

PHENOMENOLOGICAL PSYCHOLOGICAL AUTOPSIES:
A SURVIVOR DRIVEN MODEL FOR
UNDERSTANDING SUICIDE

by

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ABSTRACT

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Over a million people worldwide die by suicide each year. 32,000 of these deaths occur in the United States. Strikingly, that number is miniscule in comparison to the 300,000 additionally recorded and 775,000 estimated non fatal attempts in that same year's time (Centers for Disease Control and Prevention, 2008; Maris, Berman & Silverman, 2000). In 1999, suicide was recognized by the Surgeon General as a serious public health issue (Satcher, 2000).

The purpose for this study was two-fold. First and foremost the effort was to increase knowledge about why people die by suicide. Second, the author hoped to assess the suitability and advantage of using the qualitative method known as phenomenology to conduct psychological autopsies. The findings from this study cannot be generalized because of the number of participants and the nature of the method. However, the findings are thought-provoking and present a telling picture of the struggles of both the decedents and their survivors. The narratives, when compared to the presented theories, demonstrate the way in which few people perfectly fit a theoretical mold.

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CHAPTER 1

INTRODUCTION

Over a million people worldwide die by suicide each year. Over 32,000 of these deaths occur in the United States. Strikingly, that number is miniscule in comparison to the 300,000 additionally recorded and 775,000 estimated non fatal attempts in that same year's time (Centers for Disease Control and Prevention, 2008; Maris, Berman & Silverman, 2000). In 1999, suicide was recognized by the Surgeon General as a serious public health issue (Satcher, 2000).

Recent research presented by the National Center for Injury Prevention and Control found suicide to be the second leading cause of death in 25 to 34-year-olds, the third leading cause in 15 to 24- year-olds and the eleventh leading cause across all ages. Between 2003 and 2004, the number of suicides in the 15 to 24-year-old age range increased by an astounding 8%.

Although the ranking decreased from the eighth leading cause to the eleventh in 1999, the numbers of people dying by suicide have increased. In that year, 29,183 people died by suicide. The most recent federal statistics released for 2005 showed no change in the ranking for suicide as a cause of death, but recorded that 32,629 people took their own lives (CDC, 2005). Maris, Berman and Silverman (2000) estimate that those 32,629 who suicide yearly leave behind 186,000 survivors.

In the United States, White males make up the greatest percentage of those who die by suicide each year. They are sequentially followed by non-White males, White females and non-White females (Maris, Berman & Silverman, 2000). Internationally, the percentages of those who die each year by suicide vary greatly. The United States, Canada and India show similar

numbers, each reporting that slightly over 1% of their population suicide yearly. In contrast, Great Britain, Brazil and Russia have considerably higher percentages equaling 6.65%, 4.10% and 3.27%, respectively (World Health Organization, 2008).

For some countries, the outlook is dispiriting. A study conducted with Nigerian youth between the ages of 10 and 17 produced shocking results. Out of 1429 participants, 22.9% reported suicidal ideation and 11.7% indicated they had attempted suicide in the previous 12 months. Predictors for males included alcohol consumption and going hungry. For females, contributing factors were sexual activity, sexual abuse and unstable family life. For both groups, the study revealed the following as predictors for suicide attempts: sexual abuse, physical attack in the last year, involvement in a physical fight in the past year, and living in an urban location (Omigbodun, Dogra, Esan & Adedokun, 2008).

1.1 Effect on Survivors

The impact of suicide is far-reaching. Avrami (2005) shares that when a person dies by suicide, they leave behind family members, friends and co-workers who become known by a term coined by Cain – “survivors of suicide”. These survivors experience not only the excruciating pain of losing a loved one, but also experience a type of grief and isolation shown by research to be unique. Studies have found that survivors mourn differently from others in several ways (Avrami, 2005; Cain, 2005; Cvinar, 2005; Jordan, 2001).

First, there are lingering and often haunting questions for survivors concerning why a loved one suicided. Second, they may feel more isolated from their extant social networks because of the violation of social norms suicide represents. They also may feel guilty or responsible - afraid they may have somehow contributed to the event or could have at least prevented it somehow. In addition, there may be feelings of rejection or anger developing from a sense that their loved one chose to leave them behind (Jordan, 2001).

The process of grieving is complicated. Survivors of suicide do undergo some grief reactions that are similar to the responses of others who lose a loved one to a cause other than

suicide. These might include denial, acute somatic and emotional discomfort and social withdrawal (Stroebe, Stroebe, & Hansson, 1993). Armour's (2006) study showed that other violent deaths from accidents and homicide produced somewhat similar experiences of grief. She explains that the similarity lies in the fact these types of death are all unexpected, often violent and offer little explanation or information about the cause.

However, the grief experience of a survivor of suicide is also unique in many ways. Cobain and Larch relay that those left in the wake of a suicide are "stricken with shock and disbelief" and that they "experience virtually the same psychache felt by the loved ones who took their own lives" (41). In addition to normal feelings and processes of bereavement, other factors complicate the grieving process. Because of the complicated and unusual circumstances involved with suicidal death, suicidal ideation may occur in those who have lost a loved one to suicide. This places survivors at a far greater risk for suicide than others who are bereaved (Jordan, 2001). In addition, the grieving process can be compounded by other elements such as the possible development of Post Traumatic Stress Disorder, the social stigma associated with suicide and the suddenness of the loss (Cobain & Larch, 2006).

Physical symptoms have also been shown to appear in addition to psychological and emotional pain. Research shows that severe forms of bereavement, often termed traumatic grief, can be accompanied by high blood pressure, heart trouble, increased food, alcohol and drug consumption and possibly cancer (Bower, 1997).

In the aftermath of a suicide, survivors agonize over the haunting "why" question for which there is rarely a satisfying answer. For some, the suicide of a loved one is the culmination of years of internal struggle which may have been openly shared. For others, there were few perceivable signs preceding the suicide. In any case, whether there were obvious warning signs or not, survivors may question why their loved one's life ended so abruptly and at their own hands. The struggle is not limited only to internal processes. The bereaved also frequently find that they become conversationally isolated from those around them. Because

suicide violates social norms those who might rush to comfort and aid under other circumstances may be reticent to become involved (Petty, 2000). Feelings of rejection, increased shame and perceived stigmatization are common in survivors of suicide as are mental health issues such as abnormal grief reactions and depression (Saarninen et al., 2002), complicated bereavement (Latham & Prigerson, 2004) and even Post Traumatic Stress Disorder (Murphy et al., 2003).

Postvention is the process of interacting with survivors of suicide in an attempt to help relieve psychological pain, or what Schneidman (1996) terms psychache. Survivors themselves are shown to be at greater risk for suicide and it is, therefore, vitally important to assist them in the grieving and recovery processes (Cain, 1972; Smolin & Guinan, 1993). Postvention can consist of treatment that ranges from individual therapy to support groups. Jordan and McMenemy suggest that support groups specifically for survivors of suicide can be helpful for participants and Reed identifies such groups as the most commonly respected and utilized form of postvention (as quoted in Aguirre & Slater, forthcoming).

1.2 Current Attempts to Address the Problem

Some developed countries, including the United States, have extant suicide prevention plans. Silverman and Felner (as cited in Substance Abuse and Mental Health Services Administration SAMHSA, 2009) propose that the difficulty in creating and maintaining effective plans lies greatly with the necessary body of research that is notably lacking. Evidence based prevention plans are difficult to develop because the amount of existing research related to the efficacy of suicide prevention plans is less than ideal. In addition, the existing plans that seem to make a difference are in serious need of evaluation in order to establish more substantial validity and reliability.

A comprehensive and systematic narrative synthesis was conducted by Mann et al (2005), The results of the study gave evidence that interventions such as increasing education for medical doctors concerning depression and suicide, as well as legally restricting access to

lethal means, decreased suicide rates. Reports on other types of prevention such as public and media-related education as well as screening were identified as being in need of more testing in order to conclusively determine efficacy.

Currently most states, with the exception of Arkansas, the District of Columbia, and New Jersey, have an existing plan for suicide prevention. 30 states are identified by SAMHSA (2009) as maintaining award-winning prevention programs. However, that remaining 20 states have either non-existent or poorly constructed plans. For example, Vermont has only a platform instead of an actual plan and Rhode Island's plan is only designed for the 15 to 24-year-old age bracket.

Some trends in prevention planning include emphasizing suicide as a public health issue and decreasing the associated stigma with both suicide and mental health treatment. In addition, efforts are made to educate those in the public sector who come into contact with those in high risk age groups or circumstances such as medical doctors, educators, religious leaders and university dormitory directors. Many states also make efforts to increase the availability of mental health and substance abuse services, because of the documented association with suicidality (Suicide Prevention Resource Center SPRC, 2005).

1.3 Purpose Statement

The purpose for this study was two-fold. First and foremost the effort was to increase knowledge about why people die by suicide. Secondly, the author hoped to assess the suitability and advantage of using the qualitative method known as phenomenology to conduct psychological autopsies.

CHAPTER 2

LITERATURE REVIEW

Suicide has historically been a controversial issue. Every culture and time has had its own opinion concerning if, and under what conditions, taking one's own life is acceptable. For some societies, the issue was decided by religious leaders and other cultures considered it more of a political issue, allowing philosophers and officers of state to guide public opinion.

In ancient civilizations, suicide was often given a less severe title; it was known as voluntary death. In Greco-Roman times, opinions were divided. Some viewed it as honorable and others as cowardice. Early Christians did not view suicide as sacrilege, however following the works of Saint Augustine suicide was identified as falling under the Biblical sixth commandment "do not kill". In later centuries both Catholic and Protestant writers and philosophers attributed suicide to satanic persuasion (Minois, 1999). In modern times, societies continue to hold their own unique perspectives and no consensus exists.

In the United States suicide has traditionally been seen as an act outside of social norms, though postmodern philosophy has raised many questions about the right to die and euthanasia. In other modern cultures suicide may be considered acceptable if used to protect family honor or to avoid capture by an enemy (Howarth & Leaman, 2003; Weaver, 2009; Minois, 1999).

Many, from philosophers to medical and mental health professionals, have attempted to answer the same question; "why"? Although numerous risk factors have been identified over the years, they are simply descriptive and cannot provide plausible arguments for causality. Although we know that mental health issues such as mood disorders, clinical depression and schizophrenia are present in at least 40 per cent of suicides, their presence does not explain why some take their own lives and others do not (Kastenbaum, 2003).

Those statistics are descriptive and cannot be considered evidence for causality. For instance, the fact that 40 per cent of suicides involve those who are mentally ill does not demonstrate that 40 per cent of the mentally ill attempt or complete suicide. Therefore, mental illness can be identified as a risk factor but has not been proven causal. For any risk factor to be causal, a randomized controlled trial, (which would be extremely difficult considering ethical and statistical constraints) would be necessary (Isaacson, 2000).

Numerous studies have been conducted in regard to the potential biological components of suicidality. One biological component found in some suicides is a disturbance in serotonin levels. Slaby and Åsberg purport (as cited in Maris, Berman and Silverman, 2004) that suicidal behavior and completed suicides that are violent in nature are connected with changes in the way serotonin is metabolized in the body. Postmortem examination of brain tissue shows that there is frequently an abnormally low amount of serotonin (5-HT), or conversely of its metabolite (5-HIAA) in those who have completed suicide.

Though this fact, in and of itself, supports the existence of depression in the deceased, the existence of the serotonin deficiency is present independent of any specific psychiatric disorder. This suggests that the serotonergic abnormalities could be linked to a predisposition to suicidal behavior irrespective of existing psychiatric conditions (Maris, Berman & Silverman, 2004).

Others research presents salient concepts of suicidality that involve traits, social environment. Some studies of identical twins, as well as adopted children, show evidence that there is a strong familial and perhaps even genetic, element to suicide. However, causality is again an issue. It is unclear if the data support suicidality itself as a trait or if the familial relationship is affiliated with the existence of other traits conducive to suicidal behavior. There seems to be more data supporting genetically transmitted psychiatric factors such as aggression, impulsivity, alcoholism and mood disorders than for suicidality as a unique trait. (Baldessarini & Hennen, 2004; Brent and Mann, 2005; Maris, Berman & Silverman, 2000). In addition, Durkheim (as cited in Yen & Syme, 1999) found that the social environment

contributed to a person's sense of reality as well as their development and maintenance of specific beliefs, customs and tendencies.

Two current psychologically based etiological theories addressing suicide are Baumeister's (1990) theory of escape from self and Joiner's theory of perceived burdensomeness. Baumeister purports that those who die by suicide often view themselves very negatively and associate failure with personal worth. He suggests that this is also often exacerbated by elevated standards that cause such disappointments to seem dynamically more severe, bringing about a state of heightened self-awareness.

In addition, the theory presents the concept of cognitive deconstruction by which the sufferer attempts to separate from emotional pain. This devolution of cognition brings with it precipitous characteristics including, passivity, lack of affect and inhibition, and irrational thinking. Suicide then, according to Baumeister, is the final effort to escape extreme emotional pain and cognitive disturbance.

In contrast, Joiner's (2005) theory of burdensomeness suggests that there are three elements that will be found present in those who are suicidal: the ability to self-harm, a sense that one is a burden to one's family or group of loved ones, and the perception that one is lacking interpersonal connectedness with a group of people or relationship of value. He proposes that to be able to follow through with the desire to kill oneself, suicidal individuals must have some sort of tolerance to pain and violence, often created by incremental instances of self-harm such as self-mutilation.

In addition, a perceived or actual deficit in connectedness may result from or accompany feelings of being a burden to loved ones. Sufferers may, for example, experience prolonged bouts with depression or physical illness, which can cause friends and family members financial and emotional strain. These factors may, according to Joiner, eventually be so disturbing to a person that he or she would take their own life.

CHAPTER 3

METHOD

The purpose for this study was two-fold. First and foremost the effort was to increase knowledge about why people die by suicide. Secondly, the author hoped to assess the suitability and advantage of using the qualitative method known as phenomenology to conduct psychological autopsies.

This study uses data gathered during the summer of 2008. The author conducted all interviews with participants under the supervision of Regina T.P. Aguirre. The IRB approval application was submitted on January 30, 2008. The IRB approval number is 07.249s. A copy of the IRB approval letter is available in Appendix A.

A psychological autopsy is the attempt to reconstruct the lived experience of the decedent. The goal is to understand, to the best of one's ability, how they thought, handled emotions and what things such as their greatest fears, struggles, and dreams were. The phenomenological approach to conducting a psychological autopsy was used for several reasons. First, the goal of the project was to understand the lived experience of the deceased in the last few days and months of their life in the hope of adding to current prevention research. It was the author's opinion that vicariously understanding the experience of another person is a challenge. Research shows that obtaining rich and meaningful data through the testimony of a surviving family member is difficult when using quantitative surveys. Even structured qualitative interviews may inhibit participants' ability to explore and express the lived experience of the deceased, thus the phenomenological approach was deemed appropriate for this study because of its descriptive versus explanatory perspective (Aguirre & Machtmes, n.d.; Moustakas, 1994).

Secondly, after extensive research it seemed that there were few existing examples of singularly qualitative studies utilizing phenomenological techniques to conduct psychological autopsies. The strength of a qualitative study lies in the ability it affords the author to gather rich data that is not bound by multiple choice answers or scales which may or may not appropriately describe a feeling, intention or circumstance. The qualitative interview, especially when minimally directed, creates an atmosphere conducive to unhindered and unadulterated expression on the part of the interviewee (Bryman, 1988).

One study was identified as attempting a similarly focused study. Researchers in China conducted interviews with survivors (multiple survivors for each deceased person) using what they reported as qualitative psychological autopsies. Though they did use researchers who interviewed the participants, the design seemed to be highly structured, as there were numerous standardized measurements guiding the interviewer's process with the families. The participants were asked to identify three major life-events they perceived as having the most significant effect on the deceased; however that probe seemed to be the only open-ended question asked. In addition, though the data gathering method was identified as qualitative, the results were converted to quantitative data (Zhang, Conwell, Zhou & Jiang, 2004).

3.1 Selection of Participants

In order to acquire participants, the thesis advisor contacted the Suicide and Crisis Center where she previously conducted other research and there were existing relationships with the director and staff. They were supportive of the concept and agreed to extend invitations to clients who met the study's requirements. The agency support letter is available in Appendix B. Requirements included that the survivor was a minimum of two years past the death of their loved one and that they had participated in either the Survivors of Suicide (SOS) 8-week support group or comparable individual therapy.

Invitations were extended to potential participants by means of a letter delivered via email by the SOS coordinator that explained the purpose and method of the study. A copy of the invitation letter is available in Appendix C. Potential participants were instructed to contact

the author by mail, phone or email. After first contact willing participants were mailed, emailed or hand delivered a copy of the informed consent form. A copy of the informed consent form is available in Appendix D. Participants read and signed the informed consent form and were each given a copy signed by both themselves and the interviewer.

In one case recruitment took place through an existing participant. One mother acted as a liaison between the author and her son, who wished to participate. He was presented with the same invitation letter and informed consent forms and chose to enter the study. There were a total of 5 participants who contributed on the behalf of four deceased.

3.2 Instrumentation and Data Collection

The study was conducted through a series of three interviews with each participant, totaling 15 interviews. In this study, the author conducted all interviews and was, therefore, the primary instrument used. The interviews were conducted under the supervision of Regina T.P. Aguirre. She provided training for this author in qualitative research methods and interviewing techniques prior to the beginning of the study.

Each participant agreed to attend three interviews. They were all conducted by the author and typically lasted between 45 minutes and an hour. The first two interviews were separated by one to two weeks out of considerations for the emotional content involved. Following the qualitative phenomenological model, the interviews were unstructured aside from a single guiding question presented at the beginning of each. The questions for the respective interviews were as follows: 1. I want to get to know your loved one through you. What did you cherish the most about your loved one? 2. What answers did you come up with for “why?” and how did you come to those conclusions? 3. Can you give me a brief overview of the services you received after the loss of your loved one?

For each of the previous questions there were contingency questions or ideas that could be introduced if conversation lulled. These contingencies were aimed at provoking memories that would assist the participant in answering the questions. For example during the first interview the author asked “When you think about your loved one, what makes you smile?”

and in the second, "Are your opinions now different than right after you lost your loved one?" It was the author's intent whenever possible to follow the lead of the participant, allowing them to share whatever they found pertinent and to ask appropriate questions as informational gaps became apparent.

In the second interview, the author presented questions that were unresolved in the previous interview to give the participant an opportunity to expound on facts presented or statements made. Many times the most cohesive and insightful information surfaced during this interview; participants were asked for their opinions concerning what the contributing factors may have been for their loved one's suicide. They also completed an ecomap, genogram and timeline for life as they applied to the deceased. Durkheim's (1979) work supports the efficacy of using ecomaps to visually represent and provide perspective for the social supports in one's life as well as those people or circumstances in life that cause stress. For the previous reasons, the second interview tended to be the longest of the three interviews.

Likewise, Baumeister (1990) supports the use of a timeline to gain a sense of major life events that may be contributors to negative affect. He purports that those who are suicidal or in danger of becoming so often wish to stop their lives at a certain moment in time and depression or substance abuse may be initial attempts to "escape from broad time perspectives and that suicide is simply an escalation of these efforts to stop time" (100). The genograms, are essentially a construction of the deceased's family tree including notation of divorce, death, adoption, and severe illness including type of disease and cause of death - most specifically looking for history of suicide or suicide attempts among family members.

The third interview entailed making any necessary corrections or additions to the ecomap, genogram and timeline. The author also asked any final questions needed for the sake of clarity or continuity. The interview then segued into an opportunity for the participant to share what helped them the most in their personal process of grieving and healing from their loss. All but one participant had taken part in a survivor's support group, so much of the discussion

surrounded that subject. One participant chose to seek individual psychotherapy instead of a group setting, and thus shared those experiences instead.

Most interviews took place at the Suicide and Crisis Center, which was centrally located for the participants and was a familiar and comfortable setting for most. Two participants had different wishes or needs. One participant felt uncomfortable meeting at the Center for personal reasons and accommodations were accordingly made to meet at the participant's home. The second with different needs lives in another state and therefore her interviews were conducted via Internet video conference.

Each interview, including the video conference interviews, was recorded using a small digital recorder. After the conclusion of the appointment, the files were downloaded to a laptop and transcribed. Both the audio files and the transcripts were saved to a 14 digit password protected USB drive and were also uploaded to a secure university web storage system protected by a 14 digit password known only to the author, the thesis supervisor and the external associate. For the current study, all participants and others named in their interviews have been assigned pseudonyms for the sake of confidentiality.

3.3 Credibility of the Researcher

In phenomenological qualitative research, the primary instrument is the researcher conducting the interviews. To address potential subjectivism or overt interference with the way participants report or researchers analyze data, it is vital that those conducting interviews are well trained in and kept accountable for their data collection methods. This includes triangulation using qualified external associates. One important consideration is the credibility of the researcher. It is vital that those directing the research and the training of the researchers are competent in the area of study and the research method being used (Patton, 2002).

The author holds a Bachelor of Arts in Psychology and is currently pursuing her Master of Science in Social Work degree. She has previous experience in conducting research from her undergraduate level psychology program. She was invited by the thesis advisor to be involved in suicide research. As an intern the author conducted all qualitative interviews,

transcribed all audio materials, and analyzed the initial set of data. In addition she is personally a survivor of suicide, having lost four extended family members to suicide.

The thesis advisor, Dr. Regina T.P. Aguirre, is a Licensed Master Social Worker-Advanced Practitioner (LMSW-AP) with extensive training in suicide intervention and crisis counseling including Applied Suicide Intervention Skills Training (ASIST) and specialized survivor training. She spent several years as a researcher and practitioner in a suicide and crisis center. She also has copious training in phenomenological inquiry and is an assistant professor of social work, teaching human behavior and research courses at the University of Texas at Arlington. In addition, she has published numerous articles relating to suicide and suicide prevention.

Holli Slater was an independent associate who acted as an impartial third party and assisted in triangulating data. She earned her Bachelor of Arts degree in Psychology with a focus in phenomenology having completed an undergraduate thesis utilizing phenomenological methods. She has also been trained in suicide assessment and holds a Master of Science in Social Work (MSSW) degree from the University of Texas at Arlington. The title of her MSSW thesis was, *First responders: Coping with community traumatic events*. She also contributed to an in press article to be published in *Death Studies* entitled *Suicide postvention as suicide prevention: Improvement and expansion in the United States*.

3.4 Data Analysis

The process of analyzing the data consisted of a multi-tiered course of action. After the transcripts were completed, the author as well as the triangulating associated read through the group of transcripts from each of the participants' interviews and physically identified themes or patterns termed horizons in the deceased one's story. Moustakas (1994) describes the process of identifying horizons by explaining that

“Something else in the phenomenon becomes horizontal; a different kind of expectation; something not seen is now recognized...inevitably we make corrections as things come into sharper focus and clarity” (p. 95).

For instance, some of the identified patterns in this study included mental health issues, illness, and trauma. The nuances and strength of contribution regarding such concepts developed as information continued to be presented by participants.

After completing this initial task, the author and thesis advisor shared horizons with the independent associate. The three then convened to compare data and from this meeting a list of horizons was created. Over time, as more interviews were assessed, the horizons that developed were grouped into themes where appropriate letters or combinations of letters were assigned. As we considered the identified horizons and themes, two of the previously discussed theories continuously emerged: Escape Theory (Baumeister, 1990) and Burdensomeness Theory (Joiner, 2005).

CHAPTER 4

RESULTS

The results of this study are presented as narratives. Each narrative uses pseudonyms for all named persons as well as created names or general geographical regions in cases where specific locations might breach confidentiality for the deceased or his family. The account attempts to incorporate the most salient facts about the lived experience of the deceased as recounted by their loved ones.

4.1 Dylan

Dylan was in his late 20's. He was the second of six children and was a very outgoing and vibrant child. He also had what some would call a roller coaster personality – often moody and emotional. He had a learning disability that caused him to have to repeat Kindergarten and in high school was prescribed Ritalin for ADHD, which he resented taking. In tenth grade, he was touched by tragedy when a friend was traumatically killed. He and some friends were drinking near the train tracks when his friend was unexpectedly hit and killed by a passing train as Dylan and his other friends watched helplessly. His parents put him in counseling immediately. He saw the counselor for a year and according to his mother did not engage in the process, fooling the counselor into thinking he was making progress. He eventually stopped going to counseling. He continued to drink and smoke both marijuana and cigarettes through high school. While in high school he was very involved in the theatre program and when he graduated in 1993, he entered college as a double major in theatre and education. While there, he experienced success in acting, earning the Actor of the Year award on several occasions. His best friend had begun college with him, but soon transferred to another school where many of their other high school friends were attending. Dylan had been dating the same girl since his

freshman year at that time and went back his junior year primarily to be with her. She broke up with him a month into the fall semester. In October of his senior year, terrible news came once again. His dad was leaving the family. His relationship with his dad had been strained for several years as his father had slowly begun to push everyone in the family away. The day the news was broken to the family, Dylan was the only one of the six children who had to find out over the phone. He was devastated. The divorce proceedings went on for a year, during which time Dylan graduated and moved to The City to pursue an acting career. October of 1997 almost exactly one year after his father left, the divorce was final. Dylan attended acting classes and worked as a waiter, hopping from restaurant to restaurant, as he had a difficult time keeping a job because of his problems with authority. In 2001, he moved to Tennessee to help a friend with his music career where he continued to work as a waiter. In the summer of 2001, some of his siblings traveled to Tennessee for a concert. That weekend, they observed strange behavior in Dylan that they later identified as his first truly manic episode. In April of 2002, devastation struck again with the death of his beloved grandfather with whom he was extremely close. Not long after, his dog Jake also died.

In December, he moved home where he worked student teaching for several months. Over Easter, another manic episode took place and the behavior grew increasingly strange – he went rollerblading at one o'clock in the morning and washed the car in the middle of the night. After the mania during Easter, Dylan's behavior was relatively normal until Mother's Day when he took a sharp turn for the worse. The day before Mother's Day, Dylan's mother returned home to find him standing on the back porch without a shirt, wearing a bow tie and pontificating on nothing. Alarmed by his strange behavior, she called the psychiatrist her younger daughter had been seeing for an eating disorder, letting her know that it was an emergency and urgent that they see her. She agreed to see Dylan, who wouldn't even put shoes on to leave the house, and immediately diagnosed him with bipolar. He was admitted to a psychiatric hospital where he stayed for five days.

Although he was prescribed medication, which was filled by his mother, he did not take it long. A few days after being released, he moved several hours south to Southtown where he lost the job he'd moved there for within a week. He remained there for the summer. Over the fourth of July weekend, his mother and sister went to visit him and witnessed another manic episode. Though it was not as severe as the previous, his behavior was still exceedingly odd. He got lost on the way back to his apartment and became so agitated that the only way he could calm down was to sit through the soothing noise of a car wash. Two months later over Labor Day, he moved home once again. This time the manic episodes had all but disappeared, replaced by a depressed state. He spent two weeks despondent, lying on the couch.

On Tuesday night, September 16th, Dylan attended an AA meeting. Wednesday morning, according to his family, he woke up acting like the "old Dylan". He got up off the couch, went to a movie and began acting happier. That weekend, his mother left to attend a wedding. Over the weekend, he called all of his siblings, which was unusual for him to do. On Monday, Dylan went to the office where his mother worked and attempted to fax a form to his phone company to cancel his service. That night he did not come home but his mother thought nothing of it since he had seemed so much more normal. She assumed he was out with friends or had "hooked up" with someone.

On Tuesday, Dylan's brother Aidan went by his mother's house and found a pad of paper sitting on the table left with impressions from a note that had been written. Aidan tried to read it and though he could not make out most of it, he could read enough to recognize his brother's hand writing and was concerned about the content. He called his mother and she called Dylan's counselor, who he had been to see earlier that week. He began to call local hospitals in an effort to find Dylan but had no luck. That afternoon, police officers came to the door and notified Jessica that Dylan's body had been found and that he was dead.

He had written a suicide note at home, and then taken it with him to a local hotel. His first attempt to die was to cut his wrists. This attempt failed. Next, he walked across the street to

a pharmacy and bought a bottle of cold medicine with pain reliever, returned to the hotel room and took them. According the toxicology report, he grew impatient and did not wait long enough for the drugs to take effect. After writing a continuation of the original note on the back of the sheet of paper, he hung himself from the air vent, killing himself. The custodian at the hotel found Dylan's body and called the police who located Jessica. "He's dead isn't he?" she asked when they came to the door. The officers sadly affirmed her fears.

4.2 Jack

Jack was 49 years old. He was married, had three children and was a successful businessman. He and his sister were raised by hardworking Catholic parents ,with whom he had mercurial relationships. When Jack was five years old, his grandfather died and his grandmother moved in with the family where she remained until her death many years later. She was a harsh woman and though Jack cared for her, she created a negative atmosphere in the home. As a sophomore in high school, Jack was involved in a serious car accident in which he sustained a significant head injury. He saw a psychiatrist once after the accident, but left the initial meeting declaring that he would not go back, and he didn't until much later in his life.

He met his wife Shelly in college and they married two weeks after graduation. Within a year of their marriage, she gave birth to their first child and they began to travel the country because of Jack's job. She described him as a "roller coaster" type of person who was always up and down. Their marriage was admittedly rocky partially due to his domineering personality. They finally settled in the south where Jack began his own business, which became extraordinarily successful in a short period of time. Not long after he began the company, he endured a cervical neck fusion after a golf accident. He was incapacitated for several weeks.

Three years later in 1997 he once again experienced serious physical issues when he was diagnosed with Leyomiosarcoma, a form of colon cancer. Within a year, he had endured excruciating surgeries to remove portions of his urinary and intestinal systems followed by chemotherapy and radiation involving innumerable complications. During his illness, he

continued to work and sold his business, making a healthy profit a year into his illness. He began to take on real estate projects – buying, refurbishing and selling homes, including a new home for he and his family. He insisted that working on the homes gave him something to look forward to while going through so much physically. In the midst of his new venture, he was sued by one of his contractors for over 200,000 dollars. The prolonged litigation went into mediation over and over. Jack was extremely agitated over the lawsuit, not only because of the potential financial ramifications but because the contractor who was suing him was a friend. The lawsuit continued until after his death. In 1999, Jack was declared in remission. Though he was cancer free, he continued to have physical issues, requiring an exploratory surgery that revealed twisting intestines.

In early 2000, he was dropped by his insurance company and was literally uninsurable. He and Shelly applied to their state's program for the uninsurable but had received a reply before he died. Life became increasingly challenging – each day was a struggle. Just weeks before his death, he had the chance to see all of his children and his grandchildren. Days before he killed himself he watched his daughter, who had come home to visit for the weekend, as she drove out of the driveway and down the street. She later told her mother that she felt as if seeing her dad in the rearview mirror would be the last time she would see him. On Thursday April 13th, unbeknownst to his wife, Jack stopped taking all of his medications.

He told Shelly that he was afraid the intestinal issues were returning and Saturday the 15th he woke up to the whites of his eyes being filled with blood. Shelly tried to convince him to visit the emergency room, but he refused, stating that he already had a scheduled doctor's appointment on Monday and would take care of it then. The next day, Shelly had been out during the morning and returned to Jack drinking, which he had not done in the three years he had been ill. Soon he became argumentative and a violent fight ensued. She was packing her bags to leave and he grabbed her by the throat. He had done so before, but had never gone so far as to actually harm her, so she did not fight back until she looked into his eyes.

They were empty, as if he were not there. She became afraid and worked to push him away. He ran to the nightstand and pulled out the gun they kept there for safety, asking her if she wanted him to “do it” there or outside. She was panicked and begged him not to do anything inside the house. He ran outside into the backyard and shot himself. She heard the shot and called the police, then ran outside to see what had happened. She said, “I was lucky he didn’t shoot me too”. He had mentioned suicide before. At first it was a joking matter – he would say “you’d be better off financially if I were dead”. She did not find it funny. Later, when he was sick, he mentioned the same thing to her in a more serious manner several times as close as week before the suicide. He was seeing a psychiatrist and taking medication for depression in addition to the other medications he was taking, however, when the psychiatrist asked only a week before his death if he was suicidal, he emphatically replied that he was not.

4.3 Bill

Bill was in his late 50’s and had no known history of depression or suicidal ideation. He was a successful professional who was invested in his career, had meaningful relationships with his family and friends and was in a committed relationship. He was a very thoughtful person who could, and desired to be, a friend to anyone he met. Bill was self-sacrificing to a fault and seemed to never let any circumstance frustrate him, always believing someone else had it worse than he did.

Bill and George grew up together and their families were close. After high school, Bill went to college in the south, while George moved north. George moved back to the south after earning his degree and Bill continued his education, earning an advanced professional degree. He moved to where his parents lived immediately after graduating to help his mother care for his ailing father. He lived and worked there for three years until his mother convinced him that he needed to move to the city he had originally planned to open a business in. He agreed and moved, opening a successful business. A year later, his father passed away.

Though George and Bill had remained friends over the years, it was after Bill moved back to the same area where George was already living that they began to spend more time together. A few years later, they began a committed relationship with each other, which George shared they always knew they would. The following decade passed with little to note other than a continuously happy relationship and successful business. George and Bill had strong bonds with their friends and family who were very accepting and supportive of their relationship. In the mid-1980's, an employee of the company threatened to "out" Bill and George's relationship which was temporarily a frustration, however, the employee never followed through with the threat and Bill's position as a professional in the community was not threatened.

In 1984, he lost his mother to natural causes and in 1989 his oldest brother Frank died of Alzheimer's. Approximately one month before he died by suicide in 1993, Bill woke up to severe pain in his eyes. He had experienced no such previous issues. That morning he walked to the optometrist's office, which was just down the street and saw his doctor. George arrived home that afternoon to find that Bill was still gone. Concerned, he called the doctor's office. Bill was still there, and the doctor suggested that George come pick Bill up because he was afraid he might not be able to make it home safely by himself.

The news from the doctor was not good. Bill was diagnosed with Closed Angle Glaucoma - an incurable, untreatable condition that would cause him to become blind in a very short period of time. At that point, Bill began to turn over his workload to others in his company in preparation to retire early because of his imminent vision problems. He and George went on a trip to South America with family shortly after Bill's diagnosis. He was already significantly impaired by that time, and while in South America, Bill wore a laminated identification card with his personal information and contact information for George in case they were separated. He was beginning to lose his independence, though he did not share any frustration about that fact with others.

In fact, just a week before his death, George asked Bill if he would ever kill himself. Bill replied "Not a chance, not a chance". Soon after returning from South America, George took Bill back to the optometrist's office where they were told that Bill had lost 90% of his sight and would be completely blind within a few days. In the car on the way home, Bill said, "Well, I'll move into an assisted living place and you can get on with your life". "Well, if you move into one, get a room for two 'cause I'm moving in with you", George replied. "Well, ok we'll try it" Bill responded, giving in quickly to George's protest. George explained to Bill that he could take care of Bill and that if there came a point where they needed professional help, they could afford to hire someone.

In George's opinion, Bill decided that day in the car that suicide was going to be his way out. Though he didn't recognize it at the time, it was unusual for Bill to give up on such a life-altering decision without an intense conversation between the two of them. When they arrived home, Bill asked to see the life insurance policies that he and George had taken out on each other. Using his large magnifying glass, Bill spent a day reading through them, and then returned them to George declaring that they were good policies. He asked George if he had sent the premiums for the policies to the insurance company, to which George replied that he had. Bill did not mention the policies again.

Nine days later, on July 9, 1993 George and Bill had plans to eat dinner with friends. George was out with friends that afternoon and called Bill to let him know what time he would be by the house to pick him up. Bill closed the conversation by saying "I love you, Georgy boy". Though George found it somewhat out of the ordinary for Bill to add something more to the usual "I love you", he could not have imagined that it was Bill's way of saying goodbye. Later that afternoon, George went to pick Bill up and found that he had shot himself in the garage. He left a note, which was in his wallet. In it he apologized for what he was doing, saying that he was sorry, but that he couldn't live in a world of darkness and be a burden on George and that he had concluded that suicide was his best way out. His suicide was very planned out. It was

later suggested by George's accountant that Bill asked to look at the life insurance policies to ascertain the existence of a suicide clause.

The policy stated that if the insured person died by suicide within three years of taking out the policy, it was rendered ineffective and the beneficiary would receive no money. Bill died nine days after the three year anniversary of the policy. In addition, he signed his suicide note with his full legal signature to ensure that George would not in any way be implicated. He also shot himself in a way that he knew he would die instantly, which was later confirmed by the authorities. To George's great relief, it was determined that the gunshot ended Bill's life immediately and that he did not suffer.

4.4 Doug

As a child he had been abused and his mother had ended her own life, as had several other family members. As an adult he was an abuser, which would have shocked his friends. He was described as "the best friend anyone could want". His loved one shared stories of how he would "do anything for anyone except his own family".

As kind and relational as he was with his friends and acquaintances, he was equally horrible to his family. He abused them both verbally and physically. Sometimes that abuse involved alcohol and other times it did not. His first wife and the mother of his two children, a son and daughter, eventually divorced him because of the abuse. He then married a woman who was nearly his equal in abrasiveness and abusiveness. They mistreated each other frequently and their relationship also ended in divorce.

Doug struggled with mental health issues, which were at one time severe enough for hospitalization. In his early 50's he had to apply for disability because of the severity of his mental health condition. He had worked for the same company for decades and the management position they had previously promoted him to required that he be available 7 days a week, 24 hours a day. The stress involved became too much for him to handle and he

experienced a nervous breakdown. He was prescribed medication at that time and his mental fragility only increased over time.

During the last fifteen years of his life, his daughter was his caretaker. A couple of years before he died, when his second wife had left him for the sixth time, he decided to stop taking his medication which resulted in a “crash”. Doug frantically began taking medicine again but was unable to reestablish a dosage that produced equilibrium. He agreed to allow his daughter to take him to a psychiatric hospital for the purpose of balancing his medications.

During his intake interview (of which his daughter was a part) he revealed that he had suicidal ideations. When the intake coordinator asked him how often he thought of harming himself, his reply was “how often am I awake?” When she asked him how he would kill himself, he replied “I would take a blanket onto the back porch and lay down and then I would put a pistol to the roof of my mouth and, and kill myself”. “Why a blanket?”, she asked and he replied “So Carolyn (daughter) and Daniel (son) wouldn’t have to clean up”. The hospital instructed Carolyn and Daniel to remove all guns from the home. When Doug found out about the instructions, he said ““Take my guns if you want, but do you think if I want to kill myself I won’t get a gun? Cause I will”.

A couple of years later, when Doug was 65, began asking Carolyn and Daniel to discuss finances and end of life wishes with him. They were resistant to discussing death and related issues and when he questioned them about how their mother handled such information, Carolyn told him that she wrote everything down in a book for them. That day (according to the dates given) he began keeping notes in a book. The notes detailed all of his financial accounts as well as instructions regarding debts owed to him, who to give certain items to and what should be done for the funeral. At the end of the book, it was signed “Love, Dad”. That was the only personal reference.

A few days before he died, he spoke with Carolyn over the phone and they had a great conversation. He sounded better to her than he had in many weeks. The day before he died, he

went to a friend's house whose wife was studying to be a nurse and asked to borrow an anatomy book because he was interested in learning about the heart. She lent it to him. The day he died, he went to a different neighbor's house to have his blood pressure checked by a friend's wife who was a registered nurse. While he was there, he asked her to listen to his heart. She did and then he asked her to draw a circle around where the stethoscope was on his chest. When she questioned him about it, he told her he was studying the heart and wanted to be able to listen to his heart later.

That afternoon he spoke with his son and had an argument with him over the phone about the legal situation he was facing with his former employer. The company was denying him over 30,000 dollars in sick leave that was owed to him. Daniel had called him that day to ask him for a document that would substantiate the claim and clear the issue. He told Daniel that he didn't know where it was and that he thought he had thrown it away. Daniel became angry with him (knowing that Doug knew where it was and that he never threw anything away) and told him "Stand up and be a man for once in your life". They were still arguing when the phone call ended.

Later that night, he meticulously laid out the book he'd been compiling along with several other items like pill bottles with money in them for specific people along with his watch and glasses. He went outside and lay down underneath a tree that he knew was within sight of his neighbor's home (they frequently used binoculars to check on each other as they lived in a rural area). He was without a shirt and shoes. Around 10 in the evening, as he lay on a blanket, he placed the barrel of a sawed off shotgun on the circle drawn on his chest and pulled the trigger. The next morning, his neighbor used his binoculars to check on Doug and saw him lying under the tree. He thought Doug had simply fallen asleep outdoors and drove to his house to wake him up and found him lifeless.

As they made final funeral preparations, Carolyn and Daniel went to their father's home to choose burial clothes. As he looked in his father's closet, Daniel saw the hatbox containing

the cowboy hat he and his dad used to joke about. Daniel had loved the hat and begged his father to let him have it years earlier. "You can wear it at my funeral", his father told him. The funeral hat is what it had hence been called. Daniel pulled the hatbox down, declaring, "Here's the funeral hat!" He opened the box to find another puzzling forethought on his father's part – he had intentionally placed the document Daniel knew he had that would settle the lawsuit with Doug's company over the money owed him. Years of self-hate, mental illness, abuse and frustration create a picture of a man who reacted to his life in a way that could fit with any and all presented theories.

CHAPTER 5

DISCUSSION

What is gathered from qualitative interviews cannot be generalized; however, there is a great deal of valuable information that can be extrapolated (Patton, 2002). Using the phenomenological method for conducting psychological autopsies provides an unparalleled depth and breadth of information, which allows insight into the detailed and very individual realities of the deceased – their lived experiences.

There were innumerable elucidations that arose as a result of studying the four deceased. One of the most substantial subjects related to the previously discussed theories and how those we studied both paralleled and differed from extant thought and research. While Bill's story seems to fit well with Joiner's (2005) theory of burdensomeness, there are also clear indications that he may have also been driven by a need for escape from his circumstances which more closely mirrors Baumeister's (1990) theory. His conversations with George about long term care when he encouraged George to "get on with your life" suggested that he felt his ensuing blindness would ultimately be an enormous burden to his loved one. However, he also made statements such as "I can't live in a world of darkness and be a burden on you". So, it seems that his desperation was rooted in both his concern about being a burden on his loved one as well as his despair regarding his suddenly acquired disability. It was nine days after he was told that the condition was irreversible that he ended his life.

Dylan was very different from Bill. His psychological suffering was stretched out over a number of years and was related to both painful circumstances such as his parents' divorce as well as his long standing battle with mental illness. His suicide note was very much focused on stopping the pain and frustration he'd felt for years. He said "The howling in my head has taken

over...I have been in pain for too long, and it is time for that pain to end...I have now found the Quiet that has been so elusive over the years.” His words lead one to believe that his suicide was rooted more in the need to escape and in hopelessness: “The pain that I am in is so severe that it makes living intolerable...I have run out of dreams. That is the most painful of all.”

Jack’s story seems similar in some ways to Dylan’s in regard to motivation, however, his seemed rooted more in hopelessness and an overall narrowed perspective, which erupted into an impulsive escape. He had dealt with great physical pain for several years and had been through additional personal and financial trauma before and during his illness. In his final days, the outlook seemed grim through his eyes. He had been dropped by his insurance and was in the process of attempting to qualify for state insurance, he was involved in a lawsuit and in the few days preceding his death he had been experiencing some symptoms that caused him to worry that the cancer might be returning. After consuming alcohol for the first time in years, he flew into a rage becoming abusive toward his wife and with no warning grabbed the handgun out of the nightstand that was kept there for protection and used it for destruction. There was no suicide note, and little to no discussion about suicidal thoughts previous to the event.

Doug’s death, even more so than Bill’s seems to be a mixture of hopelessness, burdensomeness and escape although his circumstances were drastically different. He was very obviously mentally ill, and a product of abuse as well as an abuser. He abused his medication and had very mercurial relationship with his son and a co-dependent one with his daughter. He was beginning to lose to death friends who were aging. He wished he had been a good dad and felt he had not, knew his daughter was burdened as a caretaker and was feeling intense stress concerning his financial situation. His capacity to handle stressors, according to his daughter, was minimal at best.

The previous four individuals and their stories certainly demonstrate that although theories of suicide can be descriptive of some, they cannot necessarily be prescriptive and most

assuredly should not be viewed as simply polarizations of motivation to end one's life. People are individuals. Every story and every setting is unique. If there is one thing that can be emphasized from this study, it is this; that the "why" questions cannot always be (and perhaps the argument could be made that they rarely are) answered only by one theory or another's explanation for human behavior. Although it is exceedingly clear that the existing theories have identified substantial themes in the study of suicide, caution must be taken when the temptation is to identify a suicide as simply one type or another as if it were the result of one sort of disease or another.

A myriad of factors from temperament and personality to environment, learned coping mechanisms, biology and life circumstances all create a complicated web of individuality. In light of this fact, perhaps our concept of suicidality could be more appropriately viewed as a metaphorical tree. The roots of the tree are psychache, which feed the trunk of hopelessness and that hopelessness branches out in every direction. Imagine that to the left is burdensomeness and to the right is escape. Where their branches wave in the wind and move this way and that, the lines between the two become blurred and here lies the continuum. Perhaps some stories appear to identify very clearly with the left and others with the right, while still others may consist of leaves from both one side and the other or may vacillate from one side to the other. What is clear is that people and their thought processes and motivations are dynamic. The picture that is painted by those who were studied reveals that rarely does one theory fit someone and their story singularly or perfectly.

Another result of the study was to establish the value of using phenomenology when conducting psychological autopsies. The depth and breadth of information gathered using this method is vast. It also produces a dualistic benefit. Not only can the researcher truly learn the lived experience of the deceased through the survivor, but the survivor seems to benefit greatly simply from the experience itself. One participant shared that "...your interviews were better than several expensive sessions with a therapist." And another's sentiments echoed a similar

feeling; “I’m really happy that I participated in the study...I think it helped my healing even more. It also got me to focus more on the good stuff.”

What we can learn from statements like these are that simple questions and empathetic listening even in the midst of a clearly defined research setting can be a cathartic experience for all involved. A note of interest in regard to the information gathering process, further supporting the natural story-telling process used is that the author never had to prod any participant to share the details of the suicide and the surrounding circumstances. In each of the first interviews, those facts were shared freely and without provocation as a very organic step in the process. The first question asked of the participants, as mentioned previously, concerned what the survivor cherished about their loved one. This gave the participants freedom to disclose as much or as little about the actual event itself and instead offered the opportunity to focus on positive aspects of the deceased one’s life. Without the intention and subsequently without fail each survivor delved into even the most gruesome and painful details of their loved one’s death.

This came as a surprise to the author as I expected that a much longer period of time would be necessary to build enough rapport for such revelations. This should also be considered when thinking about settings for survivors that promote healing. Each mentioned that a stigma free environment where they could hear others’ stories and share their own among others who understood a similar type of loss provided the greatest healing. They also mentioned that time and using their pain to help others through things like advocacy and volunteering were also very beneficial. Perhaps, then, the qualitative phenomenological research setting could even be viewed as a valuable part of the journey of healing for a survivor. Such an endeavor combines three out of four named ways to aid healing including a stigma free environment, a way to advocate for those who are suicidal as well as survivors, and time spent volunteering intended to benefit others in honor of the lost loved one.

Aside from the more obvious benefits of a wealth of information obtained interactively and advancing healing in survivors, there were also benefits for the author. There were many

invaluable gains made in clinical skills, as the author was the primary tool in the study.

Although good preparations were made and training given, I found that the greatest learning took place in the moments of interaction with participants and subsequent reflection.

It has now been a year since the interviews. Time has flown and many lessons have been learned in 12 months. Some of those lessons, I feel, have only been learned in retrospect. The value of the experience has become clear as the skills and perspective gained have filtered through months of advanced practice courses and, most especially, another internship. The ability to read clients' facial expressions and body language in regard to their level of comfort and willingness to share is something that takes practice. Now as I work with clients who have painful stories to tell, I feel less daunted at the task of asking hard questions. I have already asked the hardest ones. I have heard the worst stories. I have seen some of the darkest places of the human soul and mind. And, I have learned that sometimes just the asking and the listening can bring healing or enlightenment to another.

When I first began forming my skill set for social work the thought of asking clients probing questions about their personal lives, such as financial situations and legal or medical history was terrifying to me. However, now as I combine my experiences from this project with my most recent internship in the medical setting, I feel that I can approach those conversations with confidence. I have discovered the beginnings of my style – my version of art versus science in this field. Because I am so research-minded, I feared that I would be found lacking in the ability to work in a direct practice field. What I have found is that qualitative interviewing (and perhaps an argument could be similarly made that therapy), is as Janesick (1994) terms it, like a dance.

There was a delicate balance of leading and following that I had to learn. A conversation would often traverse the path of pain, further and further into the recesses of soul and mind laying bare the truth. The scientific challenge was to remain engaged while willfully choosing not to interfere with the movement or interject any personal direction. The art involved

being present with the participant and connecting enough with their pain to know when it was appropriate to help provide momentary relief by making an empowering comment, highlighting a positive aspect of the subject at hand and, or simply demonstrating empathy.

I found that over time my ability to perceive when this type of intervention was needed, and how to effectively provide it, was sharpened. I have many hopes for the wealth of information that emerged from this study. The ultimate desire, of course, is that it would contribute to lives being saved. There is also much to learn about survivors and what is helpful to them as they heal. In addition, I hope that this thesis will serve to support the multi-dimensional value of phenomenology and other qualitative research techniques.

Three tools used with each participant that were very helpful in reconstructing the life of the deceased were the ecomap, timeline and genogram. Each person that was interviewed completed an ecomap showing what the support system looked like for the deceased (see appendices). Positive life-giving influences in the deceased's life were noted with arrows pointing toward the center circle which represented the deceased. Negative issues (those that took energy from the deceased) were denoted by an arrow, which pointed from the center to the circle containing the description of the identified influence. The extent to which each issue or person impacted the individual was indicated by the thickness of the line, the direction of the arrow and the existence of other demonstrative markers such as plus signs for stressful relationships, dashed lines for tenuous relationships or a bar cutting through an arrow perpendicularly showing a broken relationship. Some were identified as both taking and giving energy, which was shown by an arrow pointing both to and away from the center circle.

These ecomaps were beneficial in several ways. First, they were introduced at the interviewer's discretion, providing a task that was helpful while at the same time a bit more emotionally neutral. The author found this especially useful when it was apparent that the participant was becoming emotionally exhausted and needed a more factual task to complete in order to continue. Also, it presented a holistic visual representation of the stressors and

supports present during the deceased's final days. This often assisted the participant in articulating their thoughts regarding the second interview question: "when you tried to answer the "why" question, what did you come up with?" Lastly, many times this exercise spawned elucidating explanations for previously mentioned facts or even introduced new facts about the deceased. For instance, it became clear for instance Dylan's ecomap showed that some of his strongest supports were also the ones that, at times, were the most draining as well. For Jack, some of the things he enjoyed doing the most, such as golf, were things that his illness inhibited him from participating in.

The timelines were similarly helpful. The participant was asked to construct a timeline for their loved one from birth to death, which was to include their opinions about the most meaningful moments in the deceased's life, whether positive or negative. This sequencing of events was often very enlightening for all involved. It provided a much more clear picture of the months and weeks leading up to the suicide with the simultaneous perspective of the person's entire history. For instance, Bill's demise took place over a very short period of time. His life history until his diagnosis was predominantly filled with happiness and success. After his diagnosis, which facilitated a dynamic shift in his view of life, his spiral downward took place in just a few weeks. There were few, if any, discernible signs of his intentions that would have been possible to understand as suicidality in the time period during which they occurred. Doug's life history was very different. His past was riddled with painful experiences, suicide (several family members including his mother) and unsuccessful relationships in addition to issues with mental health. His final days were marked by more typical signs of suicidality such as putting affairs in order, selling or giving things away, and elevated mood. Constructing these timelines with the survivor not only provides a visual representation of the development of psyche but also seemed to be enlightening to the survivor as several of them made statements afterward about how the 'bigger picture' seemed to help make more sense of a generally incomprehensible act.

The genogram was completed in order to better understand the deceased's family background especially in regard to both mental and medical conditions as well as relationships between family members. This allowed the author to see where there was a history of suicide, depression, or other mental illness as well as when and between whom divorces, marriages, and births took place. This was often very explanatory when considering the history of mental illness in the family. There were often family members with a history of mental illness that had not been previously mentioned. This greatly added to both the consideration of biological and environmental components in the deceased's life experience.

5.1 Conclusions

The findings from this study cannot be generalized because of the number of participants and the nature of the method. However, the findings are thought provoking and present a telling picture of the struggles of both the deceased and their survivors. The preceding narratives when compared to the theories previously introduced demonstrate the way in which few people perfectly fit a theoretical mold. Among this group of deceased, there were some whose demise seemed to more closely follow the model of burdensomeness while others' motivation or reasoning seemed rooted in both feelings of burdensomeness and the need for escape, for others it was difficult to develop a clear picture of underlying motivation.

For this reason, the author recommends that clinicians be familiar with the various theories concerning why people die by suicide. This is deemed important for the sake of effectively recognizing potential or existing suicidality as well as utilizing an eclectic approach in working with suicidal clients. Baumeister's (1990) theory not only presents the concept of escaping extreme psychological pain or dynamically aversive circumstances, but also gives some insight on other factors that might contribute to completed suicide.

He presents that someone with very high expectations for themselves may feel failure or disappointment more keenly than others. He states that for those who have high expectations and are very self aware, may make "internal attributions" (95) after a disappointment which can

lead to suicidality. Such patterns can over time catalyze cognitive deconstruction, which can develop into concrete thinking patterns, or narrowed perspective as it is termed by Schneidman (1998). These cognitive processing deficits are also associated with suicidality. Armed with this knowledge, a clinician may be able to screen for the risk or existence of suicidality in someone before the client is in crisis.

There are many experiences that contribute to each of the deceased's stories. Some had painful childhoods, while others did not. Some demonstrated patterns affiliated with suicidality while others evidenced an absence of pattern. Each person and story was unique. There were two elements, however, that were observed in the lives of all four: psychache and hopelessness. As previously defined, psychache is psychological pain (Schneidman, 1996).

When psychache is joined by hopelessness, the situation is far more precarious for the one in pain. For each of those in this study, there were varying combinations of these two factors. For some like Dylan, the psychache existed for many years but hopelessness seemed to develop more toward the end of his life. For Bill, the psychache revolved around his sudden and traumatic physical condition and was followed very shortly by hopelessness. His condition worsened quickly and dramatically. He felt that he would be a great burden to George and did not seem to see a way for things to be different outside of suicide – he felt hopeless.

In regard to the individual ways in which the suicides took place, the level of planning varied. For Jack, the psychache grew as his illness progressed and other business related and interpersonal crises took place. His suicide however, seemed very reactive. He was drinking in the morning, had a violent disagreement with his wife and then suddenly grabbed a gun, ran outside and shot himself. The only statement that demonstrated any sort of thought about the event was asking his wife (after already having retrieved the gun) if she wanted him to do it inside the house or if he should go out to the back yard. Though he had mentioned briefly some consideration of suicide, he did not write a note and the actual time and circumstance of the suicide came across as more reactive than meticulously planned. Oppositely, Doug was

extremely methodical, taking weeks to make preparations and plans for everything that could be involved with his death, including writing a book with detailed instructions regarding the most particular minutiae.

5.2 Implications

Many people experience psychache at one time or another in life. The death of a parent, loss of a job, or a divorce, for example, can cause great psychological pain and frustration. For this reason, it is extremely important that practitioners take all mention or signs of suicidality seriously. If any suspicion exists, clinicians should be prepared to assess the client for risk factors such as previous attempts, family history, significant changes to daily functioning and habits, or suicide survivorship that might afford a more complete picture of risk level.

Some of those studied demonstrated what would be considered typical signs of having a plan to suicide such as a suddenly elevated mood or returning borrowed items, while others showed few if any predictive behaviors. Although this study cannot be generalized, this clear demonstration of differences should alert practitioners to the fact that not every client experiencing suicidal ideation will exhibit behaviors that fit the molds presented by extant theories. It is important to pay close attention to all of the typical predictive signs, to be familiar with the client's background and larger social environment. Also vital is awareness of the client's level of psychache and potential development of hopelessness or a constricted view of potential solutions to their unpleasant or painful circumstances.

Another implication from this research is the advantage of utilizing qualitative phenomenological methods when conducting psychological autopsies. This relatively unstructured interviewing technique allows for a true sense of the lived experience of the deceased versus a more standardized method that may or might contain items that can adequately capture the reality and expanse of the deceased's life. In addition to the depth and breadth of information shared, this study demonstrated the additional benefit of the process for survivors. Each of the five participants shared that the process of the three interviews was

meaningful and provided a measure of healing and perspective that they did not expect. This suggests that the open-endedness afforded by conducting phenomenological psychological autopsies provides a potentially cathartic opportunity for the participant.

5.3 Recommendations

The need for further suicide research is profound. The lack of a robust body of literature as well as the historically desultory organization of foci demonstrates the existential necessity for a progressive and resolute approach to increasing the knowledge base (SAMHSA, 2009). The author, therefore, recommends that the phenomenological psychological autopsy method be more frequently used, especially where it is possible to interview multiple survivors regarding the same loved one. The depth and breadth of information gained from this approach provides unparalleled perspective on both the lived experience of the deceased as well as the recovery process of the survivor. This kind of study can provide valuable implications for prevention efforts as it elucidates the nuances of psychological pain and the way in which suicidality develops. It is also useful for understanding the complicated grieving and healing process experienced by survivors and can, as testified to by participants, be part of their healing process.

In addition, this study showed that half of the deceased were regularly seeing psychiatrists (who were their only mental health providers) who were not aware of their client's suicidality and who did not know much, if anything, about their traumatic backgrounds (Luhmann, 2000). Although information regarding the deceased's interactions with their respective psychiatrists is secondhand, the impression the families had was that the doctor was largely disconnected from their loved one's history of pain. If this perspective was accurate, it may suggest the need for such professionals to make a more concerted effort to consistently screen patients for suicidality. In addition, it would seem prudent for practitioners to gather a more complete psychosocial history with thought toward predictors of suicide. Also, depending on the role of the professional, a better effort may need to be made by some to refer to other

mental health professionals who can provide more in-depth services for assessment and treatment. It is also recommended by this author that helping professionals from a variety of fields including doctors, counselors, teachers and social workers might, in the best interest of their clients, pursue training specifically designed for understanding suicidality and suicide intervention.

It is the author's opinion that this type of awareness and referral should become a far greater focus for all those who interact with known at-risk groups such as teens, young adults and older adults. It should become more instinctual for medical doctors, teachers, social workers, among others to watch for life circumstances, verbal statements and other behaviors that might intimate not only extant suicidality but the condition of psychache that might eventually lead to suicidality. If it is possible to prevent cognitive constriction and deconstruction rather than being limited to intervening when the afflicted is already in crisis, perhaps prevention efforts would be more successful.

APPENDIX A

IRB APPROVAL LETTER



INFORMED CONSENT

PRINCIPAL INVESTIGATOR: Regina T. P. Aguirre, PhD, LMSW-AP

TITLE OF PROJECT: Psychological Autopsies with Survivors of Suicide: A Phenomenological Approach

This Informed Consent will explain about being a research subject in an experiment. It is important that you read this material carefully and then decide if you wish to be a volunteer.

PURPOSE:

The purpose of this study is to investigate the lived experience of persons who have died by suicide through phenomenological interviews with suicide survivors who have completed the eight week Survivor of Suicide (SOS) program through the Dallas Suicide and Crisis Center or some other form of grief therapy (individual or group).

DURATION

It is requested that you meet with the principal investigator's social work intern three to four times (to be determined) at the Dallas Suicide and Crisis Center. (Alternate arrangements may be feasible with the principal investigator's approval. The meeting time would be determined by the social work intern and you collaboratively.

PROCEDURES

The procedures, which will involve you as a research subject, include:

You will be required to participate in three to four scheduled interviews which may last between 1 and 2 hours. The first interview will be a chance for you to celebrate and discuss your loved one's life. The second interview will be a time for you to discuss your understanding of the events that led up to your loved one's suicide. The third interview will be a time for you to review the researchers' understanding of what you have shared. You will be asked to provide feedback on the accuracy of the findings. If the findings are deemed inaccurate by you, the researchers will revise accordingly. Either in the third interview or in a fourth, you may also be asked to discuss your experiences in the Survivors of Suicide group or other bereavement therapy.

JUN 2 5 2008

APPROVED BY THE UTA - IRB
The IRB approval for this consent
Document will expire on

JUL 2 3 2008

APPENDIX B

AGENCY SUPPORT LETTER

You Are Not Alone.

Suicide & Crisis Center

November 11, 2007

2808 Swiss Avenue
Dallas, Texas 75204-5991
www.sccenter.org

Institutional Review Board
University of Texas at Arlington
202 E. Border, Suite 201 Box 19188
Arlington, TX 76019

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Executive Director
Margie Wright

Dear Review Committee:

I am writing to express my strong support for the research program that Regina T. Praetorius, PhD, LMSW-AP (University of Texas at Arlington) is submitting to the Institutional Review Board Committee for review.

The Suicide and Crisis Center has a continuing interest in understanding what motivates crisis volunteers to volunteer which Dr. Praetorius focuses upon in this proposed research. The possibility of furthering our understanding of crisis line volunteers, namely what motivates volunteers to support the crisis line as well as what motivates volunteers to continue to volunteer, is paramount to the continued functioning of the Suicide and Crisis Center.

The prospect of collaborating with this researcher to understand the experience of crisis volunteers at a deeper level is an exciting one that I am confident supporting as Executive Director of the Suicide and Crisis Center.

I look forward to hearing that they have been successful in obtaining support from the IRB for this endeavor.

Sincerely,



Margie Wright
Executive Director

214.824.7020
Administration

214.828.1627
Fax

214.828.1000
Crisis Line

1.866.672.5100
Toll Free

APPENDIX C

PARTICIPANT INVITATION LETTER



THE UNIVERSITY
OF TEXAS
AT ARLINGTON
School of Social Work

Box 19129
211 S. Cooper Street
Arlington, Texas
76019-0129
T 817.272.3181
F 817.272.5229

[Pick the date]

Regina Praetorius, PhD, LMSW-AP
University of Texas at Arlington
School of Social Work
211 S. Cooper, Box 19129
Arlington, TX 76019-129

[Type the recipient name]

[Type the recipient address]

Dear Mr. or Ms. _____,

I am writing you because you have indicated a willingness to participate in research related to suicide prevention. I am submitting this request for you to consider participating in a voluntary research study to be conducted with survivors of suicide. The purpose of this study is to investigate the lived experience of persons who have died by suicide. This will be accomplished by conducting a series of interviews with suicide survivors who have completed the eight week Survivor of Suicide (SOS) program through the Dallas Suicide and Crisis Center.

The research will be conducted at the Dallas Suicide and Crisis Center and will be under my direction. I will be contacting you to confirm your interest in participating in the study and to set up the first interview. Please review the enclosed Informed consent form which will be reviewed in detail during the first interview. If you have any questions, please contact me at 817-272-1360 or by email (rtpraetorius@uta.edu).

Regards,

Regina Praetorius, PhD, LMSW-AP
Assistant Professor/Principal Investigator
School of Social Work

APPENDIX D

INFORMED CONSENT FORM



INFORMED CONSENT

PRINCIPAL INVESTIGATOR: Regina T. P. Aguirre, PhD, LMSW-AP

TITLE OF PROJECT: Psychological Autopsies with Survivors of Suicide: A Phenomenological Approach

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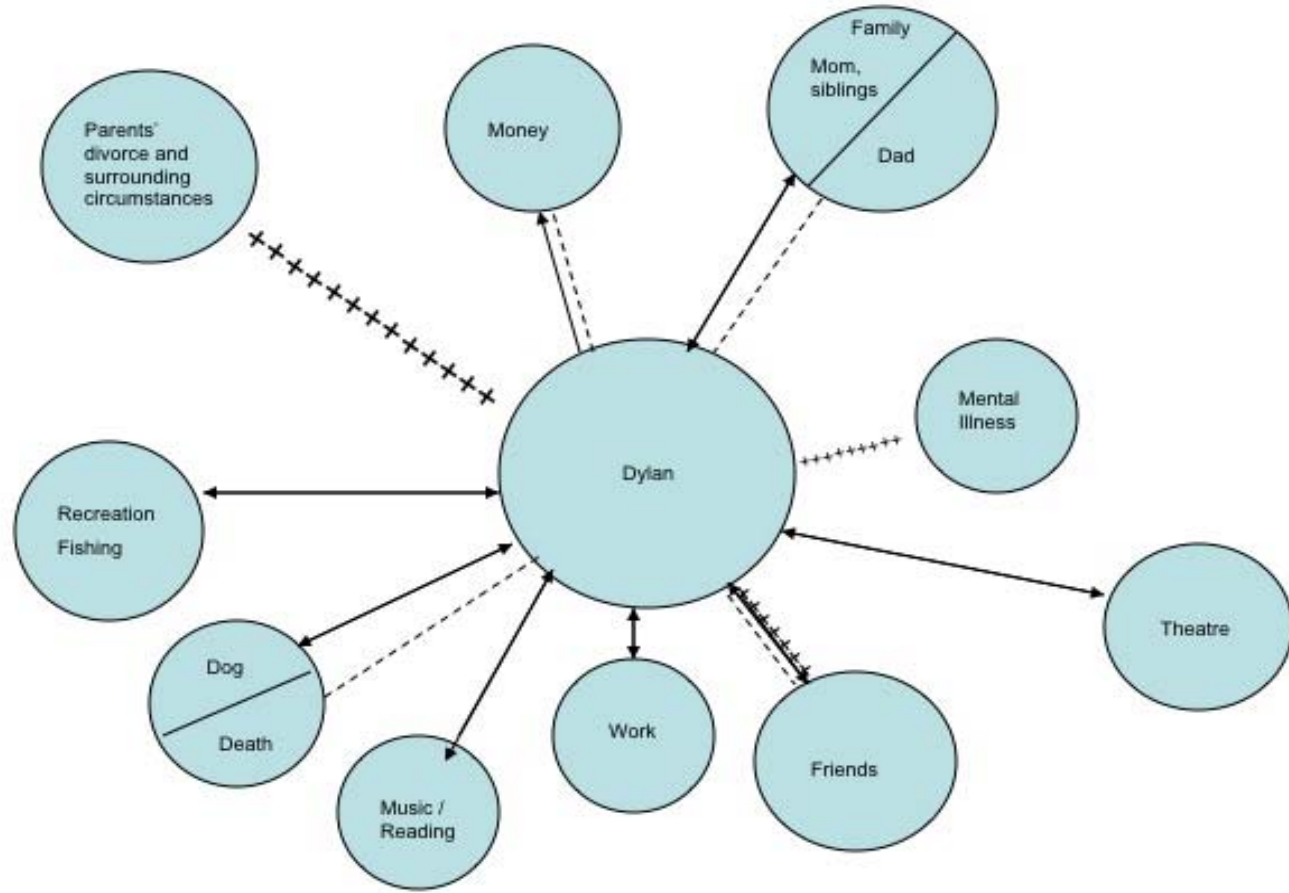
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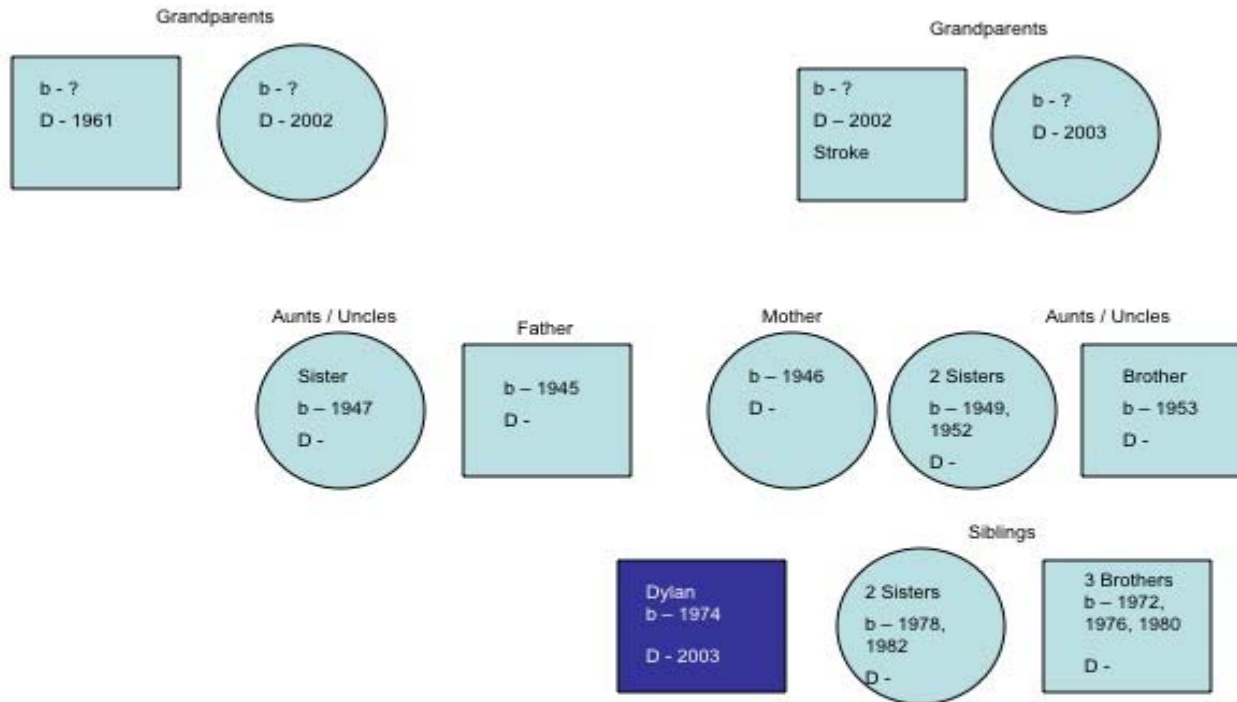
APPENDIX E

DYLAN ECOMAP



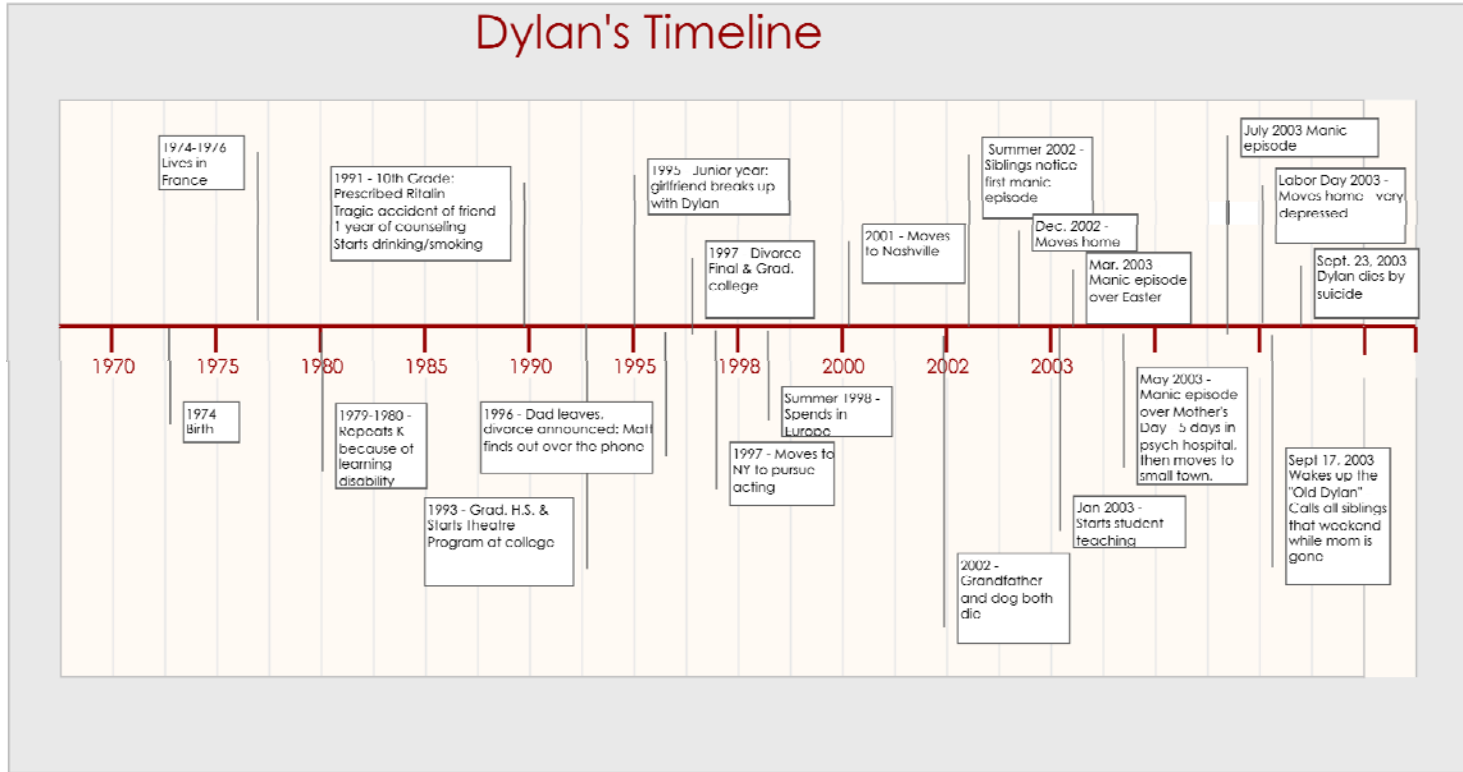
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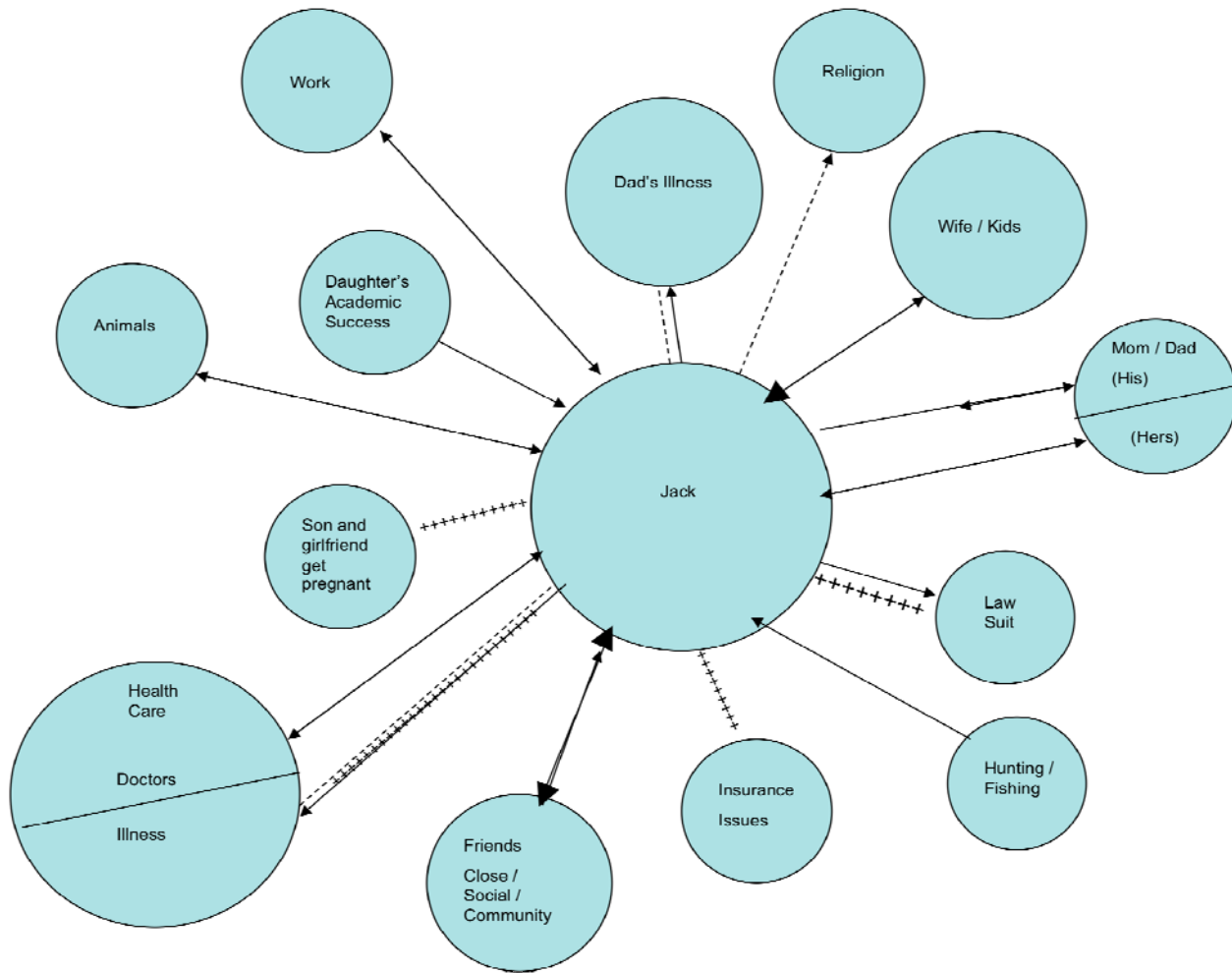


APPENDIX G

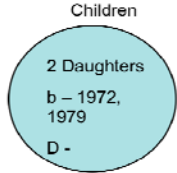
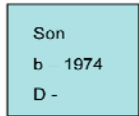
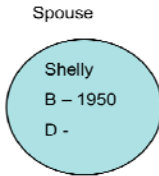
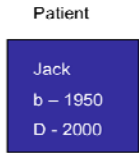
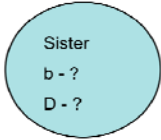
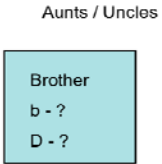
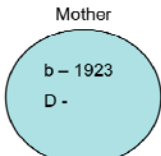
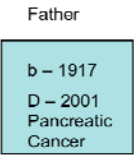
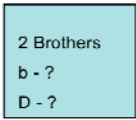
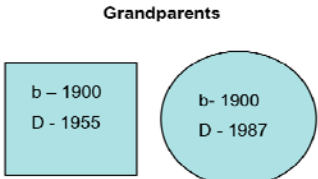
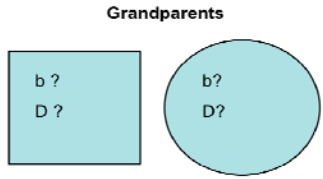
DYLAN TIMELINE



APPENDIX H
JACK ECOMAP

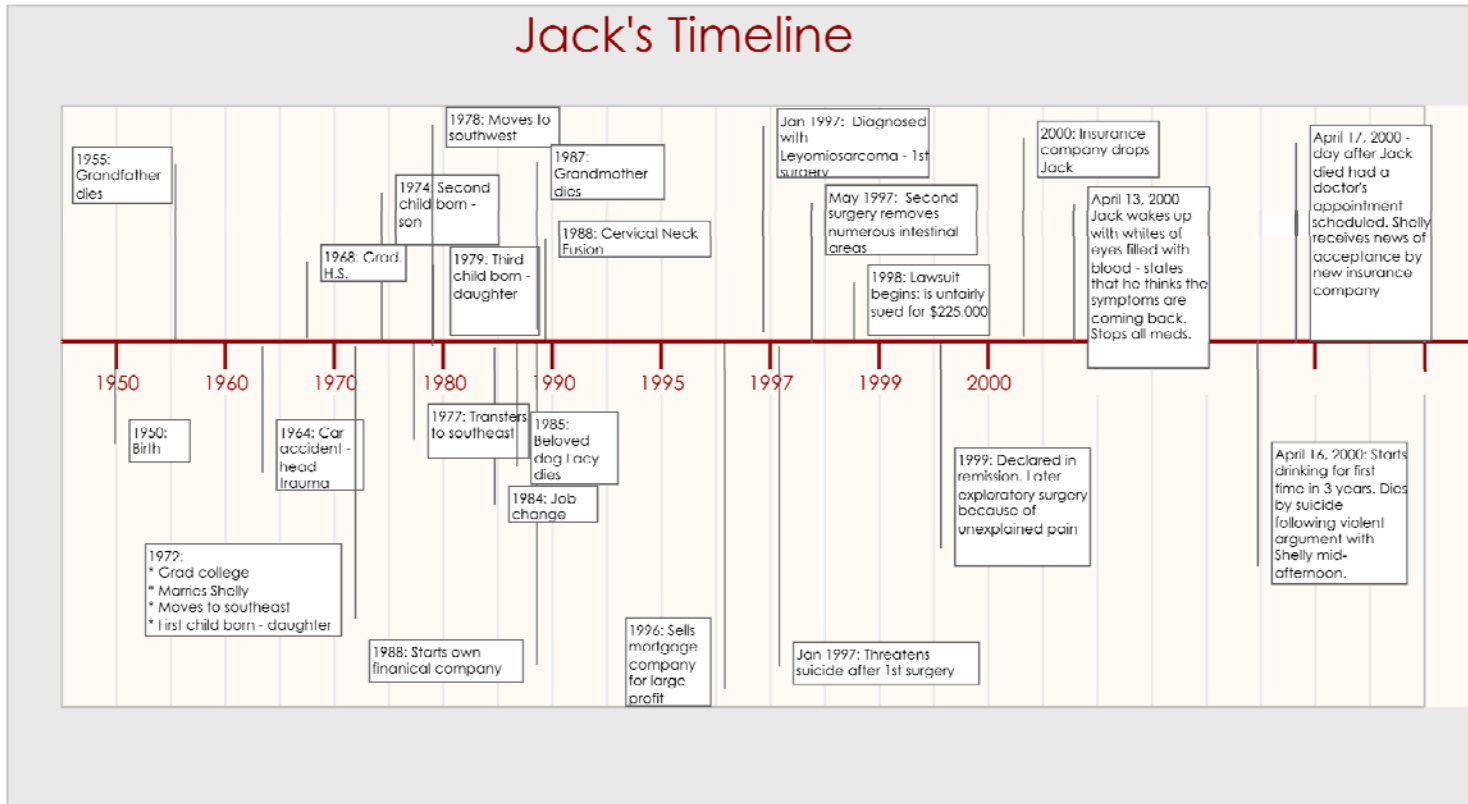


APPENDIX I
JACK GENOGRAM

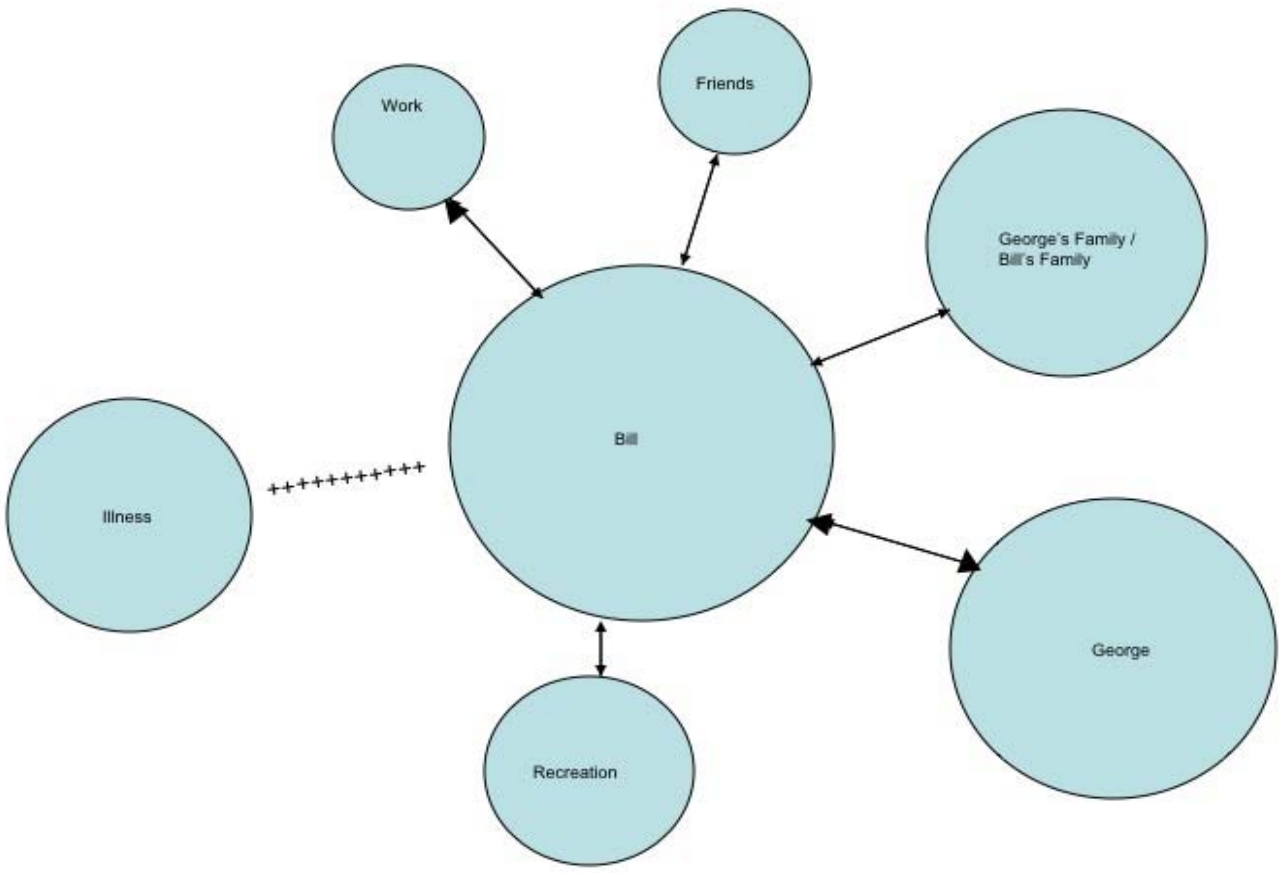


APPENDIX J
JACK TIMELINE

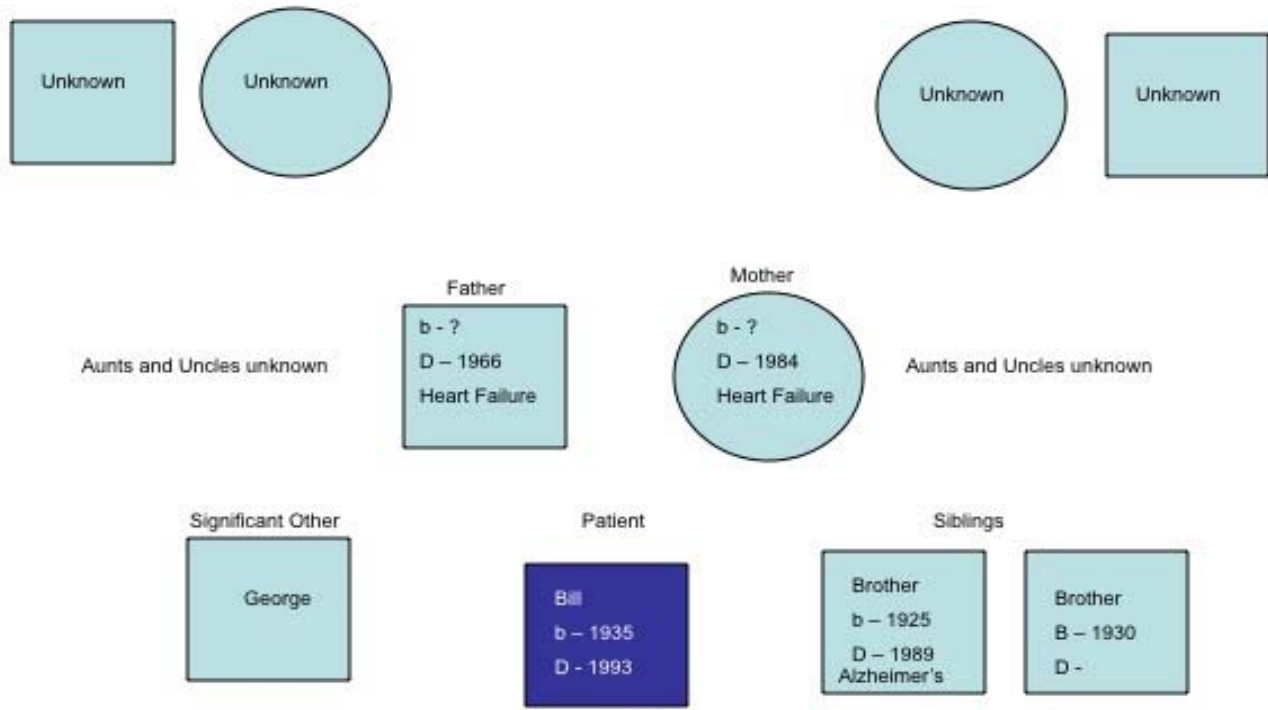
Jack's Timeline



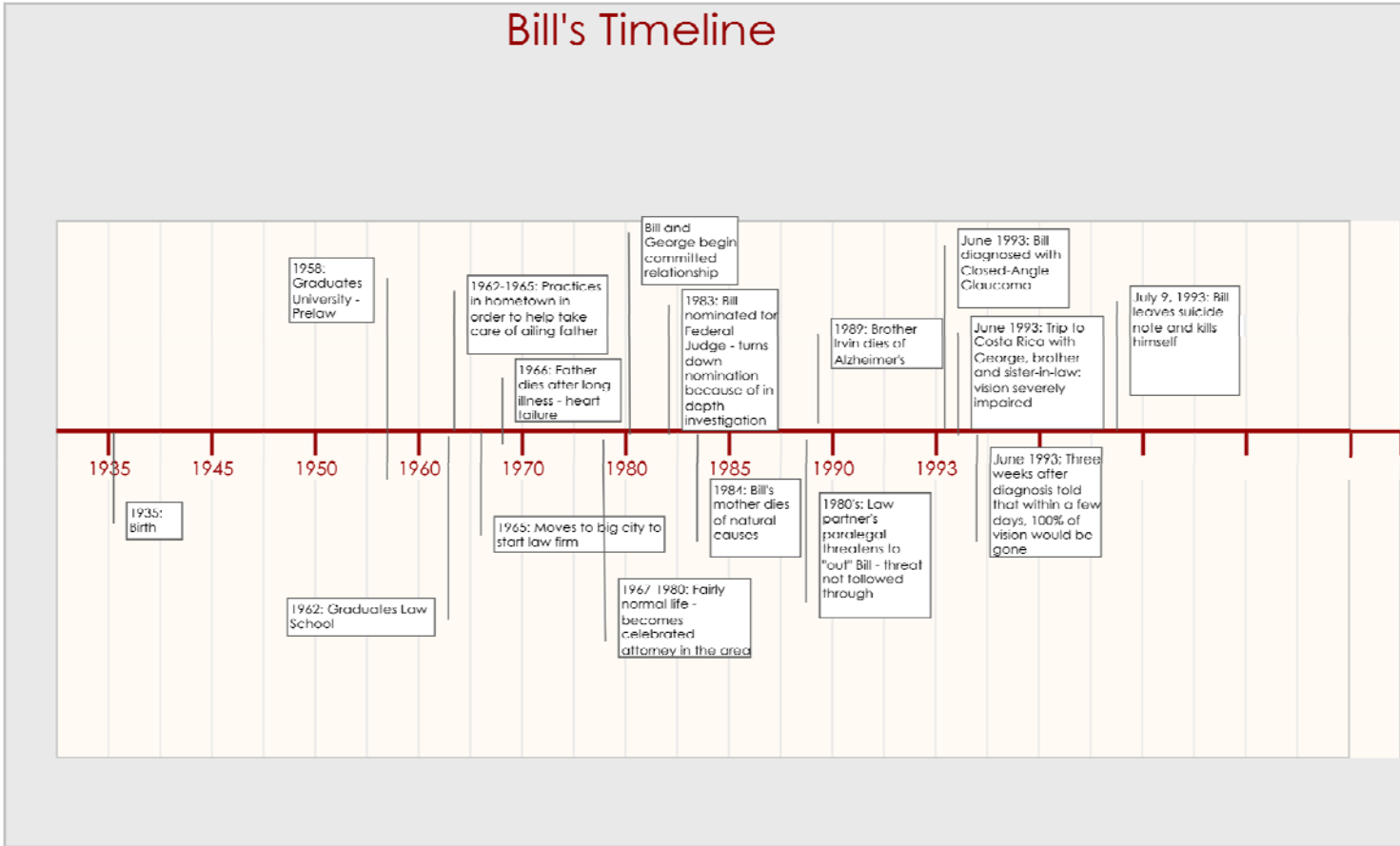
APPENDIX K
BILL ECOMAP



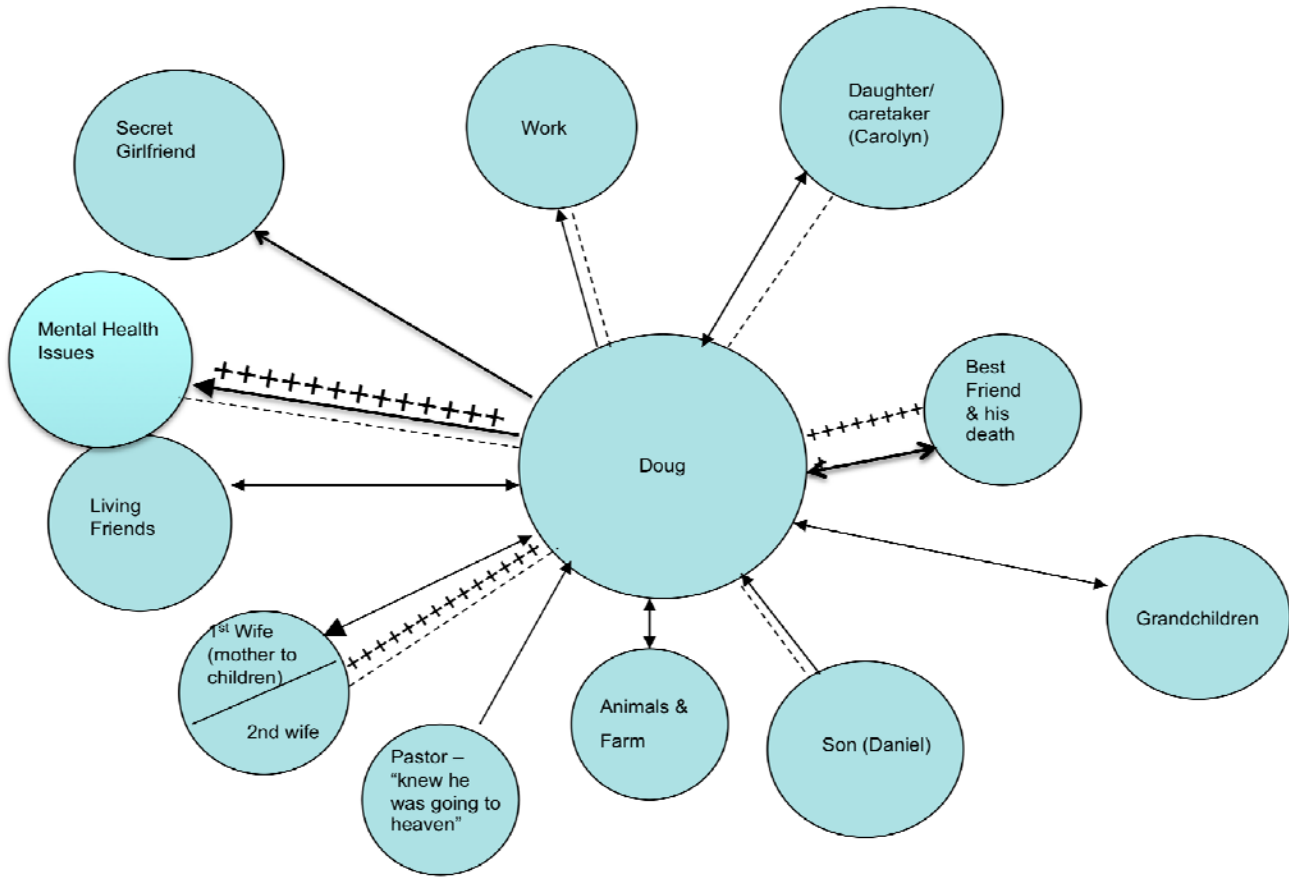
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BILL GENOGRAM



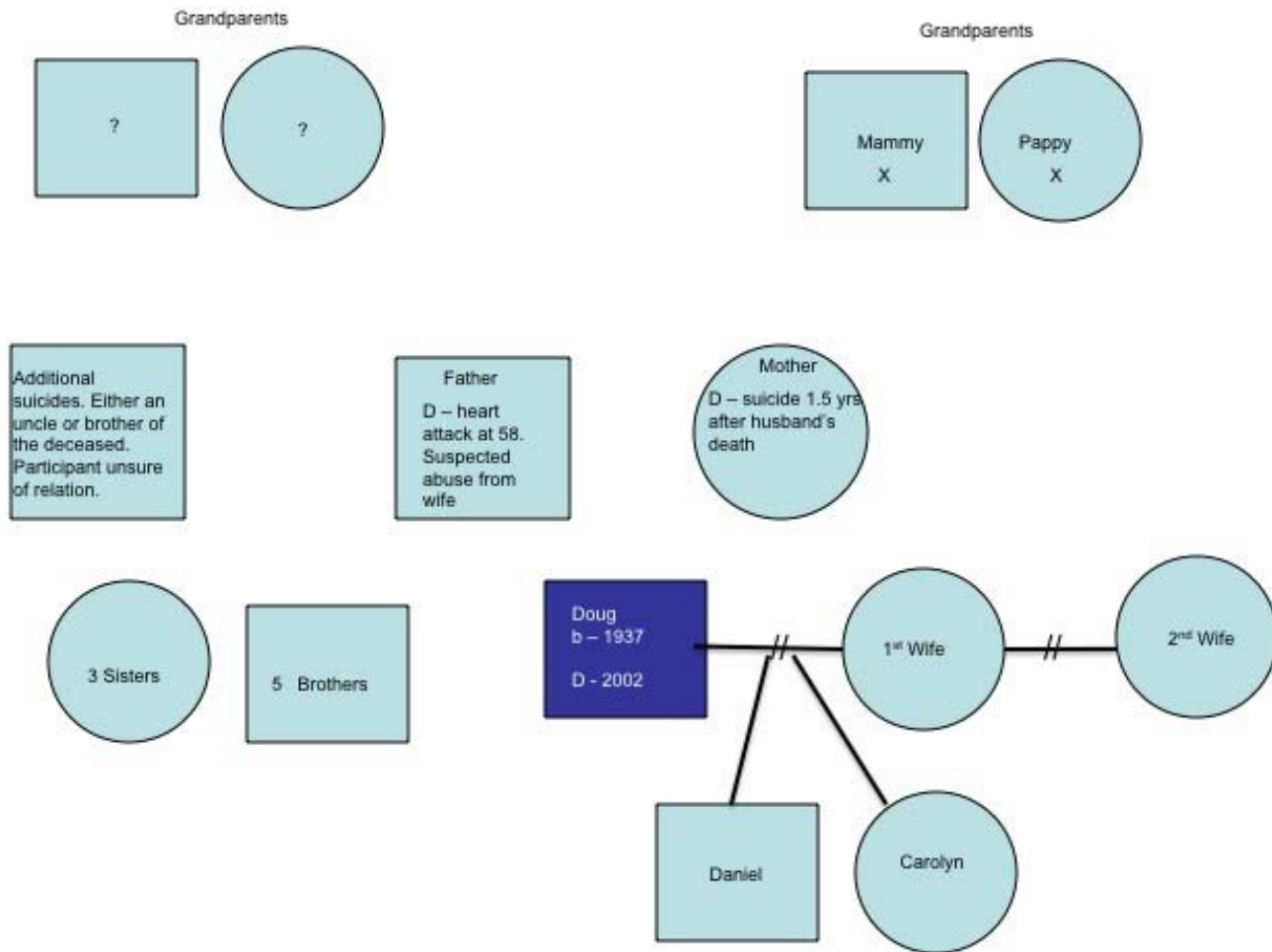
APPENDIX M
BILL TIMELINE



APPENDIX N
DOUG ECOMAP

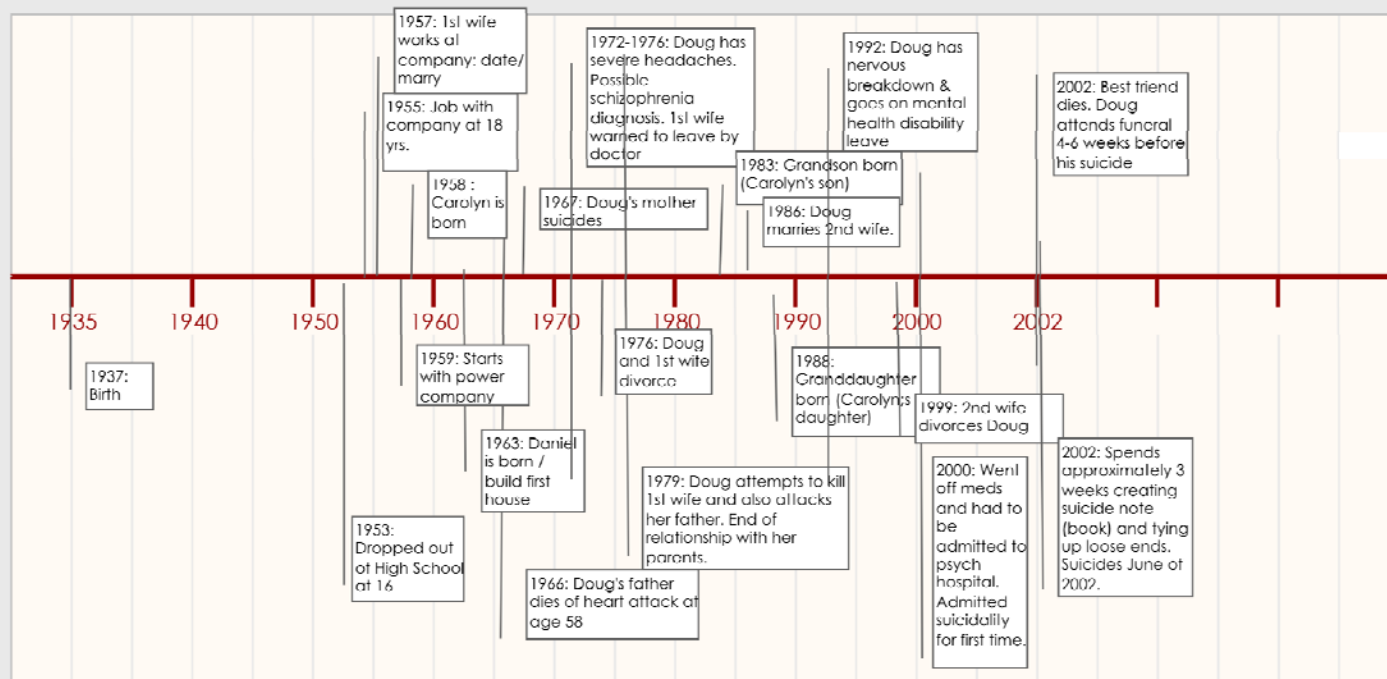


APPENDIX O
DOUG GENOGRAM



APPENDIX P
DOUG TIMELINE

Doug's Timeline



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BIOGRAPHICAL INFORMATION

Elizabeth A. Mitchell graduated Magna Cum Laude from East Texas Baptist University in 2004 with a Bachelor of Arts degree in psychology and counseling. While at ETBU, she completed an experimental research project, which entailed a quantitatively driven study about the relationship between perceived body image and the existence of, or risk for, an eating disorder.

In August, she began the graduate social work program at the University of Texas at Arlington and became involved in research during the following summer. From this internship evolved not only this work, but also inspired concepts for further articles and potential expansion of suicide research using phenomenological psychological autopsies.

She also completed an internship at Texas Scottish Rite Hospital for Children during 2009 where she developed an interest in medical social work, and specifically helping the families of children with disabilities. Elizabeth expects to graduate from the University of Texas at Arlington School of Social Work in December of 2009, at which time she will seek state licensure and an occupation in medical social work or community outreach.