queensland human resources company in 2002, in response to numerous suicides in the Noosa hinterland region. It is a community-based program that provides a 24-hour coordinated crisis response to assist survivors. It is an evidence-based model constructed using insights garnered from the discourses of trauma, loss, grief and suicide bereavement. The aim is to reduce any potential adverse mental health developments and to intervene in addressing further suicidal behaviour. The available emergency, community support mechanisms, and agencies are involved in the service. These agencies include the police, ambulance, coronial services and community groups. The service strives to help survivors in 'accessing the right support, at the right time and in the right place' (LIFE).

Another focus of postvention is how to intervene when a suicide happens in a school. In addition to the individual survivors, the school itself is also a survivor unit. Anxiety may be more intense and the concern is on how to prevent further suicides from happening. Postvention policies should ensure that the response is offered proactively rather than reactively (Lamb and Dunne-Maxim, 1987). The postvention work in the schools has much in common with the work with post-traumatic stress victims (Wenckstern and Leenaars, 1991). Guiding principles are highlighted, such as: the suicide should not be glamorized or dramatized; doing nothing can be as harmful as doing too much; and the students cannot be helped until the faculty is helped (Lamb and Dunne-Maxim, 1987).The following eight principles of postvention are proposed by Judith M. Stillion and Eugene E. McDowell:

1. Begin as soon as possible after the tragedy.
2. Expect resistance from some but not all survivors.
3. Be willing to explore negative emotions towards the victim when the time is right.
4. Provide ongoing reality testing for the survivors.
5. Be ready to refer when necessary.
6. Avoid cliché and banal optimism.

7. Be prepared to spend significant amounts of time (generally several months) in one school.
8. Develop the postvention program within a comprehensive health care setting that also includes prevention and intervention. (Stillion and McDowell, 1996: 232)

Before proceeding to three specific interventions for survivors (group work, psychological autopsy, and narrative approach), it needs to be mentioned that not every survivor needs therapy from the health professions; some survivors can recover from the traumatic loss in their own ways (Farberow, 1994).

Intervention I: Group Work

There are basically three types of group interventions for survivors: classical group therapy, peer-led groups, and homogenous groups facilitated by service providers. Since I am not a therapist and this thesis is not aiming to find effective therapy approaches for survivors, the discussion hereafter will be limited to group work, with its main focus being on community settings[35].

We will start with the second type of group, the peer-led group that is usually called a suicide survivor group. The designated function of a peer-led group is to provide a space for survivors to 'share their experiences and feelings', and to provide them an arena for 'giving and gaining support from each other' (SOBS). It enables survivors:

> to find a renewed reason for living. Survivors can be of help to others by reaching out in a supportive, caring way and through social advocacy. They begin to relinquish the passive victim role, become more engaged in living,

35 In an early study on bereavement, the interventive psychotherapies were mainly individual therapy or family counselling. See FARBEROW, N. L. Ibid.The Los Angeles Survivors' After-Suicide Program. Rev. ed.

For classical group therapy (including family therapy and couples therapy), the family can enter therapy as a unit. According to Farberow, group therapy can tackle the issues of scapegoating, blaming, isolation, and disturbed behaviour, especially when they manifest in children; therapists' attention needs to focus on the type of loss (kinship), time elapsed since the loss and any other kinds of losses that have occurred since the suicide. The therapist needs to be aware of his/her own attitude toward suicide. See FARBEROW, N. L. 1993. Bereavement after Suicide. In: LEENAARS, A., A. (ed.) Suicidology: Essays in Honor of Edwin S. Shneidman. London: Jason Aronson Inc.

> and even experience a sense of competence again through becoming "helpers". (Appel and Wrobleski, 1987: 223)

In this peer group, survivors often feel supported by the presence of others who have been through the same experiences (SOBS), and "senior" survivors may serve as role models for the newly bereaved (Feigelman and Feigelman, 2011a, Feigelman and Feigelman, 2011b, Rubey and McIntosh, 1996). By witnessing how seasoned survivors endure the loss, a newly bereaved person may have a sense of hope that things will improve (Cerel et al., 2009b)[36].

Evidence has shown that the population attending support groups is often female and middle-class. Survivors at the lower and upper ends of the socioeconomic spectrum are absent from survivor groups. These groups are also less successful in reaching highly vulnerable males, widowers, bereaved parents, young people and adults who were bereaved as children (Appel and Wrobleski, 1987). The most positive results that survivors experienced from group interventions were the result of active participation in a group on the part of the survivor on a long-term basis[37].

The third type of group, a homogenous group offered by service providers, is normally facilitated by a survivor-facilitator and a therapist. Farberow reviewed the Survivors After Suicide Program that was conducted at LASPC. The format was a closed-end approach, which included survivors of mixed kinship to the deceased.

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36 The identification among fellow survivors is not transference stemming from the past but is 'empathy with real peer in the present'. See Klass and Shinners, cited in APPEL, Y. H. & WROBLESKI, A. 1987. Self-Help and Support Groups: Mutual Aid for Survivors. In: DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) Suicide and Its Aftermath: Understanding and Counseling the Survivors. London: W. W. Norton & Company.

37 The average post-loss time of survivors who showed personal growth is 5 years. By becoming volunteers in suicide prevention programs or facilitators for support groups, some survivors recognised the importance of 'giving back' which offers the opportunity to transform negative experiences to positive ones. Other factors which contribute to a positive outcome include: involvement in more care-giving activities in the community; promoting the awareness of the general public to prevent suicide; engagement in fund-raising for suicide research; participation in religious activities, etc. See FEIGELMAN, W., JORDAN, J. R. & GORMAN, B. S. 2009. Personal growth after a suicide loss: cross-sectional findings suggest growth after loss may be associated with better mental health among survivors. Omega: Journal of Death & Dying, 59, 181-202.

The sessions which were led by a professional and a survivor-facilitator were conducted once a week. The positive outcomes included: a general decrease in grief, anxiety, depression and guilt among most participants; the survivors felt reassured that their feelings were acceptable. For these survivors, sharing experiences of a similar loss created a sense of belongingness; they felt safe in the nonjudgmental atmosphere of the sessions where they learned about suicide from their peers and helped each other in finding coping strategies. The setting was permeated with a sense of security due to the presence of a professional therapist; alternatively, the survivor-facilitator provided hope of functioning well again and provided a role model to learn from. Many survivors became involved in suicide prevention activities as they gradually integrated the losses into their lives (Farberow, 1993: 343-5, Mogil, 2010).

However, the participation of professionals was considered a 'major trouble spot' (Heilig 1985, cited in Appel and Wrobleski, 1987: 225). Survivor peer groups were part of the self-help movement which became 'popular' after the Second World War (WHO/IASP, 2008: 3). Its philosophy incorporates a 'critique of professionalism', with the aim of countering professional limitations and compensating for the lack of experiential expertise (Gartner and Riessman, 1976: 785). Instead of arguing for the efficacy of a professional presence, it may be more important to make sure that the psychological space is emotionally safe.

> It is crucial to keep in mind that suicide survivors have been psychologically wounded and are in a vulnerable emotional condition in which they can easily be reinjured in their social interactions with others. Thus, the overarching job of the facilitator is to ensure that the group is as emotionally safe as possible for all participants. … To promote group interaction that manifests this group attribute of psychological safety, the facilitator must monitor and protect the process of the group to make sure that it stays within the guidelines designed to promote emotional security for the members. (Jordan, 2011: 291)

The research of the Los Angeles program showed the benefit of combining help: the survivors can turn to the professional for 'information and security', and to the survivor-facilitator for 'shar[ing] their feelings' (Farberow, 1994: 184).

One example in the UK is the outreach program run by Cruse and the Samaritans, which aims at providing a closed group for survivors mixed in kinship. The group meets once a week over a six-week period. Senior volunteers who are not necessarily survivors facilitate the sessions. The facilitators emphasized that the sessions are not group therapy, but instead a space for survivors to talk about their experiences. The Samaritans charity was developed in 1953 by Chad Varah, an Anglican clergyman in London, in response to the suicide of a young girl. The name of "The Samaritans" was chosen from the parable of Jesus. His advocacy of 'befriending' suicidal people is not only a method of reducing suicidal risks, but also 'a philosophy and a way of life'. Its philosophy is 'based on respect and tolerance for others' (Varah, 1987: 37-8). Their helpline service started on November 2, 1953, and their volunteers are 'extraordinary ordinary people'. They are chosen:

> for their ability to listen, actively and supportively; for their ability to communicate warmth; for seeing 'people' not problems; for caring about 'feelings not facts; for being able just to sit there rather than wanting to [do] something; for being able to resist any temptation – or not even feeling it – to advise, to judge, to solve problems, to promote one idea or philosophy. … for their tolerance, their humility, their patience; and for their willingness to stand alongside someone who is teetering on the edge of the precipice of their life and to hold their hand. Also, for their willingness to be hurt by the pain of those who call them, and for their ability to be wounded but not to bleed. (Armson, 1994: 98-9)

Intervention II: Psychological Autopsy

The purpose of psychological autopsy (PA) is to have a 'thorough retrospective investigation of the *intention*' of the deceased, especially when the death is equivocal (Shneidman, 1993: 180). It is designed to find out why,

how, and when the individual died; and the most probable mode of death. The information is obtained by conducting interviews with individuals who were close to, and had sufficient knowledge of, the deceased's personality, actions and behaviour. The method of PA, according to Shneidman, originated in 1958 when the Los Angeles County Chief Medical Examiner-Coroner, Theodore J. Curphey, M.D., failed to certify some drug deaths despite his own efforts in including the help from toxicologists and nonmedical investigators. He then approached the LASPC requesting their help in a joint collaboration. A multidisciplinary approach involving behavioural scientists led to the success of this approach, and it was gradually expanded by researchers as a therapeutic tool to help survivors (Curphey, 1965, Litman et al., 1963, Curphey, 1967, Shneidman and Farberow, 1965, Jacobs and Klein, 1993).

Litman and colleagues (1963) observed that PAs were therapeutic, helping most of the interviewees accept the fact that suicide had happened. They reported that the 'interviews nearly always reduced guilt in survivors and made it easier for them to accept the death of a victim' (1963: 927 cited in Jacobs and Klein 1993: 223). Because of the isolation of survivors and their lack of support from the community, the interviewers were often the first people outside of the immediate family and institutional staff with whom survivors had conversed (Cain and Fast, 1972). These autopsies were described as having 'therapeutic secondary benefits' (Curphey, 1965: 116) and were 'a rewarding experience' for the interviewees (Shneidman and Farberow, 1965: 128).

To help survivors, an 'empathic investigator' is needed to conduct the interviews in order that they have therapeutic value to the survivors

(Shneidman, 1993: 198). D. E. Sanborn and C. J. Sanborn were first among the early authors advocating exclusively the validity of using PA for therapeutic purposes. For them, PA is helpful because it enables counselling, referral and practical information to be brought to the survivors directly (Sanborn and Sanborn, 1976). To really understand the experiences of suicide surviving, Jack Kamerman proposed that we need to locate survivors 'generationally', which means to take into account the kinships, individual biological time (when the suicide happened) and historical context (Kamerman, 1993: 354).

David Brent looked into methodological issues when using PA for adolescent suicide. The issues include: the choice of informants, the manner of approach to informants, the influence of the time lag between the suicide and the interview, survivors' mood in bereavement at the time of the interview, integration of various data sources, the choice of a control group, and the choice of domains and assessment tools. The informants for adult suicide are generally spouses or first-degree relatives; those for adolescents are parents, siblings and close friends (50% of suicides had confided to another peer). When approaching the informants, the interviewer needs to remember that the informants are not patients in order not to provoke a possible guilt reaction, and should remain nonjudgmental. Even where semi-structured interview instruments are used, the interviewer needs to make sure to follow the family's lead and be flexible with the length of the interview. The interview timing should not be too early (the bereaved might still be in acute grief reaction) or too late (the recall of events may be unclear). Normally, the interviews are conducted at an average of four months after the suicide (Brent, 1989).

The emotional state of the informant might have an impact on the quality and quantity of data obtained during the interview. For instance, the informant might exaggerate the presence of psychopathology in the deceased to expiate the sense of guilt, or the latter might be idealized with all disorder negated. However, by examining some PA studies, Brent denied the possibility of significant bias. Furthermore, these studies showed high compliance and consistency of results across a wide age range and diverse geographic groups. The integration of data obtained through PA with that found through other approaches (e.g. biochemical, toxicological, and epidemiological) will enhance our understanding of suicide. Even though there is an asymmetric relationship between the comparison of the suicide victims and those of a live control group (because the suicide victims cannot be interviewed), successful completion of PA studies will shed light on suicide motivations, enabling the investigators to help patients who resemble suicide completers[38].

Intervention III: Narrative Approach

There are two orientations in narrative intervention for survivors: one focuses on the trauma and its treatment, the other on community-building and empowerment through sharing stories. For the trauma and its treatment, there are roughly two tenets of trauma discourse. The first is the narrative therapy tenure; and this approach has had a trajectory that can be traced back to the works of Freud (Parry and Doan, 1994: 9, Gilmore, 2001). The contemporary psychotherapy profession is considered to belong to this line and mainly deals with personal trauma. The second orientation is social trauma, and the catalyst for this study

38 The division of suicide attempter membership has been set up in AAS in 2014. To understand suicide attempters (rather than survivors) is argued to be more effective for understanding suicide.

was research on survivors of concentration camps (Caruth, 1995, Felman and Laub, 1992). This line of research has raised questions on the validity of memory, what constitutes truth, the meaning of silence, and how to speak the unspeakable[39]. The issues of memory, history, responsibility and justice permeate this trend of social trauma discourse (Hodgkin and Radstone, 2003). However, it is noted that the boundary between personal and social is contestable (Rogers et al., 1999, Gilmore, 2001, Golden and Bergo, 2009). The focus of the following section will be on individual trauma, a discussion of the community-building and empowering storytelling will follow and be explored under the heading of "narratives in therapeutic contexts".

In *Beyond the Pleasure Principle*, Freud described trauma as an event that 'breaks through the protective shield' (Freud, 1984: 301). Trauma, in Freudian studies, has a double meaning: it may refer to a new wound or the 'reopening' of an old one (Gilmore, 2001: 27). Leigh Gilmore cited Freud saying: 'in mental life, nothing which has once formed can perish' (Gilmore, 2001: 28), which implies that the memory would be permanently recorded in the mind and could be unearthed by psychoanalysis. The therapist's job is to 'rework the meaning of' narrative and 'draw out the story' (Leydesdorff et al., 1999: 8). Before Freud, Jean-Martin Charcot studied female patients with hysteria in the 1870s. Memory, then, was linked to psychic trauma. However, looking at this through the lens of gender politics, it can be argued that this line of trauma narrative is problematic since

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39 Dori Laub, a Jewish-American psychoanalyst and the survivor of the Shoah, wrote that the horror of the Nazis 'was beyond the limits of human ability (and willingness) to grasp, to transmit, or to imagine'. See LAUB, D. 1995. Truth and Testimony: the Process and the Struggle. In: CARUTH, C. (ed.) Trauma: Explorations in Memory. Baltimore: Johns Hopkins UP. P. 68.

[T]he imperative to tell the story of the Holocaust is inhibited by the impossibility of telling, and therefore, silence about the truth commonly prevails … [S]urvivors who do not tell their story become victims of a distorted memory … The events become more and more distorted in their silent retention and pervasively invade and contaminate the survivor's daily life. Ibid.

women did not enjoy social equality and were largely considered to be ethically inferior. For example, Haaken commented that, since the 1980s, sexual violence has functioned as 'the paradigm for women and trauma'. She warned against the literalization of trauma storytelling in therapy sessions; instead of identifying whether memory was right or wrong, attention should be paid to the relationship between memory and therapeutic narrative about the experiences (cited in Gilmore, 2001: 26).

Narrative therapy has been used in bereavement (Neimeyer, 2012, Neimeyer et al., 2006a), family therapy (Papadopoulos, 1996, Papadopoulos, 1999, Flaskas et al., 2007), and for people who have suffered from PTSD resulting from organizational violence (Neuner et al., 2004, Onyut et al., 2005). Narrative therapy has also been used with those suffering from bereavement as a result of suicide (Neimeyer and Sands, 2011). When facing losses, in whatever forms, one needs to construct a life story drawing on the available social discourses (Neimeyer et al., 2010b). The positive result is a self-narrative in which one finds meanings in the adversity they have experienced (Neimeyer, 2004, Neimeyer et al., 2010a). With the support of a therapist:

> the client-as-narrator rediscover[s] a significant "through line" in his or her self-narrative. It relies on an overarching cognitive-affective-behavioural structure that organizes the "micro-narratives" of everyday life into a "macro-narrative" that consolidates our self-understanding, establishes our characteristic range of emotions and goals, and guides our performance on the stage of the social world. (Neimeyer, 2004: 53-4)

Evidence has shown the effect of narrative intervention in the field of bereavement (Neimeyer and Currier, 2009). This includes encouraging the clients to revisit the story of the loss in vivid and slow-motion detail (Shear et al., 2005), to retell the experience as if to a supportive friend (Wagner et al., 2006), to write about themselves from the standpoint of a compassionate other and process the unsought benefit in the experience (Lichtenthal and Cruess, 2010), and to have

dialogical exchanges with themselves (Neimeyer, 2012). Utilizing a constructivist approach, the narrative helps survivors to construct and reconstruct meaning to accommodate the loss and 'the vicissitudes of living' (Sands et al., 2011: 250).

Family therapists have been using a narrative approach to develop families' capacity to hope for positivity when facing adversity and/or achieve 'forgiveness and reconciliation' (Flaskas et al., 2007). Papadopoulos implemented the Jungian approach to family therapy, incorporating Jung's theory of archetype to examine the deeper systemic dynamics. By identifying the patterns, themes and trends underlying a family system, an 'archetypal destiny of the family' can be revealed and a 'delicate' healing process set in motion at the interpersonal and transpersonal levels (Papadopoulos, 1996: 148). Papadopoulos also emphasized the functions of individual and collective narratives to form one's 'secure base' by co-constructing a meaningful narrative. With 'shared narratives', a 'storied community' is formed that offers 'the coherent narratives which are essential ingredients of resilience' and 'a transitional space which can act as [one's] secure base' (Papadopoulos, 1999: 330).

Narrative Exposure Therapy is a short-term treatment for people who have suffered from PTSD resulting from organizational violence (Neuner et al., 2004, Onyut et al., 2005). The patients are asked to describe the worse traumatic event in detail while re-experiencing all emotions and sensations related to the event. In the meantime, they are asked to reconstruct a consistent narrative by accessing their autobiographical memory. The emphasis is on the integration of emotional and sensory memory within the autobiographical narrative.

Narratives in Therapeutic Contexts

For therapeutic community-building and empowering storytelling, ample examples can be found on on-line blogs and in survivors' story-writing. The homologous genres used to describe the revelation of one's experience, especially of adversity, have been evolving as autobiographical genre, trauma discourse, illness narrative, life story, and personal narrative. They are sometimes overlapping and interchangeable, although we can sense the differences and what their focuses are. The functions and meanings of illness narrative (IN) and life story are chosen as two genres to see how they can serve survivors to reconstruct their lives.

Illness Narrative

Illness here is an analogy; suffering profound loss and grief for survivors is an un-easy experience. Survivors are wounded. Furthermore, if survivors are inflicted with traumatic symptoms (e.g. clinical depression), they need to find a way to live with the dis-ease. Freud implied a connection between symptoms and meanings: 'the symptom carries a meaning and is connected with the experience of the patient' (Freud, 1920b: 221). The persuasive power of a coherent narrative can:

> fill the gap between two apparently unrelated events and, in the process, make sense out of nonsense. There seems no doubt but that a well-constructed story possesses a kind of narrative truth that is real and immediate and carries an important significance for the process of therapeutic change. (Spence, 1982: 21)

From the mid and late 1980s, anthropologists began to investigate narrative and its relationship to illness and healing in the context of biomedical care. In contrast to the medical model and illness ideology that are 'characterized by thinness in descriptions of patient experience, with a tendency to measurement and quantification', narrative is seen as the 'corrective' to biomedical discourse (Segal, 2007: 20) because it:

> focus[es] on the meaning making aspects of illness and healing. … Stories reveal a world. They can help transform identity, interpret the meaning of the past, and even provide images of possible futures. Stories can render

> experience meaningful by placing events into a culturally and personally understandable plot. (Mattingly, 2007: 407)

Cheryl Mattingly proposed a theory of 'therapeutic emplotment' to examine the social construction and reconstruction of illness and healing. One's coming to terms with illness is a fluid and shifting journey influenced by structural mechanisms, cultural meanings and the potential emergency of illness. Therapeutic emplotment offers a framework for investigating one's clinical life 'as a series of existential negotiations' that explore 'the meaning of illness, the place of therapy within an unfolding illness story, and the meaning of a life which must be remade in the face of serious illness' (Mattingly, 1998: 20-1). Both the therapist and the patient:

> try to emplot particular actions so that they become part of a narrative which will move them toward that future. They project narrative anticipations onto the present so that the very sounds and sights and smells of the current moment become portents of future meaning and perception itself becomes a narrative act imbued with ghosts of past and future. (Mattingly, 1998: 169)

Strictly speaking, in Mattingly's cases, the narrative interventions are therapy; however, this line of approach overlaps with the characteristics of intervention for a community setting. On some on-line blogs for survivors, the space for narratives (SOBS) and memorials for the deceased (The-Alliance-of-Hope-for-Suicide-Survivors) are offered to survivors.

Another example of narrative is the books written by survivors. Those writings have two orientations: the first one looks at personal grief and loss, aiming at working through the personal journey by the writing. The narrative would normally outline a chronological order of the survivor's life and may not serve pedagogical functions or purposes (Wickersham, 2008). The second orientation combines personal experience with the language of professional discourses (e.g. the theories of bereavement), with the purpose of encouraging other survivors and offering the personal experience as a

model. The narrative would be organised by a thematic order and presents a wish to educate people to understand suicide as well (Bolton, 2005, Fine, 1997). No matter which orientation, the narrative would end on a hopeful note, indicating the survivor/writer has moved on and obtained some directions or insights.

Life Story

In the 1990s, there was a rapid development of the genre of life story (LS). LS refers to the groupings of stories told by the same person at different time lines. LS comprises ‘a set of stories that are retold in various forms over a long period of time and that are subject to revision and change as the speaker drops some old meanings and adds new meanings to portions of the life story’ (Linde, 1993: 219-20). According to Charlotte Linde, a LS consists of a ‘primary evaluation’ about the narrator and a story within a life story which has ‘extended reportability’ (Linde, 1993: 21). Whether something is reportable or not depends on the nature of the experience, on the relation of the speaker and the listener, the duration of time that has passed between the occurrence and the narrating of the story, and the speaker’s narrating skill. The personal subjective sense of life is linked to the understanding and meaning of the past, the present and the future. A sense of coherence is created, and one is looking for more ‘dynamic and agent-centered ways’ to review life experiences (Garro and Mattingly, 2000: 16).

Although there will be interruptions of continuity and variations in the narrator’s status in various talks and in different settings, coherence pursued by the life storyteller is required not only at the textual level (the parts including words, phrases, sentences are in a recognisable relationship to the whole), it is also ‘a social demand and an internal, psychological demand’. Coherence needs

to be understood as ‘a cooperative achievement of the speaker and the addressee’ (Linde, 1993: 220, 12).

The growth that takes place in the telling of life stories is ‘a movement toward acknowledging the importance of personal truth from the subjective point of view’. This approach illustrates that personal meaning and reality are constructed by and during the making and telling of one’s narrative. Stories are ‘our way of organizing, interpreting, and creating meaning from our experiences while maintaining a sense of continuity’ (Atkinson, 2007: 232). Suzette Henke used ‘the process of writing out and writing through traumatic experience in the mode of therapeutic reenactment’. For her, the writing of a story of one’s psychological journey, one’s life-writing, has a healing effect, which can ‘mimic’ effectively the psychoanalytic process of working-through, and can reach ‘abreaction and the reconstruction of a fragmented analytic subject’ (Henke, 1998: xii, 141). The journey of rehearsal and reenactment in her surviving narrative helped her to reach psychological catharsis.

> The act of life-writing serves as its own testimony and, in so doing, carries through the work of reinventing the shattered self as a coherent subject capable of meaningful resistance to received ideologies and of effective agency in the world. (Henke, 1998: xix)

One example of a survivor’s life story can be seen in the books written by Michelle Linn-Gust, such as *Do They Have Bad Days in Heaven? Surviving the Suicide Loss of a Sibling* (2001), *Ginger's Gift: Hope and Healing Through Dog Companionship* (2007), *Sisters: The Karma Twist* (2011), and *Conversations with the Water: A Memoir of Cultivating Hope* (2012). In addition to life-story writing, she has contributed efforts in the past twenty years educating people worldwide about coping with loss and change following the suicide of her younger sister.

In this chapter, we have discussed the three levels of suicide prevention, in which the intervention for survivors, the postvention, is situated at the third level. We have discussed three interventions for survivors: group work (classical group therapy, the peer-led group, and a homogenous group facilitated by service providers), psychological autopsy (with the main purpose of identifying the causes of suicide and the secondary benefit to survivors' understanding of suicide), and the narrative approach (which is focused on narratives used in therapeutic contexts). The genres of illness narrative and life story have been indicated as two vehicles for survivors to tell their stories, reconstruct their lives, and generate deeper meaning from the loss.

Those interventions require various levels of professional input (e.g. a qualified therapist to offer therapy; qualified practitioners to do psychological autopsy) and the sensitivity to meet the needs of survivors (e.g. how to facilitate experiences that are empowering). It requires a team of professionals to work together in practice and develop sound methodology on survivors' research. The advance in practice and theory will benefit survivors greatly and contribute to suicide prevention and reduction. A satisfactory surviving journey after loss to suicide is an exciting, encouraging and positive development, providing evidence for human resilience and growth. Those narratives warm us up to understand survivors' various responses and their contributing factors which are one of the main research questions in this thesis. These questions will be discussed in Chapter Eight.

From Chapter One to Chapter Three, we have discussed the history and aetiology of suicide, how survivors experience the suicide in both negative and positive ways, and the therapeutic approaches used to help survivors. Those three chapters comprise the field and discipline of suicidology. The next three

chapters will lay out three other theoretical disciplines: Analytical Psychology (AP), Narrative Inquiry (NI), and Applied Theatre (AT). AP, as we will see in the next chapter, provides me with a psychological language to explore the formation of my theory of a suicide complex (a full discussion will be presented in Chapter Nine). NI is an advanced qualitative methodology in sociology, in the context of which this research is situated. AT is part of the research design, the implementation of the empirical work within a narrative methodology, and contributing to a unique exploration of this thesis.

PART TWO

THEORETICAL FRAMEWORKS

4. Analytical Psychology

Let us start with Analytical Psychology (AP). In this chapter, Jungian theories of complex and archetype will be introduced concisely in order to lay down an understanding of human psyche. The theory of archetype has caused confusion and heated debates among researchers, and a section will therefore be devoted to the revision of Jung's classic model of archetype. The theories explored in this chapter will underpin the central thesis in this research – a hypothesis that a suicide complex will be constellated in survivors' psyches which is the reason why they have a higher risk of suicide (Krysinska, 2003, Knieper, 1999). More details will be presented in Chapter Nine after the analysis of the empirical data. At the end of this chapter, I will present a critique of Hillman's attitude on suicide as he is an important Jungian whose theory on suicide cannot be ignored.

AP was developed by Carl Gustav Jung. Its literature is vast, and here I can only indicate some groupings of Jung's writings and the developments of depth psychology based on his theories. In addition to *The Collected Works*, Jung's psychology has been explored in theoretical and practical terms (Jacobi, 1973, Jaffé, 1970, Stein, 1998, Stevens, 1990), and for clinical analysis (Fierz, 1991, Schaverien, 2005, Fordham et al., 1973, Sedgwick, 2001). The major biographies of Jung can be roughly categorised in three spirits: 'hagiographical, hostile, and (in varying degrees) neutral' (Bishop, 1999: 23, note 1). A huge amount of the work done on analytical psychology is on the development of Jung's theories (Young-Eisendrath and Dawson, 2008, Walker, 2002, Von Franz, 1998, Papadopoulos, 2006a, Main, 2004, Papadopoulos and Saayman, 1991, Papadopoulos, 1992, Hillman, 1974). Quite a few focus on Jung's contribution to

modern science (Shamdasani, 2003, Samuels, 1985, Homans, 1995, Hogenson, 1994), and some on his contribution to the arts in general (Rowland, 2010, Rowland, 2005, Hockley, 2001, Berk, 2012, Hauke and Alister, 2001, Hauke and Hockley, 2011).

Jung's Theory of Complex

The term 'complex' was first introduced by Theodor Ziehen of Berlin (1862-1950), for whom it was just a conscious phenomenon[40]. Jung's theory of complex was developed during the Word Association period between 1904 and 1911 while working with his young colleague Franz Riklin (1878-1938) (Jung, 1973). The Word Association Test, first invented by Sir Francis Galton (1822-1911), was designed to elicit the hidden issues of the subject by analyzing the patterns and duration of their responses to certain words. After administering the testing words to the subject twice, the subject was asked to write down the associated words accordingly. The examiner would take notes of the subject's hesitation, lack of response, forgetting, repetition, discrepancies, and so forth. This information provides the therapist with some insight into the underlying problems of the patient.

The earlier development of complex theory brought Jung and Freud together; ironically, it also tore them apart (Hauke, 2006). Fundamentally, for Freud, a complex exists 'only as a manifestation of illness'; whereas for Jung, it is part of the constitution of a 'healthy human being' (Jacobi, 1957/1959: 20). A paragraph

40 Ziehen had warned against using the association method for reaching the unconscious as Jung did, avowing that it was 'erroneous, artificial and even dangerous' to have applied the method to the research on dementia praecox. See JONES, E. 1955. Sigmund Freud Life and Work, Volume Two: Years of Maturity 1901-1919, London, The Hogarth Press. Cited in P. 127.

from Jung's work may illustrate the necessity of complexes to his thinking on the psyche.

> [T]o have complexes does not necessarily indicate inferiority. It only means that something discordant, unassimilated, and antagonistic exists, perhaps as an obstacle, but also as an incentive to greater effort, and so, perhaps, to new possibilities of achievement. In this sense, therefore, complexes are focal or nodal points of psychic life which we would not wish to do without; indeed, they should not be missing, for otherwise psychic activity would come to a fatal standstill. They point to the unresolved problems in the individual, the places where he has suffered a defeat, at least for the time being, and where there is something he cannot evade or overcome - his weak spots in every sense of the word. (Jung, 1931b: par. 925)

Jung averred that the complex is 'the *via regia* to the unconscious' – the royal road to the unconscious; the complex is 'the architect of dreams and of symptoms' (Jung, 1934: par. 210). Complexes are parts of the psyche that are 'split off from consciousness' and not in the control of our conscious mind. Complexes 'lead a separate existence in the dark realm of the unconscious, being at all times ready to hinder or reinforce the conscious functioning' (Jung, 1931b: par. 923). The complexes are 'the feeling-toned contents'. Each complex comprises 'a nuclear element and a large number of secondarily constellated associations'. There are two components in the nuclear element: one is 'innate in the individual's character', and one is related to the experience and 'environment' (Jung, 1928a: par. 18). Jung emphasized that the complexes have a strong connection with affects --- especially in their cores, wherein reside a huge amount of feelings and which can attract the respective amount of psychic energy.

> The nuclear element is characterized by its feeling-tone, the emphasis resulting from the intensity of affect. …The nuclear element has a constellating power corresponding to its energic value. It produces a specific constellation of psychic contents, thus giving rise to the complex, which is a constellation of psychic contents dynamically conditioned by the energic value. … *[T]he constellating power of the nuclear element corresponds to its value intensity, i.e. to its energy.* (Jung, 1928a: par. 19)

Jung believed that 'the essential basis of our personality is affectivity' (Jung, 1907: par. 78) and '*[e]very affective event becomes a complex*' (Jung, 1907: par. 140).

One's early experiences lay down the structures of affect-toned complexes waiting to be activated in later life. A pathological, monopolistic complex was like a dam that blocked the transmission of positive affects into one's ego-complex. When it reaches its greatest intensity, it becomes unbearable; one's rational function, reasoning ability and judgment are impaired[41]. When one is possessed by pathological affects, s/he experiences these as 'an invasion' from the unconscious. According to Jung:

> You experience sometimes what you call "pathological" emotions, and there you observe most peculiar contents coming through an emotion: thoughts you have never thought before, sometimes terrible thoughts and fantasies … Those are invading fragments of the unconscious, and if you take a fully developed pathological emotion it is really a state of *eclipse* of consciousness when people are raving mad for a while and do perfectly crazy things. That is an invasion. (Jung, 1976: par. 65)

Complexes are autonomous and they behave like *'splinter psyches'* (Jung, 1934: par. 203). They 'have not only an obsessive, but very often a possessive, character'; they 'cut across the adapted performance of consciousness' (Jung, 1956: ix). When a complex manifests in a pathological way, it is the same as 'a fragmentary personality' (Jung, 1934: par. 202). A highly charged complex:

> has the tendency to form a little personality of itself. It has a sort of body, a certain amount of its own physiology. It can upset the stomach. It upsets the breathing, it disturbs the heart - in short, it behaves like a partial personality. … [C]omplexes have a certain will-power. (Jung, 1976: par. 149-50)

The forming of complexes not only results from the development in childhood whose psyche utilized the mechanism of repression and splitting (Jung, 1938/1940: par. 22), but also from external traumatic events.

> Certain complexes arise on account of painful or distressing experiences in a person's life, experiences of an emotional nature which leave lasting psychic wounds behind them. A bad experience of this sort often crushes valuable qualities in an individual. (Jung, 1920/1948: par. 594)

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41 The mental pain, which Edwin Shneidman called 'psychache', an example of unbearable affect, echoes the description of a complex.

> Complexes are psychic fragments which have split off owing to traumatic influences or certain incompatible tendencies. (Jung, 1937: par. 253)

Jung also identified the other sources of complexes 'that have never been in consciousness before and therefore could never have been arbitrarily repressed'. This group of complexes grows out of the unconscious and invade the conscious mind with their weird and unassailable convictions and impulses (Jung, 1938/1940: par. 22). Complexes are manifested 'in *identity, compulsiveness* and *primitivity, inflation* and *projection'* for as long as they remain unconscious (Whitmont, 1969: 58). We not only have the complexes, but the complexes 'have us' (Jung, 1934: par. 200); when this happens, we experience 'madness' (Ulanov, 2013). Once a complex is constellated or actualized, it can 'openly resist the intentions of the ego consciousness, shatter its unity, split off from' the ego and behave as an autonomous entity (Jacobi, 1957/1959: 9).

Carl Alfred Meier categorized complexes into three grades: Grade One complexes are those that have never been conscious; Grade Two are unconscious due to the mechanism of repression in the Freudian sense; and Grade Three are partly conscious and recognisable (Meier, 1992: 205). Jolande Jacobi summarized that Jung's theory of complex contains two roots: not only from infantile experiences, but also from events/conflicts throughout life; the nature of a complex could be 'morbid' or 'healthy'; complexes are 'bipolar', resulting in positive and negative manifestation (Jacobi, 1957/1959: 25). Ann Belford Ulanov writes of the positive quality of complexes, when a complex:

> tries to communicate something we know and do not know, need to know, to unravel and find symbolic representation for, so we can be free from acting it out and discover what precious part of ourselves has been sheltered there. … [T]he complex, like a good dog, keeps at us, herding us toward the opening into consciousness to receive its communication. (Ulanov, 2013: 12)

Complexes are 'the motors of the psyche' which 'give the drive, the impulse and the aliveness to the psyche' (von Franz, in Boa, 1988: 26), and they offer us the

chance to experience the totality of psychic manifestation. This is to compensate the over-developed thinking function, or to reevaluate internal conflicts. Complexes are the indicators of one's meaning and value systems (Jung, 1951/1959/1968a: par. 52). Our ego can have four different attitudes toward the complex: 'total unconsciousness of its existence, identification, projection, or confrontation' (Jacobi, 1957/1959: 17). The first three attitudes are not the "good" options: complexes demand one goes on a journey of self-discovery by confronting ourselves, and when these complexes are integrated, one's life is enriched and transformed (Puchalska-Wasyl, 2011, Stein, 2006a, Ulanov, 2013).

> The reintegration of a personal complex has the effect of release and often of healing, whereas the invasion of a complex from the collective unconscious is a very disagreeable and even dangerous phenomenon. (Jung, 1920/1948: par 591)

On this note, I will turn to the theory of archetypes, since, metaphorically speaking, complexes and archetypes are two sides of the same coin. The complexes are to the personal unconsciousness what the archetypes are to the collective unconscious (Stevens, 2006: 86). Complexes are '*personifications* of the archetypes; they are the means through which archetypes manifest themselves in the personal psyche' (Stevens, 1994: 35). Some Jungians have developed the doctrine of a 'cultural complex' (Singer and Kimbles, 2004a, Singer and Kimbles, 2004b) to illustrate how cultural factors play a part in one's psyche and in a group's collective psyche. The 'scapegoat complex' investigates how blaming and scapegoating function to maintain civilization (Peresa, 1986).

Jung's Theory of Archetype

Similar to complexes, affect/emotion is a key term to the understanding of archetype. Emotions, as Jung averred, 'have a typical "pattern" … they follow an

inborn archetype which is universally human' (Jung, 1975: 537). The significance of emotion is also recognised by James Hillman.

> The primary contact with the soul of another person is emotion … In short, emotion is wholeness and the affective contact is the first level of healing, of making whole. ... It is only this wholeness perhaps which works a cure. (Hillman, 1992: 275)

To talk about archetypes, we need to start with the collective unconscious (CU). Jung expanded Freud's theory of personal unconscious to include the existence of CU (Hauke, 2006, Stevens, 2006). CU is 'a collective, universal, and impersonal nature which is identical in all individuals. This collective unconscious does not develop individually but is inherited'[42] (Jung, 1936a: par. 90). CU encompasses instincts and archetypes:

> Instinct is an essentially collective, i.e., universal and regularly occurring phenomenon which has nothing to do with individuality. Archetypes have this quality in common with the instincts and are likewise collective phenomena. (Jung, 1919/1928: par. 270)

Jung used the term 'archetype' to refer to the inherited parts of the psyche; 'an element of our psychic structure and thus a vital and necessary component in our psychic economy' (Jung, 1940: par. 271). He also linked the archetypes and their functions to the instincts, that archetypes are 'the *instinct's perception of itself,* or as the self-portrait of the instinct'. For Jung, archetypes are the 'correlates' of instincts (Jung, 1919/1928: par. 277, 281).

There are three stages that marked Jung's development of this theory. First, from his self-analysis and from his work in the Burghölzli Hospital, Jung found that the images from the unconscious were similar to motifs and patterns that were

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42 This is a problematic term that caused confusion in understanding Jung's theory of archetype. As we shall see, in his later writings Jung distinguished between 'archetype-as-such' and 'archetypal image'. He clarified that what is inherited is the form and pattern, not the content of archetypes. See JACOBI, J. 1957/1959. Complex/Arthetype/Symbol in the Psychology of C. G. Jung, London, Routledge & Kegan Paul. P. ix-xi.

Trying to resolve the problem, Jung expressed that the term "archetype" does not 'denote an inherited idea, but rather an inherited mode of psychic function'. In JUNG, C. G. The Archetypes and the Collective Unconscious. CW 18. par. 1228.

reminiscent of myth, legend and fairy-tale. At this stage, he used ‘primordial images’ to express his intuitive findings (Jung, 1929: par. 229) – a term he borrowed from Jakob Burckhardt. Later in 1917, he used the term ‘dominants’ of the collective unconscious.

> [W]hen fantasies are produced which no longer rest on personal memories, we have to do with the manifestations of a deeper layer of the unconscious where the primordial images common to humanity lie sleeping. I have called these images or motifs "archetypes”, also "dominants" of the unconscious. (Jung, 1917/1926/1943: par. 102)

At the third stage, the term ‘archetype’ first appeared in his essay ‘Instinct and the Unconscious’. Jung wrote:

> [W]e also find in the unconscious qualities that are not individually acquired but are inherited, e.g., instincts as impulses to carry out actions from necessity, without conscious motivation. In this "deeper" stratum we also find the *a priori*, inborn forms of "intuition”, namely the *archetypes* of perception and apprehension, which are the necessary *a priori* determinants of all psychic processes. Just as his instincts compel man to a specifically human mode of existence, so the archetypes force his ways of perception and apprehension into specifically human patterns. (Jung, 1919/1928: par. 270)

The archetypes ‘are simply the forms which the instincts assume’ (Jung, 1927/1931: par 339), and the positions of archetype and instinct are situated in psychology and biology respectively. This division of the two into psychology and biology proved to be a false distinction as body and mind are interconnected. Jung later revised the positions to propose that archetypes are as ‘fundamental’ as instincts (Samuels, 1985: 27).

Jung further differentiated between ‘archetype-as-such’ and ‘archetypal image’: what is perceivable is the archetypal image, not archetype-as-such which is an unknowable nucleus – an ‘*unconscious core of meaning’.* And ‘the ultimate meaning of this nucleus was never conscious and never will be’ (Jung, 1940: par. 266). Archetype-as-such is unperceivable, and what appears is a representation of the archetypal image; what is inherited is the form and the pattern, not the content. The example of a crystal and its axial system has been used to analogize

the difference between archetype-as-such and archetypal image (Jung, 1938/1954: par. 155).

Archetypes ‘manifest themselves only through their ability to *organize* images and ideas, and this is always an unconscious process which cannot be detected until afterwards’ (Jung, 1947/1954: par. 440). The ensuing archetypal images not only ‘*represent* and *evoke* the instinct’ but also ‘signify *the goal* of the instinct’ (Samuels, 1985: 29). One aspect of archetype is ‘orientated “upward” towards the world of images and ideas’, while the other is ‘orientated “downward” toward’ the instinct (Jacobi, 1957/1959: 39). Hence, the archetypes comprise two poles: ‘instinctual and spiritual’ (Jung, 1947/1954: par. 417-20), which cover the whole range of human needs, drives and activities.

Confusion and Debates on the theory of archetype

There has been confusion and debate about the natures of archetype and complex. Complex is less of an issue as it is confined to a personal level and easy to accept, for it can be seen as the issue with one’s inner objects (Perry, 1970, West, 2013). For those sympathetic to Jung, the theory of complex (and that of archetype) has been argued to be consistent with scientific approaches to psychology and compatible with some developments of contemporary neuroscience (Cope, 2006, Solomon, 2000, Schore, 2007, Wilkinson, 2007). The theory of archetype has been interpreted to be in accordance with evolution (Haule, 2011) and has been extended to illustrate the phylogenetic dimension in psychiatry (Stevens and Price, 1996). However, another group of Jungian and post-Jungians made demands for clarity and precision of the theory (Zinkin, 2008, Urban, 2005, Stevens, 1998, Saunders and Skar, 2001, Samuels, 1983b, Roesler,

2012, Pietikainen, 1998, Merchant, 2009, Merchant, 2006, Martin-Vallas, 2013, Knox, 2010, Knox, 2003, Jones, 2003, Jones, 2000, Hogenson, 2010, Hogenson, 2003c, Hogenson, 2003a, Hogenson, 2003b, Goodwyn, 2010).

According to John Ryan Haule, there are six 'partly complementary, partly contradictory, meanings of *archetype'* in Jung's writings and they can be identified thus: (1) as 'a substantive' referring to the 'hypothesized "source" of typical images'; (2) as 'typical images' (e.g. "mother archetype", the "child archetype"); (3) as 'the teleological component in instinct'; (4) as 'a dynamic/structural component of the psyche', which is analogous to Freud's "id, ego, and superego"; (5) as five archetypes (i.e. "ego, persona, shadow, anima or animus, and self"); (6) as something that prescribes 'a quality of experience' (i.e. "numinous") or as a complex (e.g. personality "No. 1", "No. 2") (Haule, 1984: 252-3). Based on the philosophical and scientific contributions to Jung's theory of archetype, Jean Knox listed four models of archetype which she classifies: as 'biological entities', as 'organizing mental frameworks', as 'core meanings' with 'symbolic meaning', and as 'metaphysical entities' (Knox, 2003: 24). The confusion has arisen when people have tried to understand the theory from the various meanings that have evolved in different times.

In general, the arguments can be observed in relation to scholars' understanding of the issues of: (1) Jung's rhetorical style and development of this theory. This line of argument is totally sympathetic with Jung and smooths over any issues. (2) The development of evolutionary theories, which were not available to Jung in his time. It is now used to argue the significance of Jung's insight into the human psyche. One important figure along this line is Anthony Stevens, but this biological line seemed to sacrifice the cultural and hermeneutic functions of archetype represented by Petteri Pietikainen. (3) With the advance of

developmental perspectives and the interactive quality on human development, the irreconcilability between biology and cultural development has been deemed a fundamental problem for the validity of this theory. This new insight calls for revisions on the issue of innateness and transmission of archetype. Jean Knox is an outstanding figure [43].

In order to explain the confusion caused by Jung's writing style, Leopold Stein suggested that Jung developed his theory of archetype based on the 'account of the theoretical entities which he has contrived rather than observed or even deduced' (Stein, 1958: 10). He made the distinction between discrete archetypes and abstract aggregates to avoid the erroneous assumption that complex is archetype. R. F. Hobson also pointed out a basic confusion between archetype as an explanatory term and as a phenomenological concept (Hobson, 1961/1971). George H. Jensen considered Jung's separation of "form" and "content" to be problematic, and suggested we see "form" as the carrier of "emotion" or "affect". He persuaded without success that, by this equation, the debate about whether archetype is universal or historical will be deemed unnecessary and the distinctions between the "inner" and "outer" will dissolve (Jensen, 2004: 26, note 19). Susan Rowland contended that Jung's writing is 'experimental' and in a 'phenomenological' spirit, and that it is sometimes aiming at the effect of 'rhetoric' (Rowland, 2010: 23, 164).

For the second source of confusion, Elie Humbert pointed out that Jung's initial use of archetype connoted 'more the idea of *model* than of *process'* (Humbert, 1992: 309). Jung's definition of archetypes gradually evolved 'from representations to potentials', meaning it grew from the "innateness" to the

43 Jean expressed: "I certainly consider archetypes to be emergent, not innate." KNOX, J. 4 Feb 4 Feb 2015. RE: Personal communication about whether Jean would consider herself an 'emergencist'. Type to TU, H.-C.

organizing potential in the psyche. As mentioned earlier, Anthony Stevens is the exponent of evolutionary theory as a mode of understanding archetype. For him, Jung's usage of the term 'primordial images' led Jung to the inevitable accusations of Lamarckism[44], which pushed him to make the distinction between archetype-as-such and archetypal images (Stevens, 1982). For Stevens, it is a paradigm shift to introduce evolutionary developments into psychology. He considered the theory of archetype to be as significant as gravity for Newton, relativity for Einstein, and natural selection for Darwin. 'The full implications of archetypal theory have yet to be realized' (Stevens, 2006: 87, 90).

Pietikainen evaluated Jung's theory of archetypes with the philosophy of symbolic forms of Ernst Cassirer. He preferred to see archetypes as 'culturally determined functionary forms organizing and structuring certain aspects of man's cultural activity'. Archetypes as 'symbolic forms' not only clears the 'rather unfruitful discourse on the genetic inheritance of archetypes', but also provides a 'potentially valuable contribution to hermeneutical and cultural studies' (Pietikainen, 1998: 325). For Stevens, to advocate against biological evolution is a 'complete regression to pre-Jungian *tabula rasa* psychology and pre-Darwinian life science'. Without taking account of evolution, the anti-biological Jungians may 'strike a blow at the epistemological foundations of Jungian psychology' (Stevens, 2003: 259).

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44 Jean-Baptiste Pierre Antoine de Monet, Chevalier de Larmarck (1744-1829) was one of the prominent zoologists of his time. According to George B. Hogenson, Larmarck was significant in promoting research on how life on earth changed/progressed over time. He was an opponent of 'creationist views' , and in a way he helped 'set the stage for Darwin'. The fault of his theory is his advocacy of inheritance; i.e. an organism acquired some characteristics in reacting to the environment and would pass them onto its offspring. Hogenson further augued that Jung was more familiar with the theories of James Mark Baldwin and Conway Llyd Morgan who did not agree with Larmarck's original ideas. The so-called 'Baldwin effect' and its psychological elements not only rescue Jung from Larmarckism, but also can help to understand 'the emergent properties of the dynamic developmental system of brain, environment, and narrative'. See HOGENSON, G. B. 2001. The Baldwin effect: a neglected influence on C. G. Jung's evolutionary thinking. Journal of Analytical Psychology, 46, 591-611. Cited from P. 594, 607.

The third source of confusion arose with the irreconcilability between biology and culture resulting from the advance of developmental perspectives and the interactive quality on human development. According to John Merchant, some scholars along this line advocated for seeing archetypes as '"emergent properties" and as aspects of Dynamic Systems Theory[45], self-organization and emergentism' (Merchant, 2009: 339).

Peter Saunders and Patricia Skar adopted the biology of self-organization in the brain/mind; they rejected the *a priori* status of archetype and proposed that an archetype is 'an equivalence class of complexes'[46]. Self-organization results from the movement and the dynamic of a system itself; it is a phenomenon in which order and pattern arise automatically without a template. Many patterns in nature emerge not from an *a priori* structure, but as the interactive result of the system, its dynamic, and the contextual environment. From a biological point of view, they suggested that part of the confusion is because Jung 'conflat[ed] form with the process' (Saunders and Skar, 2001: 312, 311), hence they suggested us to see archetype as 'an equivalence class of complexes'.

According to Skar, human beings, as any open system, can go through some disordered stages and reach orderly phases by their systemic dynamic. The basic instability of the systems paradoxically contains a potential to enable them to adapt to any changing situations (Skar, 2004). She summarizes the features of self-organizing systems as: 'open and intimately connected with their

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45 Dynamic systems refer to levels of organization in animate or inanimate constitutions. According to Maxson J. McDowell, there are three levels of organizing systems: a simple dynamic system, a complex dynamic system, and a complex adaptive system. MCDOWELL, M. J. 2001. Principle of organization: a dynamic-systems view of the archetype-as-such. The Journal of Analytical Psychology, 46, 637-654. Cited in 653, note 1.

46 For a similar line of exploring Jung's struggle to express the Self as emergent processes, see JUNG, C. G. 1951/1959/1968b. The Structure and Dynamics of the Self. CW 9ii. Par. 409. CAMBRAY, J. 2010. Emergence and the Self. In: STEIN, M. (ed.) Jungian Psychoanalysis: Working in the Spirit of C.G. Jung. Chicago, Illinois: Open Court.

environment', 'creative' because they are capable of creating 'new structures and new modes of behaviour', and the different parts of the system are 'interconnected' (Skar, 2004: 249). We can apply these features of self-organization and emergent phenomena as a way of understanding the archetype as an emergent property of the activity of the brain/mind.

The emergent model is epitomized in Jean Knox's research. According to Knox, the emergent model arose from the debate in cognitive sciences between 'modularity and constructivism', which has reconciled some opposing viewpoints on either side. This line of new developmental models sees the gene as 'catalyst' rather than 'blueprint', which means the gene is 'highly interactive with the environment' and 'contains no information in isolation'. This model rejects any claim of innate, genetically coded archetypal imagery; it sees the brain 'as a self-organizing structure' and regards human psychological development as the processes of interacting with the environment. She adopted the concept of 'image schemas'[47], which cognitive scientist Jean Mandler developed as a 'metaphorical' explanation for archetypes, thereby endowing a prolific ground for archetypal imagery (Knox, 2003: 47, 49, 52, 67).

Knox then evaluated the four models of archetypes that Mandler put forward and convinced the readers of the compatibility of these archetype models with the evidence of emergent models. Thus, she concluded that archetypes are 'psychic patterns of relationship rather than specific contents' and they result from 'a

47 According to Knox, image schemas are spatial models that are developed in the early years (i.e. as infants) of one's mental development and registered important information about the spatial relationship of objects (in the sense of object relations) around us. The formation of image schemas is considered 'the earliest and the most primitive form of representation in that they are conceptual structures mapped from spatial structures'. KNOX, J. 2003. Archetype, Attachment, Analysis: Jungian Psychology and the Emergent Mind, London, Routledge. Cited in P. 56.

process and emergent pattern of relationship' (Knox, 2003: 67, 68). Merchant praised Knox's research, stating that:

> it combines both a developmental perspective and an emergent one thus enlarging its explanatory power. The developmental component has to do with the formation of the image schemas (archetype-as-such) in the first place and the emergent component has to do with the later scaffolding process (which underpins archetypal imagery). (Merchant, 2009: 342)

Following the lines taken by Knox, Christian Roesler reviewed the debates about archetype from 'emergence theory, Gestalt theory and the humanities' (Roesler, 2012: 223) and suggested we take account of 'socialization and enculturization' for the formation of archetypes (ibid: 239).

To defend the biological position of archetype, Stevens argued that 'the biological implications of archetypal theory are enormous in their ramifications and help to place the whole Jungian edifice on firm epistemological foundations' (Stevens, 1998: 351). However, the findings of current neuroscience are calling into question the 'innatism and what Developmental Systems Theory in biology calls "preformationism"'[48] (Merchant, 2009: 340). The innate structure of archetype has been used to provide us with access to reach a transcendental reality in which synchronous events happen. Knox's research has shown that the genetically coded innateness of archetypes is losing the battle, which then puts Jung's other important theory, that of synchronicity, in a vulnerable position. Knox concurred with Merchant that we need to 'make a choice between a biological and a metaphysical view of archetypes' (Knox, 2003: 39). The observation of self-organization diminishes the significance of archetype-as-such, which provides grounds for symbolic representation.

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48 According to Merchant, 'Preformationism in biology is the view that the information for producing an organism is contained in the zygote and becomes "read-out" in an environment. The parallel position in analytical psychology is that archetypes are pre-existent in the psyche and are "read-out" into experience'. MERCHANT, J. 2009. A reappraisal of classical archetype theory and its implications for theory and practice. Journal of Analytical Psychology, 54, 339-358. Cited in P. 340.

To further close the gap between the biological model and the metaphysical function of archetypes, Knox pointed out that Maxson J. McDowell's definition of archetype-as-such in mathematical terms was cogent (McDowell, 2001), and this can bridge the gap between the biological and metaphysical models of archetype. McDowell also refuted the concept that archetypes are hard-wired into the genes, although he also took issue with Saunders and Skar (2001) who suggested that archetypes are equivalent to complexes. For McDowell, archetype-as-such 'can be described as a mathematical principle', which manifests in various ways such as biology, personality and psychology. Mathematical principles not only govern one's psychological development, but also produce certain patterns or physical objects in an inanimate world (e.g. whirlpools). If we take the mother archetype as an example, the subjective experience of maternal containment or holding is one of the abstract patterns that archetype-as-such has incarnated (McDowell, 2001: 647).

The above examples of debates and revisions prove that the word "archetype" has been 'shrouded in associations, value-judgments and auras'. Andrew Samuels defended archetypal theory for '*the space and importance it accords the person dimension*', and it is therefore '*useful*' (Samuels, 1985: 45). The researcher's purpose here is not to exhaust all the trajectories of each argument, but instead to pave the way for an interpretation of suicide complex (SC) in Chapter Nine. As it is beyond human endeavour to prove SC as innate, or as *a priori*, the emergent model will be a cogent theory to argue for the formation of SC which emerges from the interaction between people and their environment after encountering suicide. Archetypes will appear with "as if" quality due to their affectivity, and the emergent/developmental model of archetypes (i.e. image schemas) as proposed by Knox provides a language to understand the

mechanism. '[I]t is evident that archetypes do not operate spontaneously and autonomously as if divorced from personal experience' (Merchant, 2012: 75).

Critiques of Hillman's Attitude on Suicide

As mentioned earlier in Chapter One, the theories explaining suicide range from biochemical to depth psychology. The archetypal theory of suicide put forward by Hillman cannot be ignored in the field of Analytical Psychology. However, not everyone agrees with Hillman's high theory. For example, an Jungian analyst, David H. Rosen, differentiates 'egocide' from suicide: egocide is defined as 'the letting-go of a hurt and hurting dominant ego-image or identity' (Rosen, 1996: xxi)[49]. One does not need to kill oneself, but only that part of the ego that is hurting, experiencing despair and in an unbearable pain. While Hillman criticized the therapists for not dealing with suicide with detached objectivity, Rosen insisted that whenever someone wants to kill him/herself, we 'need to evaluate suicide subjectively as well as objectively' (Rosen, 1996: 29).

I personally also do not agree with Hillman's position on suicide. The argument that analysis is to 'increase consciousness' and therefore it does not 'exist to prevent suicide' is a rhetorical fallacy. Neutrality is not only insufficient but fails to see the real face of suicide. When the patient raises the issue of suicide, I will argue, it is the analyst's responsibility not only to increase the patient's awareness, but also to prevent the suicide. The analyst's responsibility to do so becomes clear after examining the following perspectives: firstly, the analyst needs to be capable of strengthening the container of the alchemical opus; secondly, the analyst needs to be aware of conflating an ego-dystonic reaction

49 I would like to express my gratitude to Andrew Samuels for pointing out Rosen and his work to me which has high relevance with my thesis.

with the so-called “soul’s call”; thirdly, the analyst needs to work through the countertransferential feeling of impotence and helplessness (Maltsberger and Buie, 1974) in order not to abandon the patient at the gate of hell. In the following, I will try to stick to the Jungian and post-Jungian theories as closely as possible to tease out the contradiction and blind spots.

Firstly, using the metaphor of alchemy as one’s psychological development, the state of *nigredo*, the blackening, is a significant and necessary stage. The “killing” element in suicide is closely related to the *albedo* (the whitening) and *rubedo* (the reddening) – ‘growth, resurrection, rebirth’ (Edinger, 1985: 148). What one wants to kill by suicide can be many things, ranging from part of oneself (e.g. the rotten me), to the inner objects (e.g. the bad mother; the malignant other), to the experiences (e.g. the pain, the suffering, failure), and to the abstract ideas (e.g. injustice, void). It is not only important to find out ‘*what it means in the psyche*’ (Hillman, 1973/2011: 37) but also crucial to resist the temptation to break the analytic frame by literalizing the impulse. Jung emphasizes the importance of firmly closing the alchemical vessel (Jung, 1936b: par. 218). In the darkness of being suicidal, the patient urgently needs the analyst to hold his/her hands in order to ‘acquire steadfastness and philosophic patience in face of suffering’ (Jung, 1943: par. 185).

It seems counter-intuitive to say that the death experience may fulfill ‘*a demand for a fuller life*’ and ‘the possibility of suicide’ could be denied (Hillman, 1973/2011: 63), but it is debatable that whether the analyst has failed to regulate the subtlety of ‘the frame/holding/container triune’ (Cwik, 2010) by romanticizing the necessity of suicide. When someone is contemplating suicide, s/he needs someone ‘to be equally in touch with very dissonant pieces of reality that have not yet come together’ (Vesey-McGrew,

2010: 18). Insight and understanding may be important, but equally important is the 'lived experience with the analyst' (Theodore Jacobs, cited in Vesey-McGrew, 2010: 18). By implicitly suggesting that suicide is the patient's own business, the analyst may fail the patient by breaking the vessel earlier than the time is due.

Secondly, the irresistible pull to suicide may not be the goal of the psyche or the soul but an ego-dystonic manifestation or a complex. I am not suggesting here that analysts cannot conduct a proper assessment, but from the indifference, "neutrality", and romanticisation of analysts' attitude, a subtle confusion and complicity can be detected. There is an implication that suicide is too difficult to handle, so let us play it safe. If we really respect the unknowability of the collective unconscious, on what basis can we interpret that suicidal ideation is the soul's call? What if it turns out to be 'egocide'? – one wants to kill 'a hurt and hurting dominant ego-image or identity', as Rosen referred to a 'metaphorical' death of the ego. The "neutral" attitude could result from the conflation of a literal interpretation of egocide with the soul's call to suicide. What if the act of suicide is an act of literalization, instead of symbolic fulfilment of a destructive impluse?

The analysts should be cautious of the spectrums of suicidal risks ranging from a minor form of pondering or entertaining the thought of killing oneself, to a chronic and persistant desire to terminate one's own life, and finally to an acute risk of taking lethal action. It can be seen as a trajectory of "development" and how much the ego yields to the power of the underlying ego-dystonic elements. John Perry observed that 'the entire psyche is structured not only in complexes, but in their bipolar systems or arrangements'. When two complexes are in conflict with each other (e.g. the wish to kill oneself and the wish to sustain oneself), as in the case when people become suicidal, they are ambivalent and grappling with an equal force that generates from life and death (Williams, 1997: 151, Stengel,

1969: 117, Shneidman, 1993: 21, Joiner, 2010: 64). The weakened ego can yield to the power of the activated complex (Perry, 1970: 9).

Fredric Matteson demonstrated that suicidal patients are in a 'bifurcated' state: they are trapped in a gap between 'who they are to us' and 'who they are to themselves'. They are trapped in an unknown space[50]. The difficulty or impossibility of containimg both themselves and the 'unreal, painful, disconnected state' leads one to 'a lethal spiral downwards' (Matteson). Conflicting complexes 'cluster together to create centres of "not-I-ness", or inner Otherness' (Austin, 2009: 585). The Self can be a 'violent Other' (Huskinson, 2002) who is disguised as a soulful figure yet threatens, and may aim, to destroy oneself. It would be foolish to interpret the evil destruction as a romantic transformation.

Lastly, the analyst needs to work through their counter-transferential feeling of impotence and helplessness in order not to abandon the patient at the gate of hell. When a patient is suicidal, the analyst is pulled into the battle of identity: "Who am I now to the suicidal client? Should I continue to be the mother? Father? Or what?"

> Thus, at these anxiety-ridden moments in the symbiotic phase, the therapist feels his own personality to be invaded by the patient's pathology, and feels his identity to be severely threatened, … (Searles, cited in Hamilton, 2004: 286)

It is also a relational crisis between the analyst and the client:

> Playing the odds with death almost always involves a test for the person who is cast in the role of potential rescuer: "Which is it to be", the attempter

50 For suicidal persons, there is confusion between (1) the individual as s/he experiences her/himself (Is), including experiencing her/himself as s/he experiences others – the here-and-now introspective experiences; and (2) the "individual" as s/he is experienced by others (Io). See SHNEIDMAN, E. S. 1967. Sleep and Self-Destruction: A Phenomenological Approach. In: SHNEIDMAN, E. S. (ed.) Essays in Self-Destruction. New York: Science House, Inc. P. 512.

> unconsciously asks, “Will you save me from death and demonstrate your love, or will you abandon me to death and demonstrate your aversion?” (Jensen and Petty, 1996: 131-2)

Jung warns the analysts to ‘resist the continuous onslaught of the patients' collective unconscious’ (Jung, 1976: par. 354). Analysts may use Jung’s warning against identification with ‘the saviour complex’ to defend one’s “neutrality” or indifference. However, Jung has averred that, although the projection is ‘unfortunate’ for the analysts, their job is to ‘give that value back to the patient’.

> [T]he analysis is not finished until the patient has integrated the treasure. So, if a patient projects the saviour complex into you, for instance, you have to give back to him nothing less than a saviour - whatever that means. But *you* are not the saviour - most certainly not. (Jung, 1976: par. 352)

After losing a patient to suicide, Rose Hamilton asked, when the clients are given the freedom to come off their medication, ‘are we giving them the freedom to take their own life as well?’ (Hamilton, 2004: 284) Similarly, it can be asked when we say, “suicide can be chosen”, are we “giving them the freedom to take their own life as well?” I am not suggesting that we can have control of another’s suicide, but quite the opposite; just as we do not have a full control of the issue, the suicidal person does not have full control either, especially in the acute crisis, so we need to express our concerns, and not be worried about over-intervention.

To be neutral is not enough, for the therapist being the ‘blank object’ would only push the client ‘back into the abyss’ (Waldron, 2013: 110). Neutrality is one of the classical techniques which aims at anonymity and the illusion of the therapist being a blank screen, on which the client can project what they need (Braun and Otscheret, 2010: 180), but it is not the only stance for analysts to fall back on[51]. To

51 The difference between the synthetic and reductive approaches is another issue to be aware of. For instance, the synthetic approach of analysis is ‘not reducible to making the unconscious conscious but is a search for the means of

analyse the suicide on the couch or chair is not enough, it is suggested that we ‘work seated at the suicidal individual's bedside, trying our very best to feel what that person feels and how these feelings lead the wish to die’ (Pompili, 2010: 59). Fundamentally, the issue of suicide will demand the analysts to ‘face up to death’ and achieve a genuine ‘reconciliation with the reality of death’ in themselves (Klopfer, 1965: 203). This is the muddled area in which countertransference can be used as a defense against one’s failure of intervention and impotence of resolution.

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engaging with unconscious processes that allow mutual influence (conscious and unconscious) upon one another’. See CAMBRAY, J. & CARTER, L. 2004. Analytic Methods Revisited. In: CAMBRAY, J. & CARTER, L. (eds.) Analytical Psychology: Contemporary Perspectives in Analytical Psychology. New York: Brunner-Routledge. P. 121 [cited in VESEY-MCGREW, P. 2010. Getting on Top of Thought and Behavior Patterns. In: STEIN, M. (ed.) Jungian Psychoanalysis: Working in the Spirit of C.G. Jung. Chicago, Illinois: Open Court. P. 18.]

5. Narrative Inquiry

“Narrative” is an umbrella term and any attempt at definition is a daunting task (Mishler, 1986, Mishler, 1995), for its ever-expanding state is nearly anarchic (Mishler, 1995). Fundamentally, narrative is ‘international, transhistorical, transcultural: it is simply there, like life itself’ (Barthes, 1966/1977: 79). Narrative is also ‘a basic human strategy for coming to terms with time, process, and change’ (Herman, 2009: 2). When one encounters illness, trauma, tragic loss, calamity, violence, injustice, either naturally or artificially, one needs to understand the experience, to make sense of it, and to live with it (Bruner, 1990, Neimeyer, 2000, Neimeyer and Sands, 2011). The greater community also has a need to understand and integrate these encounters (Langellier, 1999, Rylko-Bauer, 2005). The ubiquity of narrative can be observed from being within the province of literary study to an expressive vehicle crossing disciplinary boundaries – it can be artistic, communicative, social, or political. The form narrative takes can be that of the written, the spoken, the interactive, the embodied or the performed (Austin, 1962/1975, Bauman, 1986, Bruner, 1991, Herman, 2009, Langellier, 1999, Langellier and Peterson, 2006).

Narrative inquiry (NI), a branch of qualitative research, is a significant theoretical framework embedded in the empirical section of this research. This chapter will investigate NI as an established qualitative methodology (Clandinin and Connelly, 2000), methods of narrative analysis, and an trend of experimental development in qualitative research.

Narrative Inquiry as Methodology

Narrative inquiry (NI) is a qualitative methodology that engages the reconstruction of a person's experience, the person's relationship to others and to a social milieu. It is a method of understanding experience (Clandinin and Connelly, 2000).

> It is a collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that make up people's lives, both individual and social. … [N]arrative inquiry is stories lived and told. (Clandinin and Connelly, 2000: 20)

NI as a methodology is a Twentieth Century development that evolved across the various disciplines of the humanities (Riessman and Speedy, 2007) and is a cross-disciplinary phenomenon (Riessman, 1993, Herman, 2009, Clandinin, 2007). Judy Segal used the term 'postdisciplinarity' to indicate the loosening of disciplines in narrative, and the term was coined by Louis Menand which includes 'multi-', 'cross-', 'trans-', and 'interdisciplinarity'. Postdisciplinarity 'recognises, and preserves, the virtues of disciplinary research, while it refuses to enshrine disciplines in the form in which they were invented' (Segal, 2007: 16).

Narrative inquirers adopted John Dewey's pragmatic philosophy to explore the ontology of experience (Clandinin and Rosiek, 2007, Connelly and Clandinin, 2006). Dewey urged us to understand experience as 'something which no argument and no term can express' (Dewey, 1980: 325, footnote 1). He disagreed with non-empirical philosophers who tried to find something beyond the experiences; for Dewey, experience is 'an existence' (Dewey, 1981a: 12). Experience is 'meaningful and human behavior is generated from and informed by this meaningfulness' (Polkinghorne, 1988: 1). The so-called 'common experience is capable of developing from within itself methods which will secure direction for itself and will create inherent standards of judgment and value' (Dewey, 1981a: 41). Deweyan theory of experience does not presuppose the existence of a

precognitive, precultural, or transcendental ontology; rather, it is deemed 'transactional' and 'characterized by continuous interaction of human thought with our personal, social, and material environment' (Clandinin and Rosiek, 2007: 39).

> [E]very experience is constituted by interaction between "subject" and "object", between a self and its world, … and hence can be understood only as we take into account the total normal experience in which both inner and outer factors are … incorporated … In an experience, things and events belonging to the world, physical and social, are transformed through the human context they enter, while the live creature is changed and developed through its intercourse with things previously external to it. (Dewey, 1981b: 251)

The relationship between narratives and experiences is reciprocal.

> [N]arratives are not just about experiences. Experiences are, in a sense, about narratives. That is, narratives are not primarily after-the-fact imitations of the experiences they recount. Rather, the intimate connection between story and experience results from the structure of action itself. … [N]arrative and experience are bound in a homologous relationship, not merely a referential one. (Mattingly, 1998: 19)

The purpose of NI in human science is to understand and obtain insight into the human condition and existence, rather than to prove, explain or predict any truth with old-fashioned scientific objectivity (Mitchell et al., 2011). NI has been used to explore human experience as meaningful, contingent, and contextual (van Manen, 1990, Parse, 2001). Because of NI's pragmatic emphasis, 'temporality' (i.e. our experience unfolds through time), 'continuity' (i.e. the continuous flow of life as we experience it), and the social aspect of our experiences are embraced (Clandinin and Rosiek, 2007: 39-41). These dimensions are essential to NI. Researchers need to attend to the complexities between lives and contexts, and the ever-changing relationship between them. We 'learn what it means to live and inquire into lives as they are temporally and situationally composed and recomposed' (Craig and Huber, 2007: 268-9).

Methods of Narrative Analysis

Narrative analysis (NA) refers to a number of methods of interpreting texts that are written, spoken, performed or visually produced. It includes thematic analysis, structural analysis, and dialogic/performance analysis (Riessman, 2008). According to Catherine Kohler Riessman, the focus of thematic narrative analysis is on '"the told" – the events and cognitions to which language refers'. The local context is often disguised; language is seen 'as a resource, rather than a topic of inquiry' (Riessman, 2008: 58-9). NA is 'an accessible and theoretically flexible approach to analyzing qualitative data' (Braun and Clarke, 2006: 77); it aims at 'identifying and analyzing patterns of meaning in a data set' (Joffe, 2012: 209).

Structural analysis is similar to thematic approaches with topics and voices included. William Labov's approach, which focuses on the function of clauses, is one example of this. William Labov and Joshua Waletsky in *Narrative Analysis: Oral Versions of Personal Experience* (Labov and Waletzky, 1967) examined the factors of narrative. The study was reprinted in the special issue of the *Journal of Narrative and Life History* (now *Narrative Inquiry*) in 1997 and it demonstrated that narrative and/or personal narrative (PN) generated intense discussion across different disciplines in the humanities and social sciences. Labov and Waletzky defined PN as being made up of six components: the 'abstract' (what the story is about), the 'orientation' (who, what, when, where?), the 'complicating action' (and then what happened?), the 'evaluation' (what is the point?), 'the result' (what finally happened?) and 'coda' (what conclusions can be drawn?).

There are two formal linguistic units to evaluate the functions of PN: 'referential clause' and 'evaluative clause'. Referential clauses recapitulate "what happened" in a temporal sequence while evaluative clauses convey the personal meaning and the significance of the experience. Both are needed to become a narrative and the event needs to be specific in time to fulfil the referential function.

The evaluative one ‘justifies the tellability of the story and presents the meritorious qualities of the narrator’ (Langellier, 1989: 246-7, Labov and Waletzky, 1967).

The third method of NA in Riessman’s thesis, the dialogic/performative approach, looks for dramatic elements, such as talking to the audience, asides or using expressive sounds. It investigates “how” a speech is delivered, “who” an utterance is directed to, “when”, and “why”. The researcher is ‘an active presence’ in the scene and the text. It also emphasizes the signification and significance of interaction (Riessman, 2008: 105). The boundaries of these approaches are not discrete, for they are overlapping, fluid and can be combined. There are five ‘levels of representation’ in the research process of using NA: ‘attending to experience’, ‘telling about experience’, ‘transcribing experience’, ‘analyzing’, and ‘reading’ (Riessman, 1993: 8-14).

Mishler proposed a typology of NA using three models: ‘reference and temporal order’ shows the sequence of real events and their order in the telling; ‘textual coherence and structure’ examines narrative strategies and the way that the text’s appearance, coherence and structure creates a space that allows for the generation of meaning; and the ‘functions’ model which looks into the multiple contexts and consequences of narrative, including the functions of self-making, cultural meaning-making, social and political advocacy (Mishler, 1995). Kristin M. Langellier used five theoretical points to analyze PN: PN ‘as story-text’, ‘as storytelling performance’, ‘as conversational interaction’, ‘as social process’, and ‘as political praxis’. Her article expanded the boundaries of narrative from text to context, from story to discourse, and from personal to political (Langellier, 1989).

Experimental Development in Qualitative Research

Among the ‘Seven Moments’ of qualitative research (‘the traditional period’, ‘modernist phase’, ‘blurred genres’, ‘crisis of representation’, and ‘the postmodern[52] period of experimental ethnographic writing’, ‘postexperimental’, ‘the future’) (Denzin and Lincoln, 2003: 19-29), NI has been situated in ‘the fifth moment’ (Denzin and Lincoln, cited in Clandinin and Connelly, 2000: 5) while the argument between objectivity and truth is no longer straightforward. The blossoming of qualitative research has encouraged researchers to challenge the traditional concepts of “objectivity” or “scientific truth” by using poetic and/or dramatic forms. Social sciences can be seen ‘as continuous with literature – as interpreting other people to us, and thus enlarging and deepening our sense of community’ (Rorty, cited in Mienczakowski, 1995: 365). Connecting art with science, dramatic methodology encourages and stimulates dialogue (Gergen and Gergen, 2000). This line of creative methodology can represent different lived experiences and allow multiple voices, including conflicting messages and/or those silenced (Richardson, 2000).

Laurel Richardson considered that ethnographic writing is ‘allied to the rhetorical and emotional center of literary writing’ (Richardson, 1994: 12). James Clifford talks about research as ‘true fiction’ (Clifford, 1986: 6), and it is more of a ‘co-construction’ than a monopolized endeavour (Steier, cited in Alvesson and Sköldberg, 2000: 283). In the postmodern culture of openness, multiplicity,

52 Postmodern and postmodernism can function as either a historical or a stylistic term although contradictions exist among different theorists. Both terms are often used interchangeably. As a historical term, it means after the era of modernism. In a narrow sense, it refers to the year after the avant-garde movement in 1960s. As a style, it refers to the art work that contains ‘a self-conscious relation to the formations of postmodern culture; ’it has to do with what Fredric Jameson called ‘the cultural logic of late capitalism’. For the sake of clarity, when it refers to a historical era, the term “postmodern” is used; while it refers to style or cultural practices, then “postmodernism” is used. See AUSLANDER, P. 1992. Presence and Resistance: Postmodernism and Cultural Politics in Contemporary American Performance, Ann Arbor, University of Michigan Press, JAMESON, F. 1992. Postmodernism, or, the Cultural Logic of Late Capitalism, Durham, NC, Duke University Press, RICHARDSON, L. 1991. Postmodern Social Theory: Representational Practices. Sociological Theory, 9, 173-179.

uncertainty, ambiguity, doubt, and moral agony that NI is situated in, anything that claims to present “reality” is contestable (Bauman, cited in Schwandt, 1997: 305).

> It is a battleground where armies of the personal, the political, the cultural, the linguistic, the racial, the gendered, the classes collide in symbolic combat. It is a fractured landscape of struggle and resistance, of border crossings of all description, where margins meet the center, where no human escapes without wounds, where engagements and withdrawals mark the day from dawn to nightfall, where doubt pervades every encounter. (Tierney and Lincoln, 1997: x)

The truth has always been ‘updating’ (Mienczakowski, 1995: 366). To present through interpretive creative forms is to provide ‘descriptive’, ‘insightful’, ‘useful and explanatory’ accounts of experiences, and it is done ‘in spite of’ the scientific methodology, not ‘without’ (Mienczakowski, 1995: 367).

In this chapter, I have explored NI as a well-developed qualitative research method, helping researchers to understand people’s experiences, especially those full of affects, secrets, and emotional contagion and transmission (Wetherell, 2012). It also assists researchers with analytical tools to investigate how a discourse is formed, the relationship of discourse with power, how social resources are allocated, and what are the potential positioning strategies for special populations (such as immigrants, AIDS sufferers, cancer patients) (Potter and Wetherell, 1987, Horton-Salway, 2001).

As mentioned in Chapter Two, suicide survivors used to be an invisible group of people and they were historically subjected to the dominant discourses of suicide. These discourses include that of the church (Murray, 1998), of the state (Alcoz, 2007), and that of medicine (Dripps et al., 1959, Murphy et al., 1999). Their subject formation is intertwined with, and compromised by, the discourses and the resulting limited understanding. What they experience is full of complexity, and is unsuitable for quantitative, statistical or so-called scientific/objective approaches (Mcintosh, 1993, Cerel et al., 2009a). Here, I

am not denying the necessity or function of scientific/objective approaches, by which we may identify a trend and a tendency at a macro level; but they are not capable of presenting a persuasive knowledge of what it means to be a survivor. These considerations indicate that the choice of NI as a methodology is appropriate for finding a deeper and meaningful understanding of survivors' experience.

6. Applied Theatre

Applied Theatre is another theoretical framework embedded in this research. In this chapter, I will first present its historical development and the overlapping historical root with dramatherapy and psychodrama. Then I will discuss its pedagogical, social, and political functions, and key concepts. This is followed by the discussion of personal narrative as performance, and the element of performative.

Drama derives from the Greek word *dran*, meaning “to make or do”; theatre comes from *theatron*, meaning “viewing place”. Drama, in its strictest sense, means the text or the written script (but not necessarily in a dialogic form), which the participants interpret and perform. Theatre once meant the architecture or building that holds a performing space, but is now also considered as the practice of theatrical production. Applied drama/theatre is an inclusive term referring to various practices that use the theatre process as ‘a form of community building’, working with the issues presented by a group of participants, and facilitating change in the community and society (Prentki and Preston, 2009: 12). Applied drama/theatre as a discipline blossomed in the UK after the Second World War when there was a growing interest in the social sciences.

Because of the inseparability of drama and theatre, in this thesis the term “applied theatre” (AT) will be used to refer to practices in community settings, including the applied drama paradigm without trying to separate drama from theatre rigidly or to treat each as a fixed entity, and the words drama and theatre will be used interchangeably.

AT practices include drama in education (DIE), theatre in education (TIE), theatre in different social contexts (such as prison, hospitals, caring institutions), theatre for development, forum theatre, legislative theatre, oral history theatre and reminiscence theatre. AT crosses the borders of sociology, cultural studies, psychology, anthropology, education and the legal system. The focuses are more on the group or social transformation than on individuals. As a hybrid and interdisciplinary subject, AT has gained acknowledgement in academic research and the cultural industry since 1990. At the micro sphere, the emphasis in AT is on personal development and community participation. In the United Kingdom, the provisions of the Welfare State and the 1944 Education Act had established the background for this multidisciplinary subject to develop. In the international sphere, the Inaugural Address of President Truman in 1949 and the Bretton Woods organizations helped start the boom in applied drama/theatre that took place in the following decades. Learning through drama/theatre has been held to be an effective approach since the 1960s.

Before embarking on the subject of AT, I need to point out that the historical development of AT as a discipline overlaps with those of dramatherapy (DT) and psychodrama (PD). It occurred in the 1960s while theatre practitioners promoted drama/theatre as a liberating tool (Casson, 2014). As will be shown later, AT could be therapeutic, but it is not aiming for therapy. Those working to make changes in the personality and the group later found ways to certify themselves as qualified therapists using this approach. In the UK, the evolvement of certified programmes of DT started in the 1960s; whereas in the USA it became its own entity in the 1970s, where it was called “drama therapy” (Jennings, 1987, Landy, 1986). In the UK, the professional certified body is the British Association of Dramatherapists, which defines its practice as:

> Dramatherapy has as its main focus the intentional use of healing aspects of drama and theatre as the therapeutic process. It is a method of working and playing that uses action methods to facilitate creativity, imagination, learning, insight and growth. (BADth)

There are at least six models of DT: 'theatre model', 'therapeutic drama', 'role theory model', 'the anthropological approach' (Meldrum, 1994), 'developmental model' (Cattanach, 1994), and the'developmental transformation model' (Johnson). In contrast to the diverse founding figures of DT, PD was established by Jacob L. Moreno (1889-1974)[53] (Kellerman, 1992). PD can briefly be described as a method of group psychotherapy put into action. However, as Peter Felix Kellermann indicated, it is not easy to clearly define psychodrama. A classic PD session contains: 'a warm-up, protagonist selection, contracting, enactment and sharing' although not every PD follows the classic structure (Karp and Farrall, 2014: 10). Its conception is based on encounter, spontaneity, and creativity; and its practice has been integrated with other therapeutic approaches such as group analysis, family systems therapy, cognitive behavioural therapy, and attachment theory (Holmes et al., 2014). PD makes good use of role theory (e.g. double, mirroring, the auxiliary ego) and the psychodramatist (also called "director") works directly with the client's issues. For the similarities and differences between DT and PD, there are studies that have tried to tease out these two seemingly similar but different practices (Chesner, 1994, Davies, 1987, Casson, 2014).

The Functions of Applied Theatre

In addition to being therapeutic (though not intended as therapy), AT serves a different purpose: one that influences our world via different means by its

53 Another resource showed that Moreno was born in 1892 and died in 1974. See DAVIES, M. H. 1987. Dramatherapy and Psychodrama. In: JENNINGS, S. (ed.) Dramatherapy: Theory and Practice 1. London: Routledge.

pedagogical, social and political functions. ‘Intentionality’ is important in AT practice (Ackroyd, cited in Nicholson, 2005: 3), for it could be used to change society, make life better, empower marginal populations and create new possibilities.

Pedagogical Functions

In its application to education, AT was strongly influenced by Brazilian Marxist educator Paulo Freire (1921-1997), who advocated that learners, not teachers, are the focus of the pedagogic process. In Europe, the progressive education system used the approach of “doing” to help children learn during the 1960s, and this is why DIE and TIE has blossomed since. According to Nicholson, citizenship and pedagogy are two of the core concepts that influence AT. The theories of citizenship provide a constructive way to conceptualize the dynamic relationship between society, individuals, and AT practices. Citizenship:

> is a dynamic social practice, an identity that is constructed through networks of identification, open to change and renewal, rather than a fixed and immutable legal state. An emphasis on citizenship as an embodied social practice not only implies that it is revitalized by public debate and political action, it also draws attention to the ways in which people support each other and take responsibility for others as well as for themselves. (Nicholson, 2005: 27-8)

The purpose of pedagogy, as Freire advocated, is to encourage interaction and collaboration among pupils, as opposed to the authoritarian and didactic ways of traditional learning practices. Educators are not to ‘*teach* or to *transmit* or to *give* anything’, but to ‘learn, with the people, about the people’s world’ (Freire, 2009: 311). It aims to facilitate the learners’ motivation to access knowledge, raise public awareness and reflexivity, with the intention of preparing learners to be able to challenge how discourses are formed. Critical educators need to set up the conditions for students ‘to engage in cultural remapping as a form of resistance’. Pedagogy not only offers the diversity of cultural histories and spaces to students,

but also highlights the fragility of identity as 'it moves into borderlands crisscrossed with a variety of languages, experiences and voices' (Giroux, 2009: 259). Henry Giroux pointed out that education as a 'discourse of opposition and hope' is possible only when it offers students:

> the opportunity to engage in the multiple references and codes that position them within various structures of meaning and practice. … [W]ith the opportunities to read texts as social and historical constructions, to engage texts in terms of their presences and absences, and to read texts oppositionally. This means teaching students to resist certain readings while simultaneously learning how to write their own narratives. (Giroux, 2009: 260)

Social And Political Functions

Using theatre as a tool for social activism is a significant branch of AT practice. Influenced by the practice of Vsevolod Emilevich Meyerhold (1874-1940)[54], Erwin Piscator (1893-1966)[55] and Bertolt Brecht (1898-1956), the activists of the political left, utilized theatre for social reforms. Brecht could be seen as 'the founding father' of AT because of his idea that theatre should be used as a means of social change (Prentki and Preston, 2009: 12).

> Our conception of the 'popular' refers to the people who are not only fully involved in the process of development but are actually taking it over, forcing it, deciding it. We have in mind a people that is making history and altering the world itself. We have in mind a fighting people and also a fighting conception of 'popularity'. (Willett, 1964: 108)

The contemporary Brazilian director Augusto Boal was influenced by Brecht and Freire. He developed The Theatre of the Oppressed and wrote a book with the same title to express his ideas (Boal, 1979). He has analyzed how the theatre was

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54 Meyerhold was a Russian and Soviet theatre director, actor and producer in the early 20th Century. He was famous for provocative experiments dealing with physical being and symbolism in an unconventional theatre setting. He encouraged actors to connect psychological with physiological processes using gestures and movements as a way to express emotion physically.

55 Piscator was a German theatre director and producer. He used still images and cinematic projections from 1920s and complex scaffold stages. He advocated the socio-political content of drama; and his dramaturgy of contrasts generated a sharp political critique of society and politics. He was an important figure in the Western political theatre.

used as an oppressive apparatus by the ruling power over the people. According to Boal, theatre has been allied to political purpose since Greek times, and ever since it has been used by those in power as a way to control their subjects. The audience watched the drama passively, reached catharsis and then went home, life continued and the powerful stayed in power. Boal encouraged the audience to go on stage, take the role of the protagonist and offer a personal solution to the problem. Later in his Legislative Theatre (a book title as well as a theatre form), Boal used theatre to elicit opinions about the issues of everyday life, to stimulate political debates and influence legislative processes. He considered this process one of 'making theatre as politics rather than making political theatre' (Boal, 1998: 20).

During the Twentieth Century, we saw theatre being used as a deliberate tool of social revolt and political activism (e.g. the Workers' Theatre Movements in the 1920s). Community theatre, or grassroots theatre, prevailed after the second avant-garde theatre movement of the 1960s. After the social liberation and grassroots movements in the 1960s, the category of what is considered art has been expanded. High art is no longer the only kind of art that is valued or given cultural recognition, nor is it limited to a particular class. Access to the arts has become a basic right for every citizen. For AT, 'involvement, participation and engagement' are its values (Nicholson, 2005: 8). Tony Kushner argued that art could be a tool for cultural and social change: 'Art is not merely contemplation, it is also action, and all action changes the world, at least a little' (Kushner, cited in Nicholson, 2005: 8). AT offers the space to explore one's identity, belonging, and community. It is the 'most democratic of theatre practices', and has no less ethical concern. It is 'a discursive practice', and a tool of 'conceptualizing and interpreting theatrical and cultural practices that are motivated by the desire to make a difference to the lives of others' (Nicholson, 2005: 16).

With time, the paradigm in Western cultural practices has shifted from art being a vehicle for 'transgression' to art serving as a means of 'resistance' (Foster, 1985: 153). Hal Foster suggested that the transgressive politics were influenced by the modernist avant-garde movement. During this time, artists assumed a peripheral position and transcended social norms to make a critique of the mainstream aesthetic. But when alternatives were trimmed into the mainstream, transgression was no longer feasible; political artists of 'resistant politics' accepted that all discourse is contextually constructed and acknowledged that power is distributed unevenly. The task became to challenge dominant representations, examining 'the processes and apparatuses' and the mechanisms which dominate them.

In this globalized era, many aspects of human life have been reduced to businesslike transactions. With the increasing gap between the rich and the poor who are excluded from society, the on-going responsibilities of practitioners include: working towards 'the restoration' of the participants' identities as citizens; raising the awareness of identity, community, local cultural values and the distribution of global power; and searching for alternative social interventions which are of benefit to people (Prentki, 2009: 365).

Key Concepts

To defend the legitimate status of AT against aesthetic "pure" theatre, Helen Nicholson used Pierre Bourdieu's analysis of the social implications of taste-based judgments to illustrate the historical context of the pure/applied theatre distinction. According to Bourdieu, the aesthetic has been deemed to have transformative power for individuals and society at large since the Eighteenth Century. The arts became a new faith, a new religion. However, the encounter of

goodness with beauty did not achieve a democratizing effect; on the contrary, it formed a social hierarchy in aesthetic tastes and artistic practices. A group of highly cultivated individuals maintained a detached, pure, and disinterested attitude towards judging arts. By owning the symbolic capital and the power of political economy, the bourgeois dominated cultural productions. Theatre became a place for passive, educated, middle-class audiences; whereas popular art displaying the spectators' enthusiasm and group participation was considered inferior (Nicholson, 2005: 5-8, Bourdieu, 1984). However, with the elevated awareness of people's consciousness, the indifferent bourgeois could not uphold their power for long. Some key terms of AT need to be explored to show its people's spirit: community, identity and identification, space, and intervention.

Community

Community is not just a location, a building, or a tangible boundary, but is also a feeling of belonging, a sense of identification. It is operated by the mechanism of 'inclusion/exclusion', depending on who belongs or not (Heddon, 2004: 221). The complex participation-based relationships of a community can be seen from three angles, bearing in mind these angles can also overlap:

1. Theatre 'for' a community
2. Theatre 'with' a community
3. Theatre 'by' a community (Prentki and Preston, 2009: 10-1)

The first category, theatre 'for' a community, means that a theatre company brings their piece of work to a group of people (e.g. students in a school). The director and performers have a clear view of the artistic intention and are responsible for the aesthetic as well as moral responsibility of their works. Theatre 'with' a community involves participants in the creative process, and the members can have a say if they want the work to be performed to another public audience. It can take the form of workshops or focus on the process -- the journey of the

participants. Theatre 'by' a community might involve an AT practitioner or facilitator working towards specific aims or communications that a particular community wishes to achieve. Some communities may generate the capability to direct and plan the whole event, alternating between different roles (e.g. director, playwright, actors) by themselves.

The concept of community has been 'de-territorialised', shifting from communities of 'locality' to those of 'identity', focusing on 'mobility' rather than 'stability', and opening to the potentiality of 'multiple identities'. The emphasis has moved from the 'idealisation of homogeneous local communities' to various styles of 'collective identification' (Nicholson, 2005: 84). Benedict Anderson suggested that communities are 'imagined' by the people who have similar interests and have formed an identification with each other; communities are beyond the limits of geographical areas (Anderson, 1983). Identity is a context-specific construction relating to the subjectivity formed not only in local communities, but also in 'imagined communities' (Brah, 1996: 93). In contrast to Anderson, Vered Amit argued against the abstract or imagined concepts of community, suggesting that informal social groups and networks have more potential for generating a sense of belonging, rather than fixed social concepts such as social class, gender, race, etc. Any social grouping is a fluid process occurring within different periods of time and involving the interactions and connections of daily life.

> [T]he most common avenues for forming a sense of fellowship, of belonging and social connection are realized through modest daily practices that are often not strongly marked by symbolic categorical identities. These are people and relations known loosely as friends, neighbours, workmates, companions in a variety of leisure, parenting, schooling, political activities. Many of these associations are partial and limited in time and space to particular places and activities. (Amit, 2002: 165)

Amit reminds us of the importance of emotional bonds in the social sphere; communities are formed by building on personal relationships and networks

in the present moment, rather than on collective identification. A community can be seen ‘as being *achieved* rather than assumed’, and is based on the theory of deconstructed sexual and gender politics (Heddon, 2004: 222). Under this ethos, the artists’ representations of their sexuality are aiming for inclusion, acceptance and acknowledgement, rather than to challenge the dominant discourse.

Identity And Identification

In drama workshops, there is a need to negotiate between the participants’ narratives of identity, the discourses of others and the narratives of the drama itself. Participants are constantly ‘in dialogue with others’.

> A deeper sense of belonging to a community … derives from shared interpretations of experience. … [C]ommunities of identity are constructed when people recognise their own experiences in others, and share an understanding of each other’s values or stories. (Nicholson, 2005: 94)

Unlike in sociological studies (where identity is valued with the development of agency) or in philosophy (where it is seen if one has developed the 'continuity' of one's sense of self) (Butler, 1999: 23), drama, as a type of narrative, creates a space to investigate ‘the ethical gap between description and prescription, hypothesis and factuality’ (Nicholson, 2005: 64). It allows a ‘continual process of *becoming*’ in contrast to ‘a pre-given expression of *being’,* and allows us to reflect on how identity is constructed. The aesthetics of self-construction rely on the recognition of the ‘convergence and interplay’ of multiple narratives; we can therefore see that the self-narrative and the construction of selfhood is not only a creative process, but also an ethical endeavour (Nicholson, 2005: 65). Identity ‘is process’; Atvar Brah contended that ‘what we have is a field of discourses, matrices of meanings, narratives of self and others, and configuration of memories which, once in circulation, provide a basis for identification’ (Brah, 1996: 247).

> Identity is always in part a narrative, always in part a kind of representation. It is always within representation. Identity is not something which is formed outside and then we tell stories about it. It is that which is narrated in one's own self. (Hall, cited in Heddon, 2008: 27)

For the complexity of identity and identification, Freud, Brecht and the feminists have contested the differences between the essentialist and the deconstructionist views. Freud's *On Narcissism* (1914) and *Group Psychology and the Analysis of the Ego* (1921) showed the process of primary identification. A child is in a narcissistic phase without clear awareness of the differences and boundaries between self and others. The uncritical identification at the primary state is mimetic and based on self-love. It could extend to adulthood, where identification with an idealized figure is still fixed in the mind, resulting in narcissism or hysteria.

In *The Interpretation of Dreams* (1900), Freud wrote about the 'secondary identification' of hysterics in which the sense of self is threatened by fantasies. In the secondary identification, one has a clearer sense of boundary and knows the difference between self and others, and there is a 'potentially positive dynamic in the process of self-creativity'. Following this line of interpretation, identification 'both produces and destabilises identity'. When identification is involved with fictional narrative, a space for 'self-reflexivity' and affective engagement with others is opened (Nicholson, 2005: 72).

However, the identification with multiple narratives does not necessarily lead to social equality. This is the reason the theatre director Brecht distrusted identification and empathy in theatre, and he argued that the audience's identification with characters inhibits their thinking and reflection. He was keen to shatter the illusion of the fourth wall, disrupting narrative on

stage, and encouraging the audience to identify with the performers instead of the characters. He also asked the actors to keep a distance and avoid total identification with the characters.

> The performer's self-observation, an artful and artistic act of self-alienation, stopped the spectator from losing himself in the character completely, i.e. to the point of giving up his own identity, and lent a splendid remoteness to the events. Yet the spectator's empathy was not entirely rejected. The audience identifies itself with the actor as being an observer, and accordingly develops his attitude of observing or looking on. (Willett, 1964: 92-3)

For Brecht, theatre was a social mechanism to achieve change, and identification was the battlefield that he wished to deconstruct. Similarly, the feminist Hélène Cixous alerted us to be cautious of identity and identification:

> One never reads except by identification. But … [w]hen I say "identification", I do not say "loss of self". I become, I inhabit, I enter. Inhabiting someone, at that moment I can feel myself traversed by that person's initiatives and actions. (Cixous and Clement, 1986: 148)

The feminist and post-colonial theorists have argued that any discussion of self and other is political. Freud's theory of identification has an historical aspect and is related to a dominant self. Following this logic, one can speculate that a marginalized and objectified other is created. According to Judith Butler, Freud's theory of Oedipal complex determines our identification with both parents, but results in our identity being full of 'conflicts, convergences, and innovative dissonances' (Butler, 1999: 85). In *The Ego and the Id*, Freud wrote:

> [W]e succeeded in explaining the painful disorder of melancholia by supposing that an object which was lost has been set up again inside the ego -- that is, that an object-cathexis has been replaced by an identification. (Freud, 1923: 28)

In this essay, Freud modifies his earlier distinction between mourning and melancholia that he made in the aptly titled *Mourning and Melancholia*: the processes are changed from being 'oppositional' to 'compensatory'. The identification relating to melancholia becomes a 'precondition for the work of

mourning'. Hence, Butler expanded her critique of the incest taboo and the power of prohibition and repression, arguing that one's gender identification is 'a kind of melancholia' (Butler, 1999: 79, 80). She further argued that identity is created by 'performative' acts and gestures; it has no 'ontological status'. Those constituents of identity are 'fabrications manufactured and sustained through corporeal signs and other discursive means'. The rigidity and fixity of phallogocentrism and heterosexual hegemony make the affair of identity 'fixed and phantasmatic' (Butler, 1999: 173, 85).

Space

Drama contains two realities: fictional (or imaginative) and autobiographical (or real), playing with the possibility and construction of multiple selves. Blurring the boundaries of fiction and reality, it creates a safe space or distance for participants to project experiences into dramatic forms. The symbols, metaphors and vessels allow participants to explore alternative choices, test out new ideas, or reveal their fantasies. Paul Ricoeur pointed out that storytelling is 'deploying an imaginary space for thought experiments in which moral judgment operates in hypothetical mode', that the narrative is situated at 'the crossroads between the theory of action and moral theory' (Ricoeur, 1992: 170). Similarly, in AT, it is this 'creative' space where people feel safe enough to take risks and try alternative solutions (Nicholson, 2005: 129).

Henri Lefebvre analyzed three concepts of space: 'spatial practices', 'representations of space' and 'representational spaces'. 'Spatial practices' are the structures underlying the social world that manifest the achievement of social functions. 'Representations of space' are constructed and conceived conceptually as a way of codifying space according to ideology and power structures. 'Representational spaces' are embodied in everyday life and articulate the

complexity of lived experience through symbols and images (Lefebvre, 1991: 38-9). The three spaces, ‘perceived’, ‘conceived’, and ‘lived’, are ‘interconnected’ in AT practice, which takes place in multiple contexts and in different organizational settings (Nicholson 2005: 127-8). A practitioner needs to be aware of how spatial practices are discursively structured and perceived. The work is not only to move from reality to an imaginative space, but also to develop a ‘spatial competence’ to make social intervention possible (Lefebvre, 1991: 38).

Instead of seeing AT as a discipline with fixed boundaries, Nicholson suggested a ‘diasporan’ space because of its mobile, renegotiating and re-interpretative potentials.

> In diaspora space, the boundaries that define and confine knowledge, meaning-making and understanding are subject to continual critical scrutiny, and the ways in which power is constructed are closely examined. … [I]t is an approach to theatre-making that embraces diverse forms of cultural learning and many different theatre forms. The concept of diaspora space … offer[s] ways of thinking about how boundaries are encountered and transgressed, how those on the margins can move to the centre, and how the global asserts itself into the local. (Nicholson, 2005: 159)

Intervention

Theatre for Development is a cultural practice that emerged in the mid 1990s embracing various practices undertaken by non-governmental agencies. Its functions include: mobilizing resources to support national development; enabling the participants to become aware of power issues between local, national and international levels; building up a reciprocal communication between the community members, between the community and (non-)governmental agencies; offering space for group discussion and searching for solutions; fostering solidarity inside the village and among villages; and stimulating local cultural expression (Mda, 2009). It has been utilized to tackle issues such as HIV/AIDS (Auger and Heather, 2009), identity and immigration (Cohen-Cruz, 2009), racism (McCreery, 2009), and offending behaviours (Watson, 2009, Weaver, 2009).

While practitioners eulogize the efficacy of AT, Terry Eagleton pointed out the link between the creative imagination and the birth of capitalism (cited in Hughes and Ruding, 2009: 222). AT emerged in a period of social change, characterized by the 'globalization of uncertainty and disorder' after the collapse of Cold War polarities and the ensuing bankruptcy of the political left (Hughes and Ruding, 2009: 223). It has been legitimized with various agencies working towards the globalization of markets and the generation of capitalism. However, the social and cultural contexts were different from the pre-discipline period, where theatre practice was seen as 'an antidote to the alienating effects of industrial capitalism'. The intention and motivation of such practices need to be examined critically (Nicholson, 2005: 11).

The senior AT practitioner and educator, James Thompson, had worked on an AT project for a child soldiers' rehabilitation centre in the village of Bindunuwewa, Sri Lanka. Three months later, a massacre occurred resulting from the clash between the villagers and the centre. This was an unexpected incident and the project should not be seen as being responsible for the complex political situation and power struggle in that country. Thompson argued that AT projects constantly happen in settings that generate and are generated by multiple narratives that are competing with each other in the public domain. Thompson urged: 'In contested situations AT needs to consider the complex interrelation of the private and public and understand the shifts between tactical and strategic performance practice' (Thompson, 2009: 121-2).

The ideas of 'tactics' and 'strategies' come from the theories of De Certeau: 'tactics' are 'ways of operating' that cannot transcend the context, whereas 'strategies' are 'a subject of will and power' which can make structural change. Thompson reflected upon the practice and questioned whether AT functions 'as

strategy or tactic'? He pointed out that AT often operated at the level of tactics, although it aspired to achieve strategic change. It could hardly equip people to change reality. If AT could not facilitate the strategic form of change, the work might make the participating communities more vulnerable rather than empowering them. Because AT works in contexts that are regulated by both tactical and strategic actions, being focused only on the level of the tactical and private could not avoid the liability of being manipulated strategically or becoming a target to be attacked. For him, the experience in Bindunuwewa means an 'end of a narrow vision' of AT. He is calling for a form of practice which integrates both public and private factors, tactical and strategic functions (Thompson, 2009: 123).

Similarly, Schininà, based on his work in war zones and with refugees, observed the contradiction and ethical dilemmas that arise when psychosocial interventions were conducted by other countries, mainly by the countries with gun-power. In the Third World countries, the people may 'have been reduced to passive recipients of inputs from information monopolies' (Constantino, 2009: 316). Some projects, ironically, were 'message-laden plays' aiming for 'pre-determined behavioural outcomes' (Etherton, 2009: 356). Some interventions were labelled "humanitarian", like the one in Kosovo; some "preventive", like that in Iraq.

Schininà saw the psychosocial approach as the 'internationalization of the risk management approach'. He quoted Pupavac's research on psychosocial intervention and trauma risk management, criticizing the psychosocial approach on the basis that it is 'the non-participative preventive actions that inform the social policies and activities of many western governments' (Schininà, 2009: 42). The major importance of politics and participation had been replaced by the promotion of the therapeutic administration of societies. The right of people as

political subjects to take action to resolve major issues was taken away from them and handed over to some political delegates. It was only when the risk management approach went wrong (e.g. the failed intervention in Iraq) that this displaced authority was questioned. Situated in the hierarchical structure, the people were deprived of means and media to help themselves in disastrous situations, and were 'powerless to do otherwise within an unfair global economic order' (Etherton, 2009: 354).

Performance and Personal Narrative

AT overlaps with the discipline of performance studies (PS), especially PS that focus on everyday life and ordinary people. Performance is an expansive term including drama/theatre in a traditional sense, performing arts (including theatre, dance, music), popular culture, play, sports, storytelling, ceremony and ritual. This field can be viewed as a 'broad spectrum' or 'continuum' of human actions (Schechner, 2006: 2). Richard Schechner used an image of a fan and a web to express the connectedness of the two disciplines. He defined performance as a 'restored behavior: physical, verbal, or virtual actions that are not-for-the-first-time; that are prepared or rehearsed'. He also referred to it as 'twice-behaved behavior'. A performance happens as 'action, interaction, and relation'. It is not 'in' things, but 'between' (Schechner, 2006: 29-30). Performance is not only entertainment, it is a 'contested concept' (Madison and Hamera, 2006: xii). It is 'a mode of communication, a way of speaking' that is carried out 'above and beyond its referential content' (Bauman, 1986: 3).

The act of performance requires a performer and an audience (Brook, 2008), and it can happen everywhere – in the classroom, on the street, or in the shopping mall (in short, the daily living space). Once the performance is perceived beyond

the domains of performing arts (i.e. off stage), it becomes an act of personal narrative (PN). PN brings focus to the teller and is ‘a way of creation and being’. It is also a tool that can be used to ‘interrogate and enrich our basic understanding of history, identity, community, nation, and politics’. The teller needs to convince the listener who was not there when something significant happened (Riessman, 1993: 20). The narrator takes from experience – the narrated event, making it a narrative event. S/he experienced something horrible but survived it and voiced the experience to the public, who may or may not have had the same experience. The audience plays an important role as witness or participant.

Performing PN involves ‘bodily participation in the system of relations that shift fluidly among storyteller, audience, narrator, and character’ (Langellier and Peterson, 2006: 157). The body is revealed in front of the audience, allowing the representation of past experience to flow and allowing it to re-experience the past. As Maurice Merleau-Ponty said, ‘This subject which experiences itself as constituted at the moment it functions as constituting is my body’ (Merleau-Ponty, 1960/1964: 94). Performing PN is ‘an ongoing struggle for agency and meaning’ (Langellier and Peterson, 2006: 164-5), and we can see the performing narrative as ‘strategic’ in multiple systems, designing tactics to reach the goals as ‘a strategy of identity formation’ by identification, subversion or transgression.

Performative

The term “Performative” refers to a series of acts that are repeatable – ‘a *stylized repetition of acts*’ (Butler, 1999: 179) – and it has become a dominating theory in feminism and PS (Diamond, 1996). Judith Butler used this concept to subvert the fixated gender configurations. Butler argued that gender, sex, identity, race, age, and experience, etc. are not inherent or

biologically determined but the products of discourse. By reciting and repeating, the 'regulatory force is made clear as a kind of productive power, the power to produce – demarcate, circulate, differentiate – the bodies it controls' (Butler, 1993: 1).

Before the feminists adapted the concept of the performative to the critique of the fixed formation of gender, role and sexuality, at least two linguistic philosophers had laid the groundwork for this formation. J. L. Austin, in lectures given in 1955 at Harvard University, coined the term "performative" to describe utterances as ways of doing things. He elaborated: 'The uttering of the words is, indeed, usually a, or even *the*, leading incident in the performance of the act ' (Austin, 1962/1975: 8). In giving certain utterances, such as promises, bets, or curses, people perform acts. Those utterances do not describe or represent actions, but they are actions themselves.

John Searle advocated that whenever there is an intention to speak, it is performative. The basic unit of communication is a 'speech act'.

> [S]peaking a language is performing speech act … The unit of linguistic communication is not … the symbol, word or sentence, or even the token of the symbol, word or sentence, but rather the production or issuance of the symbol or word or sentence in the performance of the speech act. … [T]he production or issuance of a sentence token under certain conditions is a speech act, and speech acts … are the basic or minimal units of linguistic communication. (Searle, 1969: 16)

Austin's use of the term performative and Searle's speech act expanded human communication beyond syntax, lexicon, and grammar. The behaviour, the context and the narrator's subjectivity are brought into the picture.

Schechner suggested that performative is 'both a noun and an adjective': 'The noun indicates a word or sentence that does something … The adjective

inflects what it modifies with performance-like qualities'. Scholars often use performative and performativity interchangeably. Performative-as-noun, or performativity, covers 'a whole panoply of possibilities opened up by a world in which differences are collapsing, separating media from live events, originals from digital or biological clones, and performing onstage from performing in ordinary life' (Schechner, 2006: 123). When restored behaviour is enacted in real life, it is performative (Turner, 1986); when it is rehearsed and presented on stage, it is performance. The liberal effect of postmodernism contributes to the fertile adoption of the performative and performativity in various disciplines. Performativity describes a 'discursive compulsion to repeat norms of gender, sexuality, and race' (McKenzie, cited in Langellier and Peterson, 2006: 156).

By linking performance, performativity, and narrative, the communicative speech acts are expanded and broadened to manifest the constitutiveness of performance. Jill Dolan conceptualized performativity as 'the non-essentialized constructions of marginalized identities'. In this sense, performativity is not only citation, but also 'a symbiosis of identifying experience that is determined by compilations of difference' (cited in Madison and Hamera, 2006: xix). Homi Bhabha adopted the idea of subversive performativity as an action that interrupts, disturbs, disavows, and disrupts hegemonic powers (Bhabha, 1994). The performative and performativity are embedded in daily life (Goffman, 1990), yet they are highlighted and crafted in cultural performances. When performativity 'materializes' as performance, negotiating between a 'doing' (which reiterates a norm) and 'a thing done' (which is a discursive convention), between one's body and the embodiment practice, the access to cultural meanings and critique is revealed (Diamond, 1996: 5).

Performative and/or performativity – as ‘repetition or citationality’ – can normalize as well as transgress norms and orders. The boundary between normative and transgressive citational performances is slippery, to discern their differences is ‘deceptive, elusive, tricky’ (Langellier and Peterson, 2006: 156). It can mask the forming mechanism, normalizing the ordering of events, experience, identity and context. When used skilfully, it can subvert a normative practice, a mainstream formation, and lay bare the underlying structures. The potential space offered by the theory of performative is that it reveals to us an identity, and its practices are not ‘a fact of life, but are based upon repetitions and fabrications of human behavior’. Performativity may be seen as citationality, but it can also be ‘an intervention upon citationality and of resisting citationality’ (Madison and Hamera, 2006: xviii).

> Indeed, it is the instabilities, the possibilities for rematerialization, opened up by this process that mark one domain in which the force of the regulatory law can be turned against itself to spawn rearticulations that call into question the hegemonic force of that very regulatory law. (Butler, 1993: 2)

PART THREE

MY WORK – THE OPUS

7. The Research Design and Methods

After the investigation of theoretical disciplines in Part Two, the next three chapters (Seven, Eight and Nine) will be concerned with empirical research. This chapter focuses on the research design and methods that I have employed; Chapter Eight on the analysis of the data; and Chapter Nine on its implications.

As mentioned earlier, the main objective of this research was to investigate the long-term survivors' experiences of losing someone to suicide. More specifically, I wanted to explore the conditions and circumstances that contribute to various responses after the loss such as: (1) the many forms of negative responses to the adversity that had befallen the survivors (e.g. psychological and psychiatric symptoms), (2) the various positive qualities that were a part of the survivors' personalities before their exposure to adversity and which were retained after this exposure (i.e. resilience), and (3) the various new positive qualities and characteristics that they acquired as a result of being exposed to adversity (Adversity-Activated Development). The selection criteria required the participants:

- ✧ To be aged over eighteen years.
- ✧ To have personal experience of losing someone to suicide and consider themselves a survivor.
- ✧ To be willing to share their personal experiences and interact with other co-researchers in the sessions.
- ✧ The post-loss time needs to be at least 5 years.

- ✧ The participant will not be a person falling into any clinical category (i.e. that s/he suffers from any specific psychological or psychiatric disturbance). Those who have such a history and are still having mental health issues were excluded from participation.

The research design comprised an initial interview, a theatre group workshop and a follow-up interview. The rationales of the interventions at various stages will be explored in the section titled Empirical Work. From the outset, the choice of combining narrative and theatrical approaches was to investigate their methodological efficacy. This work is situated alongside an investigation of survivors' various responses and personal developments in reaction to their experience of loss. The merit of theatrical approach is that it allows me to expand upon the individual accounts of the survivors that I worked with and to include the collective voice. Thus the initial interview served as the assessment of their suitability for involvement as well as warm-up for the survivors to prepare them for the group work. The intention behind the formation of the applied theatre group was to create a space for collective exploration. The aim of the final interview was to reflect upon each group member's experience and their level of participation and to facilitate a process of closure. Next, the procedures of each stage will be outlined briefly. The procedures for the initial interview were as follows:

1. Sending out a recruitment letter (including information sheet and consent form, see Appendix A & B of Appendix 1) to the suitable participants. The participants were obtained via the contact list from SOBS (Survivor of Bereavement by Suicide) London.
2. After receiving the information sheet and signed consent form, the participants were invited to an interview by me for assessment purposes. They were asked semi-structured questions (according to the 'Trauma Grid') to describe their journey. One of the areas that the assessment focused on was the emotional readiness of the prospective participants and the existence of a sufficient support system for them.
3. After the assessment, suitable participants received an invitation letter, informing them of the date/time of the group.

The procedures of the applied theatre group were:

> After the interviews, the survivors were given the information about, and invited to join, the group (see Appendix D & E of Appendix 1). In the group, applied theatre methods were used, including myth/drama, movement,

> voice-work, enactment, painting and creative writing. The play *Romeo and Juliet* was used as an entry text for survivors to explore their lives after the suicide. A qualified therapist and I co-facilitated the group.

For the procedure of the follow-up interview:

> The group participants were informed and contacted for the follow-up interview. The focus of this second interview explored: (1) Whether this research helped the survivors understand their experiences (or not)? (2) In what ways did this research help the survivors understand their experiences better (or not)? (3) What contributed to their understanding (or not) of various responses? (4) What were the experiential differences of participating in the interview process (narrative approach) and the applied theatre group (performative approach)?(5) Finally, participants were asked to provide any relevant feedback they had for the researcher.

Ethical Issues

This section will discuss the ethical issues of empirical research interventions. I obtained ethical approval for my empirical work from the Centre for Psychoanalytic Studies at the University of Essex, where I conducted my research (see Appendix 1). Participating in the research has the potential to make survivors feel more vulnerable. This is due to: their original experience of trauma (having lost a loved one to suicide) as well as the fact that the main activities required them to reconnect with that painful experience. I tried to reduce this vulnerability to the minimum amount possible by recruiting survivors who have been bereaved for at least five years. Furthermore, the participants were recruited via the SOBS London group, which means that they would have repeatedly addressed their loss and its consequences. Although it was not stated explicitly, any survivors who might have exhibited psychological symptoms would not be invited to participate out of concern for their well-being.

During the initial interview, I explained the three stages of the participation and expressed to the interviewees that the project was for academic purposes. The participants were informed that they were free to

leave the research at any time without needing to provide any explanation or justification. If distress occurred due to the participation, I would refer them to see a therapist at the participant's cost. A particular intervention was set up for the theatre group that a qualified therapist collaborated with me, with a one-to-one follow-up session with the therapist for the participants if the need arose. However, the necessity for intervention from the therapist after the group never arose. Since I am also a survivor, I have been undergoing personal therapy from the beginning of the empirical work to the final stage of analysis and writing up, making sure any repercussions from the empirical work are processed with my therapist.

All information was kept in accordance with the Data Protection Act 1998. The Letter of Consent and Personal Information Sheet were saved in coded format. Interviews, art-work and video transcriptions were separately coded. The consent for recording the interviews and group sessions, and for using the materials for research purposes, was obtained from all participants. Moreover, materials were presented anonymously with identifying details changed or excluded.

The Empirical Work

I started to work with my participants from June 2012 and ended in July 2013. Through the dissemination of SOBS London, eight survivors had returned the consent form and information sheet; hence eight initial interviews were conducted (for the list of the participants, see next section). The average interview time was between one and two hours, with a few interviews going over two hours; five of the interviewees attended the applied theatre group which was split into two groups,

each group lasting from 10am to 4pm; and five follow-up interviews were conducted.

Before the interview, the survivors were asked to provide a brief biography in the information sheet. To prepare the participants for the theory of the Trauma Grid (TG), they were asked to write down as much or as little as they wanted to about how the suicide changed their lives in terms of negative, positive, and unchanged aspects. In the interview, survivors were asked to tell the story of how they first learned about their loved one's suicide. For instance, how did they hear about it? Who informed them? The interview questions were loosely structured according to the TG (see Appendix 2) which served as a template for me to navigate internally the scope of the narrative. Most of the survivors expressed the experience chronologically; the experiences that were narrated in the beginning were mostly negative (such as how shocked, how incomprehensible … etc.) and focused on the individual level. In principle, I followed the survivors' narratives. Once a sense of the story was felt, I weaved in questions about various responses other than the negatives, such as: "Are there any positive changes that you have noticed in yourself that are the result of the surviving journey?" "What positive responses have you developed as a result of surviving suicide?" "Have you experienced any positive changes to your family, neighbours, or the wider community?"

After the initial interviews, all the interviewees were invited to join a one-day group workshop. It was emphasized that the group was not a therapy group nor did it aim to be a clinical intervention. Due to the emotional depth of the subject matter and loss to suicide, the group was co-facilitated by a therapist, Emily Duval and me. Emily is also a survivor whom I knew through a bereavement workshop. The purpose of her presence was to safeguard the emotional wellbeing of the

participants; the homogenous experience and the therapeutic containment she provided were germane to the composition of the group. The applied theatre (AT) approach utilized in the group work included: physical warm-up exercises, games, and role-play. The day was comprised of four sessions with different tasks: warm-up (e.g. trust-building), main event (e.g. role-taking), reflection (e.g. group discussion), and grounding (see Appendix 3).

At the start of the first group session, I briefly outlined the details of the research project and explained that the purpose of video-recording was to assist me in remembering what went on in the sessions for future analysis and write-up purposes. Emily facilitated the discussion of safety, confidentiality, and ground rules (such as non-judgmental attitudes). After everyone in the group had an opportunity to introduce themselves, they were invited to share briefly whom they had lost and how their lives had changed since. The sense of transparency that came from the sharing and the ensuing physical warm-ups were used as a way of building up trust and creating a sense of group cohesion. Once the safety issues and trust had been sufficiently built up amongst the participants, we introduced the play *Romeo and Juliet*, and group members were asked to choose a role from it that they wanted to explore. The role could be from the existing characters in the play (e.g. Juliet's mother) or be created to the world of the play (e.g. Juliet's child)[56]. The reasons for choosing *Romeo and Juliet* are that it contains one male suicide and one female suicide which cover two genders; and the different familial and social contexts provide ample depth for the exploration of various impacts on family, community and society levels that are embedded in the TG. After an

56 The roles of Romeo and that of Juliet should not be selected since both of them killed themselves. The researcher felt it would take the participants to the issue of suicide rather than that of being a survivor, even though Romeo and Juliet were survivors for a short time, e.g. when Romeo found Juliet "dead", he was Juliet's suicide survivor; when Juliet woke up from the sleep, Romeo was dead, so she was also a suicide survivor. The participants were encouraged to take, even create, any role except these two.

introduction to the play and the selection of characters, the participants were given the template of the TG (see Figure 1) to aid them in understanding one of the main methodologies used in the research. They were also invited to use the theory to interview their fellow survivors.

To warm up the participants to get in touch with the surviving experience but not to get deeply into their stories, a hot-seat interview was utilized to assist their role-play. A hot-seat interview can be utilized in applied theatre or in dramatherapy. It is an exercise designed to help a person express their experiences through a role (rather than through a personal account). For example, once the survivor chose the role, she[57] was invited to sit in front of the group, and she said who she was (e.g. Romeo's sister). We then greeted her in the role chosen (e.g. "Hell, Romeo's sister, what is your name?") and addressed the incident of suicide, then the group asked her questions about her character's survivor journey according to the TG.

The following reflection and discussion session was similar to the method of a focus group[58], aiming to facilitate a discussion of contributing factors and of various responses. The participants sat in a circle and were given post-it notes (with three colours representing three responses). They were asked to write down one factor on a post-it note and at the end of the discussion the notes were

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57 All the group participants were female.

58 Focus group as a research method was initially developed in the work of the Bureau of Applied Social Research at Columbia University in the 1940s under the guide of Paul Lazarsfeld for marketing research. It can solicit the data on the 'meanings' and the 'normative understandings' that groups assume to reach their judgement. See BLOOR, M., FRANKLAND, J., THOMAS, M. & ROBSON, K. 2001. Focus Groups in Social Research, London, SAGE Publications Ltd. P. 4.

Focus group is simple and flexible and can be applied to 'essentialist' (e.g. to elicit participants' understandings, views of opinions) and 'social constructionist' (e.g. to explore how views/opinions/understandings are 'advanced, elaborated and negotiated in a social context') frameworks. See WILKINSON, S. 2008. Focus Groups. In: SMITH, J. A. (ed.) Qualitative Psychology: A Practice Guide to Research Methods. London: Sage. P. 188-189.

gathered and listed under various response categories (i.e. negative, positive, and 'neutral'). The reasoning behind this list was that the participants could have an overall view of the group contribution. This contribution represented a further digestion and processing of survivor–hood in a collective sense. The collective understanding also echoed the similarities in the experiences shared by the group while at the same time respecting and honouring the differences within the group.

The grounding session, which was made up of a combination of reflection and drawing, was aiming to prepare the participants for ending the group. Emily facilitated the group in a guided imagination, in which participants were invited to visualize their ideal futures. This intended generation of positive elements regarding one's future was intended to introduce "hope" to the traumatic encounter of suicidal loss, and to guide the participants towards focusing on their life and sense of self. Art materials (e.g. paper, crayons, colouring pens) were offered to create art works as a means of putting one's journey into symbols, which provide a container to carry their experiences forward. This grounding session was meant to provide care to the participants after a long day of work and make sure their transition back into reality felt smooth and supported.

The focus of the follow-up interview (see Appendix 4) was for the group participants to reflect on their involvement and engagement with my research. Participants were asked in what ways taking part in the group helped them understand their experiences. They were also asked in what ways, if any, that they felt the group did not help them gain a greater understanding of their experiences. In addition to this, they were given the chance to comment on the TG and what kind of impact they experienced with this theory and if the TG helped them in terms of their continuing journey. To conclude the interview, they were invited to review the different experiences between the narrative and the applied

theatre approach, and comment on the dual role that I assumed as survivor and researcher.

The Participants

This research explores survivors' experiences and the impact these experiences have on the wider environment. As a result of this, the ages, family histories, and careers of the participants were identified as relevant pieces of information to collect, along with information on the communities that they live within. I highlighted some elements in the following list of participants: when the suicide happened, the time span of the loss, the presence of other siblings and children, their nationality[59] (other than British), and their working status. I chose not to go into details about personal characteristics or history in order to reduce the individual's idiosyncrasies. This does not suggest that the individual process is not unique, but a strategic research choice in order to focus the lens of the study on specific contributing factors. The list is compiled according to the period of the loss in a descending order. All names are pseudonyms, whereas nationalities other than British are identified as European. Anonymity and identifiable elements have been changed in order to meet the ethical standard for protecting the participants.

- Angela is in her early 40s. She lost her mother in 1984 when she was 15 years old (29 year loss) in her country of origin. She is European and has an elder sister. Angela works as an artist.
- Vanessa is in her early 30s. She lost her father in 1994 when she was 13 (19 year loss). She is European but the suicide happened in Britain. She is the oldest child and has three siblings. She works full-time.

59 One's nationality and whether one lives in one's own country may reveal the availability of social networks and support systems, which may influence one's experience after the suicide, directly or indirectly. However, this is not as straightforward as it seems, as some survivors have shows great strength in establishing their lives in the UK where this empirical work took place.

- Daniel is in his early 60s; has 5 sons. He lost the 2nd son in 2000 at the age of 15 (13 year loss). He was a professional counsellor but took early retirement. He has been involved in youth work and has set up charitable organizations to help young people.
- Jessica is in her 60s; has 3 sons; was divorced in her 30s and raised her children on her own. She lost her second son in 2001 when he was 35 (12 year loss). He left two young children with his wife. Jessica is working part-time and taking care of a relative.
- Suzanna is in her 40s; she lost her first son in 2005 when he was 17 (8 year loss). She has been taking care of another son as she was separated from her ex-partner before the suicide occurred. A few years later, she got married to her boy-friend whom she had known for a year at the time of her son's suicide. She works as a massage therapist.
- Tracy is in her 60s; has one son and one daughter. She lost her 31 year old son in 2005 (8 year loss). He had been married for one year when he killed himself. Tracy is retired and has been travelling to her daughter's family and taking care of her grandchildren when needed.
- Jan is in her late 20s. She lost her mother in 2006 when Jan was 21 (7 years loss). She is the oldest child among six. She got married in 2012 and works full time.
- Becky is in her early 30s. She lost her only brother in 2008 while he was 33 (5 years loss). She is European and works full time as an office manager.

Narrative Analysis

A narrative methodology that employs poetic representation is utilized in this thesis. In Chapter Five, the discipline of narrative inquiry has been investigated substantially. To review, narrative inquiry is a qualitative methodology used to understand people's experience. It involves the reconstruction of a person's experience and an exploration of how this experience relates to those of others and to the wider social milieu (Clandinin and Connelly, 2000). As will be shown in Chapter Eight, the data will be presented in a poetic form combined with narrative elements. The poetic form adopted should not be confused with poetry proper. The effect of narrative inquiry is generated using rhythmic movement, linguistic

expression, and harmonious disposition[60]. The choice of poetic representation is based on the works of James Gee and Laurel Richardson.

James Gee drew on the oral tradition in sociolinguistics, using a poetic approach in order to analyse data, such as changes in pitch, pauses, and other characteristics in the speech of a woman who was afflicted with schizophrenia. He used poetic units, stanzas, and strophes to provide the narrative coherence that was lacking in her original speech (Riessman, 1993, Gee, 1991). Laurel Richardson reworked the text of an interview into a poem. The original words came from her participant and Richardson composed this material into a poetic form. She drew on poetic devices such as repetition, pauses, meter, rhymes and off-rhymes to present the subject's life as poetic. 'Poetic representation plays with connotative structures and literary devices to convey meanings; poetry commends itself to multiple and open readings in ways conventional sociological prose does not' (Richardson, 1992: 126). The innovation of poetics is that it can 'bring to language hidden aspects of reality' (Kaplan, 2003: 58).

Lyric poetry 'concretize[s] emotions, feelings, and moods – the most private kind of feelings – so as to recreate experience itself to another person' (Richardson, 1994: 9). The choice of the form of lyric poetry seems to be form that is especially appropriate for this work, since suicide is an emotional issue. In particular, a large proportion of what the survivors experience is the struggle that comes with huge emotional impact. To understand the nature of the surviving journey is to begin to feel a small part of what it is like to have lost someone through suicide. The purpose of using poetic representation is to invite the reader to experience, rather than be told or to read about suicide from a de-personalized

60 Since the 1960s, the harmonious factor has been expanded to include disharmonious ones, such as chance, discordance, noise, … etc. John Cage's music and Merce Cunningham's dance are two examples.

distance. It speaks to the heart of the readers; ‘there is a recognition that the effects of poetic art are connected to the psychology of the audience’ (Covino and Jolliffe, cited in Alexander, 1999: 108). It shows a ‘live participative embodied’ experience; it is a ‘felt-text’ (Spry, 2001: 709, 714).

The transformation of research data into poetry has the merit of ‘combining the realist with the poetic’ (Coffey and Atkinson, 1996: 126), and ‘aesthetics is at the heart of both artistic experience and qualitative research’ (Bresler, cited in Cho and Trent, 2009: 1014). However, there are two issues that need to be tackled: the researcher’s presence, and the inevitable fictionalization of narrative. Jim Mienczakowski cited the difference between the ethnographer making the ‘authorial presence‘ obvious and being a ‘conduit’ through which the researched story is ‘channeled’ (Mienczakowski, 1995: 371). For instance, in Richardson’s poetic dramas, the ethnographer’s voice was distinguished from that of the ethnographee’s and Richardson’s influence and skill on the script was perceived (Richardson, 1994). In his ethnodrama project, Mienczakowski reduced the subjective influence of the ethnographer by continuously validating the written text through performances. By editing the transcripts ‘creatively’, dramatically and ‘strategically’, I try to capture the idiosyncrasy of each individual (e.g. tone, gesture) while ‘maintain[ing]’ their narratives rather than to ‘re-story’ them (Saldaña, 2003: 223).

Fictionalization is another issue to be examined before providing the analysis. Fictionalization as a literary device has been used to maintain the balance between the validity of what is narrated and authenticity of the narrator (Mienczakowski, 1995). Clifford Geertz wrote that anthropological writings are ‘fictions in the sense that they are “something made”, “something fashioned” – the original meaning of *fictio*’ (cited in Barone, 2007: 458). The truth-fiction dichotomy

has been reworked by researchers and tends to be considered as a spectrum nowadays.

> [A] piece of fiction devoid of any connections with known reality would be incomprehensible. … [T]here is little point in clinging to the old distinction between fiction and reality as a frame of reference. The literary text is a mixture of reality and fictions, and as such it brings about an interaction between the given and the imagined. (Iser, cited in Barone, 2007: 459)

In some ethnotheatres, snapshots of fictionalized text were validated by the contributors (e.g. interviewees) and negotiated by the researchers to meet the demands of member check (e.g. by asking the participants to read the transcript or the text), examining the writing to ascertain whether the text was truthful to their experiences. Tierney wrote that ethnographic fiction 'helps to rearrange events and identities in order to draw the reader into the story in a way that enables deeper understanding of individuals, organization, or events themselves' (cited in Coffey and Atkinson, 1996: 127). It is pointless solely to be "faithful" to "reality" (Atkinson, 1992, Silverman, 1993).

The choice of maintaining the 'vraisemblance' – the sameness or 'plausible accounts' when writing ethnographic fiction (Atkinson, 1990) was made based on the coming-out culture of alternative sexual practice. The aim of alternative culture was to fight for a space for identity, experience, and subjectivity (Salazar, 1991, Felski, 1989, Butler, 1990, Miller and Taylor, 2006), rather than creating further veils which do not allow survivors to be seen and/or heard. Tom Barone wrote of the 'political' power of storytelling. He suggested that, for storytelling to be an ethical act, the researcher should try his/her utmost to reveal the 'connections between political forces and individual lives', especially the implicit connections that are not obvious to the participants (Barone, 2007). The space generated by the poetic form is different from that of fictionalization. The poetic space allows for the possibility of a deeper understanding, igniting our powers of perception while

engaging with art appreciation. It is ‘transgressive’ over traditional representational practices (Richardson, 1994: 8).

The Editing Principles

The previous section on narrative analysis provides the rationale for the choice of poetic and narrative representation, which is mainly the preservation of the emotional elements that are important in survivors’ experiences. It does this as well as providing an aesthetic vehicle to carry the weight, and generating suitable distance for the readers to consider the emotional relevance of what they are reading. Poetic and narrative representation allow the reader/audience member to acknowledge the experience of the narrator as ‘felt’, ‘lived’, and ‘embodied’.

To analyze the field text into research text is a subtle and delicate endeavour (Clandinin and Connelly, 2000). I have kept the following considerations in mind: What is the ontological change of the narrative message that results from minimal editing? How can I keep artful ambiguity and conceptual integrity without compromising the truthfulness of the survivors’ stories? How can the balance between ideological pursuit and social conscience be maintained? How can the narrative focus awareness on both suicide and the well-being of survivors without leading to a distorted sentimentality?

To achieve a satisfactory result, I first identified the narratives that contained various responses and transcribed the relevant parts before doing any editing. I have avoided over-editing, fictionalizing, or sacrificing survivors’ voices for the sake of artistic refinement. I chose to let the survivors speak for themselves and myself as a researcher remaining behind the scene. The editing effort is focused on (1) breaking down the emotional contents in order for the readers to feel the experience; (2) allowing that each stanza expresses a unified theme; (3) framing

their various experiences, responses, and developments after the suicide in the most honest way possible; and (4) emphasizing the rhythmic, repetitive, lyrical elements of the poetic existing in the interviewees' original expression.

All the verbal repetition and slang have been removed based on the following considerations: (1) the repetitive patterns and slang in verbal expressions may sometimes be redundant in written forms; (2) the emphasis and the emotion resulting from the repetition will be contained and felt in the poetic form. However, I am not claiming that it was, in any way, a straightforward or unproblematic task; there is a tension in the undertaking of integrating the political and the aesthetic that researchers need to be aware of (Barone, 2007). Nor am I claiming that the interview context and the order of the interviewees' narratives can be made transparent without complication. Actually, it has been a messy, dialogical and relational process (Craig and Huber, 2007, Hammersley, 1992, Josselson, 2007, Spry, 2001).

Next, I will give examples of how editing was done. Jessica is in her sixties; has three sons; was divorced in her 30s and raised the children on her own. She lost her second son in 2001 when he was 35. In responding to the negative impact from her son's suicide, she said:

> It's inevitable really that one is going to fall into a depression because any grief is going to be very difficult to cope with, if it's someone close to you, if it's somebody that you cared about, you know, then you're going to be, feel much heartache, but not necessarily of course, suicidal.

It was edited as:

> It's inevitable that one is going to fall into a depression.
> Because any grief is going to be very difficult to cope with,
> if it's someone close to you,
> or somebody that you cared about.
> You're going to feel much heartache,
> but not necessarily, of course, suicidal.

In terms of what helped her in a positive way, Jessica said:

> I did find it, the greatest help I had was in having a very good partner and soul mate who was very helpful and was more or less supportive, I think that was the biggest thing.

It was edited as:

I found that the greatest help I had was
having a good partner and soul mate who was very supportive.
I think that was the biggest thing.

Here is one example of resilience:

If anything has stayed the same, I guess it's my basic everyday life, my basic everyday life is more or less the same because, well, because we still have to go on, you still have to sort of do things, don't you?

This is the finalized stanza:

If anything has stayed the same,
I guess it's my basic everyday life.
My basic everyday life is more or less the same
because we still have to go on,
you still have to sort of do things, don't you?

8. Data Analysis

In this chapter, I will present the analysis of the data I collected and a discussion of the contributing factors to survivors' responses to suicide. The data analyzed has recourse to five resources: the application form (AF), the initial interview transcript (II), the group discussion (GD), the written feedback after the group (QA), and the follow-up interview (FI). Most of the interviews that I obtained in the empirical work were initially about negative experiences, responses, impacts and developments. This tendency is understandable since suicide is a negative and traumatic event for the individual and society at large. The relationship between the individual, the family, and society is mutual, reciprocal, and sometimes dialectical. For instance, as suicide is still deemed a taboo subject, this may prevent there being space for the bereaved to express what happened to them; if the individual cannot express clearly what they need after the suicide, this will result in the inability of the community to respond to them and their needs. The individual may then accuse the community of avoiding, silencing or implicitly shaming themselves or their family; hence, the subject matter is increasingly elusive for each party – the individual, the family, the community, and society.

We can imagine that if a community/society could assist survivors and the family to find a feasible way to live through the process, the 'neutral' and the positive development (the Adversity-Activated Development (AAD)) of the survivors would give people hope that it is possible to outgrow the pain. In the current unstable and uncertain world, natural and artificial disasters are endless; thus, loss to suicide is by no means the only, or the most devastating, or the most tragic experience one can anticipate. By exploring and establishing positive

developments, however, the model of the Trauma Grid can serve to examine the potential of humanity to adversity. It is also important to understand, acknowledge and be sympathetic to the negative impacts on the survivors before identifying any resilience or AAD.

If suicide shows the limits of humanity, the ability of survivors to find resources to cope with their adversity is an indicator of human resilience. It should be noted that resilience responses are included as part of the overall positive responses. It will be shown later that the factors contributing to resilience are more about finding resources to cope with the loss, while those of AAD have more to do with a cognitive process and awareness of humanity and existence. It indicates not only the intra-psychic processes (e.g. how one experiences the adversity), but also the coping strategies developed to meet interpersonal demands (e.g. how does one fulfil the needs of one's other family members while you are going through the bereavement together), and the reciprocal effects on and between the individual, the family and the community.

From the data gathered, it is relatively easy to identify how suicide impacts the individual and the family, but the impacts on the community or society as a whole are less clear or accessible and harder to evaluate from the individual point of view. Even if there is evaluation on the macro level from any individual, the validity or objectivity of the macro view would be subjective. The analysis hereunder will be presented by integrating the factors that occur on the individual with the wider community and society as described by the participants. It is important to reiterate the importance of the relational network and mutual influences between individuals and society at large. That the impact on the broader level is hard to evaluate does not mean there is no impact, whether negative or positive.

In the following analysis, I used the term “response” interchangeably with “development”, “effect”, and “experience”. When the data of the initial interviews is included, the narrative will be presented in a poetic format to capture the intimate one-to-one interview and the emotions/affects. This format serves as a vehicle containing the emotions of the interviewee, allowing readers to digest the depth of the narrative in their own time without rushing to read as mere information. The other data, including the final interview, will be presented in a narrative form to maintain the quality of dialogue, discussion, and analysis, while acknowledging the presence of others and/or the expansion of witness-testimony space. The parallel of two discrete forms is employed to trouble the expectation of a conventional, stable, or scientifically objective representation, laying bare the complexity of survivors’ narratives and the researcher’s authorial editing.

The data from the theatre groups was extracted from the contents of the group discussion. I left out the interaction among the participants and the individual processes they went through as a result of engaging with this project; that means the personal idiosyncrasies of the group members and the performative elements (e.g. what a survivor said in the initial interview and what happened in the group) were not analysed. Moreover, the processes of role-play and the art works at the end of the group were also left without being analysed. As mentioned in the previous chapter, the art works were used to help the participants to feel a sense of closure. Role-play as a dramatic technique can solicit a social actor’s inner state whose data can be used to compare/analyze the personal developments at various locations. In this research, the purpose of role-play is to warm up the participants for the collective discussion rather than to analyze individual narratives; the stance is different from that of dramatherapy (i.e. indirect, to embody a fictional role) and psychodrama (i.e. direct intervention of

issues, inviting participants to embody the role of “self”); therefore the transcripts of theatre groups were therefore not analysed or compared with other narratives.

Negative Contributing Factors

The negative experiences that were named by the survivors include: a huge amount of difficult feelings (such as feeling angry, guilty, shocked, ashamed, feeling judged, feeling blamed), difficulties functioning in daily life (e.g. sleeping problems, loss of appetite, unable to fulfil the routine tasks), the loss of strength (e.g. loss of motivation, unable to concentrate, inability to cope), pathology formation (e.g. depression, dissociation, feeling suicidal, excessive substance consumption). Outside the realm of the individual, the structure of some families was deteriorating. This took the form of family members either blaming each other or leaving the individual to struggle alone on the bereavement journey. In terms of negative experiences regarding the community, the major theme was the community failing to respond to and care for the survivors’ needs, as a result of its struggle to digest the incident of suicide.

The contributing factors are summarized as:

1. Individual vulnerability and environmental deficiencies before the suicide and after (which include the time when the suicide happened; plus the immediate problems in the environment before and after the suicide).
2. The barriers that prevent survivors receiving support from others (including survivors not having the language to articulate the experience; the severance of the connection with others; and others’ incomprehension of the loss and of the survivors’ needs).
3. External pressures preventing the grieving process (including the need to work before being ready; and having to prolong one’s grieving process due to external demand).

Individual Vulnerability And Environmental Deficiencies Before The Suicide And After

This will be discussed under two headings: when the suicide happened, and the immediate problems in the environment before and after the suicide.

- When the suicide happened

It goes without saying that it matters a lot when the suicide happened. The meaning can differ according to whether the person is a young child, an adult, or elderly. This rough differentiation is based on the different focus and tasks for different life stages (Erikson, 1963/1995). The suicide may influence a young person whose development toward adulthood is coloured by the loss to suicide. For instance, Vanessa is in her early 30s. She lost her father in 1994 when she was 13. In the group discussion, she shared that 'I'm pretty young, in a difficult time, going through change in myself, mentally and physically'. Angela is in her early 40s. She lost her mother in 1984 when she was 15 years old.

> At the end of the day I was still a child.
> I think my father, my sister, my grandparents,
> they forgot I was still a child.
> They left me on my own so much.
> There was just nobody who looked after me really
> while I was still a child. [pause]
> I felt I never had any support. (Angela, II)

In Angela's experience, the people surrounding her were unaware of her developmental stage and needs. Her surviving journey has been intertwined with arrested development: her development was interrupted, and she was therefore unable to complete her developmental needs. As a young person struggling to develop her identity, she not only lost the care, love and support that a daughter may receive from a mother but also a model of womanhood. It is also difficult for the elderly who may see themselves nearing the end of their lives and who have fewer life events to imagine in their future. Becky is in her early 30s. She lost her

only brother in 2008 while he was 33. During the interview, she mentioned the struggle that her mother has been living with:

> She [B's mother] has been very depressed,
> she struggles every day.
> She can't understand why her son's not here.
> In that respect it's really separating us
> because she can't see a future.
> She says to me, it's because I'm young;
> maybe suicides affect older people differently because of their age.
> She says, "I'm 65 and I've nothing to look forward to
> other than to question every day why my son killed himself.
> You're 32 and you'll get married, you'll have children,
> you have a future.
> You get up,
> you go to work.
> I can't get up;
> I don't have a job;
> I don't have a family to look after.
> I get up every day,
> I sit at the breakfast table
> and I question why my son decided to kill himself". (Becky, II)

It is important to point out that the factors in one's development after the loss, both positive and negative, are multiple. No single factor can claim to be the main cause. Similarly, suicide in different life stages can mean different things for survivors. For young people, who have to develop themselves in order to face the world and their future, losing a parental figure is as painful as losing one's child for adults and the elderly, who would be deprived of the joy of seeing their children and grandchildren grow up. While facing old age and deterioration in health, diminishing social life and resources, losing one's child to suicide can be the most devastating experience a parent can undergo.

◆ The immediate problems in the environment before and after the suicide

Although it is not uncommon to identify some existing problems before the suicide, this is not to suggest that the family or the survivors are the ones to blame. Angela recognised the problems between her mother and father years later after the suicide and believed that her mother's suicide had something to do with her father and the family dynamic. After the suicide, she even needed to take care of her father.

After my mother died, my father said:
“I’m not going to stay at home grieving”.
Every night he went out drinking and chatting up women.
He was like this big Casanova, a playboy in the pubs.
I had to do these difficult studies
and he came in my room and disturbed me every evening.
I had to be a therapist for him.
He constantly threatened to kill himself in front of me.
Often he was crying,
sitting there in my bedroom crying, when he was drunk:
“I miss your mother”.
When he was sober he never expressed his feelings.
Nobody ever listened to me.
It was all about him. (Angela, II)

The family has subsequently disintegrated; and from what Angela said, the unhealthy dynamic in the family had contributed to some pathological symptoms.

So all of a sudden my father and my sister
were playing mummy and daddy.
This whole family that I grew up in and I felt was so perfect, was not.
It brought life to a standstill.
It brought a shock to my development.
They made a scapegoat of me,
punished me,
didn’t let me develop my life.
They just vented all their anger and their sadness.
They took everything out on me.
They projected all their badness on me,
I think I started to collapse under all that pressure. (Angela, II)

Not only was it that her father ‘started drinking straightaway’, but also her sister ‘became obsessed with cleaning’, and the family ‘was completely derailed’. Her mother’s suicide also influenced a neighbour’s daughter badly.

She was close to a child who lived opposite our house.
The girl was 11.
This little girl had to go and see a therapist
because she couldn’t cope with it.
My grandfather died soon after of cancer. (Angela, II)

Jan lost her mother when she was 21. She needed to become a maternal figure for the other siblings and shared the duty with her father. In a way, this forced her to be grown up:

I felt I’d lost a lot of my innocence.
I felt a little bit cheated,
I had to, suddenly, grow up,
the naivety that I had before was lost.
So I felt a bit sorry for myself,
for not having a mum around is really difficult.
I felt I wasn’t free anymore.
I had a duty towards my family,
I couldn’t just be young and just go out whenever I wanted;
I had to think about the rest of the family in a kind of mother way
I felt resentment … I was too young. (Jan, II)

Barriers To Receiving Support From Others

The barriers to receiving support from others can be at least twofold – from survivors themselves and from others – and the effect is reciprocal (e.g. being unable to express what one needs, results in the other's failure to offer help). The analysis will be discussed under three subthemes: survivors not having the language to articulate the experience; the severance of the connection with others; and the other's incomprehension of the loss and of the survivors' needs.

◆ Survivors do not have the language to articulate the experience

Suicide was and is still a taboo subject, even though the attitude towards suicide and survivors is more sympathetic. As Becky said, "You don't sit there with a glass of wine over dinner and say, 'Have you thought about killing yourself recently?' You don't talk about those sorts of things". It is important that people learn that survivors have difficulties articulating the experience.

> I wasn't really talking about how I felt about it to people.
> I was just completely and utterly devastated
> and I found it a bit too much to cope with,
> I find it very hard to articulate what I feel about it anyway.
> It's too big …
> it's too … difficult and painful to talk about really.
> Everyone was really sympathetic;
> my friends were waiting for me to come and talk to them.
> They were all saying, "Call me".
> But I didn't …
> I just found it too difficult to talk about;
> I just tried to forget about it;
> just be in my own space;
> and just cry about it for hours. [pause]
> It's hard to explain
> because there are so many different emotions. [cry]
> I think that no-one understands what you're going through. (Suzanna, II)

The internalization of negative interpretations of suicide also contributes to the inhibition of talking about suicide, rendering acceptance more difficult.

> My mum told her best friend that Gordon died in a car crash.
> But I told her the truth.
> Mum was very, very angry with me for having told her that he committed suicide.
> I said to her, "you've known this woman for 35 years, mama,
> why would you lie to her?"
> She was like, "because I'm ashamed of what my son did". (Becky, II)

Sometimes there may be a cost to bear in an environment in which it is not safe to mention suicide.

> When I started that new job, I felt like I couldn't tell people
> because they were going to judge me,
> and because they didn't know me and because at the start of this new job,
> I felt like I was being judged anyway,
> I didn't feel comfortable to tell people,-
> rather than seeing you as a survivor and that you've been through a lot
> and it's a positive thing.
> You worry that people will see it as a negative thing,
> and then start thinking that you're emotionally unstable,
> or that you can't cope, or, I don't know, I just [cannot tell them]. (Jan, II)

The impact of suicide is beyond the individual, for the broader community feels implicated as well:

> Even if it's just a small group of people that … Joseph's death has affected, because everybody felt guilty, it wasn't just me and my immediate family. Even family friends felt guilty, well, [they thought] what could I have done? I could have helped him and made him feel better or whatever. (Tracy, GD)

- The severance of the connection with others

Suicide sometimes creates an irreconcilable break or a hiatus in the existing connections between family members. For Vanessa, the loss of her father came with the loss of the relationship with his family:

> When it first happened, they didn't want to have anything to do with my mum … they demanded we gave things back … we didn't speak for quite a long time. (Vanessa, GD)

Becky and her parents had been entangled in blame, their connection was broken, and they could not comfort each other when they needed each other the most. Each one was left to cope with the tragedy alone.

> There's a lot of blame as well.
> My mum was blaming my dad;
> My dad was blaming my mum;
> they then blamed me.
> We were just blaming each other.
> For a while I thought I'd never be able to speak to my mother again
> because we were pulled apart.
> I was angry with my mother and my dad
> because I wanted them to be there for me as parents.
> I wanted them to support me for having lost my brother.
> They couldn't because they'd lost their son.
> For them it was also overwhelming grief that
> they couldn't deal with.
> They were in their own state of grief
> and they weren't going to be there for me;
> because they couldn't even be there for themselves.
> It was a very difficult time.
> That went on for at least two years. (Becky, II)

◆ Other people's incomprehension of the loss and of survivors' needs

As mentioned earlier, the incomprehension of others of the extent of the survivor's loss becomes an obstacle to mutually supportive communication, and this effect is reciprocal. A vicious cycle of miscommunication can take place when mutual avoidance between survivors and others occurs. Suzanna mentioned one of the aspects of her experience was 'not being understood and not being allowed to feel what you are experiencing'. People do not want to, or know how to, bring up the subject of suicide, worrying that it will upset survivors. In consequence, either no one talks about it or they end up by saying the wrong things:

> For the first few years, it was hard to talk about it. I have a huge amount of guilt for not being able to protect my son. I felt a massive failure. But whenever I did try to talk about how I felt, when I said I feel guilty, everyone would say, 'no, no, don't feel guilty. It's not your fault'. But I do. For God's sake, I just want to say I'm guilty. I know it's irrational. I've been emotional. My son has just died. …Everyone was just trying to make it better. (Suzanna, GD)

Tracy recalled the experience of going back home and visiting her own community while her sister accompanied her. Both Tracy and the other people avoided talking about it, and she used visiting the supermarket as an example:

> Going to the supermarket,
> you always meet people that you know.
> I felt like: 'Oh God, I still don't want to talk to people'.
> Nobody really wants to talk to you either.
> They must feel like, 'Oh my god, here she is, what am I going to say?'
> I know it's very hard for them;
> that's why I appreciated the fact that so many people
> extended their hands in friendship
> when it must have been very, very uncomfortable for them.
> They did what they could. (Tracy, II)

External Pressures Preventing The Grieving Process

Suicide does not happen in a vacuum, and survivors are left with many things to juggle with: from the immediate decisions about the funeral, how to deal with the deceased's belongings and possessions, attending the inquest, and in some cases how to make a living when the deceased was once the main wage earner. The survivors may be forced to go back to work before feeling ready due to certain

constraints, or one's grieving process may be prolonged due to external demands, such as needing to take care of another family member.

- Needing to go back to work before being ready

Suzanna mentioned the pressure of going back to work before being ready. She had bills and rent to pay, and she also needed to take care of another son who was deeply traumatized by his brother's death. Angela was asked to complete her studies, which she found difficult to continue.

> The first year I was trying not to think about it.
> Just get on with life as it was.
> At school I used to do well
> with these heavy studies of Latin, modern languages and mathematics.
> I was in the fourth year, I still had to do two more years.
> I asked my father if I could do something less difficult.
> I'd gone through all this,
> I wanted to take it easier.
> I felt that I was not the same person anymore.
> I said to my father, "I want to study something easier now".
> He didn't allow this.
> "No, you have to finish your Latin studies".
> These studies became more and more difficult.
> I became more and more nervous
> and insecure.
> I became more and more derailed
> because I was trying to stay strong.
> I had this mask on,
> and it really started to crack.
> I became very anxious,
> depressed,
> at one point I suffered from facial tics
> and at other times I would hyperventilate.
> I continued to have problems with concentration.
> At school I was often very dreamy,
> looking outside the window.
> If I was not dreaming, I was a rebel,
> I started to make a lot of trouble in the classroom. (Angela, II)

- Prolonging one's grieving process due to external demands

Suicide influences the family members in different ways. For Suzanna, it entailed looking after her other son by herself because her ex-partner was unable to support her:

> My son's Dad was unhelpful in the aftermath of our eldest son's death which made it very difficult for me to cope on my own. … it's really disappointing …he dealt with his grief in a very different way … he was wrapped in his own grief, not really helping at all. (Suzanna, GD)

Suzanna had been in a relationship with her then boyfriend for one year. Although he had stood by her and supported her along the journey, and a few years later

they got married, for her at that time trying to maintain a new relationship after losing her son was extremely demanding. In the group discussion she said, “At that time I felt a massive pressure to be a girlfriend, to be in a relationship, I was in a mess, I didn’t have anything to give anyone”. However, Suzanna reckoned that being distracted from her own grief due to the external demand of taking care of her other son prevented her from indulging in her own pain. She put her son’s needs before her needs. This may have prevented her from grieving, for it kept her ‘going’, which in the end contributed to her resilience response. The reversal of negative and positive responses is an interesting phenomenon and will be discussed later.

Becky mentioned that she felt she needed to take extra care of her parents, since she became the only child after her brother’s suicide. It was so difficult for her that she even developed suicidal ideation.

> Yet all the while you're trying to remain normal
> in front of other people.
> You have all these thoughts going through your head.
> I was trying to support my mum and my dad,
> listening to them and how they felt.
> I had this pressure on me --
> the pressure to be the strong one;
> be the bond in the family;
> be there for everybody else;
> help them deal with what happened.
> I felt really lonely in what I was going through.
> No one understood.
> I felt like I couldn’t see the light at the end of the tunnel,
> just that everything was very blackened,
> that it wouldn’t get any better.
> I felt like that for eight to nine months. (Becky, II)

Contributing Factors of ‘Neutral’ Responses

In the Trauma Grid “resilience” is used interchangeably with the term ‘neutral’ responses. It refers to one’s strength; positive qualities, characteristics and capacity to function that existed before the adversity and have been retained

afterwards, even though one may have lost any of them temporarily. As iterated before, resilience – 'neutral' responses categorized in the TG – is considered part of a positive outcome of one's surviving journey. Resilient responses result mainly from one's ability to find resources to cope with the extreme difficulties in life after the suicide, which emerge more from the interpersonal sphere and can be observed from the outside. AAD, on the other hand, results from the expansion of personal boundaries and the spiritualization of the individual, which is more intra- and transpersonal. It can also result from the politicization of personal values which is toward social engagement. In both cases, the cognitive process is involved.

As shown in the previous section, survivors experience a huge amount of negative emotions and incidents after the suicide, and the reported 'neutral' reactions from the participants (including AAD) should be understood not as inevitable, but as a consequence of the strenuous effort to maintain the structure after the rupture. The factor of time in the analysis of 'neutral' and AAD is also important, meaning that the responses identified here are not a conscious choice, but an organic result of the personal and the existing resources to help survivors get through the days (and hence, are mainly interpersonal). What this means is that survivors' resilience is formed by engaging in tangible tasks, such as following a routine to keep themselves going. It also has to do with maintaining one's identity, which ensures daily jobs are completed and one's social position is stabilised. In terms of personal elements, a positive attitude towards life (e.g. seeing the glass half full), a willingness to accept one's personal limits (e.g. things in life are not fully in one's control), and a limited but barely enough energy to engage with the outside world are of importance. The existing available structure, the access to support and engagement in simple tasks show the significance of

the social network in helping improve survivors' well-being and to maintain their level of functioning.

The factors contributing to one's maintenance of resilience, or one's ability to find the resources to maintain one's adaptation, or re-obtain one's resilience after losing the capacity temporarily are:

1. Making good use of the existing support (from family, friends, and work) and security (such as financial security).
2. Seeking available resources (undergoing therapy; understanding suicide by reading and/or by joining a support group).
3. Developing and maintaining effective coping strategies (ability to focus on reality; identifying progressive cultural values).

Making Good Use Of The Existing Support And Security

Support from family members and friends, from work, and the security provided by significant others are key factors to resilience.

- Support from family and friends

Suzanna said, "My boyfriend of a year standing by me through very difficult times [of losing my son to suicide]". The fact that he had been with her solidified their relationship and they got married some years later. Jessica mentioned how important it was that her then-partner was there for her.

> There was nothing I found that anybody could do to make things better for me, to make me feel better. In looking back, I found that he was able to help me simply by a) being there, b) listening to what I had to say and taking on board, and c) just helping me in the smallest of ways, like offering a cup of tea as soon as he saw me. "Come in, sit down, would you like a cup of tea? Would you like a sandwich?" He would take me shopping. It was just the smallest of things but I found in looking back they were the biggest things that helped me in the end. [He] took away a lot of my worries, and much of the stress ... (Jessica, GD)

The caring attitude from the community can sustain survivors when they are going through critical moments:

> One of the neighbours I'm very good friends with
> her mum was very good at the time as well,
> she was always asking me, "Are you okay, you sure you're okay, you sleeping okay?"
> Other neighbours my mum was friends with
> they were always stopping to speak to us and asking if we were okay.
> Some would come to us and say, "Oh, I remember your mum, like, I miss her and.."
> Which is quite nice. (Jan, II)

- Support from work

Tracy went back to work quickly.

> My way of coping was I wanted to get back to work really quickly. I felt as if I needed a structure, I needed something to get up for in the morning. So I went back to work. I was fortunate in that people were very supportive and I was able to work which surprised me a bit. (Tracy, GD)

Not only going back to work helped, but also the support and understanding from the company helped survivors to get on with life more smoothly:

> They [the company] did give me the opportunity that if I was upset, I could leave my work station, take myself off to the lady's cloakroom to recover, or to the canteen to recover myself. So going back to work did help, I think. Just have things to do, to keep your mind off it, rather than just sitting around and grieving. (Jessica, II)

- Financial security

Vanessa lost her father, but fortunately the family had the house. Her mum continued to work, so that they (her and the other siblings) did not have the worry of losing their home. The relative sense of security from this financial stability did prevent Vanessa from compromising her development, and it also provided for therapy that was needed at times. Even though only Vanessa indicated the importance of having the financial security that contributed to her resilience development, it can be observed indirectly how financial security helps survivors. For instance, Angela has received therapy for years; Tracy also acknowledged being helped by therapy; and Becky obtained therapy through insurance at work. They all required an adequate budget to pay for the fees, which brings us to the next factor.

Seeking Available Resources

Receiving therapy was not the only way survivors sought help in processing their grief. Survivors tried to understand suicide by reading relevant literature and/or joining a support group to digest the experience. They may not have found the answer to why their beloved took their lives, but they found reading helpful as it validated their feelings and reactions. At the same time, they discovered that

suicide happened to other people as well; i.e. they were not alone. Before embarking on a further discussion on the value of literature to survivors, let us first see how Becky thought therapy saved her:

> I went to speak to a counsellor
> through my private medical insurance at work.
> I had the best counselling I could have asked for.
> I was very lucky.
> She was a bereavement counsellor,
> specially trained in suicide bereavement.
> I still say my counselling saved me.
> She saved me because she gave me an outlet to speak. (Becky, II)

However, it also needs to be pointed out that some survivors felt the bereavement counselling, normally referred through their GP and which only lasted for 6-8 weeks, was not helpful. This was partly because the counsellors did not understand how survivors were affected by suicide and conducted the sessions within the framework of a general bereavement approach (i.e. aiming at letting go of the attachment with the deceased).

- Understanding suicide by reading relevant literature

Tracy shared how reading helped her to understand more about suicide and about her own experience:

> I didn't know anything about suicide. So I started reading every book I could get my hands on about it, and all of a sudden I realised from these books that it was not uncommon and that the feelings... and I think that was what it was, it was validating all those negative feelings that you have. The shame and the guilt and I wish "I would have and why didn't I", sort of thing … (Tracy, GD)

Developing/Maintaining Effective Coping Strategies

Some survivors developed coping strategies, mainly due to external demands. However, the ability to focus on reality without giving in to the gravity of grief requires the re-existence of certain personality characteristics. The internalization of progressive cultural values may also contribute to one's effective coping strategies.

- Ability to focus on reality

> Just having things to do,
> to keep your mind off it,

rather than just sitting around and grieving.
Because just to give in to the emotion,
just to sit and grieve,
is not going to ultimately help you to overcome the problem.
You need to try and make the effort
to pull yourself together
and do something,
anything,
even if it is just doing the washing up. (Jessica, II)

Jessica also mentioned the importance of going out and socializing with other people. For Suzanna, looking after her younger son helped to 'keep [her] going, keep trying', although it may have prevented her from grieving in her own terms: 'I have to keep focus, keep myself together to look after him because he was in a mess'. Tracy went back to work to find a structure for herself, and her "glass half full" personality was crucial:

My general approach to life has always been:
to look on the positive side -- the glass half full approach.
I don't get upset very easily,
I'm a middle of the road kind of person.
Because of this I was more able to take a more balanced view of it.
I was like 'wow, gosh, it's awful', but it's happened.
You just have to live with it.
I take a very sort of fatalistic view of life:
that bad things will happen.
The general scheme of life is:
you don't know what's going to happen;
whatever happens,
you just get on and deal with it.
This attitude is still the same for me.
I put the negative incidents to the back of my mind and
try and focus on something else. (Tracy, II)

- Identification of progressive cultural values

There are two layers of progressive cultural values. In a normal situation, human beings would seek development, growth and have an orientation toward the future (Weiner et al., 2012), although it is debatable whether the future-oriented tendency is biological or cultural (Richardson, 1999). It is fair to say, however, that humanity at large has always emphasized continuity and coherence. The opposite development towards inactivity and/or death is considered unnatural or pathological, and sometimes is due to inadvertent mistakes (Yule et al., 2000, Neimeyer et al., 2006a). When one encounters an extreme, adverse event, it brings shock to the living system and hence the internalized value system is

questioned. Yet, if one chooses to survive and wants to survive well, s/he may choose to readjust her/his inner value system, or to re-identify a value that fits life after the loss and to continue the journey after the suicide. Jan mentioned that her personal characteristics remain unchanged: she lost them for a while, but she has now reclaimed them and is determined to have a happy life:

> I've always been very hardworking and conscientious,
> I've always studied a lot,
> always made sure that everything that I do,
> I do it the best standard that I can.
> I've always been quite headstrong
> and I've always known what I've wanted.
> I've got quite a strong character,
> once I make up my mind to do something, then I'll do it.
> If I make up my mind to, like, I'm going to live a happy life,
> then I'm going to put steps in place to do that.
> and I'm quite determined,
> I try to be quite rational, sometimes if my emotions get the better of me,
> I try and talk myself into a normal state again. [laugh] (Jan, II)

The second layer of progression refers to a narrower definition of progressive culture that is coloured by the ethos, ideology and consensus of a specific period and a particular country. For instance, a wider historical development since the "second industrial revolution" around 1870-1920 has the 'progressive' value – aiming to grow and expand rather than sustain and maintain – embedded in modern life (Armstrong, 2005). The "British" characteristics of most of my participants might indicate implicitly the progressive culture of Great Britain. It refers to the social, economic and political developmental attitude of Great Britain after the Second World War, which is to counteract the decline of imperialism and colonialism (More, 2006). Suzanne identified that the internalized progressive culture has helped her to keep going and stay 'strong'.

> My Mum was brought up in the generation of living through the war,
> with a stiff upper lip.
> My mum used to say, 'Keep going dear!'
> I didn't get a lot of emotional support from her,
> although she helped out financially with things like paying for the funeral and stuff.
> It was so difficult for her to talk about it
> because we'd never really talked about emotions.
> We'd phone up and check up on each other,
> it was all a bit sort of formal. [pause] (Suzanna, II)

It is ironic that the forward movement came with the sacrifice of emotions, but this is not necessarily the case, for it could also just be the personality. It is clear that the maintenance of a progressive value system helps survivors to adapt well to external demands after the loss.

Contributing Factors of Positive Outcomes

In contrast to the negative experiences, which survivors were able to identify easily, the naming of AAD required an effort of analysis and reflection. To begin with, no survivors would like to think of any positive outcomes resulting from the loss, and it is rather a choice out of “no choice” (Suzanne). Daniel expressed it this way:

> People are sometimes amazed at how parents can go on living an ordinary everyday life after such a heartbreak and tragedy. There is nothing normal about it, we go on and keep on doing because we have no other option. (AF)

However, bringing the theory to the survivors and talking about it inspired them to review their process, to evaluate their journey and to reflect upon it. Tracy commented that ‘you don’t even realise it [AAD] is happening, you know, and then all of a sudden you realise that you’ve really improved in that area’. As mentioned earlier, in contrast to the ‘neutral’ factors which help to focus on functioning, those contributing to AAD result from cognitive processes, the expansion of one’s consciousness, personal boundaries, and the spiritualisation of the individual which are more intra- and transpersonal, and the politicization of personal values which are orientated toward social engagement.

The formation of AAD takes a longer time and is not easy to recognize because of the subtle quality in the attitudinal changes to life, humanity,

suffering and death, if not in the proactive responses to social engagement. To make meaning out of the suicidal loss to a satisfactory level depends on the gradual formation of AAD. As mentioned in the sections on positive growth and Jungian psychology, the potential to transcend or go beyond traumatic loss is part of our psychic development. Some survivors seem able to achieve more or less qualitative changes in their personality and life by being given enough space and time to digest the loss and integrate the experience; to let it become part of them.

Overall, the factors that contribute to AAD include:

1. The determination to outgrow the pain.
2. Identifying the inadequacies of a utilitarian or operative attitude toward life and seeking changes (deeper understanding of suffering and humanity and elevated awareness of self and others; the transcendence of personal boundaries and the assumptive world; the re-spiritualization of the individual; and the politicization of personal values).
3. Saying “yes” to the future (looking after oneself; setting up goals for the future).

Determination To Outgrow The Pain

Many survivors mentioned that they did not want the loss, the suicide, and the pain to be wasted, which means they struggled to reach a point where they decided to “create” meanings from the experience. Tracy in the group discussion said, ‘I just got so determined that I didn’t want this thing to have happened for nothing, and I thought, I’ve got to get something positive out of this’. She went on to set up the first support group in her local area to help other survivors. She took the initiative to offer support after hearing that some of her colleagues had experienced loss to suicide or other types of loss. It seems survivors have experienced the greatest pain and have felt profound vulnerability, which results in the determination to find a way out of the misery. Suzanne shared in the group discussion: “I am not going to let

this destroy me, you can see how easily it can destroy people and people's lives together… I'm not going to let that happen". Jessica illustrated her process:

> I got to a stage where I was sort of accept[ing] it. I think it's the acceptance stage, you know, the neutral, is when you accept and finally you know this has happened and you've got to make a decision, am I going to go on or not go on? So that was what happened for me. I decided that I would make the effort to go on. (Jessica, GD)

Jan wrote in her application form:

> I was very determined I did not want it to have a negative impact on my life and try to look on the positive side. At first I found it hard to deal with issues I was having and related everything back to what had happened. However, now I feel it has made me able to cope with difficult situations much better as I have developed coping mechanisms. (Jan, AF)

Cognitive assimilation, will, and determination prove to be the important factors for AAD. It is not a sentimental attitude, but something that has solidified in their minds, which makes survivors choose a stance, i.e. to decide they will outgrow the pain; they will not let the pain be the end of the story. Vanessa in the application form wrote that 'I have a strong desire to use my experience in a positive way so my father's death was not for nothing'. After losing his son, Daniel set up a charity involved with suicide prevention, especially for young people.

> We [Daniel and his ex-wife] began to see that there is a frightening gap in general knowledge and awareness of these issues and that provision of services for sufferers is woefully inadequate and yet suicide is the second highest single cause of death in young people! All our newfound knowledge was too late for us to save our son, but we had identified an area of need that could possibly prevent another family suffering the same devastation as our own. And so the idea of [charity] began. We want to make a difference. We want to fill the gap of ignorance. We want to see a reduction in youth suicide and we want young people to feel good about life and themselves. We want that there are services and support available at the time of need. We want to catch them before they fall. (AF)

Identifying The Inadequacies Of A Utilitarian/Operative Attitude Toward Life And Seeking Changes

After recognising the insufficiency of their previous attitude to life, survivors take actions to make changes. The themes of these changes include: a deeper understanding of suffering and humanity and elevated awareness of self and others; the transcendence of personal boundaries and the assumptive world; the spiritualization of the individual; and the politicisation of personal values.

- Deeper understanding of suffering and humanity and elevated awareness of self and others

Becky spoke of the experience making her 'realise life is short, that every day counts, it has helped me realise you shouldn't sweat the small stuff, that means not pay importance to trivial and minor matters that generally stress others out'. Understanding humanity and suffering deeply helped Jessica put things in a new perspective:

> You just put different values on things.
> You sort out what is serious and what is not.
> You suddenly realise that
> life is so much more precious than a material object.
> But we don't necessarily see this,
> when we haven't had the experience
> of losing someone very, very close
> or losing someone in tragic circumstances.
> You realise there are far greater pains in life,
> there are things that hurt us so much more than other things.
> You learn what to value and what isn't of such great value. (Jessica, II)

Angela has more respect for other people: "I suppose they give you a lot more wisdom. I'll never laugh at other people's misery" (Angela, GD). For the elevated awareness of self and others, the suicide made these survivors feel that there was nowhere to hide. Tracy said, "You can no longer fool people, right? You're so exposed, and you're just so vulnerable".

> I've become a bit more tolerant. [laugh]
> Just in general, of people.
> I no longer take things at face value.
> I once made judgments about how people are,
> thinking: 'Oh, well, they shouldn't do this, or they shouldn't do that'.
> However, you just don't know what is going on in people's lives. (Tracy, II)

This elevated awareness can manifest in different ways. For Tracy, she became more tolerant, whereas for Becky there were changes of priority in regard to her values.

> It has developed my empathy with others in some respects, of what it is to lose someone you love so much. Although having said this it has also given me impatience with others i.e. I can't understand how they get so upset by minor things … I also have become much less patient to people's ignorance on the subject of suicide and have tried to "educate" people as much as possible. (Becky, AF)

- The transcendence of personal boundaries and the assumptive world

Tragic events do shatter people's assumptions about the world (Crossley, 2003). The world is no longer stable or safe and is open to change. Death through suicide expresses a strong message that the world is discardable, which goes against the human instinct of striving for survival. Moreover, the question of where the deceased go after the suicide opens an unknowable and mysterious space in which survivors question whether there is a continuation of consciousness after death. Tangible reality is not the only reality any more. The encounter with death opens the whole tapestry of life and death, and the profound paradox of existence. For Suzanne, it means having 'greater awareness of the spiritual aspects of life and death; thoughts on the afterlife; more open to ideas'. It also means finding a continuing bond with her son:

> I went to see a clairvoyant medium lady a few times
> which I found really helpful.
> I don't have any religious belief.
> I've never had any clear thoughts about what happens after somebody dies. [pause]
> Is there an afterlife?
> I guess that helped me feel more connected to Billy,
> feeling like there was [pause]
> that possible communication between me and Billy.
> I found that really comforting. [pause]
> He hasn't gone;
> he is in your memories and your heart.
> He's still there. [pause] (Suzanna, II)

Angela pays more attention to her internal world and dreams:

> I've always been a bit psychic,
> and I do have positive dreams about the future.
> I always had a lot of dreams to guide me.
> Although I have been very low and hopeless,
> there has always been a voice in me
> saying that there is still hope.
> The voice that speaks in my dreams,
> visions that I see in meditation. [pause] (Angela, II)

- The re-spiritualization of the individual

Some survivors feel ambivalent about religion, particularly about Christianity which associates suicide with a sin and teaches that the deceased will suffer eternally in hell (Murray, 1998), even though in the Bible this is never stated explicitly (Rubey and Clark, 1987: 151-2).

> The thing that bothered me,
> really, really, really bothered me when Joseph died,
> was that according to the Catholic religion,
> you went to Hell, it was a mortal sin.
> The Catholic church is so dogmatic;
> it used to be very dogmatic.
> What kind of God would that have been?
> I learned these ideas as a child;
> they were very much ingrained in my mind.
> So I was very worried about that for Joseph.
> I think that any God couldn't possibly do that;
> it wasn't his fault,
> there's no way that that could happen. (Tracey, II)

This reflection opens Tracey to the awareness between spirituality and religion, and enabled her to adjust the dogmatic teachings she received. Some survivors do find comfort from a connection with spirituality that helps them get through the adversity:

> I'm involved in my church and I found that that helped me. It helped me spiritually. And again I had the people I could get involved with. It was nice just to go there and feel that I was with somebody that made an effort to understand what I was going through. (Jessica, GD)

For Daniel, it meant the differentiation of spirituality from religion and the pursuit of a greater sense of spirituality:

> To me, religion is there to control people;
> look at the history of it all.
> Whereas God or Christ through God wasn't there to control;
> they were there to set you free.
> But religion ties you up and so my spirituality changed.
> I didn't need the church, I didn't need that religion;
> my belief in Jesus stayed the same, really, and that helped me.
> Just to be able to sit and meditate;
> just to be able to sit and be quiet;
> to know that he cares for you --
> even though you're going through all this stress.
> It gave me comfort;
> friends gave me comfort as well.
> I believe that spirituality comes through everybody,
> whatever faith they have. (Daniel, II)

- The politicisation of personal values

Some new changes in survivors are political in essence. For the personal politic, the refusal of survivor's own suicidal impulse, whether it is for personal well-being or the other's happiness, is to show the determination of claiming one's life back to one's control, rather than to let the loss and grief dominate one's life. For the social politic, the endeavour of engaging in suicide postvention (and/or prevention)

and educating people about suicide are two evidences of survivors' politicisation. For instance, Daniel has set up a charity to help young people, Tracey has set up the first support group in her area, and Becky gets out of her comfort zone to educate people about suicide. This data echoes the research reviewed in the earlier chapters that survivors want to give back to society by sharing their experiences, by helping other survivors, and by raising awareness of suicide and survivors (Cutcliffe and Ball, 2009, Smith, 2011). No doubt the politicisation can benefit society at large. For survivors, to be political is a positive development resulting from great suffering and tremendous pain, meanwhile, it can be also a contributing factor to one's AAD, as well as an effect of one's positive development.

Say "Yes" To The Future

Although there exists an inner survival mechanism within us, the abrupt severance resulting from suicide can make life seem meaningless and purposeless. The capacity to celebrate with what happened after the loss to suicide is not a given; to say "yes" to the traumatic experience is a painstaking journey to accomplish. It may seem unnecessary to continue living, or to live well. Life may be frozen in the past; movement may be brought to a halt; no life, no future. Once survivors go through the acute state of loss, positive responses and assertions about the future can be reciprocal; that is, by saying "yes" to the future, one strives for positive developments; and with more positive outcomes, there is more engagement with the future. Survivors become more aware of the importance of self-care, and setting up goals towards the future – a better future.

- Looking after oneself

It may seem trite to say that it is important for survivors to take care of themselves. However, it is not uncommon to see them fall into a destructive life style. Having been marked by suicide, learning how to take care of yourself can be a matter of

life and death. Vanessa makes sure that she is ‘resourceful’, which means for her that she will seek help when feeling unwell. Suzanne also has more awareness and felt herself ‘better at doing it’. She was not only ‘feeling or being more aware of my own strength and recognising my ability to cope’, which was ‘impossible a few years ago’; she also appreciates friends and family more, and is aware of ‘how important they are to you; and you to them’. For Jan,

> I value my family/friends/life much more now and can get happiness from small things as I have a much bigger appreciation of life which I did not have before. I also value the importance of looking after yourself and making yourself happy and enjoying life in general. (Jan, AF)

- Setting up goals for the future

Vanessa remains ‘future-focused and goal-orientated’ and wants her career ‘to be a success’. She also wants to have her own family and ‘have a happy family home’, ‘have a stable family, although under no illusion that it’s going to be easy’. It took Jessica eleven years to reach a point where she started thinking about the future:

> I’ve started to think about
> what I wanted for myself for the New Year.
> I hadn’t thought of that in the last 11 years.
> I haven’t cared.
> I haven’t cared what next year is going to bring.
> What does it matter, when my son’s gone?
> What the heck matters anymore?
> But suddenly now I am beginning to feel perhaps --
> I should make more effort to lift myself up,
> to try and do something. (Jessica, II)

She has set up goals of doing exercise, meditation, and decorating her house as ways of changing her life.

Discussion

Some research has explored the characteristics of suicide bereavement, and some differences between bereavement through suicide and other bereavements have been identified (Silverman et al., 1995, Miers et al., 2012, Mcintosh, 1993). A few studies utilizing comparative methodology tend to minimize the impact of

suicide on survivors, or ignore the significance of survivors' experiences (McNiel et al., 1988, Dyregrov et al., 2003, Jordan et al., 2011). Part of the uniqueness of my research is that it aims to discover the contributing factors of various impacts, outcomes, and developments, hoping to deepen the understanding of survivors' experiences in a meaningful way. Further analysis of survivors' stories and factors contributing to their various responses has suggested the following:

1. Survivors' needs change as time moves on.
2. Negative factors in the early stage may become positive outcomes in later life.
3. Survivors are the greatest resource for each other.
4. The relationship with others is the key to prevent survivors' suicide.
5. Survivors need long-term support to sustain the growth.

Survivors' Needs Change As Time Moves On

It is now commonly known that grief and bereavement follow a trajectory, and it would therefore be naive to insist that the journey of survivors is simple, linear, or could be terminated as suggested by the stage theory of grief (Kübler-Ross and Kessler, 2005, Kübler-Ross, 1970) or the phases theory (Parkes, 1996, Parkes, 1993). As one study showed, survivors will face at least two types of stressors: one caused by loss and another caused by restoration (Stroebe and Schut, 1999). These two dynamics oscillate depending on how well or unwell the survivors are at different times or at different stages in their lives. Sometimes avoidance is necessary to create the space for survivors to breathe, while sometimes confrontation helps to obtain insights; the process of recovery and the experience of living with the loss is continuous (Stroebe and Schut, 1999).

As I reflect upon the data analysed, it is becoming more and more evident that survivors' needs change as time progresses. In the beginning, a huge amount of support is necessary simply to deal with the aftermath of suicide on a daily basis (including funeral arrangements, inquest-attending, and other legal aspects). Their daily lives need to be re-stabilized in order to have a new structure to follow:

for instance, to get up in the morning (to face and continue life), to have breakfast (someone needs to prepare the meal), to go to work/school (how not to let the suicide disrupt life), pay bills, … etc. Simple daily life can be difficult.

> For a long time I was just in shock;
> I just felt like I was in a nightmare;
> everything was, sort of, in slow motion;
> it was really difficult.
> Everything was difficult --
> just to get dressed in the morning,
> just do normal tasks …,
> I would forget to drink,
> I would forget to eat,
> it was just, like, shock.
> It felt really surreal and strange,
> the world just seemed really different. (Jan, II)

In the early phase of the bereavement, survivors need substantial assistance and psychological support from friends, family members and others. As time goes by, integrating the memories of the deceased and finding a place for the deceased in the survivor's life while moving on with, and without, the deceased becomes crucial (Walter, 1996). The assimilation of the loss into one's life becomes one's life story (Cohler, 1991) which will help survivors to see life with new perspectives. The understanding – seeing suicide from a bigger angle – becomes a way of knowing (Mitchell et al., 2011, by adopting Greene). It is a way of knowing humanity, existence, the mystery of life, and the paradox of life and death. Since loss through suicide has a tremendous impact on survivors, finding new meanings for life and purpose for the future becomes a long-term demand and task. From the above analysis of various responses, the development of new meanings and purposes are deemed significant to one's AAD.

Negative Factors In The Early Stage May Become Positive Outcomes In Later Life

Previous studies have shown that it is not possible to give a timeline by which survivors can judge when growth may begin (Smith, 2011, McMenamy et al., 2008). After encountering a loss through suicide, survivors grapple with many issues, from struggling to maintain their mental well-being to

finding meaning and purpose in life. There is a bipolar reaction – more negative experiences are observed in survivors (Knapp, 2012, Ratnarajah and Schofield, 2008, Valente, 2003). Dorothy Ratnarajah and Margot J. Schofield examined the impact of parental suicide on the surviving children and family units. The parental suicides influenced the individual, the family and the children's subsequent relational lives and experiences tremendously. Although there was scant resilient development, there was also 'a wide range of structural and relational changes to the family, resulting in a cascading series of negative outcomes' (Ratnarajah and Schofield, 2008: 618). Yehudit Silverman, the producer of the film *The Hidden Face of Suicide*, described experiencing loss to suicide as 'damaging' (Silverman, 2010). For a mental health professional, 'a patient's suicide is *the* trauma for the mental health professional (both intra-personally and legally) and few of us escape it' (Sudak, 2007: 333).

However, in the exploration of survivors' experiences, a trajectory of negative experiences being transformed into positive outcomes is identified. In the group discussion, Suzanna identified a few negative factors in the early stages of coping that turned out to be positive developments in later life. When she lost her son, it was 'a pressure to keep the relationship going'. It was hard for her to grieve and be available as a girlfriend. However, her then boyfriend of a year stood by her and accompanied her through this very difficult time. His 'stability' not only supported her, but also won recognition from her mother, and a few years later they formed a family. The change of outlook can mean different things.

Initially, there are far more negative aspects than survivors can cope with, including negative feelings, misunderstandings between family

members and/or with others, unhealthy dynamics (e.g. blaming each other), feeling shamed, angry, guilty, depressed, … etc. Survivors were pre-occupied with negatives and were merely struggling along; there was no space for anything other than just coping with the negative experiences.

Second, the inner process is always intertwined with external reality in any normal situation; this struggle is heightened when one is coming to terms with a loss to suicide. Survivors may have been pulled away from the inner process and been burdened with external demands. The distraction that can be caused by external demands (such as taking care of children, needing to work) prevents one from embarking on the grief process "naturally", but it also generates a break for survivors which is similar to 'sleeper effects' in the development (Clark and Clark, cited in Cohler, 1991: 187). The space/time allows the survivor's psyche simply to breathe and prepare for future integration.

Third, there is generally a human need to look for positive outcomes, and, especially in adverse situations, to make sense of what has happened. Gergen argued that the research into human development focusing on 'stability' and 'ordered change' failed to see the 'intrinsically aleatory' phenomena of life (cited in Cohler, 1991: 173-4). Because life is subject to chance, we need to create coherence, consistency, and meaning in order to cope with adversity. The continuity and coherence created by narrative is a time-honoured way of helping to develop human civilization (Ricoeur, 1983/4, Polkinghorne, 1988). There is also a common expectation and 'shared commitment' in us to an intelligible story in order to maintain personal integrity or the sense of continuity (Cohler, 1991: 186).

Transformation implies that the help provided for survivors needs to be expanded beyond the discourse of grief and bereavement. Instead of focusing solely on the grief response, or particularly on the complicated grief reactions (Mitchell et al., 2005, Clements et al., 2004), it may be equally important to find hope, meaning and potential for the future in the intervention (Neimeyer et al., 2002, Neimeyer et al., 2006b). The unfolding of one's potential development into the future can provide a bridge between "life before" and "life after" the interruption of suicide. The final example of a negative experience converted into a positive outcome can be seen when survivors are determined to renounce suicide as an option for the happiness of others. Even though my data did not indicate the trajectory of positive changes into negative ones, it needs further investigation and longitudinal research.

Survivors Are The Greatest Resource For Each Other

One of the most helpful connections that a survivor can make is with another survivor. Survivor-to-survivor communication can be an important resource for both parties (McMenamy et al., 2008). Survivors can be a help to each other by talking about the experience and/or by joining a support group. All of my interviewees confirmed the benefit of talking about it with other survivors.

> I had just found talking about it with somebody who, we were saying earlier, who... because people get bored, or you think they get bored with hearing about your story but other people who have had a suicide don't mind, *[laughter]* they don't get bored with it, … and you can get it all out and talk about all your feelings and I just realised how important that was. (Tracy, GD)

It is because they felt understood without needing to explain much, without facing the other's incomprehension or questions, and without feeling judged or alienated. In addition, the positive development of senior survivors can become a model for recent survivors to hope for:

Another friend's mum was really sweet;
she came around when she found out.
She dropped a card off with some flowers
saying, "I'm sure you're going to want to come
and talk to me so please do".
She was really helpful;
I probably tried to model myself on her
knowing that she's lost her son and she survived. (Suzanna, II)

Half of my interviewees affirmed the benefit of joining a support group. By hearing other survivors' stories, they made sense of their experiences and felt they were not alone:

> …going to the bereavement group, SOBS, has played in helping me and feeling about further development. That ability to move on … It was a very great help to have a group that I could go to, you know. I found it therapeutic, I really did. (Jessica, GD)

When you knew people's stories and who they'd lost,
it made a lot more sense to the whole thing.
It's hard to sit with other people who are that upset;
but it's also strangely comforting to be
amongst other people who have experienced the same thing as you.
You know they've experienced that same amount of pain.
You feel so different from everybody else.
People may have lost through death, but if they haven't lost the loved one by suicide,
they don't know what it is like. (Suzanna, II)

The Relationship With Others Is The Key To Prevent Survivors' Suicide

Research has shown survivors do manifest a higher risk of suicide (Reed, 1998, Krysinska, 2003, Aguirre and Slater, 2010). Studies show that the relationship with the deceased before the suicide is a significant factor in one's bereavement outcome (McIntosh and Wrobleski, 1988, Reed and Greenwald, 1991). The data gathered in my empirical work indicates that after the suicide, survivors' relationship with their significant others and the love they feel towards the people around them provides a buffer against suicide. Angela did not want her grandmother to endure the excruciating pain again.

For one week, every evening, I set my alarm clock
to go off at two o'clock in the middle of the night.
I would wake up and decided that
I was going to jump in a river.
Every night it was the same scenario.
I would walk up and down in my room …
Then I thought:

> “I can’t do that to my grandmother”.
> She had just one daughter, my mother.
> She was always so worried
> that something was going to happen to my sister or me.
> I always felt I couldn’t do that to my grandmother,
> and that always kept me alive. (Angela, II)

The decision of turning to healing is ‘an act of volition’ (Kalischuk and Hayes, 2003-2004: 62), not only for the survivors, but also for the people around them that they care about. Suzanna expressed the same concern about the wellbeing and happiness of others:

> I know I’d never do it because I have my son, husband and step-daughter.
> I would never put them through what we’d been through again! [Laugh]
> There’s just no way. (Suzanna, II)

For Becky, it is her mother who keeps her alive:

> For nine months I was so scared of what I would do.
> I didn’t want to be left alone.
> I refused to get on a tube
> because I felt like I was going to throw myself under a train.
> I just had this overwhelming grief all the time.
> …
> I wanted to kill myself ‘cause
> I didn’t want to feel the way I was feeling.
> But I wouldn’t kill myself because
> I didn’t want my mum to be on her own.
> Because I knew what suicide would do to those who are left behind. (Becky, II)

For Jessica, it was an ethical choice to stay alive, not only for others, but also for her own healing:

> Because I realised that I couldn’t leave other people behind
> to suffer what I had suffered.
> If I ended my own life,
> then they were going to have to go through
> what I’d been through,
> that self-same pain.
> I thought to myself,
> I can’t do that,
> I can't do that to another person.
> That they would feel that pain and
> that I would be responsible for it.
> So therefore I have to wait.
> In the meantime while you’re waiting,
> you’re gradually healing yourself, aren’t you?
> You’re gradually getting stronger
> and learning to cope more,
> with the passage of time. (Jessica, II)

Survivors Need Long-Term Support To Sustain The Growth

Suicide is not only a personal matter, it is also a loss for society (Hadlaczky et al., 2011). It is not only a mental health problem, but also our human ontological dilemma (Werth, 1999). Suicides create fissure, shock and ambivalence in survivors' internal systems and external structures. It is no wonder that the social attitude toward suicide has been ambivalent, if not indifferent. Survivors are forced to digest the loss of someone with whom they were connected, while trying to understand the paradox of suicide on their own. This paradox is so ingrained in humanity and in existence that it will always be a colonized object of power and authority (Marsh, 2010, Stevenson and Cutcliffe, 2006).

This thesis is unable to address the ontological dilemma, but the data clearly indicated that helping professionals need to be aware of the particular needs of survivors, such as difficulty in articulating their experiences, being isolated while dealing with the suicide, and the internalization of negative interpretations. They need to be aware of a different approach to bereavement, such as the importance of continuing the bond with the deceased (Stroebe et al., 2010, Rubin, 1996, Silverman and Klass, 1996), and the differences between maintaining a literal sense of unhealthy bonding and a symbolic one.

The language of grief, loss, and bereavement cannot do justice to the experience of survivors. As I stressed before, it is more than bereavement; for some, it is a catastrophe and finding a way to re-build one's life after catastrophe (Pompili et al., 2008). The language for survivors has not been formed consistently, although there have been some notable attempts (Dunne, 1987, Rudestam, 1987, Wrobleski and McIntosh, 1987). The only language that professionals and survivors can use is the theory of loss, grief and bereavement (Jordan and McIntosh, 2011a). Suicide is open to discussion among us only when

the contemporary medical discourse has been employed to examine its causes (Foster et al., 1997, Henriksson et al., 1995, Orbach et al., 2003). While psychological theory and social theory are valid operational tools for talking about suicide and its aftermath (Fincham et al., 2011, Sanborn and Sanborn, 1976), the language for talking about the meaning of its survivorship is still developing. More input is needed from the experiences and stories of survivors to expand the vocabulary.

The care and wellbeing of survivors need to be reconsidered, not only by health professionals, but also policy makers and educators. Education is needed for the general public as a means of creating awareness and in order to help the public know how best to respond to survivors in a sensitive way. As indicated by the participants, and confirmed by other research, it is common to hear inappropriate responses from others (e.g. “He is in a better place”, or “It is God’s decision”… etc.) (Riley et al., 2007, Silverman, 2010, Miers et al., 2012). A seemingly harmless comment or well-meant response could act as a further blow to a survivor’s rocky journey, not to mention the damaging effects of stigmatization, blaming, denial, or avoidance.

This analysis suggests that in the time after the loss, relationships with others, and the support/resources available are significant factors in helping survivors. They need to find a way to manage their grief through the acute crisis and long-term bereavement, and ultimately to ground their lives after the suicide. The analysis suggested that the experience of loss needs to be integrated into survivors’ lives. Loss becomes part of the life story of survivors, and they have to learn how to not merely go on living but to live well. The needs of survivors typically change from those of the acute crisis when they will need trauma intervention, psychological support, and grief counselling focusing on the loss, to

those of finding a way to live with the loss, finding the meaning in the experience and re-establishing a sense of purpose in life. These suggestions echo the statement that suicide bereavement is ‘an ongoing process’, survivors need to have long term support, partly because in the early years after the suicide they will have difficulties (e.g. lack of energy) initiating the help-seeking on their own (Provini and Everett, 2000: 12). Similar suggestions can be seen from Kari Dyregrov who pointed out that the participating survivors wished for follow-up contact after the study (Dyregrov, 2002), and Onja T. Grad and colleagues evidenced that survivors need immediate to long-term support (Grad et al., 2004).

To put it in another way, for the first two years, survivors need help similar to that of crisis intervention, helping them to re-establish a stable daily structure. For the mid-term, between two to ten years, they need to keep the balance between resources and demands, both internally and externally. After the initial crisis stage, the survivors continue their lives as “normally” as possible, but their resources and strength may not be enough to cope with the demands of daily life. At this stage, survivors need to be conscious of how their on-going grief influences their ability to function; having on-going psychological support will be helpful for survivors, and it will aid them in getting used to the period of living after the suicide, especially if the deceased was a significant other to them. Hopefully in the long term, survivors can outgrow the pain, find the meanings of surviving the loss to suicide, and sustain the growth.

In particular, it is important to systematically liaise survivors’ political engagement with existing support. That means survivors should not be the only people responsible for creating social change; they need to receive support from the wider community while they are making their contributions. This can create a reciprocal culture in the survivors’ social movement, which can sustain them in a

humanistic way. Simultaneously, they need to have the permission to not make contributions (if they do not want to) and for continuing their journey the way that suits them. Postvention should ‘empower’ survivors to ‘find their own paths’ rather than being ‘prescriptive’ (Grad et al., 2004: 139).

I will continue the further analysis by using Jung’s theory of complex/archetype, which has helped me to devise my theory of the suicide complex (SC), which will be discussed in the next chapter. Here, it is sufficient to mention that SC is a crucial factor in understanding survivors’ impulses to want to kill themselves. When survivors express that they would never consider suicide as an option for whatever reasons (the empirical evidence in this research showed that survivors do not want to inflict the same pain on others), it cannot be taken at face value; it only indicates an empathy with human pain and a determination not to inflict any onto others. Another important thing to consider is when a person says that s/he will not kill him/herself in the presence of stressors, it may be judged as ‘denial’, but from the perspective of positive psychology, the strengths, vulnerability and the overall contexts of survivors need to be looked at to understand the phenomenon (Ellis, 21 Aug. 2013).

The impulse to carry out the act of suicide has never been linear (Schiepek et al., 2011). I hope that an investigation of the dynamic behind SC will provide clues for an effective postvention plan that aims to help survivors – suicide postvention is suicide prevention (Aguirre and Slater, 2010).

9. Implications

Based on the data that has been gathered and the analysis discussed in the last chapter, this chapter begins with the evaluation of the participatory and empowering elements in my empirical work. I then go on to discuss the constitutive elements and applications of the Trauma Grid (TG) to the researched population; the application of the applied theatre method to the research on survivors; and the analysis of the suicide complex.

Participatory and Empowering Elements

As I have already stated, the central methodologies implemented in this research are narrative and theatrical inquiry, in which some elements of participatory research (PR)[61], autoethnography (AE), collaborative autoethnography (CAE)[62],

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61 PR was developed in the 1970's and 1980's focusing on the issue of power. It challenges conventional economic development projects and aims to empower poor rural and urban communities. The work of Paolo Freire (1996) has helped to move participatory research away from an individualistic model to a social and political inquiry. According to Julie Kent's review of literature, PR inherits a classical liberal tradition within an Enlightenment ideal of emancipation and liberation. See KENT, J. 2000. Group Inquiry: A Democratic Dialogue? In: TRUMAN, C., MERTENS, D. M. & HUMPHRIES, B. (eds.) Research and Inequality. London: Routledge.

The concerns underlying this approach include: 'participation in the research by community members, consciousness-raising and education of the participants, inclusion of popular knowledge, and political action'. See CANCIAN, F. M. 1996. Participatory Research and Alternative Strategies for Activist Sociology. In: GOTTFRIED, H. (ed.) Feminism and Social Change: Bridging Theory and Practice. Chicago: University of Illinois Press. P. 189.

The issues of 'agency, representation and power' are the targets. See CORNWALL, A. & JEWKES, R. 1995. What is participatory research? Social Science & Medicine, 41, 1667-1676. P. 1667.

62 Ethnography is a well-established methodology in social science. See JONES, J. S. & WATT, S. (eds.) 2010. Ethnography in Social Science Practice, London: Routledge. It has 'the potential to empower and improve the social conditions of minority groups'. See GOLDRING, J. E. 2010. Between Partisan and Fake, Walking the Path of the Insider: Empowerment and Voice in Ethnography. In: JONES, J. S. & WATT, S. (eds.) Ethnography in Social Science Practice. London: Routledge. [by adopting Goodley; Truman, on page 127]

and feminist approaches are embedded in my research. Those three approaches are all well-developed and inter-fertilizing methods in social research. Briefly stated, in practice, I aimed at: (1) empowering the survivors by sharing my research tool (i.e. the TG) with my participants; (2) raising personal awareness by facilitating dialogue and providing an inquiry space; and (3) being transparent in regards to my status of survivor in order to create a more equal power dynamic between facilitator and participants. However, I acknowledge that the impact of my research is limited and may be judged to have failed feministically.

During the group process, I offered the participants a template of the TG. I used the TG as a starting point for my facilitation. I also used it as a basis for creating a dialogical group space. After the participants chose their roles from *Romeo and Juliet*, the group interviewed them. By giving participants the space and authority to ask questions, survivors may have found a sustainable way to reflect on their experiences, on how they were addressed, in which contexts their journeys were located, and furthermore, on their process of self-inquiry. By being asked from, and asking questions of, other survivors about how to maintain their resilience and develop positive outcomes from their loss, it may have helped to balance the traumatic loss and negative framework imposed on them. Paulo

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AE is a qualitative research method that focuses on "self" as a study subject (i.e. the researcher studies him/herself). According to Heewon Chang and colleagues, there are two important aspects of AE: (1) the use of autobiographic data; and (2) cultural interpretation of the connectivity between self and others. Autoethnographers aim to obtain 'a cultural understanding of self and others directly and indirectly connected to self'. See CHANG, H. 2008. Autoethnography as Method, Walnut Creek, CA, Left Coast Press. P. 49.

By adopting the categorization that Ellis and Bochner set up – focusing on the research process (graphy), on culture (ethno), and on self (auto) – Chang and colleagues laid out a spectrum with one side emphasizing autobiography and the other ethnography. With the former, more focus is on 'self (auto) narration (graphy)'; whereas the latter is more on 'the cultural interpretation (ethno) of self (auto)'. See CHANG, H., NGUNJIRI, F. W. & HERNANDEZ, K.-A. C. 2013. Collaborative Autoethnography, Walnut Creek, California, Left Coast Press. P. 18.

With the theorization and reflection/reflexivity of personal experiences, AE transcends a mere narration of person history. CAE emphasizes the collaboration between the researcher and co-researchers with the researcher(s) striving toward authentic and multiple sociocultural interpretations of self-society issues. Ibid.

Freire encouraged dialogue as a means of stimulating critical thinking; dialogue helps the process of engaging in enquiry, and the possibility of perceiving 'reality as process, as transformation, rather than as a static entity' (Freire, 1996: 73). However, this is a subtle attitudinal experiment; it would be up to the survivors to further embrace, challenge, or resist, the lens of the TG.

The presence of the other survivors sharing the same kind of loss may have provided a mirroring function and generated identification-based empathy. The effective dialogical exchange may also have resulted from the homogeneity of the group: i.e. all are survivors. According to Julie Kent, for an inquiry group to be successful, it is contingent on 'good matching' between participants of the group. Hence, for a dialogical exchange to be successful, it relies on 'the strength of similarities between participants and a principle of equality based on sameness' (Kent, 2000: 81-2). The composition of the theatre groups comprising of suicide survivors showed a satisfactory degree of 'good matching' and 'similarities'; however, as the only male survivor did not join the group, the gender issue was left without being explored.

Ideally, a progressive social change can be achieved on three levels: for individual participants, for the local community and for the wider society (Maguire, 1987: 241). The empowerment that comes from change can be achieved through different effects. One such potential effect may be that the participants 'become the direct users of the research findings' (Truman, 2000: 24). Another may be by situating experiences 'in the contexts', by laying bare the circumstances of 'marginalization' in order to gain greater perspective on the basis of feelings of marginalization (Truman, 2000: 27). Third by sharing and exchanging common experience, and as a result finding other survivors to identify with (Finch, 1984).

Although I was unsure whether the participants would use the TG in their journey, I will present an analysis of the implication of the TG on survivors later.

As I stated in the Introduction, the starting point of this PhD is my own loss through suicide. The use of my own experience has been the core of the thesis. However, I did not choose an autobiographical framework but I have situated the research in between the personal and the cultural. Although there was only partial collaboration in my empirical work with other survivors, the elements of CAE approach led to: 'power-sharing among researcher-participants', 'enrichment in the research process', a deeper learning about self and others' both in the case of the researcher and the participants, and 'community building' (Chang et al., 2013: 25). These results greatly enhanced my research and improved my thesis as a whole.

Feministic Methodology

According to Sherry Gorelick, researchers using feminist methodology have been criticizing traditional methodologies on 'philosophical, moral, and practical' levels, and two 'feminist methodological alternatives' have blossomed: one is the Marxist-oriented and the other 'experiential-inductionist'. My research is aligned with the latter that focuses on ethnomethodology and interactionism (Gorelick, 1996: 23-4). Furthermore, emphasising the significance of experience, I paid attention to the 'intellectual autobiography' which is part of the criteria of the feminist approach (Stanley and Wise, 1990: 23). According to Stanley, 'intellectual autobiography' means:

> making visible what is normally, usually, conventionally, hidden to readers: the shifts, changes, developments, downturns and upturns in the way that the biographer understands the subject with which she deals. (Stanley, cited in Woodward, 2000: 43)

However, my feminist attitude resides in the research process and is limited to the realm of the personal, rather than being guided by a political agenda[63]. It is worth acknowledging that this research does not meet the criteria of feminist activism, nor was this activism one of the aims of my research. According to Heidi Gottfried, situating 'experience' as the main 'source of knowledge' will lead to a 'politics of identity' claiming 'the authority of experience'. But 'naming' one's experience is not enough; it is just 'the first step toward collective self-liberation' (Gottfried, 1996: 5). There are pitfalls to conflating experience with simplistic and essentialist notions of identity (Truman, 2000). Identifying oneself as a survivor may be one way 'we attempt to order and structure the chaos and flux of existence which would otherwise be an undifferentiated mass' (Spender, cited in Gottfried, 1996: 17, note 4). To give voice to survivors' experiences may not be enough to evoke social change (Gorelick, 1996); likewise, the revolution cannot be achieved by just being aware of oppression without those taking part having the will to challenge it (Truman et al., 2000, Fawcett and Hearn, 2004).

Ideally, researchers should create conditions in which participants can engage the process as 'an active subject' (Acker et al., 1996: 63). As part of this process, they may need to be assisted in learning to recognize 'the hidden determinants of oppression' (Gorelick, 1996: 27). Nancy A. Naples and Emily Clark explained the outcomes of this process in their research on survivors of childhood sexual abuse:

> when stigmatized groups shift from individualistic explanations to social, structural, and political analyses, they [participants] find that personal as well as collective empowerment ensues. (Naples and Clark, 1996: 178)

63 Acker et al. have categorized feminism into two areas: personal feminism and political feminism. See ACKER, J., BARRY, K. & ESSEVELD, J. 1996. Objectivity and Truth: Problems in Doing Feminist Research. In: GOTTFRIED, H. (ed.) Feminism and Social Change: Bridging Theory and Practice. Chicago: University of Illinois Press. P. 85, note 6.

Judged by this standard, the impact of my thesis is limited, although by using an inquiry-based and dialogical method, I may have enabled survivors to see the influence of loss in their daily lives and developed the ground for them to become co-investigators of knowledge in their journey. Yet, the research on survivors' developments after loss in the context of this thesis is not 'a substitute for political action' (Gottfried, 1996: 5); hence it is "not enough" based on the standard of feminist activism. The failure is my responsibility and will lead me to further reflection after finishing this PhD.

The Constitutive Elements and Application of the Trauma Grid

Despite the potential pitfalls of the TG mentioned in Chapter Two, in its application to survivors the following implications have been observed:

1. Survivors responded differently to the TG: some found it straightforward, some found it complicated.
2. Time is an important factor in evaluating one's development.
3. The subjectivism of the evaluation.
4. The potential for the TG to become a clinical tool.

In the following sections I will discuss each of these implications in further detail in order to reflect on my understanding of the TG model.

Survivors Responded Differently To The TG

In the research process, some survivors found the TG very straightforward, while others found it hard to understand the theoretical meaning behind it and took a while to digest the theory. During the group process, the group spent some time discussing questions about the theory:

> Jessica: I'm not sure that I'm completely clear on what you want. Were you saying that you don't really want us to start at the beginning?[64] Are you looking for how we're managing to cope now, going forward? … What brought us to this place? … So you're looking for how we've been coping with what happened to us. And how we're continuing to cope?
>
> Tracy: And what helps us to cope.
> …
> I think what she's saying is that I think what has happened over these last 5, 10 years, 20 years, whatever it is, how have we coped at first, what strengths we had or what weaknesses we had to deal with to get us to where we are today and actually still moving forward. Who helped us, or what helped us. Is that it?

The confusion may have been caused by a variety of factors. For example, at the outset, confusion may have been caused by the way I employed the framework. The TG has been used in different contexts. One of these contexts is used by therapists and social workers to evaluate the status quo of the clients where they were not engaged in self-reflection. In this study, I asked the survivors to directly tell me their responses and developments according to the sections in the grid. This, however, is not a standard application of the TG.

One such complication was observed In terms of the individual processes of the participants, for it became clear that there is a difference between just coping in one's daily life and evaluating one's overall development. It shows that the complexity of one's survivor-hood ranges from merely surviving at one end of the spectrum, to feeling able to evaluate one's experience at the other end. The experience of survivor-hood is not fixed at one point, nor is it linear. One can feel well one day, but fall back into a black hole the next day. Second, surviving suicide is an extremely emotional experience. Survivors may be caught up in the loss for years before the extremity of emotional reactions subsides or gradually eases. In contrast, the TG requires survivors to be in an objective, rational, and reflective space when trying to gauge their experience. Trying to assess a

64 Here Jessica meant start telling one's story in details, especially from when, where, and how the suicide happened.

subjective experience using an objective assessment tool may be a difficult task for survivors.

The third aspect of this process is the relationship a survivor has to the temporal. Time is an artificial construct, but it helps us structure daily life and organize collective activities. Time is fluid, and the experience of loss to suicide can shatter one's sense of continuity in life. Some survivors have expressed their life as having a definite "before" and "after": the life before the suicide and the life after the suicide. Asking one to look back to a time before the suicide may start to help the person bridge the inner temporal disruption and re-situate their loss back to their life as a whole, rather than just to the time after the suicide.

Overall, in the end, most survivors recognised the benefit of being asked about their positive developments.

> Not just looking back and saying, "Oh that was a terrible time", but what developed over the years and what we'll take further. … I'm thinking [of] the adversity activated development that you don't even realise is happening, you know, and then all of a sudden you realise that you've really improved in that area. *[laughter]* (Tracy, GD)

> Towards the end we were looking at the positive things that have come out of it and that's something I've always really struggled with, thinking about anything positive, because I was just like how on earth could there be anything positive? My child died. It's like I can't … How on earth can they go and make that anywhere, anything to do with a positive experience? It's just horrible. But it was really interesting going through it and it made it easy to actually see what was… They're only small positive things but there were actually some positive things that came from it. Obviously, they're massively outweighed by all the negative things, but it helped me to see that there were some positives. So that was really helpful. (Suzanne, FI)

Time Is An Important Factor In Evaluating One's Development

As mentioned above, the difficulties in understanding the TG may have had to do with time and the discrepancy between reality and the inner world. When the survivors were introduced to the TG during interviews and group discussions, they may have felt unsure about at what point they should begin assessing their experience. The participants could have evaluated their experience at any point in the process, but they seemed to have a hard time judging when it was an

appropriate time to do so. This shows the temporal discrepancy between external reality and internal experience. Some elements of this discrepancy are easier to identify. For instance, survivors mentioned having been seriously depressed in the first few years, but that the seriousness of this depression has lessened in the present. This may also indicate that the processes of bereavement and personal development are on-going; and in order to evaluate the whole picture of a person's experience as a survivor, even more temporal distance between the event and the evaluation may be needed. In other words, even though an evaluation has been done in the present, it is important to remember that the processes of bereavement and personal development are still evolving, and as a result the outcomes of these processes are evolving as well. Life for survivors continues to be a life of living with a loss to suicide.

Time is indicated as an important aspect in the evaluation of one's development, especially in the evaluation of positive outcomes. Jessica pointed out that the negative responses she had to her trauma were more about the past; the experience of resilience for her is something that is happening "now", and the prospect of AAD represents the future. Jessica said of her relationship to time, 'I found that getting to the neutral stage really was a case of a passage of time for me; it was just a passage of time because according to a great saying, time is a great healer'. It seems survivors need to digest the negative impacts on them first of all, and digest them for a substantial period of time, until the time comes for change.

> If someone just asked you how did you cope with it or how did you feel, you just tell them all the negative things immediately. They're all the things like everybody fills that bit up first don't they. Like the easiest bit to fill up is the negative things. (Suzanne, FI)

> It is quite positive to realise that we can come out of the other side and get on with our lives. Initially your brain cannot think properly, it is spinning, going round and round in circles. Eventually, order comes back to your lives after some time and you can gain from this experience. It changes us. I think it changes us as much as we have different perspectives on many things. For example, we may not crave for material things as before because we no longer feel it is important as before. (Jessica, FI)

Empirical Subjectivism Is An Ethical Stance

The emphasis on experience in social science has been developed as a reaction to scientific objectivism (Ellis, 1991). This emphasis also aims to make up for the shortcomings of the impersonal and pretentious “scientific” stance, especially when it comes to the investigation of the subjective experience and emotions (Ellis and Flaherty, 1992, Hollway, 1989). One’s personal experience is neither scientific and objective nor the only reality that exists. Experience is subjective; one’s evaluation of one’s various developments cannot go beyond the realm of the subjective. This is the ontological characteristic of life changing events.

While reflecting on one’s journey using the TG, the person who has experienced the loss and the person evaluating the process are the same person. Thus, a certain element of personal equation – individual characteristics and ideological bias – is implicated. However, it is not necessary to have a suspicious attitude towards the narrative and think survivors may have distorted what they experienced simply because it is subjective. It is more important to understand their experience through the narrative they offer (Riessman, 1993, Denzin and Lincoln, 1994), and honour the fact that the subjective aspect of their experience has been significant. Even if a methodological bias has been identified with how to evaluate one’s positive growth in subjective terms (Park and Lechner, 2006), that bias may be valid only in a theoretical perspective. It is impossible for a person to objectively self-evaluate whether it be before or after encountering any kind of traumatic event. Subjective experience cannot be satisfactorily quantified, measured or fully understood in a scientific way. One’s self-evaluation will always be coloured by one’s experiences, whether or not they are traumatic experiences. Self-evaluation is an internal and reflective process. It can be used to better understand the past and anticipate the future.

That is the ontology of experience (Denzin, 1991, Littrell, 1998, Wheeler, 2001). Let us see one example:

> I'm trying to think objectively about my experience,
> which is really difficult [laughter] when there's so much emotion there,
> it's really hard.
> When you were asking about,
> inner qualities that have helped you,
> it's like a different perspective of looking at the grief and everything.
> I feel like I've looked at it from a lot of angles,
> but I haven't really thought of,
> if my qualities have changed or if I have myself changed,
> it's quite hard to know the impact of the loss on my life and my emotional being.
> It's difficult because-
> -I'm not objective to my emotional being [laughter]. (Jan, II)

When mentioning resilience, Tracy reflected:

> I don't know, is it coping mechanism, isn't it? I cannot pat my back and say I am resilient, it is just my personality. I do not really know what resilience means. Because… It is quite subjective. (Tracy, FI)

The value of subjectively reflecting on one's surviving journey using the TG is that it opens up another perspective from which to look at loss; it brings positive elements to a tragic loss. On a wider scale, it shows the human potential for developing further in whatever ways necessary after adversity, and it offers a hopeful message to people suffering a life-long bereavement. Nevertheless, as mentioned earlier, research has pointed out that survivors may be reluctant to acknowledge their positive developments after losing a loved one to suicide (Smith, 2011).

The Potential For The TG To Become A Clinical Tool

Some survivors found the TG to be a "complicated" model to work with because it requires an analytic assessment of personal and emotional experiences. Self-evaluation is a very demanding process. Tracy questioned the meaning of the theory in her follow-up interview:

> Is it something like the depression scale? Is it a clinical tool?... What is the purpose of it? Who is it for? And why would you use it? Is it for the therapist to use? Or is it for the patient to use?… It is very complicated. (Tracy, FI)

Tracey worked in a medical environment and was therefore aware of clinical tools and methodologies. Survivors need time to process and integrate the profound emotional impact their loved one's suicide has had on them before they can reach a state in which they are able to distinguish between the "I" and the "me" (Mead, 1934). They need to do this in order to evaluate their emotional experiences and cognitive assimilation. This is an inevitably complicated task. However, based on the positive responses of the survivors, it appears that the TG has the potential to follow the path of the PTG model with the aim of eventually becoming a clinical tool and benefiting more populations. Following the PTG model would require that the inventory of the TG is further developed and tested (Tedeschi and Calhoun, 1996, Calhoun and Tedeschi, 2006, Smith, 2011). It is worthwhile to test the theory in order to map out the factors contributing to various responses. The recognition of positive outcomes after adversity not only sustains the AAD of survivors, but will also help the families, society, and health professionals to assist survivors to recovery without unnecessary medicalization, colonization or receiving a pathological diagnosis (Krysinska, 2003, Szasz, 1999). Perhaps most significantly, it will help families, the wider community and health professionals view survivors with a more humane attitude. Here are two examples of recognition of this potential from the follow-up interview:

> It's very easy because you've been through it and you know what they are. But splitting it up into that negative, neutral and positive, it is quite good to be labeling things as neutral or positive because you tend to just think of all the negative things. …It's good because it makes you think about the other things which I think a lot of people wouldn't tend to think of. I think after we'd done it, really specifically after we'd done the writing things on post-it notes, it's one thing that I really came away with, that was positive. I felt more positive about it because I'd recognised and thought about the positive things to come out of it which isn't. … I don't normally think about that at all. I just think about the negative things. (Suzanna, FI)

> In the beginning it was deeply traumatic, but I do not feel it is so traumatic now. I have moved on. … I move forward. [Pointing at the positive aspect in the Trauma Grid] that is how I am currently feeling. I am more understanding, more aware of people in the problems. I think I would think more deeply now rather than let it put on top of my head. (Jessica, FI)

Application of Applied Theatre Approach to the Research on survivors

From the outset, all the participants acknowledged that being in a homogeneous group setting (homogeneous in the sense that all the group members were survivors) provided a safe space in which to share their experiences. Jessica gave her feedback after the workshop: “I enjoyed being in a small group of people who had had my experience. I felt we understood each other’s thoughts and feelings”. The evaluation of AT methods will be discussed under two headings:

1. The ability of role-play to expand one’s perspective.
2. The dialectical relationship between fiction and reality.

The Ability Of Role-Play To Expand One’s Perspective

To warm-up the participants for talking about their experiences without going into deeply personal issues, we facilitated a role-playing session. The script of *Romeo and Juliet* was presented to the group and they were invited to choose a role which could be real or fictitious. After they chose the roles, the survivors took turns being the protagonist and being interviewed about their journey by the group members. It was suggested that group members ask questions according to the TG. Depending on the roles chosen, three participants found it helpful, and two did not. The findings indicated the potential benefit of role-play and a characteristic of memory of the suicide.

The three participants in the first group chose roles that shared a high proportion of commonalities with other surviving members of their family, that is, they chose characters that corresponded to family members. For instance, Tracy lost her son to suicide and has one daughter left. She chose to be Romeo’s sister, i.e. she placed herself in the role of her daughter, exploring how the daughter character experienced the loss. Similarly, Jessica chose to be Romeo’s brother,

i.e. the role of one of her sons. Tracy affirmed that the group work helped expand her perspective by letting her experiment with inhabiting her daughter's role:

> This group work was an interesting experience and, overall, it was helpful. What I found most helpful was the role-playing in the Romeo and Juliet activity. It helped me to see more clearly what impact my son's death may have had on my daughter and what role she was forced to play in supporting us (her parents) through the early days of our grief. This may have contributed to her shutting down her emotions over the event. It was a powerful tool because it made me really get into the person of my daughter and to have a greater appreciation of how she may have thought (and possibly still does) about her own bereavement. (Tracy, QA)

Jessica noted in the written feedback after the group that the role-play was 'helpful', for it 'broadened my outlook. It encouraged me to look deep within myself and to think more considerately of the feelings of other people close to the suicide'. During the following-up interview, she reiterated:

> It was nice that we have different perspectives. We have been interviewed and took part as another person or we could be ourselves. … I think what I enjoyed the most is the role reversal. Because that really got me thinking outside of myself. Instead of thinking of myself, I started thinking how my other sons would have felt the first time. I feel that experience is good for me. We suffer so much pain from this experience so it is natural that we just think of ourselves, we cannot think of other things. It is such a shock to our system, it's so heavy, unbelievably heavy. … Our hearts are so heavy we cannot think of other things except how we feel. It is good to think of how other people felt for a change, think of how other people my have felt about the same situation. There was good. (Jessica, FI)

The second group of participants did not choose to take on roles that represented other family members. For instance, Vanessa lost her father but chose to be Juliet's friend; while Suzanna lost her son and she chose to be Romeo's mother. They did not find the role-play helpful, and this could be because of the different dynamics in the two groups over the two days. For Vanessa, it was 'strange' for her 'to think of the bereavement from a different angle':

> I can see how this would perhaps be useful in understanding the feelings of others but I was happy to just talk about my experiences rather than have to make things up on the subject. Therefore I did not really find the theatre work helpful as when it comes to my experiences, I prefer to just be honest and straightforward. (Vanessa, QA)

Suzanne found the role-playing 'weird', and she found it hard to do the 'imagining'. She chose to be Romeo's mother, a role that directly paralleled the nature of her loss:

> So I find it all that sort of acting and role-play type of thing difficult in that respect. I find it difficult to sort of get into that role, which is again why I chose someone that was more

> like my situation because it's easier for me; because how would I know what it feels like for somebody else, I would have no idea. (Suzanne, GD)

As conjectured earlier, the bifurcated findings may seem contradictory on the surface, but they pointed out the functions of role-play and the idiosyncrasy of the loss to suicide. Role-play as a research method can 'facilitate deep interpersonal experiences and depth analysis' (Yardley, 1995: 120). One of the functions of role-play is to generate an aesthetic distance between one's self and one's problems (Landy, 1993). When someone is too close to one's issues, s/he would be too anxious to have a balanced examination of the situation; when too far from one's problems, s/he could not feel the impact and may become indifferent. This may explain what happened to Suzanne – too close to her experience that the role lost the function to create the distance; and for Vanessa – the distance was too far that it became like a game. I am by no means casting judgment on the quality of their role-playing, but am simply analyzing the possible variables that influenced their experiences. It could have been the facilitators' responsibility for failing to deliver the instruction clearly, but the different results provide a fruitful outcome for me to consider.

One clear benefit of role-play for survivors is that it expands their perspective on their journey by witnessing the other surviving members' processes. It helped survivors transcend their personal grief reaction and increase the assimilation of the loss to one's life, if not repair the fissures among family members because of the suicide. Role-play is already an established mode of intervention in dramatherapy (Jennings et al., 1994), and in an applied theatre setting it can become an effective tool for helping survivors to engage with the self-exploratory activity. The therapeutic effects will not only help the internal process but also have a relevant effect on the familial and social aspects of healing – being in the other's shoes, survivors embody how the others are impacted by the suicide, and

hence are more aware of the language to articulate the experiences and the differences of one's journey as a result of observing each other. This potential function is significant; it expands the current intervention approaches, not only in a professional health setting but also in a community setting. Next, the idiosyncrasy of the memory of the suicide will be discussed under the frame of the dialectics between fiction and reality.

The Dialectic Between Fiction And Reality

In the group discussion, Vanessa expressed that the theatre approach was 'confusing', because 'it is hard to make sense of any response, let alone when the response doesn't really feel like your own, because you are "acting"'. Nevertheless, for her, 'in a way it was kind of liberating because most of what I say is a complete lie, not a lie but nothing to do with myself':

> When you were asking the question about whether I was in touch with Juliet's family, if that was me and that was real and that had happened to me then I absolutely definitely would be in touch with her family but I know that it would be quite a stressful thing to have to do, so that's why it gave me almost like quite a relief to say no, I don't see them at all. Because probably that's what I would probably want to do, in real life, it's not very easy sometimes. (Vanessa, GD)

For Suzanne, the role-play was 'not easy' because 'it's not real, it's not our reality, I wasn't asking her about her personal circumstances, I was asking her about her sort of imaginary circumstance'. The difficulty of role-playing is not due to a personal shortcoming, but rather the unfamiliarity of art forms and their functions. Arts hold the power of transformation, which comes from the co-existence of two spaces – the real and the fictional. The fictional space, what Boal called 'the aesthetic space', is where liberation resides, in which one can 'think of impossibilities' (Boal, 1995: 21). In the context of the theatre of the oppressed, when audience members go on stage, one is situated in:

> two different, autonomous worlds: the image of reality and the reality of the image. … [H]e must make an extrapolation from his social reality towards the reality which is called fiction (towards theatre, towards image) … he must make a second extrapolation, now in the inverse direction, towards the social

> reality which is his world. *He practices in the second world (the aesthetic), in order to modify the first* (the social). (ibid, 43-44)

Boal used theatre as a means of social change. This is not the only example of art being used as a means of personal and political transformation, for there are also established psychotherapeutic approaches that are centred around using different art forms (e.g. dance psychotherapy, art psychotherapy). Even in a talking therapy setting, the client will go back to the past, embody some memory, and experience the containment, validation and experience of being witnessed by the therapist. The arts can act as a bridge into a kind of an in-between space, a liminal space that hovers between the past, the present and the future. In this liminal arts space, which is a space between reality and fiction, change can occur.

The language of theatre (and indeed of any art form) produces the quality of 'double seeing' (Salverson, 1996: 187). Any integration and transformation leading to positive changes happen in an aesthetic space, in the 'realms of the possible' (Boal, 1995: 21). By 'reassum[ing] their protagonistic function in the theatre and in society' (Boal, 1979: 95), people learn '*aesthetically* – it broadens the knowing and launches the knower in search of further knowledge' (Boal, 2006: 37).

The uneasiness of fictionalizing one's survival to suicide, I suspect, is rooted in the fact that survivors experience the loss so deeply that this experience has become part of them and from which it is hard to separate. When survivors attend the support group in London, the first thing they would be asked is their own name and who they have lost. For example, I would need to say, "I am Robin, I lost my second son, Zero". I may continue by saying, "I lost him twelve years ago when he was twelve", and then maybe "he jumped". This acknowledgement is a ritual serving a few purposes: (1) it creates a sense of safety for survivors that this is a space to talk about the suicide; (2) it acknowledges the deceased; (3) it generates

a testimony and witness circle; and, most importantly, (4) it forms a transparent culture that acknowledges that loss to suicide has happened to people and lets us be available to each other. It is a sacred ritual. No one needs to pretend it was not suicide; no one needs to fictionalize a cause other than suicide. Survivors say the names of the deceased in order to commemorate the deceased's life, which contributes to the meaning-making in their surviving journey.

The space to acknowledge the deceased (by saying their real name, the kinship and/or the means taken) is healing for survivors, especially since it is hard to talk about suicide with non-survivors. The pretence of role-play may be deemed negating to one's real experience and loss, and the spirit of embodying other roles may seem to contradict the survivors' culture. In addition to the sacred quality of memory, the uneasiness may be about resistance. When creating a fictional account of suicide, survivors may feel they have been pulled away from what is real for them. To be a survivor is a new identity that allows him/her to be addressed as such, as well as being given the position (although unwillingly) to understand what it means to be a survivor. Role-play as an intervention (even in an applied theatre setting) may transgress the limit of the sacredness of the survivors' circle. Although theatre and art-based approaches can help survivors move beyond the loss, allowing them to generate an imaginative space for themselves in order to transform the traumatic experience into a new form, the resistance some participants exhibited suggests that the impetus for this act of fictionalization needs to come from survivors themselves. They need to be willing to "play" with their experience.

As mentioned, the role-playing and the group interview served as warm-up activities to prepare the survivors for the discussion of the contributing factors to various responses. The discussion that took place in the afternoon, after the role playing, was a very fruitful one, for the participants seemed willing to share with

each other and to reciprocate each other's contributions to the conversation. I felt the activities created a balanced distance for survivors to talk about their experiences while remaining analytical. This would not have been done with one space (e.g. reality only), but is a dialectical result of the co-existence of fiction and reality.

The Analysis of Suicide Complex

In Chapter Two, we reviewed the existing literature on survivors' elevated risk for suicide and how many survivors are impacted after a suicide. In Chapter Four, we reviewed the debate about the innateness or emergent quality of archetypes. Adopting Jung's theories of complex and archetype, here I propose an extreme complex – suicide complex (SC) – as a mode of understanding suicidal thoughts and impulses that are constellated in survivors' psyches directly and in those of the general public indirectly.

Before giving a definition of SC, I need to acknowledge that I am not the first person to have formulated a theory on its existence. The Jungian analyst David H. Rosen has used the terminology of 'suicidal complex', 'suicide instinct', and 'suicide complex' interchangeably in his *Transforming Depression* (1996). However, his studies focus on those who are depressed and hence suicidal; my thesis can be seen as an expansion and development of Rosen's observations on suicide complex, with a change in focus from those contemplating suicide (because of depression) to an examination of the existence of the complex in the psyches of survivors. It is worth noting that I had come to my conclusion on the existence of a suicide complex before I came across Rosen's research. Thus, although our ideas intersect in important ways and Rosen has been an influence on this thesis, the origin of my theory comes from observing survivors rather than from Rosen's writing.

It also bears mentioning that in this thesis I opted to use the emergent/developmental model for SC due to the following considerations: (1) it is beyond all human endeavour to prove that SC exists *a priori*. (2) The emergent model provided an understandable language to describe the formation of SC, which results from the loss through suicide, the severance of one's social support and the shattering of one's assumptive world. Thus, the definition of SC is: *a complex constellated in a survivor's psyche directly and in the general public psyches indirectly, due to the encountering of a suicidal loss. It manifests from a minor entertaining thought of not being alive to an acute risk of killing oneself. This complex emerges from the interactions of survivors' highly affective responses to the suicide, their waning consciousness, and the ambivalent attitude of the society at large.*

Similar to the image schema (archetype) that Knox argued (which was discussed briefly in Chapter Four), SC is an archetypal image that is 'constellated through personal experience with the operative cause being emotionality' in one's life (Merchant, 2009: 344). However, there is a fundamental unsolvable problem that I face and which this hypothesis cannot explain: how and when do these negative experiences become a seed embedded in the psyche waiting to be constellated? Following on from this, how do a child's pre-verbal negative experiences result in the potential formation of SC? The relationship between insecure/disorganized attachment and future pathology has been evidenced (Bartholomew and Horowitz, 1991, Shear, 2011), and attachment theory convinces us that when an infant's needs are not met, his/her development is frustrated. However, the pathology cannot in any sense be equated with SC; and many people have outgrown childhood issues through attending therapy or by developing themselves continuously.

As discussed in Chapter Four, the term “archetype” in the following sections refers to the collective entity in our psyche that was theorized by Jung. The term “archetypal” means something shared by many people. I use it as a descriptive term, and reserve the differentiation between “archetype” and “archetypal”: that the effect of an archetype is archetypal, but not everything archetypal is generated from an archetype. In some contexts, “archetypal” can be read as “deep”, “wide”, or “collective”, without involvement with an archetype. What follows are the aspects of the SC that will be discussed in this section:

1. The survivor’s relationship with the unconscious is partly severed, and this severing is manifested as the shattered assumptive world and being disconnected from social systems.
2. The positive function of SC is to help survivors to understand the suicide and integrate the loss.
3. Being the scapegoat, survivors carry projections from the collective unconscious.
4. The necessity of addressing the archetypal rupture that survivors are struggling to live with.

I recognise that this hypothesis may be viewed as controversial. Thus, in the following discussions, I will draw on the data I collected working with the survivor group, available suicidology studies, theories from Analytical Psychology (e.g. Jung’s theory of individuation) and some aspects of popular myths to support my interpretation of SC.

The Survivor’s Relationship With The Unconscious Is Partly Severed; This Is Manifested As The Shattered Assumptive World And Being Disconnected From Social Systems

Survivors first experience suicide as a shocking and unexpected event that takes place in the outside world. This event intrudes on their psyches, leaving them with painful emotional and psychic wounds that result in feelings of exposure and vulnerability. When one loses someone to suicide, the outer environment influences his or her inner world. With this in mind, this thesis highlights the role

the surrounding environment plays on the formation of the SC. As Tracey described in the interview:

> the whole process was that
> you have your life --
> that's normal what's going on whatever it is.
> Then all of a sudden you have this huge cataclysmic event.
> Your life goes all over the place …
> then you're thrown one way,
> then you're thrown the other.
> Then you settle down to a new normal --
> life becomes normal, quote and unquote.
> …
> You can no longer fool people, right?
> You're so exposed,
> and you're just so vulnerable.

The emphasis on external factors does not rule out personal issues and neuroses that survivors may carry and which will make the surviving journey more complicated; in fact, they are entangled. One's grieving process is complicated by the complex constellated in the psyche, and SC can be felt as an intrusion from the unconscious. Survivors felt swamped by the collective unconscious (CU) from outside, which opens survivors' eyes to its ruthlessness. In a word, survivors' relationship with the CU is partly severed; they have seen the "dark face" of God. The "dark face" of God means depression and feeling suicidal, as Jessica described:

> Depression is an awful illness.
> It really is,
> it is awful for the whole family if one member is depressed.
> It's a killer.

She has experienced being depressed and suicidal:

> I really just didn't want to be on this planet anymore.
> It's inevitable that one is going to fall into a depression.
> Because any grief is going to be very difficult to cope with,
> if it's someone close to you,
> or somebody that you cared about.
> You're going to feel much heartache,
> but not necessarily, of course, suicidal.
> But in this instance, it was my son
> and because he died in such tragic circumstances,
> yes, my depression was very deep.
> I did feel suicidal.
> It did make me want to kill myself, yes

The dark side of the psyche ‘represents or personifies certain instinctive data of the dark, primitive psyche, the real but invisible roots of consciousness’ (Jung, 1940: par. 271), and includes, of course, the potential for a person to kill himself when the time is “ripe”.

At times, the impulse can be felt as being overcome by CU, and, like any archetypal experience, it is impossible to say whether the impulse is from the CU or the personal unconscious (Williams, 1962). Marie-Louise von Franz also noted that when the shadow and the Self point in the same direction, one does not know whether it is the Self or the shadow that is behind the struggle (von Franz, 1964: 184). When there are ‘spontaneous irruptions of unconscious complexes into the continuity of the conscious process’, the complexes are ‘comparable to demons which fitfully harass our thoughts and actions’ (Jung, 1921/1971: par. 175). Later in the section, I will use the concept of the shattered assumptive world and being disconnected from social systems to indicate how survivors are partly severed from the CU.

The intention behind highlighting the overwhelming impact from the outside world upon the survivors’ psyche is to offer a complementary view to the contemporary discourse about suicide and bereavement which often emphasizes the internal process and recovery (Barrett and Scott, 1990, Knieper, 1999). Freud’s understandings of pathological mourning and the development of object relations theory have provided discourses that focus on the internal reactions to loss, bereavement and aggression (Freud, 1917, Greenberg and Mitchell, 1983). The process of the survivors of coming to terms with their loss is complicated by intrusions from the outside environment. The suicide changes their relationship with the CU, which accordingly is seen as a malignant force. The way the CU transforms from a friendly and sustaining force to a demonic man-eater can be

seen in Becky's account of the first nine months of her bereavement. Her impulse to throw herself under a train in the first nine months was out of her hands and out of her will. The ego was struggling to resist the gravitational pull of the underworld.

> For nine months I was so scared of what I would do.
> I didn't want to be left alone.
> I refused to get on a tube
> because I felt like I was going to throw myself under a train.
> I just had this overwhelming grief all the time.
> I don't even know
> how I got through the first year.
> Five years on, now I can talk about it,
> but the first year I just can't even think of how I functioned.

Jung warned that when we identify with the constellated complex/archetype, it 'moves us or activates us as if we were marionettes' (Jung and McGuire, 1984: 217). The "overwhelming grief" that caused Becky to want to throw herself under the train may be misinterpreted as 'pathological' or as a clinical psychiatric symptom (Stroebe et al., 2001a) if we fail to take into account the severance of the relationship between the ego and CU, which may interact with the waning of ego consciousness. The "overwhelming grief" and some psychiatric morbidity may be concomitant, but the fundamental difference between traumatic bereavement and non-traumatic bereavement cannot be ignored (Brent et al., 1992).

After experiencing the suicide, the ego tends to be alienated rather than inflated. The ego is cut off from the Self and from the resource of its own life (Edinger, 1974). A model of an ego-Self axis was proposed by Edward Edinger, who elaborated on it in a developmental context: inflation and alienation are necessary at different stages for a child to grow up, and this mirrors the pain survivors felt and the energy they lost (e.g. Provini and Everett (2000) indicated that survivors' diminished energy levels prevented them from help-seeking). This can cause damage to the ego-Self axis. This damage can lead to one losing his/her contact with the Self and as a result the ego cannot function sufficiently. Donald R. Ferrell developed the idea of 'a surplus of meaning', which is generated by the Self and creates more meaning than the ego can process and integrate

(cited in Ferrell, 1995: 187). Anything that is outside of the ego's understanding contains 'a surplus of meaning' (e.g. premature death or genocide) which the ego cannot cope with, particularly the horror of what exists on the shadowy side of the Self. This is what survivors face after the suicide; and the wound can only be healed by a profound and sustained mourning for the suicide, for the losses, and for the change of one's relationship with the world and between the ego and Self.

The loss to suicide and endurance of pain, as well as the losing the grip of one's Self-ego harmony, is a "religious"[65] experience that is outside of the ego's understanding and volition. Survivors experience their world being shattered and their social support lost. Ronnie Janoff-Bulman outlined three basic assumptions that the majority of people operate under: 'the belief in personal invulnerability, the perception of the world as meaningful, and the perception of oneself as positive' (Janoff-Bulman, 1985: 15). After loss to suicide, these assumptions are turned upside down, for survivors are deeply vulnerable, meanings have been lost, and many have negative experiences of themselves. They are thus alienated from the 'assumptive world' (Janoff-Bulman, 1985, Janoff-Bulman and Frieze, 1983), and need to rebuild their world, while coming to terms with an existence in which bad things will happen.

In addition to the shattering of their assumptive world, survivors are severed from their social networks and they experience a certain degree of 'social uneasiness' (Begley and Quayle, 2007: 29-30). Mary Begley and Ethel Quayle have pointed out in their research that survivors experienced uneasy social interactions. They noted the experiences of survivors who were: 'needing support but felt let down by friends and community. Feeling marked by suicide, upset by

65 The term "religious" here does not attach to any religion, nor any dogmatic teachings of faiths. It means the deepest experience one can encounter psychologically and it can be exchanged with "spiritual".

people's responses, self imposed social isolation'. More social rejection (Calhoun et al., 1982) and substantial difficulties in the social setting are reported (McMenamy et al., 2008). On the community side, there exists 'social helplessness', which means that the social network has problems and difficulties in responding to and supporting survivors (Grad et al., 2004: 135). For the improvement of social systems, some suggestions will be made on how to accept survivors back to their "normal" life after their being scapegoated. The rest of this section will focus on how survivors' attitudes towards the world need to be adjusted in order to survive better.

Jung has made it very clear in *Answer to Job* that the encounter with the Self is often experienced by the ego as a defeat and/or wounding (Jung, 1952). Since the CU is the ordering centre of the psyche, it is transcendent and superordinate, constituting both positive and negative potentials. Despite the severance, it is crucial for survivors to maintain an aesthetic distance from the CU: not too close and not too far. People who identify with the CU will show an inflated egotistic attitude, having 'an unmistakable and often unpleasant increase of self-confidence and conceit'. At the opposite end, those who are alienated from the CU may be 'more and more crushed under the contents of the unconscious, they lose their self confidence and abandon themselves with dull resignation to all the extraordinary things that the unconscious produces'. According to Jung, the overflowing grandiose feelings of the former persuade them that they are able to 'assume a responsibility for the unconscious' and this is a dangerous attitude as no one can be bigger than the unconscious. By contrast, those who 'give up all sense of responsibility, overcome by a sense of the powerlessness of the ego against the working through the unconscious' are pitiful (Jung, 1912: par. 451).

In terms of the CU, it is more important to keep a distance with ‘a healthy measure of respect’ (Stein, 2006b: 50), rather than be carried away and surrender in a hopeless way. Our ‘rational and reflective capacities’ are required when encountering the CU (Huskinson, 2006: 210) and this encounter calls for the ‘modest wisdom of the middle path’ – not too inflated nor alienated -- with ‘a humble sense of one’s common humanity in the process’ (Walker, 2002: 103).

The SC Can Help Survivors To Understand The Suicide And Integrate The Loss

In the previous chapter, I discussed survivors coming close to killing themselves and then reaching a point where they let go of this desire. The impulse to mimic the suicide is, at best, an attempt to understand the pain of the deceased, to understand the ruthlessness of the CU and come to terms with it. The following narratives show how Angela grappled with the suicidal impulse:

> For one week, every evening, I set my alarm clock
> to go off at two o’clock in the middle of the night.
> I would wake up and decided that
> I was going to jump in a river.
> Every night it was the same scenario.

The mild form of suicidal impulse took the form of fantasy for Jan:

> I’ve entertained the thought because of what’s happened
> it’s kind of, become a possibility.
> I’ve never got to the stage where I’ve wanted to kill myself,
> but I’ve thought, “Oh, I could if I wanted to, because my mum did”. (Jan, II)

The formation of a SC can be detected after the suicide in most cases. Sometimes, it may have been forming before the suicide if the deceased had prior suicide attempts, and the future survivors had anticipated the impending final act. At the personal level, between the deceased and survivors, the kinship libido – the sense of connection -- is broken down; part of the survivors’ psyche is taken to the underworld by the sudden and catastrophic severance. Kinship libido is an instinct, a ‘feeling of belonging together’ (Jung, 1946: par. 445). The kinship libido allows one to have the

coniunctio experience and can also explain the identification with suicide: having been shown the way by their loved ones, survivors learn how to do the same – to kill themselves if they can bear the pain no longer. At a superficial level, the desire to mimic the act seems to indicate that the survivors want to join the dead; but on a deeper level, the act helps them to understand the pain that the deceased had gone through. After struggling with her impulse to kill herself, Suzanna said:

> It helped me understand why somebody would do it.
> It made me realise that it's not about wanting to die;
> it's about wanting the pain that you're in to stop,
> …
> You're just in so much pain or torment;
> you just want it to stop;
> you don't know how to make it stop.

Becky had the insight about what her brother may have gone through: "I don't know how many times my brother must have thought about killing himself before he actually tried to do it". The mimicking of the suicide not only helps survivors understand the pain, but also the awareness of the negative impact of their own suicide on others helps them to reject the impulse. For Becky, it was the concern for her mother that made her say "No!" to suicide. For Angela, it was concern for her grandmother:

> I would walk up and down in my room …
> Then I thought:
> "I can't do that to my grandmother".
> She had just one daughter, my mother.
> She was always so worried
> that something was going to happen to my sister or me.
> I always felt I couldn't do that to my grandmother,
> and that always kept me alive. (Angela, II)

Since part of the psyche has been taken to the underworld, survivors need to go down there to retrieve that piece of themselves. Two myths can be used as metaphors for the reclaiming process: Demeter and Persephone and Orpheus and Eurydice. In a symbolic way, both Demeter and Orpheus lost a part of themselves that was carried to Hell by the loss of a significant other. In this

discussion of myth, object relations and projective identification are used to illustrate the grieving and reclaiming processes.

When Persephone is first lost to the underworld, Demeter, after the breakup of her relationship with the gods, cannot resume the tasks that are expected of her; her life is chaotic and messy (e.g. she does not wash herself or eat for a period of time). She finds her way out of this consuming grief through another life context and in a different role (i.e. she disguises herself and nurses someone's child). The ego keeps functioning, albeit in a different direction. Demeter's grief response results in Persephone returning from the underworld for a temporary reunion with her mother during a part of every year. Eventually, the loss is owned and transformed, the internal process resulting in reclaiming back that part of the identity. To descend into Hell is to taste 'the bitter fruit of imagining the unimaginable' (Rowland, 2012: 169). In the case of Orpheus, the reclaiming process failed and that piece of Orpheus, represented by Eurydice, is forever lost.

The metaphors that can be mined from these myths indicate that the mind of survivors will go through a period of re-structuring (e.g. integration or breakdown); they also hint at the ways survivors can relate to the deceased (e.g. as a bond which is continued, or as one which is lost forever).

Being The Scapegoat, Survivors Carry Projections From The Collective Unconscious

By suggesting that survivors become scapegoats, carrying projections from the CU, I by no means blame the general public for this. Instead, I hope to point out that deep archetypal forces are influencing the way we perceive suicide and prevent us from being able to engage with survivors "realistically". Blaming and scapegoating are frequently observed in difficult situations; when suicide happens, family members may accuse one another of being responsible. Sometimes, survivors are demonized as being a factor in their loved one's

suicide. Jessica experienced being blamed for her son's suicide; Vanessa witnessed her relatives blaming her mother for the death, and hence, lost the connection with her father's relatives. The feelings of guilt and the shame that scapegoated survivors are forced to experience are too much to bear.

Sylvia Brinton Peresa investigated the scapegoat ritual in the Hebrew culture and developed the theory of a scapegoat complex to interpret the constellated complex in life and in her clinical practice (Peresa, 1986). Scapegoating:

> means finding the one or ones who can be identified with evil or wrong-doing, blamed for it, and cast out from the community in order to leave the remaining members with a feeling of guiltless, atoned (at-one) with, collective standards of behavior. (Peresa, 1986: 9)

It is 'a form of denying the shadow of both man and God' based on Jungian psychology. After projecting the shadow,

> the scapegoater feels a relief in being lighter, without the burden of carrying what is unacceptable to his or her ego ideal, without shadow. Those who are identified with the scapegoat … are identified with the unacceptable shadow qualities. They feel inferior, rejected and guilty. They feel responsible for more than their personal share of shadow. (Peresa, 1986: 9)

In any "normal" case of suicide, survivors are the direct victims of the loss, with the assumptive world shattered and the survivor's life turned upside down. Survivors often feel they have been rejected by the deceased (although it may not be the volition of the deceased to abandon survivors) and that they are forever marked by their loss. Even if survivors have made some ineffective interventions to prevent the suicide (or not), they are not devilish, unclean, or wrong. Scapegoating is rather the result of the people's desire to maintain its own 'wholeness', 'unity', and integration (Colman, 1995: 7, 9); by blaming the victim, the general public can maintain a feeling of personal invulnerability (Lerner, 1980). The scapegoats suffer a range of responses from their community from 'social

stigmatization, to removal from society (incarceration) and may lead eventually to execution' (Walker, 2002: 168)[66].

There exists an 'organic connection between shadow and scapegoat' (Colman, 1995: 7, 10). According to Arthur D. Colman, the scapegoat is the 'societal vessel for the shadow'; being projected as 'contagious', even though s/he is 'innocent'. The image of survivors as scapegoats implies less 'a sin-offering' who is killed and sacrificed, but more the 'expelled or escaped goat' who is marked and sent out into the wilderness 'away from the place of collective consciousness'. By carrying the 'evil' that is repressed by society, the 'wandering exiled goat removes the taint of guilt' – returning the destructive force to 'its origin in the unconscious' (Peresa, 1986: 16-7, by adopting Kluger).

People want to forget about the scapegoat, ignore it, leave it alone, and hope the world will take care of it. The trauma of victimization activates negative images in the victim (Horowitz et al., 1980). Similarly, survivors are invisible and are forever marked. While people just want to get on with life, survivors, by being projected and/or identifying with the projection, carry the cross all their life. For Becky, her brother's suicide is her "cross": "For me, that's my crucifix that I have to carry". The projection and identification are highly complex interactions, and the processes of shadow projection and its identification have a deeper root – that of mankind not wanting to know about death. At least survivors need to be helped to dis-identify with the role of scapegoat that is projected onto them and learn to live with the suicide in a healthy way.

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66 Although Walker here was referring to the institutional "correctedness" in relation to drug addicts, we can detect from historical records that the treatment of survivors involved a similar attitudinal distortion. For instance, in the 16th -18th Centuries, the forfeit of the suicide's assets was similar to charging the family a fine; the exhibition of the body, although aimed to warn people not to follow suit, clearly had the effect of shaming and stigmatizing the family. 'Stigmatization is a social meaning disorder'. MATHERS, D. 2001. An Introduction to Meaning and Purpose in Analytical Psychology, East Sussex, Brunner-Routledge. P. 6.

Colman contended that we differentiate between those who '*take on*' the scapegoat as the beginning step towards integrating shadow and selfhood, and those who '*take in*' the scapegoat but are controlled and damaged by it. A middle-way choice would be taking the role of 'interpreter or teacher': namely, as 'the conscious scapegoat'. By maintaining the 'interpretive stance', survivors can be truthful to their experience and journey, be genuine and authentic, be aware of the projection and identification, and model healthy survivorhood from 'a place of self-knowledge' (Colman, 1995: 18-9).

Any loss can lead one to the individuation process; the loss through suicide even more so. Jung suggested that when we enter the second half of our life, it is better to listen to the Self than to the ambitions of the ego (Jung, 1947/1954, Jung, 1928b). It is equally important to 'sublimate and integrate' the numinous unconscious and make it as conscious as possible (Stein, 2006b: 48). The relationship between life stages and individuation is more complex in the context of survivors. For survivors, individuation is not a choice but is impelled by fate (Walker, 2002: 31). It is a 'push' rather than just a 'hint' (Jung, cited in Stein, 2006b: 35), and is a 'metaphor' rather than a 'literal' journey (Hockley, 2004: 79). I would like to call it the journey of "creative individuation", which is different from the classical sense of individuation that Jung advocated. "Creative" here does not mean artistic, but the capacity to hold the opposite – one of the qualities that Anthony Storr contended was possessed by creative people (Storr, 1972).

Creative individuation requires survivors first to maintain a firmer and renewed ego complex in order to rebuild a daily structure after the destructive suicide. It is not only the integration of unconscious images '*with*' the ego, but also 'a differentiation of them *by* the ego and thus an increase in consciousness' (Adams, 2004: 220). The challenge of survivors' individuation processes will be to

hold the opposite, the paradox, the contradiction between conscious and the CU, pain and joy, alienation and integration, loss of the beloved and celebration of life.

To help survivors come out of the wilderness, it is suggested that the community should be 'proactive in reaching out to survivors' (McMenamy et al., 2008: 386); the first responders (e.g. police, funeral directors, clergy) are crucial in the community setting to offer help to survivors (McMenamy et al., 2008). Celine Provini and Jessica R. Everett suggested that public education campaigns need to focus on tackling the issue of stigmatization around suicide, encouraging survivors in help-seeking and also strengthening their personal coping capacity and strategies. Social supports have the function of sustaining survivors in a long-term way, and the availability of professional assistance should be offered in parallel to the support from social networks because survivors have different needs that require support at different stages of their lives (Provini and Everett, 2000).

Social interaction and attitudes others have towards them are two of the major factors contributing to the bereavement result (Calhoun et al., 1982). As mentioned earlier, survivors can engage with helping others, particularly helping survivors, or engage with prevention or education. Communities and societies can make a big difference by embracing survivors, weaving them into their texture and helping them become part of the community "again". By being given a role (e.g. as a "helper"), survivors can loosen the gripping effect trauma has on a victim.

> Survivors can be of help to others by reaching out in a supportive, caring way and through social advocacy. They begin to relinquish the passive victim role, become more engaged in living, and even experience a sense of competence again through becoming "helpers". (Appel and Wrobleski, 1987: 223)

Engaging in community activities is a 'healing process'. By becoming a caring and compassionate person, survivors show that there is 'a transformative potential in grief', a modelling of personal growth out of adversity which gives people hope,

shows the resilience of humanity, and copes with disasters in life (Feigelman et al., 2009: 198, 195). Angela Smith has indicated that survivors are reluctant to acknowledge the gaining of insight (Smith, 2011). It is understandable that, after survivors have lost their loved ones, experienced a painful and painstaking grieving process, faced inner turmoil and external unfriendliness, been marginalized and shamed (either self-imposed or other-imposed), surviving a suicide is not something that they are able to celebrate. However, being accepted back to the community may help survivors to work through the resistance of acknowledging positive developments in their journey.

The Necessity To Address The Archetypal Rupture That Survivors Are Struggling To Live With

The archetypal force that survivors grapple with needs to be acknowledged in at least three ways: first, the seemingly pathological bereavement may not be the individual's failure to re-invest the libido in Freud's sense, but the interaction between one's waning consciousness and the unconscious. Contemporary bereavement and loss therapy have obtained an awareness of maintaining the continuing bond (Field, 2006a, Silverman and Klass, 1996), but the archetypal rupture that occurs in the survivor's psyche is still unknown territory to the helping professions. Sometimes, survivors need to reassess the ego function and its place in relation to the unconscious – specifically whether one identifies too much or is alienated from the unconscious.

Awareness of the archetypal rupture can help survivors deal with the life-long grieving journey (Wertheimer, 1991). This calls for a concept of paradoxical bonding with the deceased. This paradoxical bonding requires survivors to develop a sense that the deceased is gone but there with me, although they are not in the same space/time. This sense of paradoxical bonding should not be

confused with delusions or hallucinations, but should rather be understood as being based in a ‘psychological fourth dimension’ – a hypothetical dimension as suggested by Balint (cited in Field, 1991: 101). The theory of quantum physics questions the linear, uni-dimensional sense of time and space (Morgan, 2000, Fine, 1986). In ‘the four-dimensional space-time[,] [s]pace and time themselves are two concepts which had seemed entirely different, but have been unified in relativistic physics’ (Capra, cited in Field, 1991: 98). This idea alters the way being and non-being, life and death, and consciousness after death are understood.

Surviving a suicidal loss is akin to a religious experience. In the process of living with profound loss in our lives, the capacity to ‘rescribe meaning to a changed world through spiritual transformation, religious conversion, or existential change’ is important (Marrone, 1999). There is also a connection between one’s religious activities and positive growth (Feigelman et al., 2009). Survivors reported a renewed belief in spirituality, which helped them to make sense of the suicide (Kalischuk and Hayes, 2003-2004) and showed the meaning and benefit of ‘continu[ing] to love the deceased person’ (Kalischuk and Hayes, 2003-2004: 62). A sense of paradoxical bonding can help maintain a relational continuation with the deceased, giving survivors space and time to integrate the loss and at the same time develop one’s renewed relationship with the deceased (absent in reality but present in their heart), the environment, and especially with the unconscious.

The second important factor is the systemic impact of suicide on those who are left behind. Jung had noticed similar complexes within the same family (Jung, 1909) and in the same peer group (Jung, 1910-11). For any pairing archetypes (e.g. mother and son), they shared some common communicative structures, hence the suicide influenced the individual and the relational network. For

instance, when Angela's mother died, her elder sister was forced to become a "mum" taking care of the household, and Angela therefore lost not only her mother but her sister as well. After Joy lost her son, she and her then daughter-in-law could not be on good terms with each other, and, as a result of their conflict, Joy lost the opportunity of having a relationship with her grandchildren.

Although grief is very much a personal matter, it hurts even more when grief cannot be shared. The family system is dynamic in nature; an example of this is how the relationship between the deceased and survivors prior to suicide will influence how survivors cope with life (Cleiren et al., 1994, Reed, 1993, Riley et al., 2007). When a child dies in a family, it will influence parents and siblings in different ways; likewise, when a parent dies by suicide, it will influence the various children differently (Kuramoto et al., 2009, Runeson and Asberg, 2003, Heikes, 1997). It has been shown that there are more negative social attitudes and reactions towards parents whose children died as a result of suicide (Calhoun et al., 1980), and families with surviving children may experience more complicated bereavement (Provini and Everett, 2000). Intervention should be offered to individuals as well as families (McMenamy et al., 2008). For parents who have lost children, Dyregrov suggested that the social service (e.g. referrals to support groups or bereavement counsellors) should be maintained for up to five years after the death (Dyregrov, 2002).

The third important factor concerns the dynamics of the family system; the family members are sharing a 'relational' and 'interactional' destiny (Papadopoulos, 1996: 136-40), although, unfortunately, the pain and difficulties are also shared. The 'networks' influence the individuals and the collective cyclically and in a variety of ways rather than in a linear or reductive way (Papadopoulos, 2006b, Papadopoulos, 1996).

Social and familial networks face three stages of difficulty in recognising, identifying and responding to the suicidal crisis and supporting those who were close to the deceased: the first being the 'difficulties faced by the suicidal person in effectively communicating distress', the second being the struggle 'experienced by significant others in interpreting and heeding distress signals', and the third being the impediments 'experienced by significant others in taking action' (Owens et al., 2011: 2-3)[67]. Although this study covers the difficulties before and after the suicide, from the third level of difficulties for the significant others, it is observed that the network is destabilized and in crisis. The complications in maintaining communication in the relational network are clear. People feel that they need to tread carefully around the issue and/or discussion of suicide because of fears that they will be overcome by the difficult issues that it brings up.

The barriers preventing the systems involved from communicating, understanding and intervening in a suicidal crisis are the result of highly complex interactions (Owen et al., 2012). People do not know how to help and they are 'ambivalent about helping' (Owen et al., 2012: 426, adopted Wolk-Wasserman). The three reasons illustrated above indicate the necessity of addressing the archetypal rupture that survivors are struggling to live with in order to provide them with enough support.

By framing suicide survival in the context of the TG and Jungian psychology, I may have implied that suicide is an archetype. If judged from Jacobi's analysis of

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67 The difficulties for the suicidal person in communicating distress include personality, social pressures (e.g. young men's tendency to disguise distress), feeling shamed and embarrassed to reveal the depths of their suffering, substance abuse, etc. The difficulties for the significant others include: the demands in daily life, busy life style, explaining away the behaviours (e.g. "Here it comes again"), intolerance of the suicidal potentiality (hence the dismissal of signs), the over-stretching of the boundaries of what is considered normal, avoidance of labeling distress, disbelief that suicide will occur, the maintenance of the daily life and the ego functionality. The difficulties in taking action prevent the significant others from at least "saying something" to the suicidal person, warning others in the network or finding help outside the system.

complexes in Chapter Four (i.e. the nature of a complex could be 'morbid' or 'healthy'. Complexes are 'bipolar', resulting in positive and negative manifestations (Jacobi, 1957/1959: 25)), we can speculate that the nature of SC is morbid and the positive manifestation of SC is not entirely clear, although the data suggests that SC can help survivors understand the pain of the deceased and come to terms with the loss.

The implication that, when one can no longer bear the pain they may choose to kill themselves, is not enough for SC to become an archetype. First, from my empirical work there is not enough data to support this hypothesis. Second, from the analysis of SC in this thesis, it is not imbued with the four criteria of an archetypal theme (Hobson, 1961/1971)[68]. Third, there are more people choosing to endure the pain rather than kill themselves. Based on those three points, I cannot suggest that suicide is an archetype. Its impact may be felt as archetypal owing to its extremity and the '*intensity of affective response*' (Samuels, 2004: xiv). Rosen, who hypothesised a similar concept before me, argued against the idea of suicide being an archetype. He wrote:

> Although there is plenty of evidence to support the existence of a death instinct in the human psyche, there is little evidence to support the existence of a suicide instinct. Although we know that individuals and groups can choose to kill themselves, this could easily be based upon a suicide complex with the archetype of death at its core. This is very different from an innate tendency to self-destruction, which could be related to a suicide archetype. (Rosen, 1996: 31)

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68 On page 72, R. F. Hobson reviewed Jung's CW 9i and listed four criteria of an archetypal theme:

1. it must be independent and clearly enough to be recognized as a typical phenomenon; for instance, a motif must occur in the experience of different individuals and recur in a series of dreams of one person.

2. it must be observed to exist in many parts of the world and in many ages.

3. it must have an identical context and functional meaning.

4. the archetypal image should not have been obtained through education or learning processes.

From reviewing fairy tales and myths, Rosen concluded that:

> there is not a natural propensity to suicide at the archetypal core of the human psyche. … From an archetypal and mythic perspective, suicide is a definite possibility for individuals [to take]. But this seems to be based on a suicide complex, not on a suicide archetype. (Rosen, 1996: 32-3)

Whether suicide is an archetype or not is still an open question, and will depend on the observation of 'emergent' developments of SC within different populations (Goodwyn, 2010, Martin-Vallas, 2013, Saunders and Skar, 2001). It also depends on how we live with SC, what relationship we maintain with the unconscious, and our attitude towards life and death. Those issues are beyond the scope of this thesis.

This thesis has focused on the formation of a SC that is constellated directly in survivors' psyches, and indirectly in the collective unconscious of the general public. It shows the potential people hold for killing themselves when their vital interests are seriously frustrated. Survivors feel the archetypal impact vividly after experiencing the suicide of their loved ones. The existence of SC means that we do not need to be taught how to carry out suicide; it seems we all have some sort of knowledge that is a part of our inner psyche. It is also similar to the 'suicide construct' identified by Robert Jay Lifton that explains that suicide is "an option" which can be transmitted via familial, psychological and cultural contacts (Lifton, 1989: 464). In 1968, William Niederland coined the term 'survivor syndrome' (SS) to describe the 'emotional disorders' of the Jews who survived Nazi persecution (cited in Luckhurst, 2008: 63). Likewise, 'suicide survivor syndrome' (SSS) has been recognised, linking survivors of suicide with higher risk of suicidal ideation and behaviour (Krysinska, 2003).

SC is different from SS and SSS; it addresses not only the negative impacts on the individuals, but also covers the collective level. It is not only a symptom or syndrome that needs to be cured, but also a psychic manifestation that needs to

be understood and lived with. It looks at suicide as a deep psychic phenomenon rather than simply a mental health problem. It indicates the formation of a complex resulting from a subject interacting with his/her significant others and environment.

I want to emphasize the fact that the essential condition for SC to be resolved is not dependent on the occurrence of positive outcomes, but the decision on the part of the survivor to decisively say “No!” to the impulses awakened by the complex. They must possess a determination against these destructive impulses and against the slightest harmful fantasy that may crop up in their minds. However, there is a positive relationship between positive outcomes and the resolution of SC. It is conceivable that when one develops more positive experiences, s/he will have more strength to guard against destructive impulses and resolve the SC. This can be achieved through the integration of the painful experience, empathy, and an understanding of humanity. This integration has the potential to reduce the transmission of the contagion of suicide.

10. Conclusion

Doing research on suicide survivors involves engagement with many sensitive issues. This complexity is even more delicate since I am also a survivor. Keeping the balance between objectivity and subjectivity requires not only reflection on the whole process of the empirical work, but particularly on the lens through which I look at the data and look for answers. It was also important to ensure reflexivity on the whole set-up of research design and method (Silverman, 1985, Alvesson and Sköldberg, 2000). This chapter begins with a discussion of the layers of reflection and reflexivity that were a part of this work. Following this, the three pivots embedded in the reflective and reflexive processes are investigated: the essentialist stance and the place of the Other; identity and identification between survivors and the researcher, including the researcher's self identity; and the ethics surrounding the subjective nature of this research. This chapter ends with my self-analysis as a survivor-as-researcher, the limitations of the study, and suggestions for future research.

Reflection and Reflexivity

Human beings are reflective animals (Taylor, 1989, Taylor, 1991). Many philosophers have employed a reflective approach to questioning and searching for the meaning of our existence, hoping to obtain self-understanding and the knowledge about the world and other people.

> A reflective philosophy considers the most radically philosophical problems to be those that concern the possibility of *self understanding* as the subject of the operations of knowing, willing, evaluating, and so on. Reflection is that act of turning back upon itself as a subject grasps, in a moment of intellectual clarity and moral responsibility, the unifying principle of the operations among which it is dispersed and forgets itself as subject. (Ricoeur, From Text to Action, 1991: 12, cited in Kaplan, 2003: 9-10)

The reflective subject has been associated with getting to know the truth. However, the 'social saturation' resulting from the advance of technology in the postmodern era brings with it the loss of true or knowable selves (Gergen, 1991: 16). According to Kenneth J. Gergen, while voice, identity and subjectivity have been multiplied, truth is no longer obtainable. Truth is 'relativized'.

> [E]ach truth about ourselves is a construction of the moment, true only for a given time and within certain relationships. … And as science becomes not a reflection of the world but a reflection of social process, attention is removed from the "world as it is" and centers instead on our representations of the world. (Gergen, 1991: 16)

Reflection and reflexivity are ethical stances that qualitative researchers should be mindful of. Reflection is defined as 'the *interpretation of interpretation* and the launching of critical self-exploration of one's own interpretations'. The focus of reflexivity is extended to the handling of data and embracing 'a consideration of the perceptual, cognitive, theoretical, linguistic, (inter)textual, political and cultural circumstances that form the backdrop to – as well as impregnate – the interpretations' (Alvesson and Sköldberg, 2000: 6).

According to Mats Alvesson and Kaj Sköldberg, the word "reflexive" has a 'double' meaning. It goes beyond "reflection" which is applied to a single or specific method, research design, or any one level of interpretation. The concept of reflexivity acknowledges that 'texts do not simply and transparently report an independent order of reality. Rather, the texts themselves are implicated in the work of reality-construction' (Atkinson, cited in Taylor, 2001: 319). Reflexivity refers to reflections upon different levels and one level upon another. It is

‘multidimensional and interactive’. The levels reflected upon cover ‘the handling of the empirical material, interpretation, critical interpretation and reflections upon language and authority’ (Alvesson and Sköldberg, 2000: 248). Reflexivity is the capacity to ‘relate to oneself externally, as an object or as an other’ (Linde, 1993: 120).

> [A]s there is a dialogue between researcher and researched, text and reader, knower and known. The research report becomes “a story” with readers the audience, shaping meaning by their interpretations. (Riessman, 2008: 137)

When conducting a narrative inquiry, intersubjectivity and reflexivity go hand-in-hand. These ethical stances need to be reflected upon constantly from the beginning of the empirical work to the write-up of the research text. In addition to the on-going evaluation of research design and methodology, the theory of reflexivity points out the significance of a critical attitude toward the affective mutuality between the researcher and the researched.

Three Reflexive Pivots

In the course of the research journey, I have been reflecting on how I might have influenced my interviewees and how they have influenced me (e.g. in the way I asked questions and how they understood the interview, how it was for them to have faced a foreign researcher, and how it was for them that the researcher is also a survivor, … etc.); how I have received and reacted to the contacts and interviews; how the research has influenced the relationship of myself and my own surviving experience; is it a narcissistic and solipsistic project or can it be an academically valuable project? Overall, there are three pivots embedded in the reflective and reflexive processes:

1. The essentialist stance and the place of the Other.
2. Identity and identification between survivors and the researcher, including the researcher’s self-identity.
3. The ethics regarding subjectivism in this research.

The Essentialist Stance And The Place Of The Other

As mentioned earlier, the study of suicide survivors has not been disseminated widely and society at large still does not have a clear picture of how survivors go on with their lives after the loss to suicide (Jordan and McIntosh, 2011b, Sveen and Walby, 2008). The term “survivors” did not exist until the relationship between mental health and suicide had been recognized; from the 1960s, the question of how survivors are impacted by suicide attracted the attention of modern psychiatric professionals (Cain, 1972a, Tooley, 1972). Each survivor came to my research carrying with them the loved ones they had lost, as surviving the loss to suicide is a ‘dyadic’ experience (Shneidman, 1972: ix). With each of them, I welcomed the dead in the conversations and in the group. Although they were not there, their presence was felt in the stories shared by the survivors. The survivors shared with me the greatest pain one can ever expect to experience, the most profound loss one can ever bear, the most complicated grief one can have to recover from. The survivors talked about their relationship with the deceased before and after the suicide; ironically, they would not be survivors if the deceased had not killed themselves. The ‘Other’ is an integral part of this research (Cole, 1992: 125).

In developing a critical sociological self-reflexivity, the subtle difference between reflexive ethnography and deconstructive ethnography is noted.

> Whereas reflexive ethnography argues that the ethnographer is not separate from the object of investigation, the ethnographer is still viewed as a unified subject of knowledge that can make hermeneutic efforts to establish identification between the observer and the observed. Deconstructive ethnography, in contrast, often disrupts such identification in favor of articulating a fractured, destabilized, multiply positioned subjectivity. Whereas reflexive anthropology questions its authority, deconstructive anthropology forfeits its authority. (McLaren, 1997: 166)

I did not choose a deconstructive stance because the task required the consolidation of phenomena, to essentialize the experiences and to concretize the existence of survivors first. This was a conscious decision, even though I anticipate that this stance may attract criticism. It would be unethical if I opted for the deconstructive route – to re-write survivors' experiences instead of recognising them, to fragment the shadow instead of giving it a place, to parody the issues instead of focusing them. No matter how elegant, how fashionable, or how academically sound it would be to pursue the deconstructive route, it was not an appropriate choice for me.

The stance behind the research includes the decision to distil and preserve the witnessing quality of the interview narratives into a poetic form. The poetic representation achieves a zooming-in effect on survivors' experiences, while at the same time providing an aesthetic vehicle for the readers to sense what those experiences feel like. However, it may create an illusion that these experiences are locked in a timeless and static space. Moreover, the embedded TG framework may have prevented the survivors from talking as freely as they would have liked. Since the main focus of the research was to explore the various outcomes after the loss to suicide, some survivors may have felt hesitation in sharing other aspects of their journey that did not relate to this focus. Even though I have tried to be self-aware in conducting interviews and facilitating the group and have provided care for the participants (e.g. sensitivity, transparency, and an on-site therapist), I cannot deny that they were serving me more than I have them. The on-going reflexivity acknowledges the tension that exists throughout between experience and theory, story and data, subjectivism and objectivism, creativity and science.

Identity And Identification Between Survivors And The Researcher, Including The Researcher's Self Identity

In Chapter Six, the issues of identity and identification were explored. For survivors, the identity comes from the experience of loss through suicide which has been imposed upon the survivors involuntarily. By identifying how a senior survivor lives with the suicide, a newly bereaved survivor may sense there is hope (Cerel et al., 2009b). Because of the peculiar kind of loss one experiences through the suicide death of someone they love, the unwelcome identity of survivors would be untethered and be mirrored only after the experience of meeting another survivor. By projecting onto other survivors and feeling understood, one may gain a sense of belongingness within the survivors' community. In Chapter Seven (The Research Design and Methods), I made clear that the choice of coming out as a survivor-as-researcher was a conscious decision. This may be criticized as complicating the identification, implicitly inviting the participants to take care of me (as pointed out by a member of the ethical committee in my department). The anthropological stance that I took by entering the field (i.e. by revealing myself as a survivor from the beginning) needs to be examined with both moral and analytic rigour.

As the 'Other', the deceased, is an integral part of the research; my motivation for doing this research stems primarily from my own experience of being a survivor. Being the role of researcher grants me access to resources; if I denied, or hid, the loss of my son (which is the starting point of this research), I would be dismissing my own experience as a researcher. Standing behind the role of a researcher, whether to protect myself from over-engaging with survivors' experiences or to maintain the so-called objective requirement, I may be manipulating the participants by not being transparent or causing confusion. That I was known as a survivor to the SOBS London group before the empirical work

was not an issue that prevented me from taking on a dual role; the issue would be that the information was not shared equally with all of the participants (not all participants knew me before the research) and this may have resulted in the participants engaging in an unequal power relationship with me.

During the initial interview, in responding to some survivors' questions about my own loss to suicide, by informed intuition I shared sufficient information to enable the survivors not to feel dismissed, but at the same time tried to lead them back to the sharing of their experiences. I sensed that some of the enquiries were similar to an identity-check: i.e. "are you really an insider?" In the beginning of the applied theatre group, I pointed out that although I was a survivor, my role for the day was a researcher. In the final interview, I invited them to comment on my dual roles.

Tracey commented that I had 'more credibility' because I have the experience of being a survivor. For Jessica, it made the process of joining the group easier, 'know[ing] that you did understand what we were saying and how we felt. You actually know the emotions that we were talking about because you experienced that yourself. I felt I was able to open a bit more'. Suzanne expressed:

> It helps that you are a survivor as you are researching about it with the first knowledge about it. Obviously it helps. Unfortunately you have the experience because we know you have that understanding, you have gone through the process yourself. … It probably helps people to be interested in your research as well, because it is important to you. We know you through SOBS group. Obviously it is important for all of us.… Because it is like you are one of us, you are not just an academic person sitting there asking us how we feel. Maybe you will have analysed more.

I do not mean to show that the job was done well, but lay bare the inevitability of identity and identification existing among survivors. Although a similar position was taken by the researcher as a survivor in a study, in which the participants felt that identity 'made the exchange easier' (Smith, 2011: 425), it can also be 'inappropriately "[r]omantic"' and involves some unnamed 'assumptions' (Atkinson and Silverman, cited in Taylor, 2001: 322). It is a messy business to argue for its

representativeness when the researcher has somewhat similar experiences (Wilkinson and Kitzinger, 2009, Spivak, 1994).

Carolyn Ellis advocated ‘relational ethics’ in doing ethnography, and these ethics can be applied to qualitative research. ‘Relational ethics recognizes and values mutual respect, dignity, and connectedness between researcher and researched, and between researchers and the communities in which they live and work’ (Ellis, 2007: 4). Being both researcher and survivor myself allowed me to access the experience and translate it into theory. Although an ‘emic’ perspective (namely my insider’s position) made the involvement and interaction meaningful, the *‘eidetic*’ function that I embodied is ‘to leave the individual phenomenon behind, and to reach the so-called “essence”’ (Alvesson and Sköldberg, 2000: 37). I cannot claim, though, that I myself have been totally ‘separated from the findings’ (Willig and Billin, 2012: 123).

The Ethics Surrounding The Subjectivism Of This Research

The ethical concerns that were most central to this study were those regarding the survivors’ well-being while participating in my research and my own self-care. As the former has been discussed in various places in the thesis, the issues of how I took care of myself will be reflected on here. For instance, while being empathic, how could I fulfil the task of being a narrative inquirer? In other words, how could I (the observer) remain unaffected by what I observed (survivors) in a healthy way? While I was overwhelmed by the weight of the experiences of the survivors, how could I minimize the emotional impact and be aware of the need to care for myself? How could I just grieve for my own loss without the burden of being inflicted with this collective loss and grief?

My health has been on a downward slope since this PhD started. In the first year, I experienced a rash for about six months. When I finished the empirical work, during the stage of transcribing interviews and group processes, my back

and shoulder have been in constant pain. I reached a point when I could not work anymore, for my body simply seemed to shut down. I was aware that some of the pain was as a result of doing the empirical work, but I could not differentiate between how much was mine and how much was not mine. 'Moral echoes call forth social responsibility – actions that address a perceived wrong or injustice. An echo is also an example of embodied impact' (Mitchell et al., 2011: 389, by adopting Gablik, S.). This sounds wonderful, yet my whole system was giving me a warning: "Too much! Stop!" In addition to my identification of the collective pain that survivors endure, I may have become too grandiose, identifying with something similar to a 'saviour complex' – not in the sense of a therapist identifying with the projection from the patient (Jung, 1976: par. 354), but in taking on the mission of suicide prevention as solely my own mission, or of wanting to revolutionize the discourse on suicide bereavement.

I recognise that my process has been part of this PhD and it is equally important. I needed to integrate the loss and pain of losing my son, for otherwise this thesis would not be completed. Similarly, if I was unable to complete this thesis, I needed to find a way to continue my life without thinking of myself as a failure for not preventing my son's suicide. On 6th July 2013, I wrote in my diary:

> I was deeply depressed yesterday. I allowed myself to go down down down; I reached to an image of myself lying in a coffin, dying or dead. … I looked at myself, asking myself, "what can I do?" "What should I do?" I knew I had reached to my limit. I asked God to be there with me. I asked God to save me, I don't want to die, I don't want to kill myself, I want to enjoy life, I want to experience joy again, I choose life, not death. I asked God to give me vitality, life, oxygen, light.
> I asked her what she needed. She said, "joy, happiness, ease", … I knew I had an ethical concern here: I need to choose life, I cannot choose death; I need to save her, with God's help. It is Jung's active imagination, I need to make an ethical choice, choose life, sustain her. This is my soul's demand; my soul has been demanding that I look at this experience, digest it, integrate it, accept it, let it become part of me. I cannot escape this journey, it will be always with me.
> I have been so scared that I have been thinking of giving up. It is fear, fear of the future, fear of facing the future, fear of facing people and the world and saying, "I am a survivor". I wish I could hide, be invisible and forgotten. I have been thinking of the mythical side of femininity ... It is about death, but what can I do? Do I just wait and see when and how I can restart again? It is about the journey to the death, to the underworld, to the end of the world. But when will it turn into something else? It's so scary to be there alone, it is no man's land, it is desert. I need salvation, and rescue from spirits. Rebirth needs lots of work; I need the whole universe to help me, I need God to help me, I need people to help me, I also need myself to stand by myself. There is only one possibility that is rebirth. I don't want to die there, I want to live again.

> I lit a candle for myself last night. It was a vigil. I need to guard my body, my spirit, my soul. I say no to the dark spirits, I say yes to life. I need to keep myself for the rebirth, waiting for the rebirth. I need to be patient, compassionate, and to forgive myself. It has been a long journey, a difficult journey. I need to allow myself to have time, to take time. It cannot be rushed, because it is not only up to me, it is up to the whole collective psyche, the collective unconscious, to take in the voices of a survivor, the wishes of a survivor, and experiences of a survivor.

This is 'writing on the edge' and 'without a safety net', but I do not want to be trapped in a no man's land. Margaret H. Vickers encourages researchers to 'be prepared to take an informed risk and expose our own' experiences, and 'find the strength of our voice' (Vickers, 2002: 611, 613). As with other crisis incidents, to make meaning out of the loss through suicide as a survivor-as-researcher is beyond the meaning of existing frameworks. My only outlet would be to live with it, through it, and beyond it, and continue to ask open questions.

The Researcher's Self-Analysis

In this section, I will use the TG and the contributing factors to review my own journey after losing my second son, Zero, to suicide. At this moment of writing, I feel it is a painful task that I would like to avoid if it is not for the completion of the reflection as a researcher. It happened twelve years ago; Zero was twelve years old while I was thirty-seven years old and I was at the end of my MA on Theatre Studies at Taipei University of the Arts. I had all the negative reactions that survivors in the group I facilitated reported: the negative feelings (such as feeling guilty, shocked, ashamed), difficulties of functioning in daily life (I could not continue my MA study and withdrew for two years), the loss of motivation and sense of meaning, and pathology formation (I was deeply depressed and feeling suicidal at times).

As my participants experienced, there was lots of blaming, implicitly and explicitly, among family members. The pathological dynamics that existed in the

family prior to Zero's suicide accelerated and intensified; the strain of loss resulted in divorce. My first son, Swift, was angry at me and we were unable to talk about Zero's suicide for five years. Swift is twenty-six years old now and more sympathetic with me, but we still have not faced this experience and reflected on it together as mother and son.

My parents and siblings were supportive, but they were unable to comfort me in the emotional ways that I needed. They wished me to just forget about it and get on with life. It was partly a cultural factor that they were unfamiliar with emotional language (and extremely anxious about the issues of depression and suicide). Seeing me in a state of tremendous grief made them anxious, and they did not understand the meaning of the loss or what I needed from them (even I could not say what I needed clearly). Fortunately, my father supported my decision to divorce my husband so that I could just focus on my healing. Since then, my healing journey has taken a long, meandering and purposeless route. I did not have any external pressures, because I withdrew from the University for two years (or it may be more correct to say, I was unable to shoulder any external pressure). I was in my own cocoon, unable to function as a social being.

Zero's suicide occurred in the middle of a transitional period of my life. Before his suicide, the unhappiness in my marriage opened the gateway for my inner journey; I was trying to understand how my parents and childhood influenced me in the way that I struggled in the relationship. Meanwhile, I was developing myself by going to the MA theatre course and hoping to have a career after that (I worked as a sales manager in trading companies before I decided to turn to theatre studies). Being in-between two "stations", I was in a fluid space without a tangible daily structure for me to hold on to.

I had been receiving therapy from the service in the University and attending therapy training courses before and after Zero's death. In retrospect, it had not

been enough. A group of friends who were in the training group gave me support, but this only lasted for a short time. No one ever initiated a talk with me about how I grieved. Suicide was very much a taboo in the society I was living in; as a survivor I felt marked, marginalized, and invisible. There were a few research projects for survivors which I joined and expanded my awareness of suicide, its prevention and suicidology. There were also a few faculties in the University that helped me in all sorts of ways; two years later I resumed my studies and graduated. However, even as the recipient of an MA, I was unable to work or find work because of the deep wound. It seemed that all my strength and positive qualities had gone, and I even wondered whether I had any resources left. Did I deserve to be alive? The dissociation from my own resource had a lot to do with my changing career; I felt I could not go back into business, and I had not developed substantially in my new theatre career. I felt extremely confused and guilty because the suicide happened after I began theatre studies. If I could have waited until the children were grown up, would it be different?

I had only very limited financial resources after the divorce, and no identity for me to hold on to. Even though I established myself as a recognized theatre critic and published review articles in the media for two years during the MA period, I did not have the motivation to continue. For me, suicide was the whole thing: all the meaning of my existence resided in life and death, not the fanciful art world. But without any operational structure, I could not function properly. I needed someone to guide me or give me a structure to start my days. There was no such mechanism; I wished I had stayed in the job at business, for at least I could go to work and have some income. But too late, the way of return was shut. I was destined to be in this limbo for longer.

I do not have an optimistic personality. In fact, I have a melancholic nature, and rumination and depression were lurking in my emotional life feeding on each

other for a long time. Even now, depression can sneak in as the excerpt from my diary has shown, although I have known depression and learned how to live with it. I have experienced the most excruciating pain from the loss of Zero, and I do not want Swift, my parents and siblings to experience what I have gone through. I have also told myself that I will live my life for Zero and live better to make up the loss and the pain.

I wanted to transform the painful experience into knowledge, and this wish led me to applying for a governmental scholarship to study in the UK, which I received. I got a MA in Applied Drama from Royal Holloway College, University of London (UoL); a postgraduate diploma in dramatherapy from the Central School of Speech and Drama, UoL; and I am doing this PhD. I considered these turning points were the Grace from Above: they were not my "conscious" choice, but the fruit from the push of the unconscious. I cannot live in peace without thoroughly understanding this experience; I cannot face myself without integrating the loss to my psyche and accepting the experience. I have been asking for help from the spiritual realm (which I cannot explain); for me, the world comprises not only this visible world, or the psychological realm, but also a spiritual world (of which religion is one manifestation).

By doing this PhD, I put myself (half unconsciously) through an ordeal beyond my own imagination and perhaps beyond my capacity. As shown in my diary, I have had some break-downs manifested in my whole system, not just as depression, but which have challenged my determination to choose Life. I have been so obsessed with meaning-making that I was willing to die for it. I thought I would have regrets if I did not come out of this journey with good results before I die, so I needed to try harder. This was an over-reactive attitude and resulted in my own suffering. It took me some time to reach an understanding that I should give myself permission to get on with life; for not becoming a suicide prevention

activist. I should give myself permission to just enjoy the rest of my life and be free from the loss.

My attitude to life and humanity has changed; I am more able to reflect upon things in a less selfish way, and I am able to say: “Yes, maybe. Maybe there is a connection between me having changed my life direction and Zero’s suicide, but I have not done something wrong”. I have stayed on a real path, even though it was once a no-man’s-land. Fortunately, I can roughly see the end of this meandering and seemingly purposeless journey, and this thesis is an evidence of AAD. I used all of my skills and knowledge to finish the research, such as intellectual and emotional intelligence, theatre approaches and therapeutic understandings. I attended clowning courses to learn the language of laughter and joy. It took me eleven years to see the formation of those AAD, and it has not been a conscious development but an organic result of my own striving, support from my environment, and my on-going reflection of personal experiences.

Everything seems blurred when I reflect on the positive aspects of personal characteristics and strengths that have existed before and what I have retained or have been retaining after Zero’s suicide. I remember I was energetic in the pursuit of things that interested me, curious about the world, and persevered with goals that I set up. I was creative, spontaneous, and sociable. I was competent in the sales companies, and I liked to engage people and participate in meaningful activities. I was ambitious and wanted to achieve things. After Zero’s suicide, it seemed that I lost all those resilient qualities. I lost energy, curiosity, ambition, confidence and the sense of myself. Some of those positive qualities, however, came back gradually over time. What I have retained so far are a creative and playful spirit, an interest in people and meaningful events, some degree of sociability, and a clear sense of my own resources and demands.

It has been hard to retain the positive aspects of my functioning; it seemed to me I was just trying to keep myself above water in those early years. As I have lost my daily structure, self-identity, and social engagement, it is hard to judge what contributed to those once-lost-but-retained positive qualities, because it is something that I could not have planned for, or consciously asked/strived for. As mentioned earlier, I had received therapy (although it was far from enough), I read literature as a way of understanding suicide, and I had some support from family and friends. I have also been engaging in spiritual practices (including Buddhism and Christianity) which sustain me. The only coping mechanism that I can recognize as innately a part of myself is perseverance – I had switched to the theatre field and I would stick it out to the end. But, to be honest, it was a bit like being “frozen” in the middle of a game; I was unable to move until the game was finished.

It is even harder to identify the formation of AAD as it requires analysis and reflection, which manifest as a subtle attitudinal change to life, humanity, suffering and death. These changes are qualitative and meaningful for me. Through the loss and the pain, I notice how vulnerable people can be, how ephemeral life is, and how deeply people are connected without being aware of it. I have been enduring excruciating pain whenever the memory of my loss comes up, and I am determined not to surrender to the pull of gravity. No one in my family has any clues of how I survive or how it has been for me, yet I do not wish them to experience the pain that I have gone through. I wish myself to be a better person, especially when facing temptation; to be compassionate, even when facing difficulties; to be humble, appreciative, and kind in whatever ways I can be. At the same time, I am aware of how important it is to take care of myself, to keep the ego boundary when necessary, and stand on an affirmative ground to fight for myself without hurting others.

It is hard to put into a rational language what contributes to AAD. These qualities will be maintained once they are formed owing to the involvement of a transpersonal level. Somewhere in the dark and painful desert, I saw a truer meaning of life; I embraced the pain and the loss and appreciated its coming; I saw the limit of myself and called for the intervention of the Divine (on innumerable occasions). Although there is no guarantee (i.e. who knows whether God exists?), the “religious” attitude has transformed me. I feel the benefit of the religious experience, and the question that remains is how can I change my once-useless attitude towards life? Magically, once you are on the way, things change and change for the better. The formation of AAD also helps more resilient developments; or, to put it in another way, AAD helps me to function with a better ego. It is not up to me; this cannot be achieved without the Grace from the Divine.

As a survivor, I really struggled with the shattering of my life structure and identity. I felt that I lacked resource, and I was unsure of how I could survive the loss. I could have been helped tremendously by crisis management services or any acute intervention from social services. For two to eight years after Zero’s suicide, I was wandering in a no-man’s-land, with no regular structures for me to hold on to, and the scant resources offered to me were not enough to meet the demands of being a functional social being. I could have been helped by regular psychological support and in building up a friendly working environment for me to find my way through.

I could easily have been the next suicide after Zero’s death, and the struggle with suicidal ideation helped me to come up with the hypothesis of suicide complex. With the life-striving force in my psyche (although unconsciously) and the compassionate help from others, I have survived. Twelve years later, with the completion of this thesis, I have reached a place where I know how to sustain my growth (however incremental it is), and to keep a balanced relationship between

meaning and daily life. I do not know what my future will be after this PhD, but I am confident that it will be positive.

Limitations and Suggestions

The limits of this thesis are manifold. First, it looks at survivors' experiences from their point of view without examining the other family members' experiences. For the various impacts on the individual, survivors' narratives are crucial. However, for the impact on the family system, they may be biased due to the subjective interpretation of each participant. The impact on the community and society were filtered through their experiences; but the family, the community or society were not involved in the research as a unit. This explains why the analysis of factors for the community/society is weak in this research. Future efforts can concentrate on exploring the experiences in the individual, the family, and the community simultaneously or as parallel variables (i.e. the family and the community as a separate survivor unit), applying cross-sectional analysis to find out the optimal beneficial factors for survivors among different infrastructures.

Second, the mixed qualities of the participants were not enough to comprise a substantial analysis or offer meaningful comparison between variables. For instance, the kinships of the suicide were mixed, with three mothers who lost their sons, one father who lost a son, one daughter who lost her father, two daughters who lost their mothers, and one sister who lost her brother. The years of loss were also varied, ranging from the shortest at five years and the longest at twenty-nine years at the time of the interview. The ages of the survivors when the suicide happened ranged from the youngest at thirteen years old to the oldest in the late fifties. However, due to the variables (i.e. with various durations of loss and at different developmental stages) presented by the participants, I am able to identify

the trajectory of various responses/developments and indicate the different needs of survivors in the short, middle, and long terms. Future research can focus on any particular kinship, or similar duration of loss, or the age of the person at the time of loss to enhance the depth of understanding by homogenizing the demographic elements.

Third, although the participants were recruited in the UK, mainly in London, some have bi-cultural, if not multiple-cultural, backgrounds. Cultural assimilation (i.e. the decline of unique ethnic features) or cultural acculturation (i.e. the transmission of attitudes/behaviours between cultures) other than the British culture which may have contributed to various outcomes are not examined. The impacts on the levels of community and society can be examined by sociological methods (e.g. sociological autopsy (see (Fincham et al., 2011)) and mixed methodology (i.e. qualitative and quantitative) to shed light on the depth of understanding of survivors' overall experiences. This future direction may discover the factors influencing the intrapersonal, interpersonal, and transpersonal levels in a collectively meaningful way, transcending the limit of individual subjectivity.

Fourth, the participants were recruited from the SOBS London group, with one being male and seven female. Thus, the experience of males is under-represented. Moreover, survivors who attend support groups may differ in stress levels, development of coping strategies, and having role models in senior survivors, as opposed to those who do not seek support (Owens et al., 2011, Feigelman and Feigelman, 2011b, Feigelman and Feigelman, 2011a). Further research could therefore focus on those survivors outside of the support group or institution, whose experiences of the various responses may be pursued by using different media (e.g. internet on-line blog) or various approaches to recruitment (e.g. a snowball approach by asking the participants to introduce other potential participants).

Fifth, the various responses gathered from the subjective experiences of participants are taken as they are without assessing their consistency. This potential inconsistency can be within the individual – for instance, is there a cause and effect between various responses (e.g. more negative incidents result in fewer positive outcomes)? It can be implicit between individuals (e.g. A's meaning of outgrowing the pain is not the same as B's). What is the connection and oscillation between various responses? These issues are not tackled in the discussion, and further research could explore and develop a working protocol of the TG to effectively expand its applicability to survivors.

Finally, the techniques of Jungian analysis are full of complexity and subtlety, as they are in any other type of therapy. I am not a qualified therapist, and the usefulness or the value of the understanding of SC needs to be clinically observed and validated by health professionals in order to deepen the understanding of the mystery of suicide.

HOWEVER, THE JOURNEY

CONTINUES …

On the process of revising this thesis, I attended a shaking meditation weekend. To engage spiritual practice has become essential to carry this experience and wound(s) forward. Occasionally, I still hate the fact that this has happened to me, that I have been struggling and it seems that this struggle is infinite and will become part of my daily life "forever". Of course I refuse to be miserable; but I am aware that the gravity of loss is so strong that I rarely feel joyful. I tape my heart; it still sings a lament. Twelve years later; I am still in the gap of wounded-ness and healing-ness.

Who, actually, did Zero become after death? Who has he become? He is still my son even though he has gone; yet, I do not have him as a son any more in this life. Or should I say, what has he become? He would be different things depending on which belief systems I choose: from becoming a ghost; or a different sentient being; or a stream of consciousness; or been reborn and become a human again. And what have we, he as a son and me as a mother, become? Are we still mother and son? Or are we just two sentient beings who happened to be on a journey together?

In one shaking session, the grief came up again. He was there, seriously damaged and dead; I was shattered, helpless and hopeless. The severance of mother-son connection was too painful to bear. How on earth could this have happened? God[69] needs to be there with us. I do not know whether God had played a part in his suicide or not; but I know I need to recover from this trauma, my life needs to continue. It is excruciating for a mother to see her son broken, and broken in such an extreme way; no return is possible. "With God's name, I bury you, Zero, once again." I have buried him many many times after the funeral.

69 God here is a liberal concept of spirituality.

We have been coming to this space to meet each other; to tell how much love is left unattended. “For how long will we be in peace?” Of course he could not talk back. I picked up a tiny bit of him, putting it in my heart. “I will carry you this much, just this much, not all of you.” “I love you and I wish you well after death.”

Why do we, not just him and me but the whole of mankind, need to experience trauma and loss? This is a mystery.

And what, in fact, has happened to me? I do not know; what I only know is, life is metaphoric. It has been and will be.

(79,598 words)

Appendix 1. Ethical Application Form

This application form should be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research should not commence until written approval has been received (from Departmental Research Director, Faculty Ethics Committee (FEC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project.

Applications should be made on this form, and submitted electronically, to your Departmental Research Director. A signed copy of the form should also be submitted. Applications will be assessed by the Research Director in the first instance, and may then passed to the FEC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1. Title of project:

   Suicide Surviving: A Jungian Exploration using Applied Theatre

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
   Do you object to the title of your project being published? Yes X ☐/ No ☐

3. This Project is: ☐ Staff Research Project

   x☐ Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Hsiu-Chuan Tu	Centre for Psychoanalytic Studies
Renos Papadopoulos (Supervisor)	Centre for Psychoanalytic Studies

5. If external approval for this research has been given, then only this cover sheet needs to be submitted

External ethics approval obtained Yes ☐/ No x☐

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s): .....HSIU-CHUAN TU..(ROBIN).....……..

Name(s) in block capitals: ....HSIU-CHUAN TU (ROBIN).....……

Date: ……5 April, 2013……..

Supervisor's recommendation (Student Projects only):

I recommend that this project falls under Annex B / should be referred to the FEC (delete as appropriate).

Supervisor's signature:

..……

Outcome:

The Departmental Director of Research (DoR) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the FEC ☐

This application is referred to the FEC ☐

Signature(s): .....……..…

Name(s) in block capitals: .....……

Department: ……..……

Date: ……

The application has been approved by the FEC ☐

The application has not been approved by the FEC ☐

The application is referred to the University Ethics Committee ☐

Signature(s): .....

Name(s) in block capitals: ….....

Faculty: ……..……..……

Date: ……

Details of Funding

1. Will this project be externally funded?

Yes ☐ No x ☐

If Yes,

2.	What is the source of the funding?

Details of the Project

3.	**Proposed start date**: July. 2012
4.	**Probable duration**: 12 months
5.	**Brief outline of project** (This should include the purpose or objectives of the research, brief justification, and a summary of methods. It should be approx. 150 words in everyday language that is free from jargon).

This research comprises (i) an initial interview, (ii) an Applied Theatre Group, and (iii) a follow-up interview.

The main objective of this research is to investigate the survivors' experiences of losing someone to suicide. More specifically, it is to explore the conditions and circumstances that contribute to various responses after the loss: (a) the various forms of negative responses to the adversity that had befallen them (e.g. psychological and psychiatric symptoms), (b) the various positive qualities that they had before their exposure to adversity and were retained after this exposure (i.e. Resilience), as well as (c) the various new positive qualities and characteristics that they acquired as a result of being exposed to that adversity (Adversity-Activated Development). We will explore the contexts among the personal, interpersonal, family, community and societal dimensions/realms? contributing to three possible ways of responding to suicide (which are not exclusive of each other).

Selection criteria for the subjects:

- To have personal experience of losing someone by suicide and consider oneself as a survivor.
- To be willing to share their own personal experience and interact with other

co-researchers in the sessions.

- The post-loss time needs to be at least 5 years
- The participant will not be a person falling into any clinical category, i.e. that s/he suffers from any specific psychological or psychiatric disturbance. Those who have such a history and are still having mental health issues will be excluded from participation.

(i) The procedure of the initial interview:

4. Sending out a recruitment letter (including information sheet and consent form, please see the appendix) to the suitable participants. The participants will be obtained via the contact list from SOBS (Survivor of Bereavement by Suicide) London.
5. After receiving the signed consent form, the participants will be invited to an interview by the researcher for assessment purposes. They will be asked with semi-structured questions (according to 'Trauma Grid') to describe their journey. One of the areas that the assessment will focus is the emotional readiness of the prospective research subjects and the existence of a sufficient support system for them.
6. After the assessment, suitable participants will receive a confirmation letter, informing them the date/time of the group.

(ii) The Applied Theatre Group:

After the interviews, the survivors will be invited to join the group. In the group, the applied theatre methods will be used including myth/drama, movement, voicework, enactment, painting and creative writing. The play of <Romeo and Juliet> will be used as an entry text for survivors to explore their lives after the suicide. A qualified therapist and the researcher will co-facilitate the group.

(iii) The follow-up interview:

The group participants will be informed and contacted for the follow-up interview. The focus of this 2nd interview will explore: (a) does this research help the survivors understand their experiences (or not)? (b) in what ways does this research help the survivors understand their experiences better (or not)? (c) what contribute to their understanding (or not) of various responses? (d) the differences of experiencing in interview (narrative approach) and the group (performative approach), (e) any feedback for the researcher.

Method of data analysis:

The main method of data analysis will be a narrative/performative approach. The research data will be derived from: (a) the transcriptions of the initial interviews, (b) the video recordings and the transcriptions of relevant part of the group session, (c) the script written by the research subjects in the session, (d) the follow-up interviews, (e) the researcher's notes of the empirical work including two interviews and the group. Jungian Psychology will be used as the main theory to analyze and amplify the findings.

Participant Details

6. Will the research involve human participants? (indicate as appropriate)

Yes x☐ No ☐

7. Who are they and how will they be recruited? (If any recruiting materials are to be used, e.g. advertisement or letter of invitation, please provide copies).

They are suicide survivors (survivors who lost someone to suicide) and will be recruited from the London group of Survivors of Bereavement by Suicide (SOBS). SOBS is a self-help organization, one of the aims is to provide a safe, confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other. For more information, please refer to http://www.uk-sobs.org.uk/

Appendix A is the general information for the whole project.

Appendix D is the invitation to the Applied Theatre Group after the initial interview.

Will participants be paid or reimbursed?

Each participant of the group will be given a token voucher valued at GBP20.

8. Could participants be considered:

(a) to be vulnerable (e.g. children, mentally-ill)? X Yes ☐

(b) to feel obliged to take part in the research? X No ☐

If the answer to either of these is yes, please explain.

(a) Yes (but 'Maybe' is more correct), they may be vulnerable in some way: first due to their original experience (of having lost a loved one to suicide) and, secondly, because the main activities will require them to reconnect with the past. However,

the research design will reduce this vulnerability to the minimum because

I. At least five years should have passed since the loss

II. The subjects will be part of the support group SOBS (which means that they will have addressed repeatedly their loss and its consequences)

III. They will not be a clinical group, i.e. currently; they will not be exhibiting any psychiatric or psychological symptoms.

(b) No, it will be clearly indicated that the research subjects will be free to leave the group at any time without needing to provide any explanation or justification.

Informed Consent

9. Will the participant's consent be obtained for involvement in the research, orally or in writing? (Please attach an example of written consent for approval):

Yes x ☐ (be obtained in writing) No ☐

How will consent be obtained? If not possible, explain why.

The consent will be obtained by writing.

Appendix C is the consent for the initial interview.

Appendix E is the consent for the Applied Theatre Group and the follow-up interview.

Please attach a participant information sheet where appropriate.

Confidentiality / Anonymity

10. If the research generates personal data, describe the arrangements for maintaining anonymity and confidentiality or the reasons for not doing so.

All information will be kept in accordance with the Data Protection Act. The Letter of Consent with Personal Information Sheet will be saved in coded format. Interviews, art works and video transcriptions will be separately coded to ensure anonymity. Collected materials will be presented anonymously with identifying details changed or excluded.

Data Access, Storage and Security

11. Describe the arrangements for storing and maintaining the security of any personal data collected as part of the project. Please provide details of those who will have access to the data.

Only the participants (who would access to their own), a qualified therapist (hired to co-facilitate the group) and my supervisor (who is also a registered clinician) can access to the data.

It is a requirement of the Data Protection Act 1998 to ensure individuals are aware of how information about them will be managed. Please tick the box to confirm that participants will be informed of the data access, storage and security arrangements described above. If relevant, it is appropriate for this to be done via the participant information sheet x☐

Further guidance about the collection of personal data for research purposes and compliance with the Data Protection Act can be accessed at the following weblink. Please tick the box to confirm that you have read this guidance (http://www2.essex.ac.uk/rm/dp/research.shtm) x☐

Risk and Risk Management

12. Are there any potential risks (e.g. physical, psychological, social, legal or economic) to participants or subjects associated with the proposed research?

Yes x☐ No ☐

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:
The participants are not clinical subjects and that the activities designed are not therapeutic interventions, the participants will revisit the past and some painful memory will be recalled. To manage the possible risks, the following measures will be taken: 1. before the beginning of the project, each participant will be interviewed in detail and the possible risks will be explained. Only those who accept responsibility to participate (and sign to this effect) will be accepted. 2. each participant will not be a person who falls into any clinical category, i.e. that currently s/he suffers from any specific psychological or psychiatric disturbance. Those who have such a history and are still having mental health difficulties will be excluded from participation. 3. During the research period, they can choose to stop the interview or leave the group if it becomes too challenging. If necessary a referral to a qualified therapist will be (and has been) arranged at their own expense. 4. A qualified therapist will be hired to co-facilitate the applied theatre group, please refer to the CV hereunder. The Therapist CV Emily Duval, MA Psychology (MBACP Accred., MBPsS) is a California-trained psychotherapist with over 14 years experience working in a variety of settings in the US and the UK. She has worked in private practice, community counselling services, higher

education, employee assistance programmes, and the NHS. Emily specialises in grief after suicide, having extensive experience with survivors, and has facilitated 'SOS' support groups. She is an author, guest speaker and consultant in matters relating to the aftermath of suicide and its impact on survivors.

13. Are there any potential risks to researchers as a consequence of undertaking this proposal that are greater than those encountered in normal day-to-day life?

Yes x☐ No ☐

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:
By doing this research, it may touch the researcher's experience as being a survivor. The researcher may feel stressed in the empirical stage, yet, it does not mean that the researcher will be re-traumatized. There is fundamental difference between feeling/managing the stress and re-traumatization. In addition to the understanding/managing of ups and downs of surviving journey, the researcher has been in analysis with a professional Jungian analyst on a regular basis. She will continue the analysis until the empirical work finishes.

14. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of the Faculty and/or University Ethics Committees

Only the participants who have lost the beloved to suicide for more than five years will be invited to partake in this research. This is to make sure that the acute bereavement period has been digested, and the participants have the capacity to examine the wide range of their reactions (i.e. not limited only to the negative ones) to the loss. Hereunder is a list of some research showing the positive effect through participation of suicide research for suicide survivors.

Dyregrov, K., G. Dieserud, et al. (2010). "Motivation for research participation among people bereaved by suicide." Omega **62**(2): 149-168.

Dyregrov, K. M., G. Dieserud, et al. (2011). "Meaning-Making Through Psychological Autopsy Interviews: The Value of Participating in Qualitative Research for Those Bereaved by Suicide." Death Studies **35**(8): 685-710.

Gould, M. S., F. A. Marrocco, et al. (2005). "Evaluating Iatrogenic Risk of Youth Suicide Screening Programs." JAMA: The Journal of the American Medical Association **293**(13): 1635-1643.

Henry, M. and B. J. Greenfield (2009). "Therapeutic effects of psychological autopsies: The impact of investigating suicides on interviewees." Crisis: The Journal of Crisis Intervention and Suicide Prevention **30**(1): 20-24.

Appendix A

Looking for Participatory Researchers – "Surviving Suicide"

I am Hsiu-Chuan Tu (Robin), I lost my second son, Zero, 10 years ago when he was 12. This experience led me to the Centre for Psychoanalytic Studies at the University of Essex where I am doing my PhD research. My research is about how suicide survivors respond to the loss and their journey after the suicide. My research supervisor is Renos Papadopoulos who is a clinical psychologist, Jungian analyst and Systemic Family Psychotherapist specialized in how traumatic events affecting survivors of adversity in various contexts. My research proposal has gained approval from the Ethical Committee of the University.

As research has shown, losing someone to suicide could be a traumatic event in one's life. Suicide survivors have particular needs and would benefit from support tailored to their needs. Researchers in this field have been exploring to understand survivor's experiences, what it means to have lost someone to suicide, how it influences survivors' life, the family and the community. Survivors' voice is a key element in the research and has been recognized its contributory status to understanding this experience. Survivors need to be heard, and to be heard as an individual and as a group. This is the starting point of this project.

I hope you can help me to explore the space of voicing our experiences. Now I am looking for participatory researchers to join a group exploring the process. This research comprises an initial interview, an Applied Theatre Group, and a follow-up interview.

The Orientation of the Applied Theatre Group

This project will use performance/creative writing as a method for survivors to explore their lives after their loved ones took their lives. I will facilitate the sessions and use myth/drama, movement, voicework, enactment, painting and creative writing in the sessions. The session will be video recorded, and the art

works produced in the session will be kept until the research result has completed. The research will aim to:

- explore the surviving journey in depth by using art forms
- experience the transformative power of performance
- exchange empathetic understanding with other survivors
- to explore the conditions and circumstances that contribute to various responses after the loss..

This is a creative drama group and no prior performance experience is required. Please note that this is not a therapy group and the activities are not clinical interventions.

Participation in the Research

In order to be eligible to participate in this research, you will need:

- To be aged over eighteen years
- To have personal experience of losing someone by suicide and consider oneself as a survivor.
- To be willing to share their own personal experience and interact with other co-researchers in the sessions.
- The post-loss time needs to be at least 5 years

The group will meet in Stoke Newington Library. Refreshments and art materials will be provided. Please be informed that you are free to withdraw participation or consent at any stage.

Confidentiality

At all stages of the research, your information will be kept in accordance with the Data Protection Act. The Letter of Consent with your Personal Information Sheet will be saved in a coded format. Interviews, art works, and video transcriptions will be separately coded.

Any excerpts from material you provide will be presented anonymously with identifying details changed or excluded in order to protect your confidentiality. The only condition under which this confidentiality might be broken would be in order to contact a GP, personal therapist or relevant person if there is concern about your safety.

A Brief Biography for the Researcher

Robin is currently doing her PhD research at The Centre for Psychoanalytic Studies, University of Essex, UK. She holds MA degrees in Theatre Studies (Taipei University of the Arts, 2006), MA in Applied Theatre (Royal Holloway College, University of London, 2007), and Dip in Dramatherapy (Central School of Speech and Drama, University of London, 2011).

If you are interested

If you are interested in participating in the research, or would like to know more, please email Robin Tu at htu@essex.ac.uk or phone 0787 6381596

Appendix B

Personal Information Sheet

(Please fill in only as much information as you wish to give)

I am _____ (full name), I prefer to be called _____.

I am a male/female/other (delete as applicable).

My contact telephone number is _____, email:_____

Address: _____

My age group is □18-35 □ 35-50 □ 50-65 □ over 65

I am married/single/divorced/separate/other (delete as applicable) now.

I lost _____ (name), who was my _____ (relationship) on _____ (day or month and year).

The deceased's age was _____ years old.

Please provide a summary (in no more than 500 words) of your own personal experience of losing a significant other by suicide:

(allow box to expand as you type inside it)

Please describe briefly how your life changed after the death by suicide. Any positive change? Negative? Or some things which remain the same? Please describe from these three angles to give a totality of your experiences:

(allow box to expand as you type inside it)

Please briefly explain what you expect or hope to gain from participation in the research:

(allow box to expand as you type inside it)

Appendix C

Letter of Consent (for initial interview)

I give my permission for the researcher to use the materials generated in the initial meeting and in the Personal Information Sheet. I understand they are parts of the research data and will be quoted anonymously in all publications stemming from this research. I understand that all research data, as described above, will be kept safely, securely and confidentially and according to the terms of the Data Protection Act, in a coded filing system.

Signature:_____

Name Printed: _____

Date:_____

Appendix D

Invitation to attend the Applied Theatre Group

Dear _____

Thank you for having had an interview with me and contributing your experiences to this research. As the next stage, the group will be commenced on [date] from [time] to [time] at [place to be confirmed]. It will be facilitated by me and a qualified therapist (CV see below). Please accept my sincere welcome to you to attend the group.

After the group, we will meet again for the follow-up interview which is the last stage of my empirical work. The information of 2nd interview will be provided and arranged after the group finishes.

What you have and will contribute to my research is invaluable.in helping society to better understand the survivors' needs. To thank you for your participation in the group, you will receive a gift voucher (value £20) at the end of the follow-up interview. This minimal gift voucher cannot adequately represent my gratitude but is merely an appreciation of your contribution.

Hereunder is the updated information for the group for your reference. Please ask me to clarify any uncertainty or doubts before accepting this invitation and/or the group starts.

The Orientation of the Group

This project will use performance/creative writing as a method for survivors to explore their lives after their loved ones took their lives. Creative/expressive mediums such as myth/drama, movement, voicework, enactment, painting and creative writing will be used in the session. The session will be video recorded, and the art works produced in the session will be kept until the research result has completed. The research will aim to:

- explore the surviving journey in depth by using art forms
- experience the transformative power of performance
- exchange empathetic understanding with other survivors
- to explore the conditions and circumstances that contribute to various responses after the loss.

This is a creative drama group and no prior performance experience is required. Please note that this is not a therapy group and the activities are not clinical interventions.

Please note that you are free to withdraw participation or consent at any stage.

Brief description for the co-facilitating therapist

Emily Duval, MA Psychology (MBACP Accred., MBPsS) is a California-trained psychotherapist with over 14 years experience working in a variety of settings in the US and the UK. She has worked in private practice, community counselling services, higher education, employee assistance programmes, and the NHS. Emily specialises in grief after suicide, having extensive experience with survivors, and has facilitated 'SOS' support groups. She is an author, guest speaker and consultant in matters relating to the aftermath of suicide and its impact on survivors.

Appendix E

Letter of Consent

(for the Applied Theatre group and the follow-up interview)

Having read all the information in the invitation letter, I fully understand the terms of participation in this research:

I freely choose to participate in the group.

I give my permission for the researcher to use the materials generated in the research project, including the video-recorded session, audio-taped and transcribed interviews and all art works produced in the session. I understand they are parts of the research data and will be quoted anonymously if they will be included in any publications stemming from this research.

I understand that all research data, as described above, will be kept safely, securely and confidentially and according to the terms of the Data Protection Act, in a coded filing system.

I know this is an applied theatre group, not a therapy group, and it is not a clinical intervention.

I am not experiencing any acute sense of stress prior to signing this consent as far as I understand it. I have been informed by the researcher that a referral will be arranged at my own expense if I experience overwhelming distress during the group process.

I fully indemnify the researchers from liability for any harm to myself, whether negligent or non-negligent, which may arise out of my participation in this research.

I know I am free to withdraw my consent and/or participation at any stage, and this should be communicated in writing to the researcher.

Signature:_____ Date:_____

Name Printed: _____

Appendix 2. Semi-structured Interview Questions

- ✧ Can you tell me how did you know about the suicide? (E.g. who informed you?) And can you describe how it was for you in the first few days or months?
- ✧ Are there any negative responses you have experienced, or having been experiencing, after the loss of suicide?
- ✧ How has it been influencing your family or community negatively after the suicide?
- ✧ Are there any positive changes of you out of the surviving journey? What positive responses have you been developing as a result of surviving suicide?
- ✧ Have you experienced any positive changes to your family, neighbor, or a wider community?
- ✧ Are there any qualities or characteristics of you that remain unchanged?

Appendix 3. Interventions of Applied Theatre Group

Agenda of the Day

10.00 – 10.15 registration

10.15 – 11.45 session 1: warm up

11.45 – 12.00 tea break

12.00 – 13.30 session 2: main event

13.30 – 14.30 lunch break

14.30 – 15.30 session 3: reflection

15.30 – 15.45 tea break

15.45 – 16.30 session 4: grounding

end

After-group Questionnaires

1. in general, how have you found the applied theatre group work? Have you found it's helpful or not? In what ways?
2. in terms of making sense of your various responses and the contributing factors, how have you found the applied theatre approach? Have you found it's helpful or not? In what ways?
3. how have you felt the support of the facilitators?
4. any suggestion for the day or anything that can be improved to make the day more meaningful for you?

Detailed Intervention of AP Group

Time	Rationale/Structure of Method	Intervention
10.15-11.15	R to provide agenda with time schedule	
20 min	✧ Introduce the research project, making sure the project is understood correctly by everyone. ✧ Clarify any doubt, uncertainty, or misunderstandings. ✧ Clarify expectation and boundary setting	✧ Verbally go through the project outline and applied theatre approach. Not therapy group. ✧ Confirm receipt of consent letter from everyone. Explain the purpose of video recording. Name the confidentiality, safety and other issues. ✧ Emily greets group, reviews confidentiality and ground rules for the day, time keeping, etc. + mobile off or silent ✧ Open space for questions.
20 min	✧ Break the ice and warm up the group. ✧ Get familiar with each other. ✧ Introduce the elements of the ‘trauma grid’.	✧ Ask the group introduce themselves, basic personal information plus the info about the deceased, and what they hope to get from the day, why they chose to participate. ✧ Define ‘trauma’ (stress, trauma, PTSD) and Introduce ‘trauma grid’ ✧ Turn to neighbour, share one experience that is negative, positive and resilience in their surviving journey.
20 min	✧ warm up and be ready for action ✧ Build up trust among members	✧ Stand in circle, warm up different body parts. ✧ One initiates movement and sound, the group mirrors back. ✧ Walk around the space, getting familiar with the physical space ✧ Pair up, mirror movement and sound. ✧ Pair up with another, ‘yes, and’ game.
✧ TEA BREAK (15 min) 11:30-13.15		

60 min	✧ Use ‘Romeo and Juliet’ as a text to explore the themes of suicide surviving. ✧ Integrate the twelve aspects of ‘Trauma Grid’ (negative, positive, resilience in aspects of the individual, family, community, society/culture).	✧ Introduce the story of ‘Romeo and Juliet’. ✧ Emily to help summarize the story and encourage dramatic license. ✧ Each one chooses a role from the text. ✧ The facilitators demonstrate the interview. Robin proceeds the first interview, then open to the group as part of the interviewers. Focus on the various responses. ✧ Check in with individual after the role play.
45 min	✧ Identify key themes of three responses. ✧ Obtain the factors that contribute to various responses	✧ Each takes 15 min to talk about what contributes to their various responses. ✧ Write down factors on Post-it Notes and stick on a flipchart paper.
✧ LUNCH BREAK (1 hour) 13.15-14.15		
14.15-15.30		
75 min	✧ Further process the exploration of various responses.	✧ As a group, talk about contributing factors and explore in depth the experiences/development (similar to focus group discussion). Robin will facilitate the discussion. ✧ Emily to check-in on group members
✧ TEA BREAK (15 min) move tables for art		
15.45-16.30		
30 min	✧ Visualize one’s ideal image of surviving journey ✧ Generate positive elements toward one’s future	✧ A guided imagination toward one’s ideal future. Emily to encourage visualizing and experiencing ‘new normal’ ✧ Use art materials to express one’s ideal image that one wants to be in the journey. ✧ Invite the group to share (Emily?) ✧ Use the group as clays to sculpt the image, take a symbolic photo. (optional if time permits)
15 min	✧ Review the group journey. ✧ Ground the group and prepare to end the group/the project.	✧ The group as a whole, use movement/sound to express the experience of being in group – morning, lunch, now. ✧ Emily to make final check-in ✧ Robin closure and thanks (will contact for follow-up interview & gift voucher, Emily’s name card)

Appendix 4. Semi-structured Questions for the Follow-up Interview

1. How was it for you to be interviewed at the very beginning and talked about your experience of the loss to suicide?
2. How was it for you to be involved in the applied theatre group?
    - ✧ How different they are for you (one is narrative 1-1, one is performative, group) to understand your experiences (or not)?
    - ✧ The experience of asking others how they survived and being asking
    - ✧ The individual themes from the 1st interview and the group
3. Has your participation of this research help you understand your experiences (or not)? In what ways?
4. In what way have you experienced the impact of me by introducing the theory of 'trauma grid' to review the surviving journey
    - ✧ How is it to process the theory of TG, hard?
    - ✧ Time factor: 'is it about now? Or the past?'
5. How was it for you to experienced me as a survivor and a researcher?
6. Any feedback for the researcher (especially in terms of cultural differences and language)

Bibliography

AAS. *American Association of Suicidology* [Online]. Available: http://www.suicidology.org/home [Accessed 29 Jan. 2012].

AAS. *Lesbian, Gay, Bisexual and Transgendered Resource Sheet* [Online]. Available: http://www.suicidology.org/Portals/14/docs/Resources/LGBT%20Resources/LGBTresource-sheet.pdf [Accessed 24 Apr. 2015].

ACKER, J., BARRY, K. & ESSEVELD, J. 1996. Objectivity and Truth: Problems in Doing Feminist Research. *In:* GOTTFRIED, H. (ed.) *Feminism and Social Change: Bridging Theory and Practice.* Chicago: University of Illinois Press.

ADAMS, M. V. 2004. *The Fantasy Principle: Psychoanalysis of the Imagination,* New York, Brunner-Routledge.

AGERBO, E. 2003. Risk of suicide and spouse's psychiatric illness or suicide: nested case-control study. *BMJ: British Medical Journal,* 327**,** 1025-1026.

AGERBO, E., NORDENTOFT, M. & MORTENSEN, P. B. 2002. Familial, psychiatric, and socioeconomic risk factors for suicide in young people: nested case-control study. *BMJ: British Medical Journal,* 325**,** 74-77.

AGUIRRE, R. T. P. & SLATER, H. 2010. Suicide postvention as suicide prevention: improvement and expansion in the United States. *Death Studies,* 34**,** 529-540.

ALCOZ, J. B. 2007. "Por la quoal cosa es dapnado". Suicide and accidental death in late medieval Navarre. *Anuario De Estudios Medievales,* 37**,** 27-69.

ALEXANDER, B. K. 1999. Moving toward a Critical Poetic Response. *Theatre Topics,* 9**,** 107-125.

ALEXANDER, V. 1987. Living Through My Mother's Suicide. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) *Suicide and Its AfterMath: Understanding and Counseling the Survivors.* London: W. W. Norton & Company.

ALVAREZ, A. 1971. *The Savage God: A Study of Suicide,* Middlesex, Penguin Books.

ALVESSON, M. & SK LDBERG, K. 2000. *Reflexive Methodology: New Vistas for Qualitative Research,* London, Sage.

AMIT, V. 2002. Vered Amit Responds to Nigel Rapport. *In:* AMIT, V. & RAPPORT, N. (eds.) *The Trouble with Community: Anthropological Reflections on Movement, Identity and Collectivity.* London: Pluto Press.

ANDERSON, B. 1983. *Imagined Communities: Reflections on the Origin and Spread of Nationalism,* London, Verso.

APPEL, Y. H. & WROBLESKI, A. 1987. Self-Help and Support Groups: Mutual Aid for Survivors. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) *Suicide and Its Aftermath: Understanding and Counseling the Survivors.* London: W. W. Norton & Company.

ARISTOTLE 1976. *The Ethics of Aristotle: The Nicomachean Ethics*, Harmondsworth, Penguin.

ARMSON, S. 1994. The Samaritans. *In:* JENKINS, R., GRIFFITHS, S., WYLIE, I., HAWTON, K., MORGAN, G. & TYLEE, A. (eds.) *The Prevention of Suicide.* London: HMSO.

ARMSTRONG, T. 2005. *Modernism: A Cultural History,* Cambridge, Polity Press.

ATKINSON, P. 1990. *The Ethnographic Imagination: Textual Constructiions of Reality,* New York, Routledge.

ATKINSON, P. 1992. *Understanding Ethnographic Texts,* Newbury Park, CA, Sage.

ATKINSON, R. 2007. The Life Story Interview as a Bridge in Narrative Inquiry. *In:* CLANDININ, D. J. (ed.) *Handbook of Narrative Inquiry: Mapping a Methodology.* London: Sage.

AUGER, J. & HEATHER, J. 2009. My People's Blood: Mobilizing Rural Aboriginal Populations in Canada Around Issues of HIV. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

AUSLANDER, P. 1992. *Presence and Resistance: Postmodernism and Cultural Politics in Contemporary American Performance,* Ann Arbor, University of Michigan Press.

AUSTIN, J. L. 1962/1975. *How to Do Things with Words,* Oxford, Clarendon Press.

AUSTIN, S. 2009. Jung's dissociable psyche and the ec-static self. *Journal of Analytical Psychology,* 54**,** 581-599.

AWAKE! 2014. Why Go On? *Awake!* London: Watchtower Bible and Tract Society of Britain.

BADRI, A., CRUTZEN, R., ELTAYEB, S. & VAN DEN BORNE, H. 2013. Promoting Darfuri women's psychosocial health: developing a war trauma counsellor training programme tailored to the person. *EPMA Journal,* 4**,** 10.

BADTH. *The British Association of Dramatherapists* [Online]. Available: http://badth.org.uk/home [Accessed 18 Apr. 2015].

BAECHLER, J. 1979. *Suicides*, Oxford, Blackwell.

BARONE, T. 2007. A Return to the Gold Standard? Questioning the Future of Narrative Construction as Educational Research. *Qualitative Inquiry*, 13**,** 454-470.

BARRACLOUGH, B. & HARRIS, E. C. 2002. Suicide preceded by murder: the epidemiology of homicide–suicide in England and Wales 1988–92. *Psychological Medicine*, 32**,** 577-584.

BARRETT, T. W. & SCOTT, T. B. 1990. Suicide Bereavement and Recovery Patterns Compared with Nonsuicide Bereavement Patterns. *Suicide and Life-Threatening Behavior*, 20**,** 1-15.

BARRY, R. F. 1999. The Catholic Condemnation of Rational Suicide. *In:* WERTH, J. L. (ed.) *Contemporary Perspectives on Rational Suicide.* London: Brunner/Mazel.

BARTHES, R. 1966/1977. Introduction to the Structural Analysis of Narratives. *Image Music Text.* London: Fontana Press.

BARTHOLOMEW, K. & HOROWITZ, L. M. 1991. Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, 61**,** 226-244.

BATTIN, M. P. 1982. *Ethical issues in suicide*, Englewood Cliffs, N.J., Prentice-Hall.

BATTIN, M. P. & MAYO, D. J. 1980. *Suicide, the philosophical issues*, New York, St. Martin's Press.

BAUDELOT, C. & ESTABLET, R. 2008. *Suicide: The Hidden Side of Modernity*, Cambridge, Polity Press.

BAUMAN, R. 1986. *Story, Performance, and Event: Contextual Studies of Oral Narrative*, Cambridge, Cambridge University Press.

BEAUCHAMP, T. L. & VEATCH, R. M. 1996. *Ethical issues in death and dying*, Upper Saddle River, N.J., Prentice Hall.

BECK, A. T., BROWN, G., BERCHICK, R. J., STEWART, B. L. & STEER, R. A. 2006. Relationship Between Hopelessness and Ultimate Suicide: A Replication With Psychiatric Outpatients. *FOCUS: The Journal of Lifelong Learning in Psychiatry*, 4**,** 291-296.

BECK, A. T., STEER, R., KOVACS, M. & GARRISON, B. 1985. Hopelessness and Eventual Suicide: a 10-year Prospective Study of Patients Hospitalized with Suicidal Ideation. *American Journal of Psychiatry*, 142**,** 559-563.

BECKER, E. 1973. *The Denial of Death,* New York, Free Press.

BEGLEY, M. & QUAYLE, E. 2007. The lived experience of adults bereaved by suicide: A phenomenological study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 28**,** 26-34.

BERK, T. V. D. 2012. *Jung on Art: The Autonomy of the Creative Drive,* New York, Psychology Press.

BHABHA, H. K. 1994. *The Location of Culture,* New York, Routledge.

BISHOP, P. 1999. Introduction. *In:* BISHOP, P. (ed.) *Jung in Contexts: A Reader.* London: Routledge.

BLAAUW, E. & KRAAIJ, V. 1997. Suicide prevention: The global context. *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 18**,** 90-91.

BLOOR, M., FRANKLAND, J., THOMAS, M. & ROBSON, K. 2001. *Focus Groups in Social Research,* London, SAGE Publications Ltd.

The Way of the Dream: Dr. Marie-Louise von Franz in Conversation with Fraser Boa, 1988. Directed by BOA, F. Toronto: Windrose Films.

BOAL, A. 1979. *Theatre of the Oppressed,* London, Pluto Press.

BOAL, A. 1995. *The Rainbow of Desire: The Boal Method of Theatre and Therapy,* London, Routledge.

BOAL, A. 1998. *Legislative Theatre,* London, Routledge.

BOAL, A. 2006. *The Aesthetics of the Oppressed,* London, Routledge.

BOLTON, I. 2005. *My Son...My Son: A Guide to Healing After a Suicide in the Family* Roswell, Bolton Press Atlanta.

BOLTON, I. M. 1987. Our Son Mitch. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) *Suicide and Its Aftermath: Understanding and Counseling the Survivors.* London: W. W. Norton & Company.

BONANNO, G. A. 2004. Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events? *American Psychologist,* 59**,** 20-28.

BONANNO, G. A., PAPA, A. & O'NEILL, K. 2001. Loss and human resilience. *Applied and Preventive Psychology,* 10**,** 193-206.

BOTTOMLEY, R. H. V. 1994. The Health of the Nation. *In:* JENKINS, R., GRIFFITHS, S., WYLIE, I., HAWTON, K., MORGAN, G. & TYLEE, A. (eds.) *The Prevention of Suicide.* London: HMSO.

BOURDIEU, P. 1984. *Distinction: A Social Critique of the Judgement of Taste,* London, Routledge & Kegan Paul.

BRAH, A. 1996. *Cartographies of Diaspora: Contesting Identities,* London, Routledge.

BRAUN, C. & OTSCHERET, L. 2010. Dialogue. *In:* STEIN, M. (ed.) *Jungian Psychoanalysis: Working in the Spirit of C.G. Jung.* Chicago, Ill.: Open Court.

BRAUN, V. & CLARKE, V. 2006. Using Thematic Analysis in Psychology. *Qualitative Research in Psychology,* 3**,** 77-101.

BRENT, D. A. 1989. The Psychological Autopsy - Methodological Considerations for the Study of Adolescent Suicide. *Suicide and Life-Threatening Behavior,* 19**,** 43-57.

BRENT, D. A., PERPER, J., MORITZ, G., ALLMAN, C., FRIEND, A., SCHWEERS, J., ROTH, C., BALACH, L. & HARRINGTON, K. 1992. Psychiatric Effects of Exposure to Suicide among the Friends and Acquaintances of Adolescent Suicide Victims. *Journal of the American Academy of Child and Adolescent Psychiatry,* 31**,** 629-639.

BRENT, D. A., PERPER, J. A., MORITZ, G., ALLMAN, C., SCHWEERS, J., ROTH, C., BALACH, L., CANOBBIO, R. & LIOTUS, L. 1993. Psychiatric Sequelae to the Loss of an Adolescent Peer to Suicide. *Journal of the American Academy of Child and Adolescent Psychiatry,* 32**,** 509-517.

BROOK, P. 2008. *The Empty Space,* London, Penguin.

BRUNER, J. 1990. *Acts of Meaning,* Cambridge, MA, Harvard University Press.

BRUNER, J. 1991. The Narrative Construction of Reality. *Critical Inquiry,* 18**,** 1-21.

BUTLER, J. 1990. Gender Trouble, Feminist Theory, and Psychoanalytic Discourse. *In:* NICHOLSON, L. J. (ed.) *Feminism/Postmodernism.* New York: Routledge.

BUTLER, J. 1993. *Bodies that Matter: On the Discursive Limits of "Sex",* New York, Routledge.

BUTLER, J. 1999. *Gender Trouble: Feminism and the Subversion of Identity,* New York, Routledge.

CAIN, A. C. 1972a. Introduction. *In:* CAIN, A. C. (ed.) *Survivors of Suicide.* Illinois: Charles C Thomas Publisher.

CAIN, A. C. 1972b. *Survivors of suicide,* Springfield, Ill., Thomas.

CAIN, A. C. & FAST, I. 1966. The Legacy of Suicide: Observations of the Pathogenic Impact of Suicide on Marital Partners. *Psychiatry,* 29**,** 406-411.

CAIN, A. C. & FAST, I. 1972. Pathogenic Impact of Suicide Upon Marital Partners. *In:* CAIN, A. C. (ed.) *Survivors of Suicide.* Illinois: Charles C Thomas Publisher.

CALHOUN, L. G., SELBY, J. W. & FAULSTICH, M. E. 1980. Reactions to the parents of the child suicide: A study of social impressions. *Journal of Consulting and Clinical Psychology,* 48**,** 535-536.

CALHOUN, L. G., SELBY, J. W. & SELBY, L. E. 1982. The psychological aftermath of suicide: An analysis of current evidence. *Clinical Psychology Review,* 2**,** 409-420.

CALHOUN, L. G. & TEDESCHI, R. G. (eds.) 2006. *Handbook of posttraumatic growth : research and practice,* Mahwah: Lawrence Erlbaum Associates.

CAMBRAY, J. 2010. Emergence and the Self. *In:* STEIN, M. (ed.) *Jungian Psychoanalysis: Working in the Spirit of C.G. Jung.* Chicago, Illinois: Open Court.

CAMBRAY, J. & CARTER, L. 2004. Analytic Methods Revisited. *In:* CAMBRAY, J. & CARTER, L. (eds.) *Analytical Psychology: Contemporary Perspectives in Analytical Psychology.* New York: Brunner-Routledge.

CANCIAN, F. M. 1996. Participatory Research and Alternative Strategies for Activist Sociology. *In:* GOTTFRIED, H. (ed.) *Feminism and Social Change: Bridging Theory and Practice.* Chicago: University of Illinois Press.

CARUTH, C. (ed.) 1995. *Trauma: Explorations in Memory,* Baltimore: Johns Hopkins UP.

CASERTA, M. S. & LUND, D. A. 2007. Toward the development of an Inventory of Daily Widowed Life (IDWL): guided by the dual process model of coping with bereavement. *Death Studies,* 31**,** 505-535.

CASSON, J. 2014. Scenes from a Distance: Psychodrama and Dramatherapy. *In:* HOLMES, P., FARRALL, M. & KIRK, K. (eds.) *Empowering Therapeutic Practice: Integrating Psychodrama into other Therapies.* London: Jessica Kingsley Publishers.

CATTANACH, A. 1994. The Developmental Model of Dramatherapy. *In:* JENNINGS, S., CATTANACH, A., MITCHELL, S., CHESNER, A. & MELDRUM, B. (eds.) *The Handbook of Dramatherapy.* London: Routledge.

CEREL, J., PADGETT, J. H., CONWELL, Y. & REED, G. A. 2009a. A call for research: the need to better understand the impact of support groups for suicide survivors. *Suicide & Life-Threatening Behavior,* 39**,** 269-281.

CEREL, J., PADGETT, J. H. & REED, G. A. 2009b. Support groups for suicide survivors: results of a survey of group leaders. *Suicide & Life-Threatening Behavior,* 39**,** 588-598.

CHANG, H. 2008. *Autoethnography as Method,* Walnut Creek, CA, Left Coast Press.

CHANG, H., NGUNJIRI, F. W. & HERNANDEZ, K.-A. C. 2013. *Collaborative Autoethnography,* Walnut Creek, California, Left Coast Press.

CHESNER, A. 1994. Dramatherapy and Psychodrama: Similarities and Differences. *In:* JENNINGS, S., CATTANACH, A., MITCHELL, S., CHESNER, A. & MELDRUM, B. (eds.) *The Handbook of Dramatherapy.* London: Routledge.

CHO, J. & TRENT, A. 2009. Validity Criteria for Performance-Related Qualitative Work: Toward a Reflexive, Evaluative, and Coconstructive Framework for Performance in/as Qualitative Inquiry. *Qualitative Inquiry,* 15**,** 1013-1041.

CIXOUS, H. & CLEMENT, C. 1986. *The Newly Born Woman,* Manchester, Manchester University Press.

CLANDININ, D. J. (ed.) 2007. *Handbook of Narrative Inquiry: Mapping a Methodology,* London: Sage.

CLANDININ, D. J. & CONNELLY, F. M. 2000. *Narrative Inquiry: Experience and Story in Qualitative Research,* San Francisco, CA, Jossey-Bass.

CLANDININ, D. J. & ROSIEK, J. 2007. Mapping a Landscape of Narrative Inquiry: Borderland Spaces and Tensions. *In:* CLANDININ, D. J. (ed.) *Handbook of Narrative Inquiry: Mapping a Methodology.* London: Sage.

CLARK, S. E. & GOLDNEY, R. D. 2000. The Impact of Suicide on Relatives and Friends. *In:* HAWTON, K. & VAN HEERINGEN , K. (eds.) *The International Handbook of Suicide and Attempted Suicide.* Chichester: John Wiley & Sons, Ltd.

CLEIREN, M., DIEKSTRA, R. F. W., KERKHOF, A. J. F. M. & WAL, V. D. 1994. Mode of death and kinship in bereavement: Focusing on "who" rather than "how.". *Crisis: The Journal of Crisis Intervention and Suicide Prevention.*

CLEMENTS, P. T., DERANIERI, J. T., VIGIL, G. J. & BENASUTTI, K. M. 2004. Life after death: grief therapy after the sudden traumatic death of a family member. *Perspectives in Psychiatric Care,* 40**,** 149-154.

CLIFFORD, J. 1986. Introduction: Partial Truths. *In:* CLIFFORD, J. & MARCUS, G. E. (eds.) *Writing Culture: The Poetics and Politics of Ethnography.* Berkeley: University of California Press.

COFFEY, A. & ATKINSON, P. 1996. *Making Sense of Qualitative Data. Complementary Research Strategies,* London, Sage.

COHEN-CRUZ, J. 2009. Transgressing Borders in Portland, Maine. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

COHEN, D. B. 1994. *Out of the Blue : Depression and Human Nature,* New York, W.W. Norton.

COHLER, B. J. 1991. The Life Story and the Study of Resilience and Response to Adversity. *Journal of Narrative and Life History,* 1**,** 169-200.

COLE, S. 1992. Anthropological Lives: The Reflexive Tradition in a Social Science. *In:* KADAR, M. (ed.) *Essays on Life Writing: From Genre to Critical Practice.* Tornonto: University of Toronto Press.

COLMAN, A., D. 1995. *Up from Scapegoating: Awakening Consciousness in Groups,* Wilmette, Ill., Chiron.

COLT, G. H. 1987. The history of the Suicide Survivor: The mark of Cain. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) *Suicide and Its Aftermath: Understanding and Counseling the Survivors.* London: W.W. Norton & Company.

CONNELLY, F. M. & CLANDININ, D. J. 2006. Narrative Inquiry. *In:* GREEN, J., CAMILLI, G. & ELMORE, P. (eds.) *Handbook of Complementary Methods in Education Research.* Mahwah, NJ: Lawrence Erlbaum.

CONSTANTELOS, D. J. 2004. Altruistic Suicide or Altruistic Martyrdom? Christian Greek Orthodox Neomartyrs: A Case Study. *Archives of Suicide Research,* 8**,** 57-71.

CONSTANTINO, R. 2009. Synthetic Culture and Development. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

COPE, T. A. 2006. *Fear of Jung: The Complex Doctrine and Emotional Science,* London, Karnac.

CORNWALL, A. & JEWKES, R. 1995. What is participatory research? *Social Science & Medicine,* 41**,** 1667-1676.

CRAIG, C. J. & HUBER, J. 2007. Relational Reverberations: Shaping and Reshaping Narrative Inquiries in the Midst of Storied Lives and Contexts. *In:* CLANDININ, D. J. (ed.) *Handbook of Narrative Inquiry: Mapping a Methodology.* London: Sage.

CROSBY, A. E. & SACKS, J. J. 2002. Exposure to suicide: incidence and association with suicidal ideation and behavior: United States, 1994. *Suicide & Life-Threatening Behavior,* 32**,** 321-328.

CROSSLEY, M. L. 2003. 'Let me explain': narrative emplotment and one patient's experience of oral cancer. *Social Science & Medicine,* 56**,** 439-448.

CURPHEY, T. 1965. The Role of the Social Scientist in the Medicolegal Certification of Death from Suicide. *In:* FARBEROW, N. L. & SHNEIDMAN, E. (eds.) *The Cry for Help.* New York: McGraw-Hill.

CURPHEY, T. 1967. The Forensic Pathologist and the Multidisciplinary Approach to Death. *In:* SHNEIDMAN, E. (ed.) *Essays in Self-Destruction.* New York: International Science Press.

CURRIER, J. M., HOLLAND, J. M. & NEIMEYER, R. A. 2006. Sense-making, grief, and the experience of violent loss: toward a mediational model. *Death Studies,* 30**,** 403-428.

CUTCLIFFE, J. & BALL, P. B. 2009. Suicide Survivors and the Suicidology Academe: Reconciliation and Reciprocity. *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 30**,** 208-214.

CWIK, A. J. 2010. From Frame through Holding to Container. *In:* STEIN, M. (ed.) *Jungian Psychoanalysis: Working in the Spirit of C.G. Jung.* Chicago, Illinois: Open Court.

DAVIDSON, G. R., MURRAY, K. E. & SCHWEITZER, R. 2008. Review of refugee mental health and wellbeing: Australian perspectives. *Australian Psychologist,* 43**,** 160-174.

DAVIES, M. H. 1987. Dramatherapy and Psychodrama. *In:* JENNINGS, S. (ed.) *Dramatherapy: Theory and Practice 1.* London: Routledge.

DE LEO, D. & HELLER, T. 2008. Social modeling in the transmission of suicidality. *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 29**,** 11-19.

DENZIN, N. K. 1991. Representing Lived Experiences in Ethnographic Texts. *Studies in Symbolic Interaction,* 12**,** 59-70.

DENZIN, N. K. & LINCOLN, Y. S. (eds.) 1994. *Handbook of Qualitative Research,* Thousand Oaks, CA: Sage.

DENZIN, N. K. & LINCOLN, Y. S. 2003. Introduction: The Discipline and Practice of Qualitative Research. *In:* DENZIN, N. K. & LINCOLN, Y. S. (eds.) *The Landscape of Qualitative Research: Theories and Issues, Second Edition.* London: Sage.

DEWEY, J. 1980. *The Middle Works, 1899-1924: Vol. 10: 1916-1917,* London, Southern Illinois University Press.

DEWEY, J. 1981a. *The Later Works, 1925-1953, Vol. 1: 1925,* Carbondale, Southern Illinois University Press.

DEWEY, J. 1981b. The Later Works, 1925-1953: Vol. 10. Art as Experience. *In:* BOYDSTON, J. A. (ed.). Carbondale: Southern Illinois University Press.

DIAMOND, E. 1996. Introduction. *In:* DIAMOND, E. (ed.) *Performance and Cultural Politics.* New York: Routledge.

DOKA, K. J. 1995. Coping with Life-threatening Illness: A Task Model. *Omega: Journal of Death & Dying,* 32**,** 111-122.

DONNELLY, J. (ed.) 1998. *Suicide: Right or Wrong?,* New York: Prometheus Books.

DORPAT, T. L. 1972. Psychological Effects of Parental Suicide on Surviving Children. *In:* CAIN, A. C. (ed.) *Survivors of Suicide.* Illinois: Charles C Thomas Publisher.

DOUGLAS, J. D. 1967. *The Social Meanings of Suicide,* Princeton, N.J., Princeton University Press.

DRIPPS, R. D., LINDEN, M. E., MORRIS, H. H. & PHILLIPS, W. A. 1959. MEDICAL, SOCIAL, AND LEGAL ASPECTS OF SUICIDE. *Journal of the American Medical Association,* 171**,** 523-527.

DUNNE, E. J. 1987. Special Needs of Suicide Survivors in Therapy. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) *Suicide and Its Aftermath: Understanding and Counseling the Survivors.* London: W. W. Norton & Company.

DUNNE, E. J. & DUNNE-MARTIN, K. 1987. Preface. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MARTIN, K. (eds.) *Suicide and Its Aftermath: Understanding and Counseling the Survivors.* London: W.W. Norton & Company.

DURKHEIM, E. 1952/1963/1966. *Suicide: A Study in Sociolog,* London, Routledge & Kegan Paul Ltd.

DYREGROV, K. 2002. Assistance from local authorities versus survivors' needs for support after suicide. *Death Studies,* 26**,** 647-668.

DYREGROV, K. & DYREGROV, A. 2008. *Effective Grief and Bereavement Support : The Role of Family, Friends, Colleagues, Schools and Support Professionals,* London, , GBR, Jessica Kingsley Publishers.

DYREGROV, K., NORDANGER, D. & DYREGROV, A. 2003. Predictors of psychosocial distress after suicide, SIDS and accidents. *Death Studies,* 27**,** 143-165.

DYREGROV, K. M., DIESERUD, G., HJELMELAND, H. M., STRAITON, M., RASMUSSEN, M. L., KNIZEK, B. L. & LEENAARS, A. A. 2011. Meaning-Making Through Psychological Autopsy Interviews: The Value of Participating in Qualitative Research for Those Bereaved by Suicide. *Death Studies,* 35**,** 685-710.

EDINGER, E. F. 1974. *Ego and Archetype: Individuation and the Religious Function of the Psyche,* Baltimore, Penguin.

EDINGER, E. F. 1985. *Anatomy of the Psyche: Alchemical Symbolism in Psychotherapy,* La Salle, Illinois, Open Court.

ELLENBOGEN, S. & GRATTON, F. 2001. Do They Suffer More? Reflections on Research Comparing Suicide Survivors to Other Survivors. *Suicide and Life-Threatening Behavior,* 31**,** 83-90.

ELLIS, C. 1991. Sociological Introspection and Emotional Experience. *Symbolic Interaction,* 14**,** 23-50.

ELLIS, C. 2007. Telling Secrets, Revealing Lives: Relational Ethics in Research With Intimate Others. *Qualitative Inquiry,* 13**,** 3-29.

ELLIS, C. & FLAHERTY, M. G. 1992. An Agenda for the Interpretation of Lived Experience. *In:* ELLIS, C. & FLAHERTY, M. G. (eds.) *Investigating Subjectivity: Research on Lived Experience.* London: Sage Publications.

ELLIS, T. E. 21 Aug. 2013 21 Aug. 2013. Denial of Suicide Ideation -- Literature. *AASListserv Email Discussion* [Online].

ERASMO, M. 2012. *Death Antiquity and its Legacy,* Oxford, Oxford University Press.

ERIKSON, E. H. 1963/1995. *Childhood and Society,* London, Vintage.

ETHERTON, M. 2009. Child Rights Theatre for Develop with Disadvantaged and Excluded Children in South Asia and Africa. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

FAIRBAIRN, G. 1995. *Contemplating Suicide : The Language and Ethics of Self-harm,* New York, Routledge.

FARBEROW, N. L. 1967. Crisis, Disaster, and Suicide: Theory and Therapy. *In:* SHNEIDMAN, E. S. (ed.) *Essays in Self-Destruction.* New York: Science House, Inc.

FARBEROW, N. L. 1993. Bereavement after Suicide. *In:* LEENAARS, A., A. (ed.) *Suicidology: Essays in Honor of Edwin S. Shneidman.* London: Jason Aronson Inc.

FARBEROW, N. L. 1994. The Los Angeles Survivors' After-Suicide Program. *In:* SHNEIDMAN, E. S., FARBEROW, N. L. & LITMAN, R. E. (eds.) *The Psychology of Suicide: A Clinician's Guide to Evaluation and Treatment.* Rev. ed. London: Jason Aronson Inc.

FARBEROW, N. L., GALLAGHERTHOMPSON, D., GILEWSKI, M. & THOMPSON, L. 1992a. Changes in Grief and Mental-Health of Bereaved Spouses of Older Suicides. *Journals of Gerontology,* 47**,** P357-P366.

FARBEROW, N. L., GALLAGHERTHOMPSON, D., GILEWSKI, M. & THOMPSON, L. 1992b. The Role of Social Supports in the Bereavement Process of Surviving Spouses of Suicide and Natural Deaths. *Suicide and Life-Threatening Behavior,* 22**,** 107-124.

FARBEROW, N. L., HEILIG, S. M. & PARAD, H. J. 1994. The Suicide Prevention Center: Concepts and Clinical Functions. *In:* SHNEIDMAN, E. S., FARBEROW, N. L. & LITMAN, R. E. (eds.) *The Psychology of Suicide: A Clinician's Guide to Evaluation and Treatment.* Revised Ed. ed. London: Jason Aronson Inc.

FARBEROW, N. L. & SHNEIDMAN, E. S. (eds.) 1965. *The Cry for Help,* New York: McGraw-Hill.

FAWCETT, B. & HEARN, J. 2004. Researching others: epistemology, experience, standpoints and participation. *International Journal of Social Research Methodology,* 7**,** 201-218.

FEIGELMAN, B. & FEIGELMAN, W. 2011a. Suicide Survivor Support Groups: Comings and Goings, Part I. *Illness, Crisis, & Loss,* 19**,** 57-71.

FEIGELMAN, B. & FEIGELMAN, W. 2011b. Suicide Survivor Support Groups: Comings and Goings, Part II. *Illness, Crisis, & Loss,* 19**,** 165-185.

FEIGELMAN, W., JORDAN, J. R. & GORMAN, B. S. 2009. Personal growth after a suicide loss: cross-sectional findings suggest growth after loss may be associated with better mental health among survivors. *Omega: Journal of Death & Dying,* 59**,** 181-202.

FELMAN, S. & LAUB, D. (eds.) 1992. *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History,* New York: Routledge.

FELSKI, R. 1989. *Feminist Aesthetics: Feminist Literature and Social Change,* London, Hutchinson Radius.

FERRELL, D. R. 1995. The Unmourned Wound: Reflections on the Psychology of Adolf Hitler. *Journal of Religion and Health,* 34**,** 175-197.

FIELD, N. 1991. Projective identification: mechanism or mystery? *Journal of Analytical Psychology,* 36**,** 93-109.

FIELD, N. P. 2006a. Continuing bonds in adaptation to bereavement: introduction. *Death Studies,* 30**,** 709-714.

FIELD, N. P. 2006b. Unresolved grief and continuing bonds: an attachment perspective. *Death Studies,* 30**,** 739-756.

FIELD, N. P., GAO, B. & PADERNA, L. 2005. Continuing bonds in bereavement: an attachment theory based perspective. *Death Studies,* 29**,** 277-299.

FIELD, N. P. & WOGRIN, C. 2011. The Changing Bond in Therapy for Unresolved Loss: An Attachment Theory Perspective. *In:* NEIMEYER, R. A., HARRIS, D. L., WINOKUER, H. R. & THORNTON, G. F. (eds.) *Grief and Bereavement in Contemporary Society: Bridging Research and Practice.* London: Routledge.

FIERZ, K. K. 1991. *Jungian Psychiatry,* Einsiedeln, Daimon Verlag.

FIGLEY, C. R. 1985. From Victim to Survivor: Social Responsibility in the Wake of Catastrophe. *In:* FIGLEY, C. R. (ed.) *Trauma and its Wake, Vol. I: The Study and Treatment of Post-Traumatic Stress Disorder.* New York: Brunner.

FINCH, J. 1984. 'It's Great to Have Someone to Talk to': the Ethics and Politics of Interviewing Women. *In:* BELL, C. & ROBERTS, H. (eds.) *Social Researching: Politics, Problems, Practice.* London: Routledge & Kegan Paul.

FINCHAM, B., LANGER, S., SCOURFIELD, J. & SHINER, M. 2011. *Understanding Suicide: A Sociological Autopsy,* London, Palgrave Macmillan.

FINE, A. 1986. *The Shaky Game: Einstein, Realism and the Quantum Theory,* Chicago, University of Chicago Press.

FINE, C. 1997. *No Time to Say Goodbye: Surviving the Suicide of a Loved One,* New York, Doubleday, Random House.

FISHER, J. 2010. Standby: a Proactive Postvention Response Service in Australia. *In:* LINN-GUST, M. & PETERS, J. (eds.) *A Winding Road: A Handbook for those Supporting the Suicide Bereaved.* New Mexico: Chellehead Works.

FLASKAS, C., MCCARTHY, I. & SHEEHAN, J. (eds.) 2007. *Hope and Despair in Narrative and Family Therapy: Adversity, Forgiveness and Reconciliation,* London: Routledge.

FORDHAM, M., GORDON, R., HUBBACK, J., LAMBERT, K. & WILLIAMS, M. (eds.) 1973. *Analytical Psychology: A Modern Science,* London: William Heinemann Medical Books Ltd.

FOSTER, H. 1985. *Recodings: Art, Spectacle, Cultural Politics,* Port Townsend, Bay Press.

FOSTER, T., GILLESPIE, K. & MCCLELLAND, R. 1997. Mental disorders and suicide in Northern Ireland. *The British Journal of Psychiatry,* 170**,** 447-52.

FRANKL, V. E. 1963. *Man's Searching For Meaning: An Introduction To Logotherapy,* New York, Simon & Schuster.

FREIRE, P. 1996. *Pedagogy of the Oppressed,* London, Penguin.

FREIRE, P. 2009. Pedagogy of the Oppressed. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

FREUD, S. 1909. Analysis of a Phobia in a Five-Year-Old Boy. *SE X: Two Case Histories ('Little Hans' and the 'Rate Man').*

FREUD, S. 1910. Contributions to a Discussion on Suicide. *SE XI.* London: The Hogarth Press and The Institute of Psycho-analysis.

FREUD, S. 1913. Totem and Taboo. *SE XIII.* London: The Hogarth Press and The Institute of Psycho-analysis.

FREUD, S. 1917. Mourning and Melancholia. *SE 14.* London: The Hogarth Press and The Institute of Psycho-analysis.

FREUD, S. 1920a. Beyond the Pleasure Principle. *SE XVIII (1920-1922): Beyond the Pleasure Principle, Group Psychology and Other Works.*

FREUD, S. 1920b. *A General Introduction to Psychoanalysis,* New York, Boni and Liveright.

FREUD, S. 1920c. The Psychogenesis of a Case of Homosexuality in A Woman. *SE 18.* London: The Hogarth Press and The Institute of Psycho-analysis.

FREUD, S. 1923. The Ego and the Id. *SE 19 (1923-1925): The Ego and the Id and Other Works.* London: The Hogarth Press and The Institute of Psycho-analysis.

FREUD, S. 1930. Civilization and its Discontents. *SE XXI (1927-1931): The Future of an Illusion, Civilization and its Discontents, and Other Works.*

FREUD, S. 1933. Why War? *SE XXII (1932-1936): New Introductory Lectures on Psycho-Analysis and Other Works.*

FREUD, S. 1984. *On Metapsychology: The Theory of Psychoanalysis,* London, Penguin.

FRIEDMAN, P. (ed.) [1910]1967. *Symposium on Suicide,* New York: International Universities Press.

FROMM, E. 1973. *The Anatomy of Human Destructiveness,* Middlesex, Penguin.

FUTTERMAN, S. 1965. Suicide: Psychoanalytic Point of View. *In:* FARBEROW, N. L. & SHNEIDMAN, E. S. (eds.) *The Cry for Help.* New York: McGraw-Hill Book Company.

GARRO, L. C. & MATTINGLY, C. 2000. Narrative as Construct and Construction. *In:* MATTINGLY, C. & GARRO, L. C. (eds.) *Narrative and the Cultural Construction of Illness and Healing.* London: University of California.

GARTNER, A. & RIESSMAN, F. 1976. Self-Help Models and Consumer Intensive Health Practice. *Am J Public Health*, 66**,** 783-786.

GEE, J. P. 1991. A Linguistic Approach to Narrative. *Journal of Narrative and Life History*, 1**,** 15-39.

GERGEN, K. J. 1991. *The Saturated Self: Dilemmas of Identity in contemporary Life,* New York, Basic Books.

GERGEN, M. M. & GERGEN, K. J. 2000. Qualitative Inquiry: Tensions and Transformations. *In:* DENZIN, N. K. & LINCOLN, Y. S. (eds.) *Handbook of Qualitative Research, 2nd Ed.* 2nd ed. Thousand Oaks, CA: Sage.

GIBBS, J. P. & MARTIN, W. T. 1964. *Status integration and suicide; a sociological study,* Eugene, Or., University of Oregon Books.

GIDDENS, A. 1971a. Introduction. *In:* GIDDENS, A. (ed.) *The Sociology of Suicide: A Selection of Readings.* London: Frank Cass and Co.

GIDDENS, A. (ed.) 1971b. *The Sociology of Suicide: A Selection of Readings,* London: Frank Cass and Co.

GIDDENS, A. 1971c. The Suicide Problem in French Sociology. *In:* GIDDENS, A. (ed.) *The Sociology of Suicide: A Selection of Readings.* London: Frank Cass & Co. Ltd.

GIDDENS, A. 1971d. The Typology of Suicide. *In:* GIDDENS, A. (ed.) *The Sociology of Suicide: A Selection of Readings.* London: Frank Cass & Co. Ltd.

GILMORE, L. 2001. *The Limits of Autobiography: Trauma and Testimony,* Ithaca, Cornell University.

GIROUX, H. 2009. Border Crossings. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader*. London: Routledge.

GOFFMAN, E. 1990. *The Presentation of Self in Everyday Life,* London, Penguin.

GOLDEN, K. B. & BERGO, B. G. (eds.) 2009. *The Trauma Controversy: Philosophical and Interdisciplinary Dialogues,* Albany, NY: Sunny Press.

GOLDRING, J. E. 2010. Between Partisan and Fake, Walking the Path of the Insider: Empowerment and Voice in Ethnography. *In:* JONES, J. S. & WATT, S. (eds.) *Ethnography in Social Science Practice.* London: Routledge.

GOODWIN, R. D., BEAUTRAIS, A. L. & FERGUSSON, D. M. 2004. Familial transmission of suicidal ideation and suicide attempts: evidence from a general population sample. *Psychiatry Research,* 126**,** 159-165.

GOODWYN, E. 2010. Approaching archetypes: reconsidering innateness. *Journal of Analytical Psychology,* 55**,** 502-521.

GORELICK, S. 1996. Contradictions of Feminist Methodology. *In:* GOTTFRIED, H. (ed.) *Feminism and Social Change: Bridging Theory and Practice.* Chicago: University of Illinois Press.

GOTTFRIED, H. 1996. Introduction. Engaging Women's Communities: Dilemmas and Contradictions in Feminist Research. *In:* GOTTFRIED, H. (ed.) *Feminism and Social Change: Bridging Theory and Practice.* Chicago: University of Illinois Press.

GRAD, O. T., CLARK, S., DYREGROV, K. & ANDRIESSEN, K. 2004. What Helps and What Hinders the Process of Surviving the Suicide of Somebody Close? *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 25**,** 134-139.

GREENBERG, J. R. & MITCHELL, S. A. 1983. *Object Relations in Psychoanalytic Theory,* Cambridge, MA, Harvard University Press.

HAAS, A. P., ELIASON, M., MAYS, V. M., MATHY, R. M., COCHRAN, S. D., D'AUGELLI, A. R., SILVERMAN, M. M., FISHER, P. W., HUGHES, T., ROSARIO, M., RUSSELL, S. T., MALLEY, E., REED, J., LITTS, D. A., HALLER, E., SELL, R. L., REMAFEDI, G., BRADFORD, J., BEAUTRAIS, A. L., BROWN, G. K., DIAMOND, G. M., FRIEDMAN, M. S., GAROFALO, R., TURNER, M. S., HOLLIBAUGH, A. & CLAYTON, P. J. 2011. Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations. *Journal of Homosexuality,* 58**,** 10-51.

HADLACZKY, G., WASSERMAN, D., HOVEN, C. W., MANDELL, D. J. & WASSERMAN, C. 2011. Suicide Prevention Strategies: Case Studies from across the Globe. *In:* O'CONNOR, R. C., PLATT, S. & GORDON, J. (eds.) *International Handbook of Suicide Prevention: Research, Policy and Practice.* Oxford: Wiley-Blackwell.

HALLAM, E., HOCKEY, J. L. & HOWARTH, G. 1999. *Beyond the Body : Death and Social Identity,* London, Routledge.

HAMILTON, R. 2004. Irreversible: Unbearable Feelings. *British Journal of Psychotherapy,* 20**,** 281-293.

HAMMERSLEY, M. 1992. On Feminist Methodology. *Sociology,* 26**,** 187-206.

HAUKE, C. 2006. The Unconscious: Personal and Collective. *In:* PAPADOPOULOS, R. K. (ed.) *The Handbook of Jungian Psychology: Theory, Practice and Applications.* London: Routledge.

HAUKE, C. & ALISTER, I. (eds.) 2001. *Jung and Film: Post-Jungian Takes on the Moving Image,* Hove: Brunner-Routledge.

HAUKE, C. & HOCKLEY, L. (eds.) 2011. *Jung and Film II : The Return : Further Post-Jungian Takes on the Moving Image* London: Routledge.

HAULE, J. R. 1984. From Somnambulism to the Archetype: The French Roots of Jung's Split with Freud. *Psychoanalytic Review,* 71**,** 635-659.

HAULE, J. R. 2011. *Jung in the 21st Century Volume One: Evolution and Archetype,* London, Routledge.

HAUSER, M. J. 1987. special Aspects of Grief After a Suicide. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) *Suicide and Its Aftermath: Understanding and Counseling the Survivors.* London: W. W. Norton & Company.

HAWTON, K. 1994. Causes and Opportunities for Prevention. *In:* JENKINS, R., GRIFFITHS, S., WYLIE, I., HAWTON, K., MORGAN, G. & TYLEE, A. (eds.) *The Prevention of Suicide.* London: HMSO.

HAWTON, K., RODHAM, K. & WITH EVANS, E. 2006. *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents,* London, Jessica Kingsley.

HEDDON, D. 2004. Performing Lesbians: Constructing the Self, Constructing the Community. *In:* GALE, M. B. & GARDNER, V. (eds.) *Auto/biography and Identity: Women, Theatre and Performance.* Manchester: Manchester Unviersity Press.

HEDDON, D. 2008. *Autobiography and Performance,* New York, Palgrave.

HEIKES, K. 1997. Parental suicide: a systems perspective. *Bulletin Of The Menninger Clinic,* 61**,** 354-367.

HENDIN, H. 1965. Suicide: Psychoanalytic Point of View. *In:* FARBEROW, N. L. & SHNEIDMAN, E. S. (eds.) *The Cry for Help.* New York: McGraw-Hill Book Company.

HENDIN, H. 1971. The Psychodynamics of Suicide. *In:* GIDDENS, A. (ed.) *The Sociology of Suicide: A Selection of Readings.* London: Frank Cass & Co. Ltd.

HENDIN, H. 1991/1996. Psychodynamics of Suicide, with Particular Reference to the Young. *In:* MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) *Essential Papers on Suicide.* New York: New York University Press.

HENKE, S. 1998. *Shattered Subjects: Trauma and Testimony in Women's Life Writing,* London, Macmillan.

HENRIKSSON, M. M., MARTTUNEN, M. J., ISOMETS , E. T., HEIKKINEN, M. E., ARO, H. M., KUOPPASALMI, K. I. & L NNQVIST, J. K. 1995. Mental Disorders in Elderly Suicide. *International Psychogeriatrics,* 7**,** 275-286.

HENSLIN, J. M. 1972. Strategies of Adjustment: An Ethnomethodological Approach to the Study of Guilt and Suicide. *In:* CAIN, A. C. (ed.) *Survivors of Suicide.* Illinois: Charles C Thomas Publisher.

HERMAN, D. 2009. *Basic Elements of Narrative,* Chichester, Wiley-Blackwell.

HILLMAN, J. 1973/2011. *Suicide and the Soul,* Putnam, Connecticut, Spring Publications.

HILLMAN, J. 1974. *Archetypal Theory : C.G. Jung* New York, Brunner/Mazel.

HILLMAN, J. 1992. *Emotion: A Comprehensive Phenomenology of Theories and their Meanings for Therapy,* Evanston, Northwestern University.

HILLMAN, J. 1993. *Archetypal Psychology - A Brief Account Together with a Complete Checklist of Works,* Dallas, TX, Spring.

HILLYARD, D. & DOMBRINK, J. 2001. *Dying right : the death with dignity movement,* New York, Routledge.

HIPPOCRATES 1950. *The Medical Works of Hippocrates,* Oxford, Blackwell Scientific Publications.

HMHL. 2009 Nov. Supporting Survivors of Suicide Loss. *Harvard Mental Health Letter*.

HOBSON, R. F. 1961/1971. The Archetypes of the Collective Unconscious. *In:* FORDHAM, M., GORDON, R., HUBBACK, J., LAMBERT, K. & WILLIAMS, M. (eds.) *Analytical Psychology: A Modern Science (1973).* London: William heinemann Medical Books Ltd.

HOCKLEY, L. 2001. *Cinematic Projections: The Analytical Psychology of C.G. Jung and Film Theory,* Bedfordshire, University of Luton Press.

HOCKLEY, L. 2004. Detective Films and Images of the Orient: A Post-Jngian Reflection. *In:* BAUMLIN, J. S., BAUMLIN, T. F. & JENSEN, G. H. (eds.) *Post-Jungian Criticism: Theory and Practice.* Albany: State University of New York Press.

HODGKIN, K. & RADSTONE, S. (eds.) 2003. *Contested Pasts: The Politics of Memory,* London: Routledge.

HOGAN, N. S. & SCHMIDT, L. A. 2002. Testing the Grief to Personal Growth model using structural equation modeling. *Death Studies,* 26**,** 615-634.

HOGENSON, G. B. 1994. *Jung's Struggle with Freud,* Wilmette, Illinois, Chiron Publications.

HOGENSON, G. B. 2001. The Baldwin effect: a neglected influence on C. G. Jung's evolutionary thinking. *Journal of Analytical Psychology,* 46**,** 591-611.

HOGENSON, G. B. 2003a. Reply to Maloney. *Journal of Analytical Psychology,* 48**,** 265-266.

HOGENSON, G. B. 2003b. Reply to Maloney. *Journal of Analytical Psychology,* 48**,** 107-116.

HOGENSON, G. B. 2003c. Reply to Raya Jones. *Journal of Analytical Psychology,* 48**,** 714-718.

HOGENSON, G. B. 2010. Responses to Erik Goodwyn's 'Approaching archetypes: reconsidering innateness'. *Journal of Analytical Psychology,* 55**,** 543-549.

HOLLWAY, W. 1989. *Subjectivity and Method in Psychology,* London, Sage.

HOLMES, P., FARRALL, M. & KIRK, K. (eds.) 2014. *Empowering Therapeutic Practice: Integrating Psychodrama into other Therapies,* London: Jessica Kingsley Publishers.

HOLMSTRAND, C., ANDERS, N. U. & TRA¨SKMAN-BENDZ, L. 2006. Risk factors of future suicide in suicide attempters : A comparison between suicides and matched survivors. *Nord J Psychiatry,* 60**,** 162-167.

HOMANS, P. 1995. *Jung in Context: Modernity and the Making of a Psychology,* Chicago, The University of Chicago.

HOROWITZ, M. J., WILNER, N., MARMAR, C. & KRUPNICK, J. 1980. Pathological grief and the activation of latent self-images. *The American Journal Of Psychiatry,* 137**,** 1137-1162.

HORTON-SALWAY, M. 2001. The Construction of M.E.: The Discursive Action Model. *In:* WETHERELL, M., TAYLOR, S. & YATES, S. J. (eds.) *Discourse as Data: A Guide for Analysis.* Milton Keynes: The Open University.

HOWARTH, G. 2007. *Death and Dying: A Sociological Introduction*, Cambridge, Polity.

HUGHES, J. W. J. K. & RUDING, S. 2009. Made to Measure? A Critical Interrogation of Applied Theatre as Intervention with Young Offenders in the UK. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

HUMBERT, E. 1992. Archetype. *In:* PAPADOPOULOS, R. K. (ed.) *Carl Gustov Jung: Critical Assessments, Vol. II: The Structure and Dynamics of the Psyche.* London: Routledge.

HUSKINSON, L. 2002. The Self as violent Other: the problem of defining the self. *Journal of Analytical Psychology*, 47**,** 437-458.

HUSKINSON, L. 2006. Holy, Holy, Holy: the Misappropriation of the Numinous in Jung. *In:* CASEMENT, A. & TACEY, D. (eds.) *The Idea of the Numinous: Contemporary Jungian and Psychoanalytic Perspectives.* London: Routledge.

IASP. International Association for Suicide Prevention. Available: https://www.iasp.info/resources/index.php [Accessed 24 Apr. 2015].

JACOBI, J. 1957/1959. *Complex/Arthetype/Symbol in the Psychology of C. G. Jung*, London, Routledge & Kegan Paul.

JACOBI, J. 1973. *The Psychology of C. G. Jung*, New Haven & London, Yale University Press.

JACOBS, D. & KLEIN, M. E. 1993. The Expanding Role of Psychological Autopsies. *In:* LEENAARS, A. (ed.) *Suicidology: Essays in Honor of Edwin S. Shneidman.* London: Jason Aronson Inc.

JAFF , A. 1970. *The Myth of Meaning in the Work of C. G. Jung*, London, Hodder and Stoughton.

JAMESON, F. 1992. *Postmodernism, or, the Cultural Logic of Late Capitalism*, Durham, NC, Duke University Press.

JANOFF-BULMAN, R. 1985. The Aftermath of Victimization: Rebuilding Shattered Assumptions. *In:* FIGLEY, C. R. (ed.) *Trauma and its Wake: The Study and Treatment of Post-traumatic Stress Disorder*. New York: Brunner/Mazel.

JANOFF-BULMAN, R. & FRIEZE, I. H. 1983. A Theoretical Perspective for Understanding Reactions to Victimization. *Journal of Social Issues*, 39**,** 1-17.

JENNINGS, S. 1987. Introduction. *In:* JENNINGS, S. (ed.) *Dramatherapy: Theory and Practice 1.* London: Routledge.

JENNINGS, S., CATTANACH, A., MITCHELL, S., CHESNER, A. & MELDRUM, B. (eds.) 1994. *The Handbook of Dramatherapy*, London: Routledge.

JENSEN, G. H. 2004. Introduction: Situating Jung in Contemporary Critical Theory. *In:* BAUMLIN, J. S., BAUMLIN, T. F. & JENSEN, G. H. (eds.) *Post-Jungian Criticism: Theory and Practice.* Albany: State University of New York Press.

JENSEN, V. W. & PETTY, T. A. 1996. The Fantasy of Being Rescued in Suicide. *In:* MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) *Essential Papers on Suicide.* New York: New York University Press.

JOFFE, H. 2012. Thematic Analysis. *In:* HARPER, D. & THOMPSON, A. R. (eds.) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners.* Chichester: Wiley-Blackwell.

JOHNSON, D. R. *Developmental Transformation* [Online]. Available: http://primediscrepancy.wix.com/dvt40 [Accessed 17 April 2015].

JOINER, T. 2010. *Myths about Suicide*, London, Harvard University.

JOINER, T. E. 2005. *Why People Die by Suicide*, Cambridge, Mass., Harvard University Press.

JONES, E. 1955. *Sigmund Freud Life and Work, Volume Two: Years of Maturity 1901-1919*, London, The Hogarth Press.

JONES, J. S. & WATT, S. (eds.) 2010. *Ethnography in Social Science Practice*, London: Routledge.

JONES, R. A. 2000. Reply to Maloney. *Journal of Analytical Psychology*, 45**,** 613-614.

JONES, R. A. 2003. Responses On innatism: a response to Hogenson. *Journal of Analytical Psychology*, 48**,** 705-714.

JORDAN, J. R. 2011. Group Work With Suicide Survivors. *In:* JORDAN, J. R. & MCINTOSH, J. L. (eds.) *Grief After Suicide: Understanding the Consequences and Caring for the Survivors.* London: Routledge.

JORDAN, J. R., FEIGELMAN, W., MCMENAMY, J. & MITCHELL, A. M. 2011. Research on the Needs of Survivors. *In:* JORDAN, J. R. & MCINTOSH, J. L. (eds.) *Grief After Suicide: Understanding the Consequences and Caring for the Survivors.* London: Routledge.

JORDAN, J. R. & MCINTOSH, J. L. (eds.) 2011a. *Grief after Suicide : Understanding the Consequences and Caring for the Survivors*, New York ; London: Routledge.

JORDAN, J. R. & MCINTOSH, J. L. 2011b. Suicide Bereavement: Why Study Survivors of Suicide Loss? *In:* JORDAN, J. R. & MCINTOSH, J. L. (eds.) *Grief After Suicide: Understanding the Consequences and Caring for the Survivors.* Lonon: Routledge.

JORDAN, J. R. & MCMENAMY, J. 2004. Interventions for suicide survivors: a review of the literature. *Suicide & Life-Threatening Behavior,* 34**,** 337-349.

JOSEPH, S. & LINLEY, P. A. 2008. Positive Psychological Perspectives on Posttraumatic Stress: An Integrative Psychosocial Framework. *In:* JOSEPH, S. & LINLEY, P. A. (eds.) *Trauma, Recovery, and Growth: Positive Psychological Perspectives on Posttraumatic Stress.* Hoboken, NJ: John Wiley & Sons, Inc.

JOSSELSON, R. 2007. The Ethical Attitude in Narrative Research. *In:* CLANDININ, D. J. (ed.) *Handbook of Narrative Inquiry: Mapping a Methodology.* London: Sage.

JUNG, C. G. The Archetypes and the Collective Unconscious. *CW 18.*

JUNG, C. G. 1907. The Psychology of Dementia Praecox. *CW 3.* London: Routledge & Kegan Paul.

JUNG, C. G. 1909. The Family Constellation. *CW 2.*

JUNG, C. G. 1910-11. A Contribution to the Psychology of Rumour. *CW 4.*

JUNG, C. G. 1912. Appendix: New Paths in Psychology. *CW 7: Two Essays on Analytical Psychology.* London: Routledge.

JUNG, C. G. 1917/1926/1943. On the Psychology of the Unconscious. *CW 7: Two Essays on Analytical Psychology.* London: Routledge.

JUNG, C. G. 1919/1928. Instinct and the Unconscious. *CW 8: The Structure and Dynamics of the Psyche.*

JUNG, C. G. 1920/1948. The Psychological Foundations of Belief in Spirits. *CW 8: The Structure and Dynamics of the Psyche.* London: Routledge & Kegan Paul.

JUNG, C. G. 1921/1971. Schiller's Ideas on the Type Problem. *CW 6: Psychological Types.*

JUNG, C. G. 1927/1931. The Structure of the Psyche. *CW 8: The Structure and Dynamics of the Psyche.*

JUNG, C. G. 1928a. On Psychic Energy. *CW 8: The Structure and Dynamics of the Psyche.*

JUNG, C. G. 1928b. The Relations between the Ego and the Unconscious. *CW 7: Two Essays on Analytical Psychology*. London: Routledge.

JUNG, C. G. 1929. The Significance of Constitution and Heredity in Psychology. *CW 8: The Structure and Dynamics of the Psyche.*

JUNG, C. G. 1931a. The Aims of Psychotherapy. *CW 16.* Longon: Routledge & Kegan Paul.

JUNG, C. G. 1931b. A Psychological Theory of Types. *CW 6.* London: Routledge & Kegan Paul.

JUNG, C. G. 1934. A Review of the Complex Theory. *CW 8: The Structure and Dynamics of the Psyche.* London: Routledge & Kegan Paul.

JUNG, C. G. 1936a. The Concept of the Collective Unconscious. *CW 9i.*

JUNG, C. G. 1936b. Individual Dream Symbolism in Relation to Alchemy. *CW 12: Psychology and Alchemy.*

JUNG, C. G. 1937. Psychological Factors Determining Human Behaviour. *CW 8: The Structure and Dynamics of the Psyche.*

JUNG, C. G. 1938/1940. Psychology and Religion (The Terry Lectures). *CW 11*.

JUNG, C. G. 1938/1954. Psychological Aspects of the Mother Archetype. *CW 9i.*

JUNG, C. G. 1940. The Psychology of the Child Archetype. *CW 9i*. London: Routledge & Kegan Paul.

JUNG, C. G. 1943. Psychotherapy and a Philosophy of Life. *CW 16.*

JUNG, C. G. 1945. Psychotherapy Today. *CW 16.* Lodon: Routledge & Kegan Paul.

JUNG, C. G. 1946. The Psychology of the Transference. *CW 16.* 2d ed. London: Routledge.

JUNG, C. G. 1947/1954. On The Nature of the Psyche. *CW 8: The Structure and Dynamics of the Psyche.* London: Routledge & Kegan Paul.

JUNG, C. G. 1951/1959/1968a. *Aion: Rresearches into the Phenomenology of the Self,* London, Routledge & Kegan Paul.

JUNG, C. G. 1951/1959/1968b. The Structure and Dynamics of the Self. *CW 9ii.*

JUNG, C. G. 1952. Answer to Job. *CW 11: Psychology and Religion: West and East.*

JUNG, C. G. 1956. Foreword. *Complex/Archetype/Symbol in the Psychology of C. G. Jung.* London: Routledge.

JUNG, C. G. 1963/1977. *Memories, Dreams, Reflections,* Great Britain, Collins Fount Paperbacks.

JUNG, C. G. 1973. *Experimental Researches: Studies in Word Association*.

JUNG, C. G. 1975. *Letters Vol. 2: 1951-1961,* London, Routledge & Kegan Paul.

JUNG, C. G. 1976. The Tavistock Lectures. *CW 18: The Symbolic Life.* London: Routledge & Kegan Paul.

JUNG, C. G. & FREEMAN, J. 1959. The "Face to Face" Interview. *In:* MCGUIRE, W. & HULL, R. F. C. (eds.) *C. G. Jung Speaking: Interviews and Encounters.* London: Thames & Judson, 1978.

JUNG, C. G. & MCGUIRE, W. 1984. *Dream analysis : notes of the seminar given in 1928-1930,* Princeton, N.J., Princeton University Press.

K BLER-ROSS, E. 1970. *On Death and Dying,* London, Tavistock Publications.

K BLER-ROSS, E. & KESSLER, D. 2005. *On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of Loss,* London, Simon & Schuster.

KALISCHUK, R. G. & HAYES, V. E. 2003-2004. Grieving, Mourning, and healing Following Youth Suicide: A Focus on Health and Well Being in Families. *Omega,* 48**,** 45-67.

KAMERMAN, J. 1993. The Illegacy of Suicide. *In:* LEENAARS, A. (ed.) *Suicidology: Essays in Honor of Edwin S. Shneidman.* London: Jason Aronson Inc.

KAPLAN, D. M. 2003. *Ricoeur's Critical Theory,* New York, State University of New York Press.

KAPRIO, J., KOSKENVUO, M. & RITA, H. 1987. Mortality after Bereavement - a Prospective-Study of 95,647 Widowed Persons. *American Journal of Public Health,* 77**,** 283-287.

KARP, M. & FARRALL, M. 2014. Glossary: An Introduction to Psychodrama Concepts and Terms. *In:* HOLMES, P., FARRALL, M. & KIRK, K. (eds.) *Empowering Therapeutic Practice: Integrating Psychodrama into Other Therapies.* London: Jessica Kingsley Publishers.

KELLERMAN, P. F. 1992. *Focus on Psychodrama: The Therapeutic Aspects of Psychodrama,* London, Jessica Kingsley Publishers.

KENT, J. 2000. Group Inquiry: A Democratic Dialogue? *In:* TRUMAN, C., MERTENS, D. M. & HUMPHRIES, B. (eds.) *Research and Inequality.* London: Routledge.

KIM-COHEN, J., MOFFITT, T. E., CASPI, A. & TAYLOR, A. 2004. Genetic and Environmental Processes in Young Children's Resilience and Vulnerability to Socioeconomic Deprivation. *Child Development,* 75**,** 651-668.

KITANAKA, J. 2009. Questioning the Suicide of Resolve: Medico-legal Disputes Regarding "Overwork Suicide" in Twentieth-Century Japan. *In:* WRIGHT, D. & WEAVER, J. (eds.) *Histories of Suicide: International Perspectives on Self-Destruction in the Modern World.* Toronto: University of Toronto.

KLOPFER, B. 1965. Suicide: The Jungian Point of View. *In:* FARBEROW, N. L. & SHNEIDMAN, E. S. (eds.) *The Cry for Help.* London: McGraw-Hill Book.

Survivors of Suicide Loss, 2012. Directed by KNAPP, P. London, Ontario, Canada: MIKO Productions.

KNIEPER, A. J. 1999. The suicide survivor's grief and recovery. *Suicide & Life-Threatening Behavior,* 29**,** 353-364.

KNOX, J. 4 Feb 4 Feb 2015. *RE: Personal communication about whether Jean would consider herself an 'emergencist'.* Type to TU, H.-C.

KNOX, J. 2003. *Archetype, Attachment, Analysis: Jungian Psychology and the Emergent Mind,* London, Routledge.

KNOX, J. 2010. Responses to Erik Goodwyn's 'Approaching archetypes: reconsidering innateness'. *Journal of Analytical Psychology,* 55**,** 522-533.

KRYSINSKA, K. E. 2003. Loss by suicide. A risk factor for suicidal behavior. *Journal Of Psychosocial Nursing And Mental Health Services,* 41**,** 34-41.

KURAMOTO, S. J., BRENT, D. A. & WILCOX, H. C. 2009. The Impact of Parental Suicide on Child and Adolescent Offspring. *Suicide and Life-Threatening Behavior,* 39**,** 137-151.

LABOV, W. & WALETZKY, J. 1967. Narrative Analysis: Oral Versions of Personal Experience. *In:* HELM, J. (ed.) *Essays on the Verbal and Visual Arts.* Seattle: University of Washington Press.

LAMB, F. & DUNNE-MAXIM, K. 1987. Postvention in Schools: Policy and Process. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) *Suicide and Its Aftermath: Understanding and Counseling the Survivors.* London: W. W. Norton & Company.

LANDY, R. J. 1986. *Drama Therapy: Concepts and Practices,* Springfield, IL, Charles C. Thomas.

LANDY, R. J. 1993. *Persona and Performance : the Meaning of Role in Drama, Therapy, and Everyday Life* New York, Guilford Press.

LANGELLIER, K. M. 1989. Personal narratives: Perspectives on theory and research. *Text and Performance Quarterly,* 9**,** 243-276.

LANGELLIER, K. M. 1999. Personal narrative, performance, performativity: Two or three things I know for sure. *Text and Performance Quarterly,* 19**,** 125-144.

LANGELLIER, K. M. & PETERSON, E. E. 2006. Shifting Contexts in Personal Narrative Performance. *In:* MADISON, D. S. & HAMERA, J. (eds.) *The SAGE Handbook of Performance Studies.* London: Sage.

LANN, I. S., MOSCICKI, E. K. & MARIS, R. (eds.) 1989. *Strategies for Studying Suicide and Suicidal Behavior,* New York: Guilford Press.

LATHAM, A. E. & PRIGERSON, H. G. 2004. Suicidality and bereavement: complicated grief as psychiatric disorder presenting greatest risk for suicidality. *Suicide & Life-Threatening Behavior,* 34**,** 350-362.

LAUB, D. 1995. Truth and Testimony: the Process and the Struggle. *In:* CARUTH, C. (ed.) *Trauma: Explorations in Memory.* Baltimore: Johns Hopkins UP.

LEENAARS, A. A. 1993. Unconscious Processes. *In:* LEENAARS, A. A. (ed.) *Suicidology: Essays in Honor of Edwin S. Shneidman.* London: Jason Aronson.

LEENAARS, A. A. 2004. Altruistic Suicide: A Few Reflections. *Archives of Suicide Research,* 8**,** 1-7.

LEFEBVRE, H. 1991. *The Production of Space,* Oxford, Blackwell.

LENGUA, L. J. 2002. The Contribution of Emotionality and Self-Regulation to the Understanding of Children's Response to Multiple Risk. *Child Development,* 73**,** 144-161.

LERNER, M. 1980. *The Belief in a Just World: A Fundamental Delusiion,* New York, Plenum Press.

LESTER, D. 1994. *Emile Durkheim : le suicide one hundred years later,* Philadelphia, Charles Press.

LESTER, D. 2004. Denial in Suicide Survivors. *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 25**,** 78-79.

LEVINE, E. 1997. Jewish Views and Customs on Death. *In:* PARKES, C. M., LAUNGANI, P. & YOUNG, B. (eds.) *Death and Bereavement Across Cultures.* London: Routledge.

LEYDESDORFF, S., DAWSON, G., BURCHARDT, N. & ASHPLANT, T. G. 1999. Introduction: Trauma and Life Stories. *In:* ROGERS, K. L., LEYDESDORFF, S. & DAWSON, G. (eds.) *Trauma and Life Stories: International Perspectives.* London: Routledge.

LICHTENTHAL, W. G. & CRUESS, D. G. 2010. Effects of Directed Written Disclosure on Grief and Distress Symptoms among Bereaved Individuals. *Death Studies,* 34**,** 475-499.

LIFE. *StandBy Response Service* [Online]. Available: http://www.livingisforeveryone.com.au/StandBy-Response-Service.html [Accessed 5 May 2014].

LIFTON, R. J. 1968. *Death in Life: The Survivors of Hiroshima,* London, Weidenfeld and Nicolson.

LIFTON, R. J. 1973. *Home from the War: Vietnam Veterans: Neither Victims nor Executioners,* New York, Simon & Schuster.

LIFTON, R. J. 1989. Suicide: The Quest for a Future. *In:* JACOBS, D. & BROWN, H. N. (eds.) *Suicide: Understanding and Responding: Harvard Medical School Perspectives.* Madison: International Universities Press, Inc.

LINDE, C. 1993. *Life Stories: The Creation of Coherence,* Oxford, Oxford University Press.

LINDEMANN, E. & GREER, I. M. 1972. A Study of Grief: Emotional Responses to Suicide. *In:* CAIN, A. C. (ed.) *Survivors of Suicide.* Illinois: Charles C Thomas Publisher.

LINN-GUST, M. 2010. How Suicide Impacts the Family. *In:* LINN-GUST, M. & PETERS, J. (eds.) *A Winding Road: A Handbook for Those Supporting the Suicide Bereaved.* New Mexico: Chellehead Works.

LINN-GUST, M. & PETERS, J. (eds.) 2010. *A Winding Road: A Handbook for Those Supporting the Suicide Bereaved,* New Mexico: Chellehead Works.

LITMAN, R. E. 1970/1996. Sigmund Freud on Suicide. *In:* MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) *Essential Papers on Suicide.* New York: New York University Press.

LITMAN, R. E. 1994. Responsibility and Liability for Suicide. *In:* SHNEIDMAN, E. S., FARBEROW, N. L. & LITMAN, R. E. (eds.) *The Psychology of Suicide: A Clinician's Guide to Evaluation and Treatment.* London: Jason Aronson Inc.

LITMAN, R. E., CURPHEY, T., SHNEIDMAN, E. S. S., FARBEROW, N. L. & TABACHNICK, N. 1963. Investigation of Equivocal Suicide. *Journal of the American Medical Association,* 184**,** 924-929.

LITTRELL, J. 1998. IS THE REEXPERIENCE OF PAINFUL EMOTION THERAPEUTIC? *Clinical Psychology Review,* 18**,** 71-102.

LOGAN, J., HILL, H. A., BLACK, M. L., CROSBY, A. E., KARCH, D. L., BARNES, J. D. & LUBELL, K. M. 2008. Characteristics of Perpetrators in Homicide-Followed-by-Suicide Incidents: National Violent Death Reporting System-17 US States, 2003-2005. *American Journal of Epidemiology,* 168**,** 1056-1064.

LU, T.-H., CHANG, W.-T., LIN, J.-J. & LI, C.-Y. 2011. Suicide method runs in families: a birth certificate cohort study of adolescent suicide in Taiwan. *Suicide & Life-Threatening Behavior,* 41**,** 685-690.

LUCKHURST, R. 2008. *The Trauma Question,* London, Routledge.

LUTHAR, S. S. 1991. Vulnerability and Resilience: A Study of High-Risk Adolescents. *Child Development,* 62**,** 600-616.

LUTHAR, S. S., CICCHETTI, D. & BECKER, B. 2000. The Construct of Resilience: A Critical Evaluation and Guidelines for Future Work. *Child Development,* 71**,** 543-562.

MADISON, D. S. & HAMERA, J. 2006. Introduction: Performance Studies at the Intersections. *In:* MADISON, D. S. & HAMERA, J. (eds.) *The SAGE Handbook of Performance Studies.* London: Sage.

MADPIX-FILMS 2014. Can You Hear Me Now? New Voices of Attempt Survivors.

MAGUIRE, P. 1987. *Doing Participatory Research: A Feminist Approach,* Amherst, Massachusetts, The Center for International Education, School of Education, University of Massachusetts.

MAIN, R. 2004. *The Rupture of Time: Synchronicity and Jung's Critique of Modern Western Culture,* Hove, Brunner-Routledge.

MALTSBERGER, J. T. & BUIE, D. H. 1974. COuntertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry,* 30**,** 625-633.

MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) 1996. *Essential Papers on Suicide,* New York: New York University Press.

MAPLE, M. Unconvering and Identifying the Missing Voices in Suicide Bereavement Research. Suicide Bereavement is Everyone's Business: Policy, Research and Practice, 2013 The University of Manchester.

MARRONE, R. 1999. Dying, mourning, and spirituality: a psychological perspective. *Death Studies,* 23**,** 495-519.

MARSH, I. 2010. *Suicide: Foucault, History and Truth,* Cambridge, Cambridge University Press.

MARTIN-VALLAS, F. 2013. Are archetypes transmitted or emergent? A response to Christian Roesler. *Journal of Analytical Psychology,* 58**,** 278-285.

MARTINEZ-TORTEYA, C., ANNE BOGAT, G., VON EYE, A. & LEVENDOSKY, A. A. 2009. Resilience Among Children Exposed to Domestic Violence: The Role of Risk and Protective Factors. *Child Development,* 80**,** 562-577.

MATHERS, D. 2001. *An Introduction to Meaning and Purpose in Analytical Psychology,* East Sussex, Brunner-Routledge.

MATTESON, F. *Contextual-Conceptual Therapy* [Online]. Available: http://suicidetherapy.com/cct-theoretical-overview/ [Accessed 27 Apr 2014].

MATTINGLY, C. 1998. *Healing Dramas and Clinical Plots: The Narrative Structure of Experience,* Camridge, Cambridge University Press.

MATTINGLY, C. F. 2007. Acted Narratives: From Storytelling to Emergent Dramas. *In:* CLANDININ, D. J. (ed.) *Handbook of Narrative Inquiry: Mapping a Methodology.* London: Sage.

MCCREERY, K. 2009. Flight Paths: Challenging Racism in Sunderland and Newcastle. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

MCDOWELL, M. J. 2001. Principle of organization: a dynamic-systems view of the archetype-as-such. *The Journal of Analytical Psychology,* 46**,** 637-654.

MCINTOSH, J. L. 1993. Control-Group Studies of Suicide Survivors - a Review and Critique. *Suicide and Life-Threatening Behavior,* 23**,** 146-161.

MCINTOSH, J. L. 2003. Suicide Survivors: The Aftermath of Suicide and Suicidal Behavior. *In:* BRYANT, C. D. (ed.) *Handbook of Death & Dying, Vol. 1.* Thousand Oaks, CA: Sage.

MCINTOSH, J. L. & WROBLESKI, A. 1988. Grief reactions among suicide survivors: An exploratory comparison of relationships. *Death Studies,* 12**,** 21-39.

MCLAREN, P. 1997. The Ethnographer as Postmodern *Flâneur*: Critical Reflexivity and Posthybridity as Narrative Engagement. *In:* TIERNEY, W. G. & LINCOLN, Y. S. (eds.) *Representation and the Text: Re-Framing the Narrative Voice.* Albany, NY: State University of New York Press.

MCMANUS, R. 2013. *Death in a Global Age,* Hampshire, Palgrave Macmillan.

MCMENAMY, J. M., JORDAN, J. R. & MITCHELL, A. M. 2008. What do suicide survivors tell us they need? Results of a pilot study. *Suicide & Life-Threatening Behavior,* 38**,** 375-389.

MCNIEL, D. E., HATCHER, C. & REUBIN, R. 1988. Family survivors of suicide and accidental death: consequences for widows. *Suicide & Life-Threatening Behavior,* 18**,** 137-148.

American Psychiatric Association annual meeting 2013. The Changing Face of Suicide, 2013. Directed by MD-FM.COM.

MDA, Z. 2009. When People Play People. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

MEAD, G. H. 1934. *Mind, Self, and Society,* Chicago, University of Chicago Press.

MEIER, C. A. 1992. The Theory of Complexes. *In:* PAPADOPOULOS, R. K. (ed.) *Carl Gustov Jung: Critical Assessments, Vol. II: The Structure and Dynamics of the Psyche.* London: Routledge.

MELDRUM, B. 1994. Historical Background and Overview of Dramatherapy. *In:* JENNINGS, S., CATTANACH, A., MITCHELL, S., CHESNER, A. & MELDRUM, B. (eds.) *The Handbook of Dramatherapy.* London: Routledge.

MENNINGER, K. A. 1933/1996. Psychoanalytic Aspects of Suicide. *In:* MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) *Essential Papers on Suicide.* New York: New York University Press.

MENNINGER, K. A. 1938. *Man against Himself,* New York, Harcourt, Brace & World, Inc.

MENNINGER, K. A. 1989. Afterword: Reflection on Suicide. *In:* JACOBS, D. & BROWN, H. N. (eds.) *Suicide: Understanding and Responding: Harvard Medical School Perspectives.* Madison: International Universities Press, Inc.

MERCHANT, J. 2006. The developmental/emergent model of archetype, its implications and its application to shamanism. *Journal of Analytical Psychology,* 51**,** 125-144.

MERCHANT, J. 2009. A reappraisal of classical archetype theory and its implications for theory and practice. *Journal of Analytical Psychology,* 54**,** 339-358.

MERCHANT, J. 2012. *Shamans and Analysts: New Insights on the Wounded Healer,* London, Routledge.

MERLEAU-PONTY, M. 1960/1964. *Signs,* Evanston, IL, Northwestern University Press.

METCALF, P. & HUNTINGTON, R. 1991. *Celebrations of Death: The Anthropology of Mortuary Ritual,* Cambridge, Cambridge University Press.

MIENCZAKOWSKI, J. 1995. The Theater of Ethnography: The Reconstruction of Ethnography Into Theater With Emancipatory Potential. *Qualitative Inquiry,* 1**,** 360-375.

MIERS, D., ABBOTT, D. & SPRINGER, P. R. 2012. A Phenomenological Study of Family Needs Following the Suicide of a Teenager. *Death Studies,* 36**,** 118-133.

MILLER, L. C. & TAYLOR, J. 2006. The Constructed Self. Strategic and Aesthetic Choices in Autobiographical Performance. *In:* MADISON, D. S. & HAMERA, J. (eds.) *The SAGE Handbook of Performance Studies.* London: Sage.

MISHLER, E. G. 1986. *Research Interviewing: Context and Narrative,* Cambridge, MA, Harvard University Press.

MISHLER, E. G. 1995. Models of Narrative Analysis: A Typology. *Journal of Narrative and Life History,* 5**,** 87-123.

MITCHELL, A. M., KIM, Y., PRIGERSON, H. G. & MORTIMER-STEPHENS, M. 2004. Complicated Grief in Survivors of Suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 25**,** 12-18.

MITCHELL, A. M., KIM, Y., PRIGERSON, H. G. & MORTIMER, M. K. 2005. Complicated Grief and Suicidal Ideation in Adult Survivors of Suicide. *Suicide and Life-Threatening Behavior,* 35**,** 498-506.

MITCHELL, G. J., DUPUIS, S., JONAS-SIMPSON, C., WHYTE, C., CARSON, J. & GILLIS, J. 2011. The Experience of Engaging With Research-Based Drama: Evaluation and Explication of Synergy and Transformation. *Qualitative Inquiry,* 17**,** 379-392.

MOGIL, R. 2010. Didi Hirsch Mental Health Services and the Survivor Movement. *In:* LINN-GUST, M. & PETERS, J. (eds.) *A Winding Road: A Handbook for those Supporting the Suicide Bereaved.* New Mexico: Chellehead Works.

MORE, C. 2006. *Britain in Twentieth Century*, Pearson Education.

MORGAN, H. 2000. The New Physics through a Jungian Perspective. *In:* CHRISTOPHER, E. & SOLOMON, H. M. (eds.) *Jungian Thought in the Modern World.* London: Free Association Books.

MORSELLI, E. A. 1881. *Suicide : an essay on comparative moral statistics,* London, C.K. Paul & Co.

MORSELLI, H. 1903/1971. Problems in the Study of Suicide. *In:* GIDDENS, A. (ed.) *The Sociology of Suicide: A Selection of Readings.* London: Frank Cass & Co. Ltd.

MURPHY, S. A. 2000. The use of research findings in bereavement programs: a case study. *Death Studies,* 24**,** 585-602.

MURPHY, S. A., DAS GUPTA, A., CAIN, K. C., JOHNSON, L. C., LOHAN, J., WU, L. & MEKWA, J. 1999. Changes in parents' mental distress after the violent death of an adolescent or young adult child: A longitudinal prospective analysis. *Death Studies,* 23**,** 129-159.

MURRAY, A. 1998. *Suicide in the Middle Ages,* Oxford, Oxford University Press.

MURRAY, K. E., DAVIDSON, G. R. & SCHWEITZER, R. D. 2010. Review of Refugee Mental Health Interventions Following Resettlement: Best Practices and Recommendations. *American Journal of Orthopsychiatry,* 80**,** 576-585.

MYERS, M. F. & FINE, C. 2007. Touched by suicide: bridging the perspectives of survivors and clinicians. *Suicide & Life-Threatening Behavior,* 37**,** 119-126.

NAPLES, N. A. & CLARK, E. 1996. Feminist Participatory Research and Empowerment: Going Public as Survivors of Childhood Sexual Abuse. *In:* GOTTFRIED, H. (ed.) *Feminism and Social Change: Bridging Theory and Practice.* Chicago: University of Illinois Press.

NEIMEYER, R., HERRERO, O. & BOTELLA, L. 2006a. Chaos To Coherence: Psychotherapeutic Integration Of Traumatic Loss. *Journal of Constructivist Psychology,* 19**,** 127-145.

NEIMEYER, R. A. 2000. Searching for the meaning of meaning: grief therapy and the process of reconstruction. *Death Studies,* 24**,** 541-558.

NEIMEYER, R. A. 2004. Fostering Posttraumatic Growth: A Narrative Elaboration. *Psychological Inquiry,* 15**,** 53-59.

NEIMEYER, R. A. 2012. Reconstructing the Self in the Wake of Loss: a Dialogical Contribution. *In:* HERMANS, H. J. M. & GIESER, T. (eds.) *Handbook of Dialogical Self Theory.* Cambridge: Cambridge University Press.

NEIMEYER, R. A., BALDWIN, S. A. & GILLIES, J. 2006b. Continuing bonds and reconstructing meaning: mitigating complications in bereavement. *Death Studies,* 30**,** 715-738.

NEIMEYER, R. A., BRUKE, L. A., MACKAY, M. M. & VAN DYKE STRINGER, J. G. 2010a. Grief Therapy and the Reconstruction of Meaning: From Principles to Practice. *Journal of Contemporary Psychotherapy,* 40**,** 73-83.

NEIMEYER, R. A. & CURRIER, J. M. 2009. Grief Therapy: Evidence of Efficacy and Emerging Directions. *Current Directions in Psychological Science,* 18**,** 252-256.

NEIMEYER, R. A., KLASS, D. & DENNIS, M. R. 2010b. Mourning, Meaning and Memory: Grief and the Narration of Loss. *In:* CIPRUT, J. (ed.) *On Meaning.* Boston: MIT Press.

NEIMEYER, R. A., PRIGERSON, H. G. & DAVIES, B. 2002. Mourning and Meaning. *American Behavioral Scientist,* 46**,** 235-251.

NEIMEYER, R. A. & SANDS, D. C. 2011. Meaning Reconstruction in Bereavement: From Principles to Practice. *In:* NEIMEYER, R. A., HARRIS, D. L., WINOKUER, H. R. & THORNTON, G. F. (eds.) *Grief and Bereavement in Contemporary Society: Bridging Research and Practice.* London: Routledge.

NEUNER, F., SCHAUER, M., KLASCHIK, C., KARUNAKARA, U. & ELBERT, T. 2004. A Comparison of Narrative Exposure Therapy, Supportive Counseling, and Psychoeducation for Treating Posttraumatic Stress Disorder in an African Refugee Settlement. *Journal of Consulting and Clinical Psychology,* 72**,** 579-587.

NICHOLSON, H. 2005. *Applied Drama: The Gift of Theatre*, New York, Palgrave Macmillan.

O'CONNOR, R. C., PLATT, S. & GORDON, J. 2011. Introduction. *In:* O'CONNOR, R. C., PLATT, S. & GORDON, J. (eds.) *International Handbook of Suicide Prevention: Research, Policy and Practice.* Oxford: Wiley-Blackwell.

ONYUT, L. P., NEUNER, F., SCHAUER, E., ERTL, V., ODENWALD, M., SCHAUER, M. & ELBERT, T. 2005. Narrative Exposure Therapy as a treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement. *BMC Psychiatry,* 5.

ORBACH, I. 2003. Mental pain and suicide. *The Israel Journal Of Psychiatry And Related Sciences,* 40**,** 191-201.

ORBACH, I. 2004. Terror Suicide: How is it Possible? *Archives of Suicide Research,* 8**,** 115-130.

ORBACH, I., MIKULINCER, M., GILBOA-SCHECHTMAN, E. & SIROTA, P. 2003. Mental pain and its relationship to suicidality and life meaning. *Suicide & Life-Threatening Behavior,* 33**,** 231-241.

ORBACH, I., MIKULINCER, M., KING, R., COHEN, D. & STEIN, D. 1997. Thresholds and tolerance of physical pain in suicidal and nonsuicidal adolescents. *Journal of Consulting and Clinical Psychology,* 65**,** 646-652.

ORBACH, I., PALGI, Y., STEIN, D., HAR-EVEN, D., LOTEM-PELEG, M., ASHEROV, J. & ELIZUR, A. 1996. Tolerance for physical pain in suicidal subjects. *Death Studies,* 20**,** 327-341.

OWEN, G., BELAM, J., LAMBERT, H., DONOVAN, J., RAPPORT, F. & OWENS, C. 2012. Suicide communication events: Lay interpretation of the communication of suicidal ideation and intent. *Social Science & Medicine,* 75**,** 419-428.

OWENS, C., OWEN, G., BELAM, J., LLOYD, K., RAPPORT, F., DONOVAN, J. & LAMBERT, H. 2011. Recognising and responding to suicidal crisis within family and social networks: qualitative study. *BMJ,* 343.

PALGI, P. & ABRAMOVITCH, H. 1984. A Cross-cultural Perspective. *Annual Review of Anthropology,* 13**,** 385-417.

PAPADOPOULOS, R. K. 1991. Jung and the Concept of the Other. *In:* PAPADOPOULOS, R. K. & SAAYMAN, G. S. (eds.) *Jung in Modern Perspective: the Master and His Legacy.* Dorset: Prism Press.

PAPADOPOULOS, R. K. (ed.) 1992. *Carl Gustav Jung : Critical Assessments,* London: Routledge.

PAPADOPOULOS, R. K. 1996. Archetypal Family Therapy: Developing a Jungian Approach to Family Therapy. *In:* DODSON, L. & GIBSON, T. (eds.) *Psyche And Family.* Wilmette, Illinois: Chiron Books.

PAPADOPOULOS, R. K. 1999. Storied Community as Secure Base: Response to the Paper by Nancy Caro Hollander 'Exile: Paradoxes of Loss and Creativity'. *British Journal of Psychotherapy,* 15**,** 322-332.

PAPADOPOULOS, R. K. (ed.) 2006a. *The Handbook of Jungian Psychology: Theory, Practice and Applications,* London: Routledge.

PAPADOPOULOS, R. K. 2006b. Jung's Epistemology and Methodology. *In:* PAPADOPOULOS, R. K. (ed.) *The Handbook of Jungian Psychology: Theory, Practice and Applications.* London: Routledge.

PAPADOPOULOS, R. K. 2007. Refugees, Trauma and Adversity-Activated Development. *European Journal of Psychotherapy, Counselling and Health,* 9**,** 301-312.

PAPADOPOULOS, R. K. 2011. The Umwelt and Networks of Archetypal Images: A Jungian Approach to Therapeutic Encounters in Humanitarian Contexts. *Psychotherapy and Politics International,* 9**,** 212-231.

PAPADOPOULOS, R. K. in press. *'Involuntary Dislocation. Home, Trauma, Resilience and Adversity-Activated Development,* London, Routledge.

PAPADOPOULOS, R. K. & SAAYMAN, G. S. (eds.) 1991. *Jung in Modern Perspective: The Master and His Legacy,* Dorset: Prism Unity.

PARK, B. C. B. 2004. Sociopolitical Contexts of Self-Immolations in Vietnam and South Korea. *Archives of Suicide Research* 8**,** 81-98.

PARK, C. L. & LECHNER, S. 2006. Measurement Issues in Assessing Growth following Stressful Life Experiences. *In:* CALHOUN, L. G. & TEDESCHI, R. G. (eds.) *Handbook of Posttraumatic Growth.* London: Lawrence Erlbaum Associates.

PARKES, C. M. 1993. Bereavement as a psychosocial Transition: Processes of Adaptation to Change. *In:* DICKENSON, D. & JOHNSON, M. (eds.) *Death, Dying & Bereavement.* London: SAGE Publication.

PARKES, C. M. 1996. *Bereavement: Studies of Grief in Adult Life,* London, Routledge.

PARKES, C. M., LAUNGANI, P. & YOUNG, B. (eds.) 1997. *Death and Bereavement Across Cultures,* London: Routledge.

PARRY, A. & DOAN, R. E. 1994. *Story Re-Visions: Narrative Therapy in the Postmodern World,* London, The Guilford Press.

PARSE, R. R. 2001. *Qualitative Inquiry: The Path of Sciencing,* Toronto, Jones & Bartlett.

PERELBERG, R. J. 2009. Psychyoanalytic Understanding of Violence and Suicide: a Review of the Literature and Some New Formulations. *In:* PERELBERG, R. J. (ed.) *Psychoanalytic Understanding of Violence and Suicide.* London: Routledge.

PERESA, S. B. 1986. *The Scapegoat Complex,* Toronto, Inner City Books.

PERRY, J. W. 1970. Emotions and Object Relations. *Journal of Analytical Psychology,* 15**,** 1-12.

PETERS, J. 2006. Bereavement after a suicide – a survivor's perspective. *Spirituality and Health International,* 7**,** 80-87.

PETERS, J. 2010. Cultural Dimensions. *In:* LINN-GUST, M. & PETERS, J. (eds.) *A Winding Road: A Handbook for Those Supporting the Suicide Bereaved.* New Mexico: Chellehead Works.

PICKERING, W. S. F., WALFORD, G. & STUDIES., B. C. F. D. 2000. *Durkheim's Suicide : A Century of Research and Debate,* London ; New York, Routledge.

PIETIKAINEN, P. 1998. Archetypes as symbolic forms. *Journal of Analytical Psychology,* 43**,** 325-343.

PLATO 1975. *The Laws,* London, Penguin.

POLKINGHORNE, D. E. 1988. *Narrative Knowing and the Human Sciences,* Albany, NY, State University of New York Press.

POMPILI, M. 2010. From bench to bedside in the prevention of suicide: A never-ending back and forth journey. *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 31**,** 59-61.

POMPILI, M., LESTER, D., DE PISA, E., DEL CASALE, A., TATARELLI, R. & GIRARDI, P. 2008. Surviving The Suicides of Significant Others: A Case Study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 29**,** 45-48.

POTTER, J. & WETHERELL, M. 1987. *Discourse and Social Psychology,* London, Sage.

PRADO, C. G. 2011. *Coping with choices to die,* Cambridge, Cambridge University Press.

PRENTKI, T. 2009. Applied Theatre in a Global Village. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

PRENTKI, T. & PRESTON, S. 2009. Applied Theatre: An Introduction. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

PRIGERSON, H. G., BRIDGE, J., MACIEJEWSKI, P. K., BEERY, L. C., ROSENHECK, R. A., JACOBS, S. C., BIERHALS, A. J., KUPFER, D. J. & BRENT, D. A. 1999. Influence of traumatic grief on suicidal ideation among young adults. *American Journal of Psychiatry,* 156**,** 1994-1995.

PROVINI, C. & EVERETT, J. R. 2000. Adults mourning suicide: self-reported concerns about bereavement, needs for assistance, and help-seeking behavior. *Death Studies,* 24**,** 1-19.

PUCHALSKA-WASYL, M. 2011. Dialogicality and Creativity. *In:* JONES, R. A. & MORIOKA, M. (eds.) *Jungian and Dialogical Self Perspectives.* London: Palgrave Macmillan.

QIN, P., AGERBO, E. & MORTENSEN, P. B. 2003. Suicide risk in relation to socioeconomic, demographic, psychiatric, and familial factors: a national register-based study of all suicides in Denmark, 1981-1997. *Am J Psychiatry,* Apr. 160**,** 765-72.

QIN, P. & MORTENSEN, P. B. 2003. The Impact of Parental Status on the Risk of Completed Suicide. *Arch Gen Psychiatry,* 60**,** 797-802.

RAINGRUBER, B. 2003. Gaps in service in the recognition and treatment of depression and suicidal ideation within a four-county area. *Perspectives in Psychiatric Care,* 39**,** 151-162.

RANDO, T. A. 1991. *How to Go On Living When Someone You Love Dies,* London, Bantam Books.

RANGE, L. M., GOGGIN, W. C. & STEEDE, K. K. 1988. Perception of behavioral contagion of adolescent suicide. *Suicide & Life-Threatening Behavior,* 18**,** 334-341.

RATNARAJAH, D. & SCHOFIELD, M. J. 2008. Survivors' Narratives of the Impact of Parental Suicide. *Suicide and Life-Threatening Behavior,* 38**,** 618-630.

REED, M. D. 1993. Sudden Death and Bereavement Outcomes: The Impact of Resources on Grief Symptomatology and Detachment. *Suicide and Life-Threatening Behavior,* 23**,** 204-220.

REED, M. D. 1998. Predicting grief symptomatology among the suddenly bereaved. *Suicide & Life-Threatening Behavior,* 28**,** 285-301.

REED, M. D. & GREENWALD, J. Y. 1991. Survivor-Victim Status, Attachment, and Sudden Death Bereavement. *Suicide and Life-Threatening Behavior,* 21**,** 385-401.

RICHARDSON, K. 1999. *Developmental Psychology : How Nature and Nurture Interact,* Mahwah, NJ, USA, Lawrence Erlbaum.

RICHARDSON, L. 1991. Postmodern Social Theory: Representational Practices. *Sociological Theory,* 9**,** 173-179.

RICHARDSON, L. 1992. The Consequences of Poetic Representation: Writing the Other, Rewriting the Self. *In:* ELLIS, C. & FLAHERTY, M. G. (eds.) *Investigating Subjectivity: Research on Lived Experience.* London: Sage.

RICHARDSON, L. 1994. Nine Poems: Marriage and the Family. *Journal of Contemporary Ethnography,* 23**,** 3-13.

RICHARDSON, L. 2000. Writing: A Method of Inquiry. *In:* DENZIN, N. K. & LINCOLN, Y. S. (eds.) *Handbook of Qualitative Research, 2nd Ed.* 2nd ed. London: Sage.

RICOEUR, P. 1983/4. Time and Narrative. Chicago: University of Chicago Press.

RICOEUR, P. 1992. *Oneself as Another,* Chicago, The University of Chicago Press.

RIESSMAN, C. K. 1993. *Narrative Analysis,* Newbury Park, CA, Sage.

RIESSMAN, C. K. 2008. *Narrative Methods for the Human Sciences,* London, Sage Publications.

RIESSMAN, C. K. & SPEEDY, J. 2007. Narrative Inquiry in the Psychotherapy Professions: A Critical Review. *In:* CLANDININ, D. J. (ed.) *Handbook of Narrative Inquiry: Mapping a Methodology.* London: Sage.

RILEY, L. P., LAMONTAGNE, L. L., HEPWORTH, J. T. & MURPHY, B. A. 2007. Parental grief responses and personal growth following the death of a child. *Death Studies,* 31**,** 277-299.

ROBINS, E., MURPHY, G. E., WILKINSON, R. H., GASSNER, S. & KAYES, J. 1959/1996. Some Clinical Considerations in the Prevention of Suicide Based on a Study of One Hundred Thirty-Four Successful Suicides. *In:* MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) *Essential Papers on Suicide.* New York: New York University Press.

ROESLER, C. 2012. Are archetypes transmitted more by culture than biology? Questions arising from conceptualizations of the archetype. *Journal of Analytical Psychology,* 57**,** 223-246.

ROGERS, K. L., LEYDESDORFF, S. & DAWSON, G. (eds.) 1999. *Trauma and Life Stories: International Perspectives,* London: Routledge.

ROMANYSHYN, R. D. Lingering on the Margins of Psychology:In the Places of Writing. Open Seminar, 28 May, 2014 University of Essex, The Centre for Psychoanalytic Studies.

ROMANYSHYN, R. D. 2007. *The Wounded Researcher: Research with Soul in Mind,* New Orleans, Louisiana, Spring Journal Books.

ROSEN, D. H. 1996. *Transforming Depression : Healing the Soul through Creativity,* London, Arkana.

ROTEN, R. G. 2007. DSM-IV and the taxonomy of roles: How can the taxonomy of roles complement the DSM-IV to create a more holistic diagnostic tool? *The Arts in Psychotherapy,* 34**,** 53-68.

ROWLAND, S. 2005. *Jung as a Writer,* London, Routledge.

ROWLAND, S. 2010. *C.G. Jung in the Humanities: Taking the Soul's Path,* New Orleans, Louisiana, Spring Journal Books.

ROWLAND, S. 2012. *The Ecocritical Psyche: Literature, Evolutionary Complexity and Jung,* London, Routledge.

RUBEY, C. T. & CLARK, D. C. 1987. Suicide Survivors and the Clergy. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) *Suicide and Its Aftermath: Understanding and Counseling the Survivors.* London: W. W. Norton & Company.

RUBEY, T. & MCINTOSH, L. 1996. Suicide Survivors Groups: Results of a Survey. *Suicide and Life-Threatening Behavior,* 26**,** 351-358.

RUBIN, S. S. 1996. The Wounded Family: Bereavement Parents and the Impact of Adult Child Loss. *In:* KLASS, D., SILVERMAN, P. R. & NICKMAN, S. L. (eds.) *Continuing Bonds: New Understandings of Grief.* London: Routledge Taylor & Francis Group.

RUDESTAM, K. E. 1987. Public Perceptions of Suicide Survivors. *In:* DUNNE, E. J., MCINTOSH, J. L. & DUNNE-MAXIM, K. (eds.) *Suicide and its Aftermath: Understanding and Counseling the Survivors.* London: W.W. Norton & Company.

RUNESON, B. & ASBERG, M. 2003. Family History of Suicide Among Suicide Victims *American Journal of Psychiatry,* 160**,** 1525-1526.

RYLKO-BAUER, B. 2005. Bringing the past into the Present: Family Narratives of Holocaust, Exile, and Diaspora: Lessons about Humanity and Survival from My Mother and from the Holocaust. *Anthropological Quarterly,* 78**,** 11-41.

SAARINENA, P. I., HINTIKKAA, J., LEHTONENA, J., JOUKO K. L NNQVISTB, J. K. & VIINAM KIB, H. 2002. Mental Health and Social Isolation Among Survivors Ten Years After a Suicide in the Family: A Case-Control Study. *Archives of Suicide Research,* 6**,** 221-226.

SALAZAR, C. 1991. A Third World Women's Text: Between the Politics of Criticism and Cultural Politics. *In:* GLUCK, S. B. & PATAI, D. (eds.) *Women's Words: The Feminist Practice of Oral History.* London.

SALDA A, J. 2003. Dramatizing Data: A Primer. *Qualitative Inquiry,* 9**,** 218-236.

SALVERSON, J. 1996. Performing Emergency: Witness, Popular Theatre, and the Lie of the Literal. *Theatre Topics,* 6**,** 181-191.

SAMUELS, A. 1983a. The emergence of schools of post-Jungian analytical psychology. *The Journal of Analytical Psychology,* 28**,** 345-362.

SAMUELS, A. 1983b. The theory of archetypes in Jungian and post-Jungian analytical psychology. *The International Journal of Psychoanalysis,* 10**,** 429-444.

SAMUELS, A. 1985. *Jung and the Post-Jungians,* London, Tavistock/Routledge.

SAMUELS, A. 2004. Foreword. *In:* BAUMLIN, J. S., BAUMLIN, T. F. & JENSEN, G. H. (eds.) *Post-Jungian Criticism: Theory and Practice.* Albany: State University of New York Press.

SANBORN, D. E. & SANBORN, C. J. 1976. Psychological Autopsy as a Therapeutic Tool. *Diseases of the Nervous System,* 37**,** 4-8.

SANDS, D. C., JORDAN, J. R. & NEIMEYER, R. A. 2011. The Meanings of Suicide: A Narrative Approach to Healing. *In:* JORDAN, J. R. & MCINTOSH, J. L. (eds.) *Grief after Suicide: Understanding the Consequences and Caring for the Survivors.* New York: Routledge.

SAUNDERS, P. & SKAR, P. 2001. Archetypes, complexes and self-organization. *Journal of Analytical Psychology,* 46**,** 305-323.

SCHAVERIEN, J. 2005. Art, dreams and active imagination: a post-Jungian approach to transference and the image. *Journal of Analytical Psychology,* 50**,** 127-153.

SCHECHNER, R. 2006. *Performance Studies: An Introduction,* London, Routledge.

SCHIEPEK, G., FARTACEK, C., STURM, J., KRALOVEC, K., FARTACEK, R. & PLODERL, M. 2011. Nonlinear dynamics: theoretical perspectives and application to suicidology. *Suicide Life Threat Behav,* 41**,** 661-75.

SCHININ , G. 2009. Like Ham in a Temperance Hotel: Healing, Participation and Education in Social Theatre. *In:* JENNINGS, S. (ed.) *Dramatherapy and Social Theatre: Necessary Dialogues.* London: Routledge Taylor & Francis Group.

SCHORE, A. N. 2007. Psychoanalytic Research: Progress and Process -- Developmental Affective Neuroscience and Clinical Practice. *Psychologist-Psychoanalyst,* Summer 2007**,** 6-15.

SCHULTZ, C. L. & HARRIS, D. L. 2011. Giving Voice to Nonfinite Loss and Grief in Bereavement. *In:* NEIMEYER, R. A., HARRIS, D. L., WINOKUER, H. R. & THORNTON, G. F. (eds.) *Grief and Bereavement in Contemporary Society: Bridging Research and Practice.* London: Routledge.

SCHWANDT, T. A. 1997. Textual Gymnastics, Ethics, and Angst. *In:* TIERNEY, W. G. & LINCOLN, Y. S. (eds.) *Representation and the Text: Re-framing the Narrative Voice.* Albany, NY: State University of New York Press.

SCOWCROFT, E. 2014. Suicide Statistics Report 2014: including data for 2010-2012. Samaritans.

SEALE, C. 1998. *Constructing Death: The Sociology of Dying and Bereavement,* Cambridge, Cambridge University Press.

SEARLE, J. R. 1969. *Speech Acts: An Essay in the Philosophy of Language,* Cambridge, Cambridge University Press.

SEDGWICK, D. 2001. *Introduction to Jungian Psychotherapy: The Therapeutic Relationship,* New York, Brunner-Routledge.

SEGAL, J. Z. 2007. Interdisciplinarity and Postdisciplinarity in Health Research in Canada. *In:* RAOUL, V., CANAM, C., HENDERSON, A. D. & PATERSON, C. (eds.) *Unfetting Stories.* Ontario: Wilfrid Laurier University Press.

SEGAL, N. L. 2009. Suicidal behaviors in surviving monozygotic and dizygotic co-twins: is the nature of the co-twin's cause of death a factor? *Suicide & Life-Threatening Behavior,* 39**,** 569-575.

SHAFFER, D. 1994. Implications for Education: Prevention of Youth Suicide. *In:* JENKINS, R., GRIFFITHS, S., WYLIE, I., HAWTON, K., MORGAN, G. & TYLEE, A. (eds.) *The Prevention of Suicide.* London: HMSO.

SHAMDASANI, S. 2003. *Jung and the Making of Modern Psychology: The Dream of a Science,* Cambridge, Cambridge University Press.

SHEAR, K., FRANK, E., HOUCH, P. R. & REYNOLDS, C. F. 2005. Treatment of Complicated Grief: a Randomized Controlled Trial. *Journal of the American Medical Association,* 293**,** 2601-2608.

SHEAR, M. K. 2011. Bereavement and the DSM5. *Omega,* 64**,** 101-118.

SHNEIDMAN, E. & FARBEROW, N. 1965. Sample Investigation of Equivocal Suicide Death. *In:* FARBEROW, N. & SHNEIDMAN, E. (eds.) *The Cry for Help.* New York: McGraw-Hill.

SHNEIDMAN, E., FARBEROW, N. & LITMAN, R. B. 1965a. A Taxonomy of Death -- a Psychological Point of View. *In:* FARBEROW, N. & SHNEIDMAN, E. (eds.) *The Cry for Help*. London: McGraw-Hill Book.

SHNEIDMAN, E., FARBEROW, N. & LITMAN, R. E. 1965b. The Suicide Prevention Centre. *In:* FARBEROW, N. & SHNEIDMAN, E. (eds.) *The Cry for Help.* London: McGraw-Hill Book.

SHNEIDMAN, E. S. 1967. Sleep and Self-Destruction: A Phenomenological Approach. *In:* SHNEIDMAN, E. S. (ed.) *Essays in Self-Destruction.* New York: Science House, Inc.

SHNEIDMAN, E. S. 1969. Prologue: Fifty-eight Years. *In:* SHNEIDMAN, E. S. (ed.) *On the Nature Of Suicide.* San Francisco: Jossey-Bass Inc., Publishers.

SHNEIDMAN, E. S. 1972. Foreword. *In:* CAIN, A. C. (ed.) *Survivors of Suicide.* Illinois: Charles C Thomas Publisher.

SHNEIDMAN, E. S. 1981/1996. Psychotherapy with Suicidal Patients. *In:* MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) *Essential Papers on Suicide.* New York: New York University Press.

SHNEIDMAN, E. S. 1993. *Suicide as Psychache : A Clinical Approach to Self-destructive Behavior,* Northvale, N.J., J. Aronson.

SHNEIDMAN, E. S. 1993/1996. Suicide as Psychache. *In:* MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) *Essential Papers on Suicide.* New York: New York University Press.

SHNEIDMAN, E. S. & MANDELKORN, P. 1970. How to Prevent Suicide. *In:* SHNEIDMAN, E., FARBEROW, N. & LITMAN, R. (eds.) *The Psychology Of Suicide.* New York: Science House.

SILVERMAN, D. 1985. *Qualitative Methodology and Sociology,* Aldershot, Gower.

SILVERMAN, D. 1993. *Interpretating Qualitative Data: Methods for Analysing Talk, Text and Interaction,* London, Sage.

SILVERMAN, E., RANGE, L. & OVERHOLSER, J. 1995. Bereavement from Suicide as Compared to Other Forms of Bereavement. *Omega-Journal of Death and Dying,* 30**,** 41-51.

SILVERMAN, M. M. 2011. Challenges to Classifying Suicidal Ideations, Communications, and Behaviours. *In:* O'CONNOR, R. C., PLATT, S. & GORDON, J. (eds.) *International Handbook of Suicide Prevention: Research, Policy and Practice.* Oxford: Wiley-Blackwell.

SILVERMAN, P. R. & KLASS, D. 1996. Introduction: What's the Problem? *In:* KLASS, D., SILVERMAN, P. R. & NICKMAN, S. L. (eds.) *Continuing Bonds: New Understandings of Grief.* London: Routledge Taylor & Francis Group.

The Hidden Face of Suicide, 2010. Directed by SILVERMAN, Y.: Silverman, Yehudit.

SINGER, T. & KIMBLES, S. 2004a. The Emerging Theory of Cultural Complex. *In:* CAMBRAY, J. & CARTER, L. (eds.) *Analytical Psychology: Contemporary Perspectives in Analytical Psychology.* Hove and New York: Brunner-Routledge.

SINGER, T. & KIMBLES, S. L. (eds.) 2004b. *The Cultural Complex: Contemporary Jungian Perspectives on Psyche and Society,* London: Routledge.

SKAR, P. 2004. Chaos and self-organization: emergent patterns at critical life transitions. *Journal of Analytical Psychology,* 49**,** 243-262.

SKEA, B. 2003. Jung, Spielrein and Nash: Three beautiful minds confronting the impulse to love or to destroy in the creative process. *In:* BEEBE, J. (ed.) *Terror, Violence and the Impulse to Destroy: Perspectives from Analytical Psychology.* Canada: Daimon Verlag.

SMITH, A. 2011. An Interpretative Phenomenological Analysis of Posttraumatic Growth in Adults Bereaved by Suicide. *Journal of Loss & Trauma,* 16**,** 413-430.

SOBS. *Survivors' stories* [Online]. Available: http://uk-sobs.org.uk/suicide-bereavement/survivor-stories/ 28 July 2014].

SOBS. *Survivors of Bereavement by Suicide* [Online]. Available: http://www.uk-sobs.org.uk/index.htm [Accessed 29 Dec. 2012].

SOLOMON, H. M. 2000. Recent Developments in the neurosciences. *In:* CHRISTOPHER, E. & SOLOMON, H. M. (eds.) *Jungian Thought in the Modern World.* London: Free Association Books.

SOMASUNDARAM, D. & SIVAYOKAN, S. 2013. Rebuilding community resilience in a post-war context: developing insight and recommendations - a qualitative study in Northern Sri Lanka. *International Journal of Mental Health Systems,* 7**,** 3.

SPENCE, D. P. 1982. *Narrative Truth and Historical Truth,* New York, W. W. Norton.

SPIVAK, G. 1994. Responsibility. *Boundary 2,* 21**,** 19-64.

SPRY, T. 2001. Performing Autoethnography: An Embodied Methodological Praxis. *Qualitative Inquiry,* 7**,** 706-732.

STANLEY, L. & WISE 1990. Method, Methodology and Epistemology in Feminist Research Processes. *In:* STANLEY, L. (ed.) *Feminist Praxis: Research Theory and Epistemology in Feminist Sociology.*

STEIN, L. 1958. Analytical Psychology: A Modern Science (1973). *In:* FORDHAM, M., GORDON, R., HUBBACK, J., LAMBERT, K. & WILLIAMS, M. (eds.) *Analytical Psychology: A Modern Science.* London: William Heinemann Medical Books Ltd.

STEIN, L. 1967. Introducing Not-Self. *Journal of Analytical Psychology,* 12**,** 97-114.

STEIN, M. 1998. *Jung's Map of the Soul: An Introduction,* Chicago, IL, Open Court.

STEIN, M. 2006a. Individuation. *In:* PAPADOPOULOS, R. K. (ed.) *The Handbook of Jungian Psychology: Theory, Practice and Applications.* London: Routledge.

STEIN, M. 2006b. On the Importance of Numinous Experience in the Alchemy of Individuation. *In:* CASEMENT, A. & TACEY, D. (eds.) *The Idea of the Numinous: Contemporary Jungian and Psychoanalytic Perspectives.* London: Routledge.

STENGEL, E. 1969. *Suicide and attempted suicide, 2nd edition.,* Middlesex, Penguin.

STEVENS, A. 1982. *Archetype : A Natural History of the Self* London, Routledge & K. Paul.

STEVENS, A. 1990. *On Jung,* London, Penguin Books.

STEVENS, A. 1994. *Jung: A Very Short Introduction,* Oxford, Oxford University Press.

STEVENS, A. 1998. Response to P. Pietikainen. *Journal of Analytical Psychology,* 43**,** 345-355.

STEVENS, A. 2003. Archetypal Theory: the Evolutionary Dimension. *In:* WITHERS, R. (ed.) *Controversies in Analytical Psychology.* Hove: Brunner-Routledge.

STEVENS, A. 2006. The Archetypes. *In:* PAPADOPOULOS, R. K. (ed.) *The Handbook of Jungian Psychology: Theory, Practice and Applications.* London: Routledge.

STEVENS, A. & PRICE, J. 1996. *Evolutionary Psychiatry: A New Beginning,* London, Routledge.

STEVENSON, C. & CUTCLIFFE, J. 2006. Problematizing special observation in psychiatry: Foucault, archaeology, genealogy, discourse and power/knowledge. *Journal of Psychiatric and Mental Health Nursing,* 13**,** 713-721.

STEWART, C. T. 2008. *Dire Emotions and Lethal Behaviors: Eclipse of the Life Instinct,* London & New York, Routledge.

STILLION, J. M. & MCDOWELL, E. E. 1996. *Suicide Across the Life Span : Premature Exits,* Washington, D.C., Taylor & Francis.

STORR, A. 1972. *The Dynamics of Creation,* Middlesex, Penguin Books.

STROEBE, M., GERGEN, M., GERGEN, K. & STROEBE, W. 1996. Broken Hearts or Broken Bonds. *In:* KLASS, D., SILVERMAN, P. R. & NICKMAN, S. L. (eds.) *Continuing Bonds: New Understandings of Grief.* London: Routledge Taylor & Francis Group.

STROEBE, M. & SCHUT, H. 1999. The dual process model of coping with bereavement: rationale and description. *Death Studies,* 23**,** 197-224.

STROEBE, M., SCHUT, H. & BOERNER, K. 2010. Continuing bonds in adaptation to bereavement: Toward theoretical integration. *Clinical Psychology Review,* 30**,** 259-268.

STROEBE, M., SCHUT, H. & FINKENAUER, C. 2001a. The traumatization of grief? A conceptual framework for understanding the trauma-bereavement interface. *The Israel Journal Of Psychiatry And Related Sciences,* 38**,** 185-201.

STROEBE, M., SCHUT, H. & STROEBE, W. 2005. Attachment in Coping With Bereavement: A Theoretical Integration. *Review of General Psychology,* 9**,** 48-66.

STROEBE, M. S., HANSSON, R. O., STROEBE, W. & H., S. (eds.) 2001b. *Handbook of Bereavement Research: Consequences, Coping and Care,* Washington, DC: American Psychological Association.

SUDAK, M. D. H. 2007. Encountering Patient Suicide: The Role of Survivors. *Academic Psychiatry,* 31**,** 333-335.

SVEEN, C.-A. & WALBY, F. A. 2008. Suicide Survivors' Mental Health and Grief Reactions: A Systematic Review of Controlled Studies. *Suicide and Life-Threatening Behavior,* 38**,** 13-29.

SZASZ, T. S. 1989. A Moral View on Suicide. *In:* JACOBS, D. & BROWN, H. N. (eds.) *Suicide: Understanding and Responding: Harvard Medical School Perspectives.* Madison: International Universities Press, Inc.

SZASZ, T. S. 1999. *Fatal freedom : the ethics and politics of suicide,* Westport, Conn., Praeger.

TARLOW, S. 1999. *Bereavement and Commemoration: An Archaeology of Mortality,* Oxford, Blackwell Publishers Ltd.

TAYLOR, C. 1989. *Sources of the Self: The Making of Modern Identity,* Cambridge, MA, Harvard University Press.

TAYLOR, C. 1991. The Dialogic Self. *In:* HILEY, D. R., BOHMAN, J. F. & SHUSTERMAN, R. (eds.) *The Interpretive Turn: Philosophy, Science, Culture.* New York: Cornell University Press.

TAYLOR, S. 2001. Evaluating and Applying Discourse Analytic Research. *In:* WETHERELL, M., TAYLOR, S. & YATES, S. J. (eds.) *Discourse as Data: A Guide for Analysis.* Milton Keynes: The Open University.

TEDESCHI, R. G. & CALHOUN, L. G. 1996. The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress,* 9**,** 455-471.

THE-ALLIANCE-OF-HOPE-FOR-SUICIDE-SURVIVORS. *We Remember Them* [Online]. Available: http://www.allianceofhope.org/memorials/ 28 July 2014].

THOMPSON, J. 2009. The Ends of Applied Theatre: Incidents of Cutting and Chopping. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader*. London: Routledge.

TIERNEY, W. G. & LINCOLN, Y. S. 1997. Introduction: Explorations and Discoveries. *In:* TIERNEY, W. G. & LINCOLN, Y. S. (eds.) *Representation and the Text: Re-Framing the Narrative Voice.* Albany, NY: State University of New York Press.

TOMASI, L. 2000. Emile Durkheim's Contribution to the Sociological Explanation of Suicide. *In:* PICKERING, W. S. F. & WALFORD, G. (eds.) *Durkheim's Suicide: A Century of Research ad Debate.* London and New York: Routledge.

TOOLEY, K. 1972. The Meaning of Maternal Suicide As Reflected in The Treatment of a Late Adolescent Girl. *In:* CAIN, A. C. (ed.) *Survivors of Suicide.* Illinois: Charles C Thomas Publisher.

TR MEAU, F., STANER, L., DUVAL, F., CORR A, H., CROCQ, M.-A., DARREYE, A., CZOBOR, P., DESSOUBRAIS, C. & MACHER, J.-P. 2005. Suicide attempts and family history of suicide in three psychiatric populations. *Suicide & Life-Threatening Behavior,* 35**,** 702-713.

TRUMAN, C. 2000. New Social Movements and Social Research. *In:* TRUMAN, C., MERTENS, D. M. & HUMPHRIES, B. (eds.) *Research and Inequality*. London: Routledge.

TRUMAN, C., MERTENS, D. M. & HUMPHRIES, B. (eds.) 2000. *Research and Inequality,* London: Routledge.

TURNER, V. 1986. *The Anthropology of Performance*, New York, PAJ Publications.

TURNER, V. W. 1969. *The Ritual Process : Structure and Anti-structure*, London, Routledge and Kegan Paul.

ULANOV, A. B. 2013. *Madness and Creativity: Clinical Meditations on Themes in the Red Book of C.G. Jung,* Texas, A&M University Press.

URBAN, E. 2005. Fordham, Jung and the self: a re-examination of Fordham's contribution to Jung's conceptualization of the self. *Journal of Analytical Psychology,* 50**,** 571-594.

VALENTE, S. M. 2003. Aftermath of a patient's suicide: a case study. *Perspectives in Psychiatric Care,* 39**,** 17-22.

VAN GENNEP, A. 1960/1977. *The Rites of Passage*, London, Routledge and Kegan Paul.

VAN MANEN, M. 1990. *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy,* London, The University of Western Ontario.

VARAH, C. 1987. Introduction. *In:* VARAH, C. (ed.) *The Samaritans: Befriending the Suicidal*. London: Constable.

VESEY-MCGREW, P. 2010. Getting on Top of Thought and Behavior Patterns. *In:* STEIN, M. (ed.) *Jungian Psychoanalysis: Working in the Spirit of C.G. Jung.* Chicago, Illinois: Open Court.

VICKERS, M. H. 2002. Researchers as Storytellers: Writing on the Edge—And Without a Safety Net. *Qualitative Inquiry,* 8**,** 608-621.

VIJAYAKUMAR, L. 2004. Altruistic Suicide in India. *Archives of Suicide Research,* 8**,** 73-80.

VON FRANZ, M.-L. 1964. The Process of Individuation. *In:* JUNG, C. G. (ed.) *Man and His Symbols.* Garden City, NY: Doubleday.

VON FRANZ, M.-L. 1998. *On Dream & Death: A Jungian Interpretation,* Chicago, Ill, Open Court.

WAGNER, B., KNAEVELSRUD, C. & MAERCKER, A. 2006. Internet-Based Cognitive-Behavioral Therapy for Complicated Grief: a Randomized Controlled Trial. *Death Studies,* 30**,** 429-453.

WALDRON, S. 2008. The impact of trauma on the psyche of the individual using the film Belleville Rendez-vous as an illustrative vehicle. *Journal of Analytical Psychology,* 53**,** 525-541.

WALDRON, S. 2013. 'Black holes': escaping the void. *Journal of Analytical Psychology,* 58**,** 99-117.

WALKER, S. F. 2002. *Jung and the Jungians on Myth: An Introduction,* London, Routledge.

WALTER, T. 1996. A new model of grief: bereavement and biography. *Mortality,* 1**,** 7-25.

WARREN, M. 1972. Some Psychological Sequelae of Parental Suicide in Surviving Children. *In:* CAIN, A. C. (ed.) *Survivors of Suicide.* Illinois: Charles C Thomas Publisher.

WATKINS, R. L. & GUTIERREZ, P. M. 2003. The relationship between exposure to adolescent suicide and subsequent suicide risk. 2002 Student Award Address. *Suicide & Life-Threatening Behavior,* 33**,** 21-32.

WATSON, A. 2009. 'Lift Your Mask': Geese Theatre Company in Performance. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

WATT, J. R. 2004. *From sin to insanity : suicide in early modern Europe,* Ithaca, N.Y., Cornell University Press.

WEAVER, J. C. & WRIGHT, D. 2009. *Histories of suicide : international perspectives on self-destruction in the modern world,* Toronto, University of Toronto Press.

WEAVER, L. 2009. Doing Time: A Personal and Practical Account of Making Performance Work in Prisons. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

WEINER, I. B., LERNER, R. M. & EASTERBROOKS, M. A. 2012. *Handbook of Psychology, Developmental Psychology (2nd Edition),* Somerset, NJ, USA, Wiley.

WENCKSTERN, S. & LEENAARS, A. A. 1991. *Suicide prevention in schools,* New York, Hemisphere.

WENZ, F. V. 1980. Heredity, environment, and culture in suicide. *Behavioral and Brain Sciences,* 3**,** 281-282.

WERTH, J. L. 1999. *Contemporary Perspectives on Rational Suicide,* London, Brunner/Mazel.

WERTHEIMER, A. 1991. *A special scar : the experiences of people bereaved by suicide,* London, Routledge.

WEST, M. 2013. Trauma and the transference-countertransference: working with the bad object and the wounded self. *Journal of Analytical Psychology,* 58**,** 73-98.

WETHERELL, M. 2012. *Affect and Emotion : A New Social Science Understanding,* London, Sage.

WHEELER, I. 2001. Parental bereavement: the crisis of meaning. *Death Studies,* 25**,** 51-66.

WHITMONT, E. C. 1969. *The Symbolic Quest: Basic Concepts of Analytical Psychology,* London, Barrie & Rockliff.

WHO. *Suicide Data* [Online]. World Health Organization. Available: http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/ [Accessed 28 Apr. 2015].

WHO/IASP. 2008. *Preventing Suicide: How to Start a Survivors' Group* [Online]. Geneva: Department of Mental Health and Substance Abuse, World Health Organization. Available: http://www.who.int/mental_health/prevention/suicide/resource_survivors.pdf [Accessed 13 April 2012].

WICKERSHAM, J. 2008. *The Suicide Index: Putting My Father's Deathin Order,* London, Harcourt, Inc.

WILKINSON, M. 2007. Jung and neuroscience. *In:* CASEMENT, A. (ed.) *Who Owns Jung?* London: Karnac.

WILKINSON, S. 2008. Focus Groups. *In:* SMITH, J. A. (ed.) *Qualitative Psychology: A Practice Guide to Research Methods.* London: Sage.

WILKINSON, S. & KITZINGER, C. 2009. Representing the Other. *In:* PRENTKI, T. & PRESTON, S. (eds.) *The Applied Theatre Reader.* London: Routledge.

WILLETT, J. (ed.) 1964. *Brecht on Theatre: The Development of an Aesthetic,* London: Methuen Drama.

WILLIAMS, J. M. G. 1997. *Cry of pain : understanding suicide and self-harm,* London, Penguin Books.

WILLIAMS, M. The Indivisibility of Personal and Collective Unconscious. *In:* GUGGENB HL-CRAIG, A., ed. The 2nd International Congress for Analytical Psychology: The Archetype., 1962 Zürich. S. Karger AG (1964), 113-118.

WILLIG, C. & BILLIN, A. 2012. Existentialist-Informed Hermeneutic Phenomenology. *In:* HARPER, D. & THOMPSON, A. R. (eds.) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners.* Chichester: Wiley-Blackwell.

WOODWARD, C. 2000. Hearing Voices? Research Issues when Telling Respondents' Stories of Childhood Sexual Abuse from a Feminist Perspective. *In:* TRUMAN, C., MERTENS, D. M. & HUMPHRIES, B. (eds.) *Research and Inequality.* London: Routledge.

WORDEN, J. W. 2002. *Grief Counseling and Grief Therapy – A Handbook for the Mental Health Practitioner,* New York, Springer.

WROBLESKI, A. & MCINTOSH, J. L. 1987. Problems of suicide survivors: a survey report. *The Israel Journal Of Psychiatry And Related Sciences,* 24**,** 137-142.

YARDLEY, K. 1995. Role Play. *In:* SMITH, J. A., HARR , R. & LANGENHOVE, L. V. (eds.) *Rethinking Methods in Psychology.* London: Sage.

YOUNG-EISENDRATH, P. & DAWSON, T. (eds.) 2008. *The Cambridge Companion to Jung,* Cambridge: Cambridge University Press.

YOUNG, B. & PAPADATOU, D. 1997. Childhood, Death and Bereavement across Cultures. *In:* PARKES, C. M., LAUNGANI, P. & YOUNG, B. (eds.) *Death and Bereavement across Cultures.* London: Routledge.

YULE, W., BOLTON, D., UDWIN, O., BOYLE, S., O'RYAN, D. & NURRISH, J. 2000. The Long-term Psychological Effects of a Disaster Experienced in Adolescence: I: The Incidence and Course of PTSD. *The Journal of Child Psychology and Psychiatry and Allied Disciplines,* 41**,** 503-511.

ZILBOORG, G. 1936/1996. Differential Diagnostic Types of Suicide. *In:* MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) *Essential Papers on Suicid.* New York: New York University Press.

ZILBOORG, G. 1937/1996. Consideration on Suicide, with Particular Reference to That of the Young. *In:* MALTSBERGER, J. T. & GOLDBLATT, M. J. (eds.) *Essential Papers on Suicide.* New York: New York University Press.

ZINKIN, L. 2008. Your Self: did you find it or did you make it? *Journal of Analytical Psychology,* 53**,** 389-406.