CHAPTER 4
“BEING AN ADOLESCENT SUICIDE SURVIVOR”

This chapter describes the “being an adolescent suicide survivor” results of the situation analysis’ phenomenological research component. The chapter consists of three main parts. The first part provides each participant’s context story. A context story narrates the fundamental events and experiences that are essential to understand and contextualise the specific participant’s quotations in the second and third parts of the chapter. The latter parts are structured in such a way to reflect the emerging themes of the phenomenological analysis. The second part deals with the participants’ experiences in the days around the suicide events, ending with the funeral. The third part reports on the participants’ experiences in the weeks, months and years following the suicide of a loved one. Each of these two parts are divided into three experience clusters. One or more sections occur within each experience cluster. The sections elaborate on the essential themes of the phenomenon under study - the essential themes appear in **bold**. Each section contains a number of participants’ quotations from a diary, poem or the interviews that illustrate the particular essential themes. The literature control discussions have been integrated into each section’s structure where it appears as *italicised* paragraphs. The experience cluster and section headings articulate the lived experience that is being addressed in that cluster or section (Van Manen, 1997:168).

4.1 THE PARTICIPANTS’ CONTEXT STORIES

4.1.1 Ilze’s context story

Ilze\(^1\) is a 21-year old student. Her mom completed suicide just more than two years ago. She had suffered from a chronic gastrointestinal disorder that required numerous surgical interventions. Throughout this time she had to use a lot of medicines and ultimately became addicted to analgesics (Figure 4.1, P1\(^2\)).

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1 All names, locations and identifying data in each context story have been changed to protect participant anonymity.
2 The notation “P1” refers to Picture 1 on the participant’s collage.
Figure 4.1: Ilze’s self-created collage for phenomenological interview
During her Grade 11-year, Ilze discovered that her mom was involved in an extramarital affair with her dad’s best friend. This was the beginning of many problems and arguments in their family. The affair continued despite its exposure. As a result her dad increasingly became emotionally and physically withdrawn. Ilze chose to sympathise and support him (P2) while at the same time becoming more distant from her mom. She and her mom had frequent arguments regarding the ongoing affair (P3). At times their relationship was characterised by periods of closeness, trust and support (P4), only to be followed by an argument that lead to a renewed deterioration in their relationship (P3). During this time Ilze’s relationship with her boyfriend also went through many break-ups and re-unions.

After successfully completing Grade 12, Ilze enrolled for tertiary studies and became a residential student. One specific weekend her mom arranged a special family get together. Family relationships, especially the one between Ilze’s parents, seemed to be perfect that weekend. It was Ilze’s happiest weekend for a very long time. However, disaster was just around the corner. She and her mom had a “stupid” argument a few days later (P3). Her mom reacted by leaving without an indication of when she would be back or where she was going to; something she had done on numerous previous occasions. Ilze attempted to call her, only to be told “I’m not going to return home because I’m not in the mood for further arguments ... you don’t need me” (P5). These words haunt Ilze to this day. That evening she and her dad was very worried (P6 & P7). They couldn’t find her mom despite intensive search efforts. The next morning, while washing her car (P8), her cell phone rang (P9). It was her mom’s lover/employer: “Ilze, your mom is dead”. It transpired that her mom had stayed at work the previous afternoon and took an overdose of analgesics. She collapsed in the ladies room and was only discovered the following morning. Ilze’s immediate reaction was to interpret the reason for the suicide as their argument the previous day (P10). An intense all-consuming guilt followed (P11).

Ilze’s older sister was pregnant at the time of the suicide (P12). Even though their relationship was erratic up to that point, it quickly changed into a close and mutually supportive one. After the funeral (P13) Ilze returned to her student residence. Her roommate proved to be a true friend who cried with her, comforted her and allowed her
to verbally share painful emotions and experiences. However, over the next few months her whole life seemed to fall apart (P14). The relationship with her boyfriend gradually deteriorated until they eventually broke up. Study activities were replaced by social activities. She started to abuse alcohol (P15). At first she gained 8 kg in weight, then severely restricted her food intake to the point of engaging in self-induced vomiting (P16). Luckily, this only lasted for a week.

The birth of her sister’s baby boy completely changed Ilze’s general attitude towards life in general, and her studies in particular (P17). She decided to concentrate on her studies and to live her life with a renewed focus (P18). A significant alleviation of her guilt feelings occurred one night when she experienced a very realistic dream. In the dream she had a chance to talk to her mom, give her a hug and apologise for the argument. Her mom’s reaction was to indicate that she had forgiven her a long time ago.

Some time after the suicide, her dad met someone whom he eventually married (P19). To this day Ilze find it difficult to accept her as part of the family; she will just never be able to replace her mom (P20). Nobody, except her dad’s family, actually knows that her mom completed suicide. Everyone else, including close friends, have been told that she died of cancer. Although Ilze accepts that she has completed suicide, she doesn’t want anyone to know about it; it is something very personal. Many negative emotions and experiences are still part of her daily life (P11). “Time will probably heal everything, but in the meantime things are not perfect” (P21).

4.1.2 Shirley’s context story

Shirley is a 18-year old student. Her older brother, a 20-year old engineering student, completed suicide three years ago (Figure 4.2, P1). They were very close and did everything together (P2). He looked after her; she looked after him. He was her best friend.

He stayed in a backroom at their house. One day he was very sad. Later that afternoon
Figure 4.2: Shirley’s self-created collage for phenomenological interview
he decided to retreat to his room as he wanted to listen to some music. When their dad came home after work he wanted to talk to him. Her younger brother went to call him. He knocked on the door but didn’t get any answer. Then he saw that one window was slightly open. When he tried to open the window, he saw the rope hanging from the ceiling. Her dad broke the door down. The family went into the room where they saw him hanging (P3). Everybody was just hysterical. Shirley couldn’t act and was confused (P4). Her mom fainted. He left a suicide note that only stated ‘I’m sorry I had to do this, bye’. No further explanation. She couldn’t understand why he did something alone without telling her about it (P5). Everybody expected her to know what happened because they were so close.

It was supposed to be his 21st birthday later that year. Her parents were planning to surprise him with a car. Shirley blamed herself for not telling him about it. Also, she blamed herself for not checking on her brother after a telephone call from his girlfriend on the evening of the suicide. The girlfriend told her that something was wrong because he called earlier and said ‘Bye’.

According to traditional customs, the family members should view the body just prior to the funeral. Her whole family did so, but Shirley couldn’t. She hated him too much for his selfishness to put everyone through such extreme emotional pain (P6 & P7). The funeral was the worst day of her life. She was told by family members that she shouldn’t cry and that she must be strong. As a result she has never cried since that day. Instead, she has resorted to reserved emotional expressions.

Some time after the suicide events, Shirley’s mom took her to a psychiatrist. She was experiencing memory flashbacks and concentration difficulties. Shirley felt that this visit was pointless as the pain was in her heart not in her head. She refused to use any of the medication he prescribed. Instead, she started smoking cigarettes. Also, she stopped believing in God and ceased going to church. She felt that God had let her down.

Shirley became a very self-involved person that wanted to be left alone. She couldn’t talk
to her parents about any aspect of the events. Now she was the oldest child in the house that had to provide answers for her younger brother and sister. She had to take care of everyone, including her parents.

Today, she carries a heavy burden of others’ expectations. She feels that her family expects her to live up to her brother’s potential. She had to go to university. They seemingly expect from her to be a person who can listen to everyone and not have her own problems. As a result, she pretends to be a very happy person. Shirley plans to finish her current studies in computer science because that is what her dad wants her to do. Then, she wants to study music. When she was small her dad forced her brother and herself to stay up until late to listen to music on the radio. At first she hated it, but ended loving it.

4.1.3 Maria’s context story

Maria is a 19-year old student. Her cousin, a Grade 12 scholar, completed suicide 13 months ago. The cousin was the older of two children (Figure 4.3, P1). Maria and her cousin had a very close friendship (P2). They had spent most Christmas holidays together. The cousin was young, beautiful (P3) and very fashionable (P4). She had many dreams and goals (P5).

The cousin and her younger brother lived on a plot with their parents. It was some distance away from everything (P6). She attended a prestige high school in Pretoria. Her parents expected her to excel at school and to be a role model to her brother. They were very strict with regards to where she could go and where not. She was not allowed to go out with any friends or a boyfriend because they believed that friends will only have a negative influence. However, the result was that she experienced it as a form of social “captivity” (P7). Her father was self-employed and worked from their house. She couldn’t even phone somebody to talk to, as he would be listening to and monitoring every conversation. Her parents were reluctant to accept that she was growing into an independent teenager. As a result she was always lonely, to such an extent that the loneliness was “burning” her (P8). In other words, she was living a “killer lifestyle” (P9).
Figure 4.3: Maria’s self-created collage for phenomenological interview
She couldn’t cope with the situation of always being lonely, always being restricted and to have nobody to talk to. Maria believes that her cousin’s restricted lifestyle eventually forced her towards suicide. The suicide was her “last resort” to deal with all the pressures (P10); she just couldn’t cope with it.

The cousin was noticeably angry during the week before the suicide. Despite her family’s efforts to find out what was wrong, she merely reacted by retreating to her room. Then she requested to see a priest. Her whole mood seemed to have lifted after this visit. Everyone thought she was getting better. The next morning her mother tried to wake her by knocking on her room’s door. There was no answer. Instead, they discovered her body. She had shot herself with her father’s gun.

Maria’s initial reaction was to be angry at her cousin. She couldn’t understand how she could complete a suicide without telling her anything. At first she interpreted it as personal punishment for not keeping in contact and supporting her as a real friend would do (P11). During their last December holiday together, her cousin often mentioned that they should “... always keep in contact ...” In retrospect, Maria realises that she was actually trying to reach out to her and to tell her that she was lonely. At that stage she didn’t take it seriously.

The cousin left a suicide note. The content of this letter is still unknown to Maria. She is convinced that she will be able to finally come to terms with the reasons for the suicide if she’s allowed to read the note. However, her cousin’s parents refuse to share its content with anyone. Maria believes that there are some statements and opinions in it that they don’t want anyone else to know about. She found some spiritual comfort in an acceptance that only God knows why her cousin completed suicide (P12).

Maria wrote the following short poem (P13) to express her need to know the reason/s that lead to the suicide events:

*How?? I still wonder?!
Who knows why*
Seem powerless to tell -
Still we wait patiently,
One day it will all be revealed.
The love from above
Re-assured us.

Maria places most of the blame for the suicide on the parents. On the one hand, she blames them for the way in which they have socially restricted her cousin. On the other hand, she blames them for not having kept the gun in a safe where her cousin couldn’t get to it. If it was not available, she could have tried other means and maybe she could have failed to kill herself.

Maria is experiencing some positive progress in her healing process. A psychologist has shown her that there’s so much to live for. Even though something was taken away from her doesn’t mean it’s the end. Something good came out of the suicide events because it taught her to always be open with her parents and brothers. Also, her spiritual level did a lot to comfort her after she initially blamed God for allowing the suicide to happen.

4.1.4 Megan’s context story

Megan is a 22-year old student. Her friend, Peter, a 16-year old scholar, completed suicide five years ago. She was 11 months older than him. They knew each other for only 15 months before the suicide but became very good friends during that time. On the one hand, their friendship was based on an unconditional childlike acceptance of each other despite many physical and personality differences (Figure 4.4, P1 & P2). On the other hand, she accepted a motherly role; always monitoring his behaviour and caring for him (P2). In her own mind, she knew him better than anyone else.

One Saturday she visited Peter and his younger brother Daniel. Earlier that day, Daniel noticed that Peter was searching through all the different pills in the family’s medicine cabinet. He had also asked many questions regarding the effects of the different
Figure 4.4: Megan’s self-created collage for phenomenological interview
medicines. During the afternoon Megan noticed that Peter seemed to be experiencing a negative mood state. A few times during the day he approached her with a request: “Megan, we must talk because there is something I have to tell you”.

That evening his mom and stepfather went to a social function. At one stage Peter spoke to a friend on the telephone. After a while she and Daniel heard something fall in the neighbouring room. At first they thought that Peter was playing a joke on them. When they eventually went to the room, they found him laying on the floor. He was breathing heavily and a blood-like fluid was flowing from his mouth. Megan’s first reaction was to attempt phoning his mom, without success. Then, she decided to drive to the location of their social function. His stepfather’s first reaction was to dismiss the seriousness of the situation and to blame Peter for spoiling his evening; the relationship between Peter and his stepfather had been a troubled one for a long time. His mom’s reaction was to merely indicate to Megan where general analgesics could be found in the house. On returning to the house she was met by Daniel who anxiously indicated that Peter’s condition has worsened. His pulse was weak and his facial colour has turned bluish. At that stage she decided to call an ambulance. In that moment, Peter looked at her and told her “I love you” (P3). The intended meaning of these words haunt her to this day. She is still convinced that it was meant for his mom and not her. Next, she again drove to his parents’ social function. This time, his stepfather was furious about the unfolding of events. He raced back home. In the mean time, an ambulance took Peter to the hospital (P4) where he died just before his mom arrived. The suspected cause of his death was an overdose of the stepfather’s heart tablets.

Megan stayed out of school for a whole week. She spent most of the time with Peter’s mom and brother. On her return, her school friends questioned her long absence from school as they reasoned that Peter was not directly related to Megan. She experienced it in a very negative way and felt that they couldn’t appreciate the closeness of her friendship with Peter. However, her parents and teachers provided significant positive support during this time.
After a while Megan started to misuse alcohol in an attempt to fit in with a “cool” group of school friends (P5). The loss of Peter’s friendship left her feeling “naked” - stripped of emotions, thoughts and self-worth (P6). Nothing mattered to her at that stage. She was feeling very depressed and emotionally overwhelmed by all the social and academic pressures (P8). Eventually, she took an overdose of pills about a year after Peter’s suicide (P7).

The first small step towards her healing occurred when Peter’s mom talked to her about the effects of a loved one’s suicide on family members. This was followed by visits to a number of psychologists. Today, she regards these psychologists as the “little miracle” that changed her life around and facilitated her road to recovery (P9). They helped her to rediscover her personal value, to deal with her guilt regarding his last words (P3), to deal with her negative emotions (P10), and to discover the positive aspects in the suicide events.

For two years following the suicide events, Megan remained unsure (“blurry”) about the actual facts and circumstances regarding Peter’s death (P11). She only received confirmation of suicide-as-reason-for-his-death during her first year at university. A fellow student told her that Peter’s mom, her school teacher at the time of his death, told them that he had definitely completed suicide. Megan was very angry and disappointed that his mom didn’t convey these facts directly to her. After all, she was his best friend. Megan and Peter’s mom haven’t spoken about the whole “truth” regarding the suicide events to this day (P12).

### 4.1.5 Annie’s context story

Annie is an 18-year old, Grade 12 learner. She has experienced two completed suicides and one suicide attempt of significant persons in her life. A prominent school boy and a close girlfriend completed suicide, while a cousin attempted suicide in her presence.

The first significant suicide event occurred when she was in Grade 8. A prominent Grade
12 boy, William, shot himself one morning on the school’s rugby field during the exam time (Figure 4.5, P1). Annie was a member of the first aid team who was called to the suicide scene. When they arrived he was still breathing and his heart was still beating. However, the extent of his brain injuries suggested a condition of brain death. Shortly thereafter, the ambulance and police arrived. They initially attempted to revive him (P2), but soon afterwards he was declared dead and covered with a sheet. She was shocked and disappointed by the paramedics’ unemotional behaviour. It was as if they were merely doing a job. Later that morning the headmaster called all the school’s learners to a central square where he announced William’s unfortunate death. The whole school reacted with intense emotions that were especially noticeable in their eyes (P3). The Grade 8 learners were very shocked that a Grade 12 learner in their high social status school could complete a suicide; they had always looked up to the Grade 12 learners. The Grade 12 learners themselves experienced a significant loss from their close knit group. The event elicited a lot of questions (P4) and stories regarding the reasons and circumstances of the suicide. It seemed to Annie as if the school was falling to pieces. The usual “safe” school atmosphere has changed into a “dangerous” one characterised by drugs, suicide and group pressure.

Annie’s work as a police reservist and first aid helper for private and municipal ambulance services brought her in contact with many suicide events. Many of those involved drugs (P5) and hangings (P6). She encountered a number of paramedics who responded to the suicide cases as “... another one bites the dust”.

The second significant suicide event occurred when one of her girl friends (P7), Lindi, completed suicide by shooting herself (P8 & P9). Lindi’s favourite passage from the Bible was Psalm 121 (P10) that today still serves as a reminder of their friendship. It gives Annie hope and courage to continue with life during difficult times, even though it was not enough to keep Lindi from completing suicide. Annie attended the funeral despite her mom’s “advice” not do so. She placed a letter in Lindi’s grave to reconfirm their friendship (P12). This suicide left Annie and others with many questions (P11) and broken hearts (P8). Lindi made a veiled reference to her intended suicide only two nights
Figure 4.5: Annie’s self-created collage for phenomenological interview
before the actual event by stating that “You will never again see me crying”. At that stage nobody paid serious attention to it.

Eighteen months ago Annie walked into her cousin’s room while she, Tracey, was at the point to attempt suicide with an overdose of pills (P13). They, together with Tracey’s mom, started talking about the reasons for this attempt. After a few hours they went to a hospital where Tracey was treated. Later, she was admitted to a clinic for depression treatment. It resulted in positive changes in Tracey’s self-regard and interpersonal relationships.

All these events elicited in Annie an intense realisation of the emotional pain that people experience before a suicide attempt (P14). There is so many “Why?” questions: Why do people do it; why didn’t anybody help; why weren’t I there to help (P4)? At one stage Annie went through a period where she herself considered suicide as a solution to escape from the grip of drugs (P5). Her dominant emotion at that time was one of complete hopelessness (P15). She was disappointed and angry at God for allowing people to experience so much suffering. God promises in the Bible to support those who struggle and suffer (P16), but it seemed to her as if He was abandoning them. As a result she temporarily questioned and rejected all her Christian beliefs (P4, P17 & P18).

Today, Annie is positive about the future. She realises that one can look back at all the sadness of friends’ suicides, but you can also learn from it and look forward (P19 & P20). She plans to further her training as a paramedic who can better serve those in need.

4.2 PERI-SUICIDE EXPERIENCES

This part describes the different personal experiences, as well as the different social and emotional aspects that played an important role during the time directly prior and around the day of the suicide events. Three experience clusters have been identified: 1) Awareness of victim’s suicide-associated behaviour directly prior to the suicide, 2) Immediate reactions on becoming aware of the suicide, and 3) Reactions in the days
directly following the suicide.

4.2.1 Experience cluster 1: Awareness of victim’s suicide-associated behaviour directly prior to the suicide

Changes in the suicide victim’s behaviour and mood state are often clues that one might recognise as signs of suicidal thought and an imminent suicide attempt. These changes often appear and progress slowly. As a result we often do not recognise them as significant and as real danger signals, except in hindsight (Rosenfeld & Prupas, 1984:25).

The participants’ awareness of the victims’ suicide-associated behaviour directly prior to the suicide were described in terms of two aspects, namely the victim’s behaviour and the victim’s mood state.

The victims’ behaviour included the following: A retreat from family or social interactions into an isolated personal space; an urgency to talk about serious life issues; seeking information regarding suicide agents, for example medicines; and marked behavioural changes that were noticed by others as worrisome. The awareness of the victim’s suicide-associated behaviour is illustrated by the following quotations from Megan’s interview: “... the whole day he told me ‘Megan, we must talk ... there is something I want to tell you’”; “... the previous evening his brother saw him standing in front of the medicine cabinet ... asking ‘What is this and what is that?’”; and “... a friend phoned his brother and told him ‘Keep an eye on your brother ... just watch him’”.

The victim’s mood state included the following: A non-specific negative mood state in some cases; and a sudden, marked change of an intensely negative mood state to a happy one in another case. The awareness of the victim’s suicide-associated mood state is illustrated by the following quotations:

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3 Ilze, Megan and Annie’s interviews were conducted in Afrikaans. Their quotations have been translated from Afrikaans into English by the researcher. It is as close as possible in word use, meaning and intonation as the experiences conveyed during the interviews.
Shirley: “But he was very sad that day ... I don’t know what happened”.
Megan: “I could see that he was very down ... something was not right”.
Maria: “... the week before she killed herself she was quiet, and she was angry ... then the day before she killed herself she was so happy ... the week before, when she was angry and all that, she asked to see a priest.”

A sudden change in mood state, for example when someone who has been very depressed appears to be in a more positive frame of mind, is a common warning sign of suicidal intent. Many survivors, unaware of the seriousness of such warning signs at that time, only understand its significance after the suicide event; insight that survivors achieve with hindsight. Bereaved survivors frequently return in their minds to the events leading up to the actual suicide in an attempt to understand, undo or alter the events that had occurred (Wertheimer, 1991:79, 65).

4.2.2 Experience cluster 2: Immediate reactions on becoming aware of the suicide

This experience cluster describes the peri-suicide experiences that the participants lived through during those first few minutes and hours after becoming aware of a significant person’s suicide death.

i) Emotional and cognitive reactions

The initial emotional and cognitive reactions on becoming aware of a significant other’s death are shock, emotional numbness and disbelief (Helen, 2002:11; Raphael, 1984:151; Seeber, 2002:33).

The Chinese symbol for ‘crisis’ is the combination of the symbols for both ‘danger’ and ‘opportunity’ (Jones, 1987:141)
The emotional and cognitive aspects of the immediate reactions are difficult, if not impossible, to separate from each other due to its complex interconnectedness. For this reason they are described within the same section. The initial emotional and cognitive reactions experienced by the research participants include the following: Denial, shock, horror, disbelief, surprise, confusion, guilt, loneliness, identification with the victim’s intense negative experiences during the suicide events, and an awareness of the event’s irreversibility and finality. These negative reactions are often experienced as irrepressible and overwhelming. For Ilze it felt “... as if it is destroying and crushing me from the inside”.

The immediate denial is illustrated by the following quotations:

Ilze: “... I scream, NO, NO, NO, NO, NOOOO!” and “O no, God, it is not true”. A visual representation of denial appears on her collage (Figure 4.1, P22).

Maria: “It was ‘O my ... no, no’.”

Denial is a common initial reaction and intermittently thereafter. Where the survivor has been in contact with the victim shortly before the suicide events, and everything had seemed to be normal, news of the death can seem totally unbelievable (Kinsella, Greeff & Poggenpoel, 1993:46; Rando, 1993:157; Wertheimer, 1991:40).

Denial serves an adaptive function. It delays the impact of the loss and may allow the survivor to bear what would otherwise be overwhelming. The survivor keeps an emotional distance from others to avoid feeling the pain of the loss. It functions like a buffer that allows the person to gradually absorb the reality of the loss. In a sense, it serves as emotional anaesthesia while the survivor begins to experience the painful awareness of the loss (Helen, 2002:13; Rando, 1993:33; Raphael, 1984:403; Rosenfeld & Prupas, 1984:85; Seeber, 2002:36; Wrobleski, 1984-85:180).

Shock and horror is visually represented and illustrated on Ilze’s collage (Figure 4.1, P10).
Shock and horror are common initial reactions of suicide bereavement. Shock acts as a protective blanket for one’s overwhelming emotions and thoughts. For the first few days after the suicide the survivor may feel too numb and exhausted to really take in the awfulness of what had happened (Dunn & Morrish-Vidners, 1987-88:181; Helen, 2002:11; Kinsella, Greeff & Poggenpoel, 1993:45; Seeber, 2002:33; Van Dongen, 1991:376; Wertheimer, 1991:xv).

An initial and immediate sense of disbelief and surprise are often experienced by survivors due to the unexpected nature of the suicide act. Maria described it as follows: “How can she do this? I mean, I felt we were very close...”; and “... she surprised us a lot, because I always saw her as this person who was tough, who could handle anything ... and then for her to do this ...

Reactions of disbelief are commonly seen in the first few weeks and months following a suicidal death. These reactions are likely to be more prominent and to last longer following a suicide than is usually the case with other types of deaths. It suggests a deep, mostly unconscious realisation of the question “If a seemingly emotionally strong person can complete suicide, what can prevent an average person, like myself, to not complete suicide as well?” (Calhoun, Selby & Selby, 1982:411; Dunn & Morrish-Vidners, 1987-88:181; Kinsella, Greeff & Poggenpoel, 1993:45; Reed & Greenwald, 1991:388; Wertheimer, 1991:18). [See section 4.2.3 (ii) for a “Sense of derealisation” in the days directly following the suicide].

Cognitive confusion is closely related to disbelief when an unexpected death occurs. The survivors immediately pose numerous questions in an attempt to alleviate their confusion, such as “Why?” and “How?”. The theme of confusion is illustrated by the following quotations:

Shirley: “I didn’t know how to act because I was just confused ... and I couldn’t believe it ... and I didn’t understand why it had to happen”.

Maria: “... she came back from the priest, she was happy ... only to do the opposite the next day”; and “... I was asking myself a lot of questions, ‘How can this happen,
An unexpected death challenges an individual’s assumptive world. Cognitive confusion and cognitive dissonance results when there is no available pattern of thinking or behaviour to draw upon during such an event. The suicide is experienced as in direct conflict with former beliefs about the victim and the world in general. It is very difficult to understand, absorb or grasp the implications of what has occurred (Rando, 1993:555; Thompson, 2003; Van Dongen, 1991:376).

**Guilt** feelings are often an immediate reaction to a loved one’s suicidal death. In such a case the survivor may feel directly responsible for the suicide, as illustrated by the following quotations from Ilze’s diary and interview: “Sorry Dad, it is my fault ... we had a fight”; “... it is my fault ... my mom died on the bathroom’s floor, and it’s all my fault ...”; and “I took it very badly because it basically felt to me as if it was my fault ...”. [See section 4.3.1 (i) for the theoretical discussion of “Guilt”].

In cases where the victim was a valued companion and friend, the survivor may experience an immediate sense of loneliness. Maria verbalised the immediate realisation of being left behind to continue her life without a significant relationship as follows: “Now, I’m going to like ... to be alone”.

One probable reaction to a friend or sibling’s death during adolescence within the context of a coherent social system it that it leaves the teenager with an intense sense of loneliness. Important sources of comfort, strength, support and friendship are suddenly absent and unavailable (Balk, 1983:155; Demi & Howell, 1991:352).

An identification with the victim’s intense negative experiences during the suicide events is illustrated by Annie’s initial reaction: “I wish that someone could have been there ... he sat alone next to the field ... it was as if life literally continued without him, nobody missed him ...”.
Survivors sometimes wonder what the victim went through during the last few hours and minutes before the actual suicide act. An identification with and realisation of the victim’s loneliness during the events can be a cause of considerable anguish to survivors (Wertheimer, 1991:44-45).

Some of the participants experienced an immediate awareness of the suicide events’ irreversibility and finality. [See section 4.3.2 (iv) for the “Realisation of finality” during post-suicide experiences]. This theme was described as follows during the interviews:

Maria: “She’s gone and there is nothing you can do about it”.

Annie: “… the ambulance that arrives, the police that covers him with a sheet … that is when you experience the reality that this person has ended his own life”.

ii) Behavioural and somatic reactions

The initial behavioural and somatic reactions experienced by the research participants on becoming aware of the suicide include the following: Attempts to mobilise the help of others, inability to act, and an awareness of autonomic somatic reactions.

Attempts to mobilise the help of others are illustrated by the following quotations from Megan’s interview: “… we panicked … then I wanted to phone his parents who was at a function … but I couldn’t reach them … then I drove to the function …”; “… then I ran to call the nextdoor neighbours …”; and “… then his stepfather got so angry that he got into his car and drove back home [to the suicide scene]”.

In contrast to Megan’s attempts to actively mobilise the help of others, Shirley experienced an inability to act on the suicide scene. She recalled it as follows: “Everybody was just hysterical … I couldn’t act, I didn’t know how to act because I was just confused”.

It is thought that the numbness which results from emotional shock can leave people incapable of engaging in any behavioural reaction. Such individuals experience it as
being “frozen” (Wertheimer, 1991:40).

Some of the research participants reported being aware of autonomic somatic reactions when told about the suicide events. These reactions included an increased heart rate, laboured breathing and muscle tremors. The following quotations from Ilze’s diary and Annie’s interview describe the awareness of the different reactions:

Ilze: “My heart beats in my throat, I can’t get any air in, my body trembles, I shiver…”
Annie: “William’s suicide … my body trembled …”

iii) Religious rituals and experiences

Ilze and Annie’s initial religious actions and experiences on becoming aware of the suicide revolved around prayer for themselves and/or other significant survivors. The following verbal descriptions illustrate their actions and experiences:

Ilze: “... I was hysterical and prayed a lot for calmness, for how sorry I was ... in a flash moment I experienced a calmness that I can not explain”.
Annie: “... I began to pray for his sister ...” and “... his family that doesn’t yet know ... you must pray for the family”.

[See section 4.3.3 (iv) for the “Role of religion” during the healing process; and section 4.3.3 (x) for “Intrapersonal growth” in personal religious beliefs].

iv) Interpersonal reactions/experiences

The research participants’ experiences regarding the reactions of other individuals on becoming aware of the suicide were quite varied. It included being surprised in other individuals’ reactions, being accused by other significant persons, and being disappointed in others’ behaviour.

The experience of being surprised in other individuals’ reactions was expressed as follows:

Shirley: “... I called the relatives ... they didn’t want to believe me ... they think I’m
joking ... they didn’t want to believe me”.

Annie: “... one teacher just began to cry ... I always thought he was a strong person ... it was the first time that I saw how someone, a person that I had looked up to, start to cry”.

*Survivors sometimes tend to have empathy for others’ grief reactions within the crisis situation. Research indicates that survivors, upon hearing the news of a loved one’s suicide, often retain clear memories of the circumstances, including the reactions of other significant persons (Kinsella, Greeff & Poggenpoel, 1993:45; Wertheimer, 1991:37).*

Survivors sometimes experience that they are immediately being accused by other significant persons for apparently not caring and not being involved enough in the victim’s life. Such an accusation may be an attempt of the particular individuals to project their own guilt feelings onto one or more of the other survivors. Ilze described such an accusation as follows in her diary: “Her employer don’t want me to see her body. He asks me why I haven’t searched for her?! I did.”

Survivors may experience some disappointment in others’ behaviour and responses on becoming aware of the suicide. In Annie’s case, she was disappointed in the school’s expectation that daily activities should continue as if nothing happened after breaking the news of the suicide. Also, she was disappointed in the emergency personnel’s emotionally detached behaviour. On the one hand, her disappointment in the school authority is illustrated by the following quotation: “… they expected everyone to return to their classes ... I mean, they actually should have cancelled all classes for the rest of the day”. On the other hand, her disappointment in the emergency personnel was based in their perceived non-respectful, light-hearted and trite actions. She described as follows: “... the ambulance guys acted as if they were used to it, as if they were completely emotionally dead ... the police ... I didn’t notice any emotions with them ... it was as if they were only doing their job ... that hurt me a lot”; “… one ambulance guy said ‘Another one bites the dust’, as if it was nothing”; and “... the ambulance guys ... they reacted as if it was merely a job ... they could have shown a bit more respect ...”. [See section 4.2.3]
(iv) for the “Disappointment in others’ behaviour” as an aspect of “Interpersonal reactions/experiences” in the days directly following the suicide.

Police officers and other emergency personnel who work in urban settings are quite accustomed to human tragedy. The result is that the survivors who are present at a suicide scene rarely, if ever, receive any kind of emotional or social support from them. Usually police officers are focusing on filling out the necessary documentation and do not take into account the need to be supportive. This may initiate or enhance the guilt felt by the survivors as they are left feeling alone and unable to make decisions. A brief and simple explanation to the survivors of the necessity to perform certain procedures (for example questioning the survivors and collecting evidence) can significantly reduce its negative impact. Furthermore, the negative impact can be alleviated if police officers and emergency personnel refrain from taking a moral, judgemental view of the facts of the death (Danto, 1987:164-166; Helen, 2002:11, 47).

4.2.3 Experience cluster 3: Reactions in the days directly following the suicide

This experience cluster describes the peri-suicide experiences that followed on the immediate reactions on becoming aware of the suicide. It ends with the completion of the funeral rituals.

Suicide is a major life crisis. The experiences of survivors in the period immediately following the death can be crucial in the long-term progression of the bereavement process. This life crisis brings survivors face-to-face with a state of personal disorganisation which requires them to cope with, adapt to and integrate the loss of a loved one (Wertheimer, 1991:200-201).

i) Emotional reactions

The emotional reactions experienced by the research participants in the days directly following the suicide events include the following: Intense hate and anger towards the
suicide victim; a refusal to partake in cultural rituals due to intensely negative emotions; and an inability to express emotions.

Shirley experienced an **intense hate and anger towards the suicide victim** for his perceived selfish intentional decision that has caused her and other significant persons extreme emotional hurt. She described her emotions as follows: “... I hated him because it put my mother through so much hell ... my mother was very hurt by that ... and now he decides to do this ... I was thinking ‘He is very selfish’ ... so I hated him”.

*Anger is a common initial reaction in the early phases of suicide bereavement. In some cases it may even foster the development of complicated grief, especially if the death is perceived as a preventable event (Dunn & Morrish-Vidners, 1987-88:181; Opperman & Novello, 2003:2). [See section 4.3.1 (iv) for being “Angry at victim” during “Falling apart” post-suicide experiences; and section 4.3.2 (v) for “Chronic hate and anger towards the suicide victim” as an aspect of “Emotional stuckness” during “Being shattered” post-suicide experiences].*

**Intense negative emotions** towards the suicide victim may be **expressed in behavioural actions that involve cultural rituals**. An example of such an action was Shirley’s refusal to partake in the customary viewing-of-the-body cultural ritual. She described it as follows in her interview: “... we have this tradition that when somebody passes away, you have to look at them ... the whole family had to see the body on Friday ... I couldn’t do that”.

*It is important to incorporate the reality of the dead body into the death experience of the bereaved. The viewing-of-the-body custom promotes a realisation of the loss. On an unconscious level survivors know that they must see in order to believe and accept death’s finality. There is a painful peace in the face of death. Seeing the body provides the opportunity to look and say farewell to the dead person. The body’s appearance and visible physical changes will bring a reality of the deceased’s altered state. It provides an opportunity to see and become familiar with the realities of death (Conley, 1987:174-
A failure or refusal to adhere to cultural rituals and customs in the event of death heightens the risk of the loss of family and social support. However, if survivors have lost trust and faith in the ability of cultural practices to meet their expectations for social support and/or needs for understanding of the death, it may eventually increase the risk for complicated grief (Opperman & Novello, 2003:16). [See section 4.2.3 (v) for a discussion of the “ritual” concept].

Survivors sometimes experience an inability to express emotions, for example crying. This experience is illustrated by the following quotation from Shirley’s interview: “... I’m not a very open person when it comes to emotions, so I couldn’t cry”.

Adolescents sometimes hide their feelings of grief due to a perception that an expression of emotions is somehow not acceptable in public. As a long-term result, adolescents are then often confused about the source of their recurring grief reactions. Individuals who find it difficult to cry may experience that their grief is locked inside. The absence of emotional expression is not an indication of the absence of mourning per se, but merely of visible signs of it - a form of inhibited mourning. This pattern of inhibited emotional expression may be in response to environmental, sociocultural, ethnic, religious or philosophical factors and demands. Cultural taboos on suicide are also likely to inhibit expressions of grief. In some cases the survivors’ reluctance or refusal to express emotions may be as a result of psychological conflicts around the requirements of mourning the particular victim’s death (Henley, 1984:59; Rando, 1993:157; Raphael, 1984:46; Seeber, 2002:97; Thompson, 2003). [See section 4.3.2 (v) for “Reluctance, avoidance or fear to outwardly express and verbalise deep-felt emotions” as an aspect of “Emotional stuckness” during post-suicide experiences].
ii) Sense of derealisation

A sense of derealisation was experienced by some of the research participants in the days directly following the suicide events. If one keep in mind that Annie was directly exposed to the victim’s body on the suicide scene, it is significant that she still described her experience the following day as follows: “... it was only on the second day that I started to think ‘I can not believe that it happened, I can not believe it happened’”. A number of contextual factors could have contributed to this sense of derealisation. One important factor may be the unexpected nature of the suicide, while another factor may be the absence of a chance to meaningfully end the relationship with the victim. Both these factors are illustrated in the following quotation from Annie’s interview: “... it happens so fast that you can not believe it happened ... you don’t even have time to say some last words ... you actually wanted to say something”. [See section 4.2.2 (i) for “Disbelief” as an aspect of immediate “Emotional and cognitive reactions” on becoming aware of the suicide; and section 4.3.1 (viii) for a “Sense of derealisation” as an aspect of “Negative affect” during “Falling apart” post-suicide experiences].

In the first few days after the death of a loved one there are often feelings of unreality. Survivors experience the unreality of the suicide as though what has been said or what has happened as not possible to be true, as though it must be happening to someone else. The horror of the events and its implications seem to be something at a distance and frozen in time; as if the mind erects boundaries and defences against a potentially overwhelming and threatening reality. Often the fact of the death itself is not denied, but the truth that the loved one is irreversibly gone seems unreal. The absolute irrevocable nature of the death seems to be one of the most difficult realities to acknowledge. The result is feelings of having been overpowered and helplessness. This sense of unreality is most pronounced when the death itself was totally unexpected and the world is experienced as being totally out of control and incomprehensible. Survivors’ adaptive capacities are completely overwhelmed (Carter, 1989:355; Rando, 1993:554; Raphael, 1984:34; Van der Wal, 1989-90:156).
When someone completes suicide the chance to deal with any unfinished business is denied to the survivors, including the chance for a proper farewell. The absence of forewarning compromises the ability to make sense of the death because the loss seems so disconnected and isolated from anything that preceded it. The inability to prepare for the loss and to make a gradual psychological transition appears to be a major disabling factor. The survivors’ lifeworlds, world views and assumptions are intensely violated. Having any unfinished business with the victim only increases its psychological and existential impact. The implication is that the healing process can be facilitated if survivors can find effective ways to deal and bring closure to these unfinished issues (for example to write a goodbye letter) (Rando, 1993:175; Wertheimer, 1991:19).

iii) Behavioural reactions

The behavioural reactions of the research participants in the days directly following the suicide were the following: Seeking a form of physical closeness to the victim; and avoidance of the suicide scene.

Ilze described in her diary a behavioural attempt to seek physical closeness to the suicide victim on the first evening after the suicide events, namely “That night I slept in her bed ...”.

*Behavioural attempts to symbolically hold onto the victim can be interpreted as an attempt to buy more time in the loss process (Kelly, 1997).*

An explicit avoidance of the suicide scene was clearly described by Megan as follows: “... the first night I stayed awake ... and I was too scared to go into the part of the corridor where he laid ... I was scared ... a long time afterwards I was still scared to be there ...”. [See section 4.3.1 (viii) for “Marked fears” as an aspect of “Negative affect” during post-suicide experiences].
Avoidance reactions amongst suicide survivors often involve staying away from places and objects which can remind them of the death. Especially when the victim completed suicide at home, the survivors experience a heightened sensitivity to the room or spot where the person died for varying lengths of time (Van der Wal, 1989-90:156; Wrobleski, 1984-85:177).

iv) Interpersonal reactions/experiences

The research participants reported the following interpersonal reactions and experiences during the days directly following the suicide events: Emotional and instrumental support received from others; awareness of others’ reactions; support-of-others; socio-emotional isolation; and disappointment in others’ behaviour.

Two types of support were received from others, namely emotional support and practical support. Emotional support was experienced in the form of being comforted by others, as well as others crying with the survivor. Ilze described it as follows in her diary: “I called my best girlfriend, we cry together. My boyfriend ... holds and comforts me, cry with me. My pregnant sister comforts me.” Instrumental support was experienced in the form of calming behaviour (for example being given calming agents) and being assisted with practical needs. The following quotation from Annie’s interview illustrates it as follows: “I wanted to attend the funeral ... and asked one teacher to ride with her ... I appreciated that there was at least someone, because I don’t know if I would be able to go without transport”. [See section 4.3.3 (ix) for “Effective social support” during post-suicide healing experiences].

The participants did not only experience that others supported them. Despite their own intense emotional experiences in the days directly following the suicide, they were also aware of others’ reactions. In these instances they acted as supporters for other victims of the same suicide. The following quotations from Annie’s interview illustrate her awareness of others’ reactions during the days directly following the suicide:

- Emotional reactions, such as shock, sadness and disbelief: “The whole trauma that
the school experienced for the next three days was something that I will never forget” and “... the sadness that I saw in other persons’ eyes ... the shock ... I saw so many shocked eyes, especially after the suicide at the school”.

- **Aimless behavioural actions:** “... we just walked through the [school] corridors ...”.

- **Cognitive difficulties:** “... nobody could pay attention in class ... many learners were stunned into silence ...”.

- **Spontaneous mutual support:** “Many learners didn’t really know William, but they supported the others”.

- **Asking many questions:** “... questions were asked ... how can somebody in this school commit suicide?”.

The research participants’ **support-of-others** actions are evident from the following two quotations from Annie’s interview: “... later I went to the square where all the other learners were told about [William’s] suicide, and then I could support some of them ... it was a good experience to support them” and “... at [Lindi’s] funeral ... I was there for her mom and dad ... I felt that I must be the strong one”.

After being directly exposed to the suicide scene, survivors sometimes experience a sense of **socio-emotional isolation** from other survivors who haven’t been directly exposed to the same scene. Annie described her experience as follows: “... another thing that I didn’t like, that made the emotional pain worse, it was still fresh in my memory ... many scholars were not directly on the field to see how it happened”.

Survivors sometimes experience explicit **disappointment in others’ behaviour** in the days directly following the suicide. For Annie it was “... so unnecessary that stories about such a tragic event were spread ... that did hurt others” and “... what made it worse ... was that others made jokes about the suicide ... I wanted to say ‘You don’t even know what happened, or you have no respect for that person’ ... it was too much”. [See section 4.2.2 (iv) for the immediate “Disappointment in others’ behaviour” as an aspect of “Interpersonal reactions/experiences” on becoming aware of the suicide].
Jokes, stories and rumours are frequent narrative forms in which a distortion of facts occur. They often spread like wildfires, especially after events such as a suicide. Because individuals, including suicide victims, lead private lives, not everyone knows all the dimensions of such a person. The purpose of jokes and stories is to fill in missing or unknown aspects in order to make sense of confusing thoughts and emotions. Jokes may be indicative of sub-optimal attempts to integrate the suicide events, emotions and experiences into the individual’s current lifeworld. Furthermore, the rash of jokes that appears after a major life event, such as a suicide, tends to focus societal attention on death, yet fails to actually talk about death as such - a narrative silence. Narrative silences occur throughout our society partially due to the culturally taboo nature of talking about suicide deaths (Book, 1996:340; Lamb & Dunne-Maxim, 1987:259).

v) Role of a cultural ritual: The funeral

A “ritual” is a specific behaviour or activity of an individual or group that allows the symbolic expression of certain emotions and thoughts. It is a way of defining what things mean. That is useful because when emotions, thoughts and meaning are made clear, we are more comfortable with our lived experiences. Various rituals facilitate the mourning process after the death of a loved one as it helps individuals to confront painful stimuli associated with the loss. In other words, it provides a framework for dealing with those stimuli. Rituals can also provide powerful therapeutic experiences that facilitate transition, healing and continuity. Specific rituals that follow on the death of a loved one provide a structured way to affirm the death, remember the loved one, assist in saying goodbye to the deceased person, finish unfinished business, and learn to relate to the deceased in a new way. It enables survivors to explore, clarify, express, integrate and make statements about their diverse feelings and thoughts regarding the victims. Finally, rituals can symbolise the transition back into the new world and new relationships (Lukas & Seiden, 1987:143; Rando, 1993:313-316; Seeber, 2002:99).

The research participants have had a number of specific experiences regarding the funeral ritual. The first was that it brought a realisation of the finality of the suicide victim’s
death. Shirley described this as follows: “And then the funeral came ... OK, that was where I fainted because I saw ‘This is it, he is gone’”.

Participation in a funeral ritual helps survivors to realise that the deceased truly is gone. It provides the experience necessary to validate the loss long after the funeral (Helen, 2002:53-54; Rando, 1993:317).

A second specific experience was that the funeral provided a practical opportunity to express regard for the victim’s personhood and friendship. For Annie it was “... my way of paying respect to [Lindi], because she still was my friend, and that I didn’t blame her for what she has done ... I could pay my last respect ...”.

The third specific experience was that the funeral provided an opportunity to deal with guilt feelings. Annie described it as follows: “... I wanted to go to the funeral ... because [Lindi] did experience emotional pain ... and I was not there for her ... I would have felt guilty for the rest of my life had I not gone ... I feel better that I went”. [See section 4.3.1 (i) for a theoretical discussion of “Guilt”].

Fourthly, the survivors had some intensely negative experiences regarding the funeral ritual. Shirley’s recollection of the funeral was as follows: “The funeral came ... OK, that was the worst day of my life”. On the other hand, Annie perceived a significant other’s “protective” attempt to prevent her from attending the funeral as a negative experience. She saw it as a disregard of her personal wishes and needs. In her own words: “My mom wanted to prevent me from going to the funeral, but I wanted to go ... I really wanted to go, but my mom didn’t”.

The funeral ceremony symbolises a rite of separation. It is personal in its focus and social in its consequences. On the personal side, the funeral can serve a positive healing or greeting function for adolescent survivors if they are allowed by authority figures to engage in personalised and positive symbolic actions. On the social side, the funeral rituals and ceremonies make public the death. Death’s reality can no longer be denied.
The funeral may be the first situation that many survivors come face to face with the reality of the death; they see the coffin and hear public words of farewell. Symbolically, the funeral serves important functions: It separates the dead person from the living; it affirms the life lived by the deceased; and it allows the survivors to say goodbye to that person. Furthermore, the deceased’s social network has the opportunity to pay a last respect to the victim and to express some form of social support for the bereaved (Conley, 1987:180; Helen, 2002:53-55; Raphael, 1984:37-38; Seeber, 2002:99-100; Wertheimer, 1991:22).

The funeral ceremony brings one into direct contact with the edge of an earthly, personal existence. Death is on one side of this existence, while life is on the other. One consequence of this existential realisation is a sense of one life being connected to the lives of others. In the gathering of friends and family at a funeral to remember and honour the person who died, the essential connectedness of their lives is revealed and affirmed. The mere presence of others connected to the loss provides a sense of comfort. However, while the funeral marks the end of life for the deceased person, which may have been a troubled life or one filled with suffering, it also announces the beginning of a different challenge for the survivors. Despite the sadness that goes hand in hand with a funeral, many survivors experience it as a very positive ritual with good memories. A funeral which is made beautiful - whether by flowers, music or the support of friends and family - can help to counteract the survivors’ troubled memories of the suicide act (Clark, 2002; Conley, 1987:180; Wertheimer, 1991:96-97).

4.3 POST-SUICIDE EXPERIENCES

This part describes the different personal experiences, as well as the different social and emotional aspects that played an important role in the weeks, months and years after the funeral. In order to organise the various experience clusters and sections, I would like to make use of the following story that was told by Salman Akhtar to a group of psychiatry students in response to a question regarding the effectiveness of psychoanalytic treatment of severe personality disorders (Akhtar, 1992:375):
“... let us suppose that there are two flower vases made of fine china. Both are intricately carved and of comparable value, elegance, and beauty. Then a wind blows and one of them falls from its stand, and is broken into pieces. An expert from a distant land is called. Painstakingly, step by step, the expert glues the pieces back together. Soon the broken vase is intact again, can hold water without leaking, is unblemished to all who see it. Yet this vase is now different from the other one. The lines along which it had broken, a subtle reminder of yesterday, will always remain discernible to an experienced eye. However, it will have a certain wisdom since it knows something that the vase that has never been broken does not: it knows what it is to break and what it is to come together”.

The story of the two vases are used to describe the three experience clusters within this part, namely: 1) “Falling apart” - when different aspects of life seem to be getting worse, the traumatic wind of a loved one’s suicide causes the survivor to fall and be broken into pieces; 2) “Being shattered” - when the survivor struggles to cope with a changed life, the experiences of a survivor to have been broken in so many pieces that repair is seemingly an impossibility; and 3) “Putting the pieces back together” - when the survivor experiences healing and adaptation to his/her changed life, the process of painstakingly gluing back the pieces until it is intact again.

4.3.1 Experience cluster 1: “Falling apart”

This experience cluster describes the research participants’ experiences of “Falling apart” when different aspects of their lives seem to be getting worse in the weeks, months and years following the suicide of a loved one; the traumatic “wind” of a loved one’s suicide causes the survivor to “fall” and be “broken into pieces” [See the story of the two flower vases in the first paragraph of section 4.3].
i) Guilt and punishment feelings

Guilt is defined as a “feeling of responsibility or remorse for some real or imagined offense or crime”. It is an emotion that has so many different layers that it is perhaps the most difficult feeling with which survivors must cope. Further, it is a somewhat free-floating emotional response that explicitly raises questions of blame or fault. Guilt is often accompanied by regret, remorse, negative self-evaluation or feelings that one should atone in some or other way (Dunn & Morrish-Vidners, 1987-88:187-188; Rando, 1993:478; Rosenfeld & Prupas, 1984:19-20).

Guilt and punishment feelings are both dealt with in this section due to the fact that it is very difficult, if not impossible, to deal with the one and not the other at the same time; guilt feelings are often the basis from which punishment is justified. The content of the research participants’ guilt feelings included the following: Relationship issues and inability to understand the suicide. They also reported on the duration and limiting nature of their guilt feelings.

A sub-optimal or broken relationship with the suicide victim prior to the suicide is reported by many survivors as an important content aspect of their guilt feelings. Associated with this is a tendency to accept personal responsibility for the relationship issues that seemingly directly lead to the suicide. This is illustrated by the following quotations from Ilze’s interview: “... if I could change anything ... I wouldn’t have sided with my dad as much as I did ... when they were considering a divorce ...” and “... I can’t forgive myself ... because I now know, after everything that happened, what happened to her ... she needed me and I pushed her away ... I just wasn’t there ... I feel that I could have changed it, but I didn’t want to ...”.
The origin of guilt is often based in the imperfectness of human relationships. After the death of a loved one, survivors tend to only remember the times that they were not as good, as patient, or as loving as what they could have been - the so-called “sins” of omission. They tend to measure themselves against an unattainable relationship standard, while “forgetting” about the normal imperfect nature of all relationships. In other cases survivors focus so much on their perceived negative contribution to the relationship that they fail to remember or acknowledge their positive contributions to it (Rando, 1993:481; Raphael, 1984:45).

Another content aspect of the research participants’ guilt feelings was their confusion and inability to understand the intentions or reasons behind certain aspects of the victims’ suicide behaviour. In Megan’s words: “... I experienced a lot of guilt because of Peter’s last ‘I love you’ words ... I felt bad ... that his mom was not there ... to hear those last words ... it was meant for her ... not for me ... I don’t know if it was meant for me or her”.

Survivors often experience and justify some form of perceived punishment in the light of their guilt feelings. Maria verbalised it as follows: “... that was punishment; it was too much for me ... at first I thought she did it ... because she didn’t even contact me to tell me anything ... I felt I was not always in contact with her”.

Feelings of having done something wrong are often based in social rules, religious beliefs or when an individual perceives that a personal standard has been violated. Survivors often take up personal responsibility for all aspects of jurisprudence in being the prosecutor, judge, jury and executioner. No wonder that guilt feelings result in an expectancy that some sort of punishment and a need for atonement has to follow (Du Plessis, 2003; Helen, 2002:14; Rando, 1993:480).

The intensity of the research participants’ guilt feelings were evident from their experience that it persisted and even increased over time. Two years after the suicide Ilze still described her guilt experiences as follows: “... I will always have this guilt
feelings that I have now ... some days it get to me and I feel ... it is my fault ... then some other days I feel better ... it is like a roller-coaster ...”. Intense guilt feelings were a part of Megan’s life even five years after the suicide: “... till today ... I feel bad ... I feel a little bit guilty ... there is still a lot of guilt about it ...”.

Persistent guilt feelings prevent survivors to effectively progress with their own lives. It is a burden that keeps them from effectively accepting life’s challenges and from personal growth. This is illustrated by a prayer that Ilze wrote in her diary: “Lord, forgive me for what I have done to my mom. Remove this guilt from my shoulders, release me from it and let me again live in You!”

“Static guilt” refers to guilt feelings that result in an immobilisation of the survivor’s personhood. Its unfinished nature interferes with the survivor’s ability to accept, take up and adapt to a changed life - a stumbling block on the road of life. Instead, it keeps the person chained to the past (Rando, 1993:482-483).

Guilt is a common bereavement reaction. However, in the case of suicide survivors it is perhaps the most pervasive reaction. The legacy of suicide combines guilt, stigma and anger. Guilt occurs more frequently, with greater intensity and for longer periods of time after a suicide than after other forms of death. The experience of guilt is usually associated with relationship issues, being unaware of the suicidal intent, not having prevented the suicide, or somehow feeling responsible for the event. Whatever the guilt is about, the result may be an unending list of if-only regrets. The pervading thought is that if only we’d done more, loved more, listened more or been around more, things might have turned out differently. Letting go of all these if-onlys can be very difficult. By deciding that they are personally responsible and to be blamed for the suicide, survivors are actually claiming that they had considerable power over the victim. Sadly, death is obviously not within the realm of the survivor’s control or power. Guilt-ridden survivors fail to recognise that guilt is actually a false accusation against themselves (Calhoun, Selby & Selby, 1982:417; Du Plessis, 2003; Henley, 1984:55; Jackson, 2003:16; Lukas & Seiden, 1987:33-34; Rando, 1993:478; Reed & Greenwald, 1991:397; Rosenfeld &
Part of what is so painful about the guilt that survivors feel is that there is no way they can find out from the dead person whether the guilt is justified or not. They can only speculate and continue to feel guilty. A pattern of extreme guilt often tends to follow the loss of relationships that were intensely ambivalent and/or conflicted. In such a case the survivors perceive that they could have prevented the death but failed to do so (Kinsella, Greeff & Poggenpoel, 1993:45; Lukas & Seiden, 1987:37; Rando, 1993:169, 479).

Ambivalence is a common experience during the adolescent developmental phase. As a result adolescents tend to link the negative aspects of a loved one’s death to their own guilt feelings and self-blame. The higher the level of ambivalence in the pre-existing relationship, the more complex is the task of dealing with guilt. Guilt leads to a restricted review of the relationship and an inability to successfully complete the mourning process. It becomes a destructive process in which one is worthy and deserving of punishment. In some cases it even demands punishment - either by yourself, others or God. As a result one must then somehow atone in an attempt to earn the forgiveness that you so desperately want but don’t believe you deserve. Alternatively, in an attempt to punish themselves, survivors may choose to live permanently with their guilt, believing that that is what they deserve. This makes the survivor a victim of his/her guilt feelings (Fourie, 2002; 2003:3; Lukas & Seiden, 1987:73-75; Rando, 1993:404; Raphael, 1984:155).

Self-blame/regret: “If only I had ...”

Regret is a common experience amongst suicide survivors. It refers to those tangible or symbolic things that have been lost or neglected, as well as a sense of resentment for the things that were futile in the past or now seems futile in the future (Raphael, 1984:45).

Survivors’ if-only-I arguments indicate a believe that they could have actively done something to prevent the suicide. Self-blame/regret is closely related to guilt feelings as
described in the previous section [4.3.1 (i)]. Guilt is predominantly an emotional pattern based on actions that somehow contributed to the suicide. Self-blame/regret is predominantly a cognitive pattern based on the absence of efforts and actions that seemingly could have prevented the suicide - the so-called acts of omission. Obviously, self-blame schemas can result in and be accompanied by intense experiences of guilt feelings. [See section 4.3.1 (iii) for “Blaming others/God”].

Self-blame/regret is a deeply negative experience that results in severe emotional pain and uncertainty. Shirley described it as follows: “... and self-blame is, I think, the worst pain anybody can feel ... it’s the worst pain ... cause you don’t know where you’re gonna go”.

One distinct self-blame/regret experience amongst some survivors is “If only I had given the victim a reason to continue with life”. This is illustrated by the following quotations from the interviews:

Shirley: “... it was supposed to be his 21st birthday that June ... and my parents were planning on buying him a car ... it was a big surprise ... I wanted to tell him and ... I blame myself sometimes”.

Maria: “... I was not always in contact with her ... I feel I should have done something in a way ... if maybe I called her ... the day before she thought about everything ... it could have changed everything”.

Annie: “... I wish that I was there for [Lindi] ... and I wasn’t ...” and “... those times that we spend together as friends, I would have appreciated it more ... I just wish that I could have told her how much she meant to me”.

A second distinct self-blame/regret experience amongst some survivors is the following: “If only I had acted on the cues of the imminent suicide”. This is illustrated by the following quotations from the interviews:

Shirley: “... his girlfriend called and said that something is wrong because he called and said ‘Bye’ ... it was like final, but I said ‘No man, he’s fine, he’s right here’ ... and I feel if I did go and look for him, maybe I would have found him sooner and he would
be fine .... so, I blamed myself for about two months ...

Maria: “... the holidays ... before she killed herself, she was always like, ‘Call me, we should always keep in contact’ ... and I was always ... ‘I don’t have money’, or something ... but I feel in a way she was trying to reach out to me, telling me ‘Maria, I am lonely’ ... but I didn’t take it seriously ... I feel I should have done something in a way...

Annie: “... Lindi, shot herself through the heart ... two evening before that, at a dance, she said ‘You will never again see me cry’... that was words she gave us ... I blamed myself ... ‘Why didn’t I just listen to her’ .... she made it so clear ... ‘Why was I so stupid?’ ...”.

In retrospect individuals experience that the warning signals of suicidal intent were obvious and explicit. When they know the devastating outcome of the situation this perfect hindsight tends to make survivors feel guilty and responsible. The sad part of survivors’ self-blame is that they measure themselves against some perfect criteria. However, they need to recognise and acknowledge how even professionals can miss cues indicating that someone is experiencing a suicidal crisis. Also, many suicide victims persist and succeed in ending their lives despite being rescued before by vigilant friends and family members (Appel & Wroblevski, 1987:223; Calhoun & Allen, 1991:99; Helen, 2002:44-45, 78; Jackson, 2003:20; Ojanlatva, Hammer & Mohr, 1987:181; Van der Walt, 1988:5; Van Dongen, 1990:226).

Suicide survivors report a significantly greater frequency of feeling responsible for a loved one’s suicide as compared against that of natural death survivor groups. They interpret the suicide as evidence that they have failed, if not in their social roles (such as parent, sibling, friend), then in some larger sense as human beings. Survivors continue to find reasons to blame themselves for not preventing the suicide (Bailley, Kral & Dunham, 1999:263; Dunn & Morrish-Vidners, 1987-88:182, 186-187; Hamilton & Masecar, 2001:46; Rosenfeld & Prupas, 1984:20; Sheskin & Wallace, 1976:233; Silverman, Range & Overholser, 1994-95:48; Van Dongen, 1991:379).
Children of a parent who completed suicide often engage in self-blame, especially if their relationship with the parent was an ambivalent or troubled one. They experience a sense of co-partnership for the difficulties that preceded the suicide. Sadly, unhappy parents all too often project blame on a child. Such parents leave behind the notion that it is somehow the child’s fault that they completed suicide. The child’s bereavement process is then hampered by self-blame and exaggerated guilt feelings (Lukas & Seiden, 1987:168; Raphael, 1984:60).

iii) Blaming others/God

“Blame” is the attribution of personal responsibility coupled with disapproval. Blaming others releases most of the blame and responsibility for the suicide from the victim (Dunn & Morrish-Vidners, 1987-88:184; Jackson, 2003:21; Van Dongen, 1991:376). [See section 4.3.1 (ii) for a theoretical discussion of “Self-blame/regret”].

The content of the research participants’ blaming of other persons included relationship issues and perceived acts of omission. The content of their blaming of God included perceived acts of commission, acts of omission and a questioning of Christian beliefs.

Other significant persons are often blamed for their perceived negative interpersonal relationship with the victim that, from the survivor’s perspective, has contributed to the suicide events. This is illustrated by the following quotation from Maria’s interview: “... her parents ... I am blaming them because they are the ones who made sure ... she was always restricted ... they didn’t want her to do anything ...”.

Other significant persons are sometimes also blamed for perceived acts of omission that could have prevented the suicide events. It indicates an implicit believe that the suicide could have been prevented by a single factor. Maria described such a situation: “... I blame her parents for having a gun in the house but ... not keeping it in a safe place ... you should place it where your kids ... they should not know the codes to that safe ... cause if the gun was not there ... what could she have done ... she could have tried other means and
maybe ... she could just fail to kill herself”.

Blaming is frequently found amongst survivors, often in an attempt to free themselves of guilt. Blaming others is an attempt to regain a sense of control and structure. It serves to displace anger and guilt from the deceased and from oneself onto someone else. In placing blame, the survivor identifies persons who played a significant role in the deceased’s life and whom may potentially have contributed to the deceased’s mental and emotional condition. While blaming can initially serve to restore a sense of order and control for the survivor, persistent blaming can block the free flow of communication. It may result in deep frustrations that complicate and threaten the healing process (Demi & Howell, 1991:352; Dunn & Morrish-Vidners, 1987-88:185-186, 210; Hauser, 1987:66; Helen, 2002:77; Wertheimer, 1991:110).

“Scapegoating” refers to the process of redirecting anger and guilt that might be directed at the suicide victim or toward oneself onto other people who seemingly could have prevented the loved one from completing suicide or who apparently caused the death. It protects the survivor from emotions and thoughts that are too painful to deal with. However, the result is often not the expected alleviation of emotional pain, but rather one of getting stuck in the pain of blaming. The act of scapegoating is not all negative as a little bit of scapegoating seems to be used by individuals who are actively engaged in the healing process. In this case it helps survivors to relief and deal with some of the intense anger that is periodically experienced towards the victim (Lukas & Seiden, 1987:53-54, 71-72; Ojanlatva, Hammer & Mohr, 1987:181).

Some survivors blame God for allowing the victims to experience the intense negative emotions/events that eventually result in a completed suicide; an act of commission. This experience was expressed as follows by Annie: “... they say that God lifts you up when you need Him, but I argued with Him in my prayers because I asked ‘Why weren’t You there for those people’” and “... I blamed God, I was angry with God ... ‘Why must people go through so much pain?’ ... ‘Why must everything go wrong?’ ... I always thought He was a God of love ... ‘Why does He put His children through difficult times?’”
Sometimes God is blamed for not **preventing the suicide** when He could have done so; an act of omission. The following quotations illustrate this experience:

Shirley: “... I felt God let me down ... and I didn’t want to blame Him, but I did”.

Maria: “... sometimes I would blame God ... ‘How can you let this happen?’ ... I mean He could have stopped it in a second if He wanted to, but then He didn’t”.

One outcome of the survivors’ blaming of God is frequently an intense and serious **questioning and/or rejection of Christian beliefs**. This outcome is evident from the following quotations from the interviews:

Shirley: “... I don’t believe in God anymore ... I stopped going to church that same year ...”.

Annie: “... I even questioned God and my Christian beliefs ... it felt as if I had lost contact with God ...”; “… the picture [Figure 3.5, P17] ... I wanted to highlight that hate for Christian beliefs ... as if I could throw the cross into the dark ... because I blamed God ... that’s why I wanted to completely get rid of God ...” and “ ... at that stage ... I viewed Christian beliefs as worthless ...”.

*It is common for survivors to feel intensely angry and disillusioned at God for allowing the suicide to occur. It constitutes a form of protest against God. This natural reaction results from the belief in an omnipotent and omniscient God. The suicide then results in serious questions about faith and the role of religion in the survivor’s life. Many survivors at this point experience a loss of faith, unable to pray, loss of confidence in the church, and abandonment by God (Hamilton & Masecar, 2001:48; Rosenfeld & Prupas, 1984:84; Rubey & Clark, 1987:155; Van Dongen, 1990:226).*

*Ambivalence between believing and protesting against God is indicative of the survivor’s cognitive uncertainty to make sense of life without the deceased. The struggle to make sense and interpret the death within a religious context may interfere and challenge the process of making spiritual sense. If the loss cannot be integrated into the existing religious beliefs and practices, the latter will be challenged to change in order to accommodate the loss. Adolescents may be particularly prone to ruminate on the*
unfairness of the world and God in allowing the suicide. This is one reason why adolescents often become disillusioned with the church and eventually reject religious beliefs. They lose their faith and spiritual well-being because they seldom find appropriate answers (Cain, 2002:134; Kinsella, Greeff & Poggenpoel, 1993:46; Opperman & Novello, 2003:15; Raphael, 1984:150; Seeber, 2002:34).

iv) Angry at victim

The legacy of suicide usually consists of a combination between blame, guilt, anger and stigma. Anger is often regarded as being based in some form of underlying blame or guilt (Jackson, 2003:21; Rosenfeld & Prupas, 1984:7, 29).

The research participants’ anger towards the suicide victim can be differentiated into a number of themes: Abandonment, rejection, not confiding in a trust relationship, and leaving behind emotional hurt. [See section 4.3.2 (v) for “Chronic hate and anger towards the suicide victim” as an aspect of “Emotional stuckness” during “Being shattered” post-suicide experiences].

One aspect of suicide survivors’ anger is frequently the victim’s seemingly deliberate abandonment of a “safe” family and/or relationship context where the problems could have been sorted out. Instead of confronting the problems within this “safe” context, the victims apparently rather chose suicide to deal with their problems. Ilze described her anger in this respect as follows: “... she could have prevented it if she had returned home that evening ... I’m angry about what she did to us, because it was unnecessary ... she did not have to be so hot-headed about everything ... she could have returned home, then we could have sorted out everything ... now this happened ...”.

Survivors’ loss due to suicide can be described as a “triple loss”. The first loss is the death itself. The second loss is due to the profound rejection, punishment and abandonment by a loved one who preferred death above an ongoing companionship. The third loss is due to the disillusionment in the personhood of the individual whom the
survivor had admired. The abandonment in a suicide is not symbolic, it is actual. Feelings of personal rejection follow on the purposeful desertion of one who fulfilled a significantly intimate relationship role in the survivor’s life. The dynamics of the loved one’s choice to die set the survivor up for intense feelings towards the victim. It elicits cognitive ruminations regarding how little the survivor must have meant to the victim. A number of studies have found that suicide survivors experience a greater sense of rejection and abandonment when compared to accident survivors (Dunn & Morrish-Vidners, 1987-88:182; Helen, 2002:14, 76; Kelly, 1997; McIntosh, 1993:154; Ness & Pfeffer, 1990:281; Rando, 1993:404, 524-525; Reed & Greenwald, 1991:393, 397; Silverman, Range & Overholser, 1994-95:49; Van der Walt, 1988:5).

Closely related to the experience of being abandoned is some survivors’ intense experiences of explicit rejection by the victim. In some cases the survivors have experienced the victim’s explicit rejection of reconciliation attempts to repair a broken relationship just prior to the suicide events. Such an explicit rejection is illustrated by the following quotations from Ilze’s diary and interview: “It is Tuesday. Mom and I had a stupid argument. She doesn’t return home that evening. I phone her. ‘You don’t need me’ was her words” and “She shouldn’t have said those words to me, I mean everyone argues one time or another in their lives ... her last words weren’t right ... if she knew that she was going to do it, why did she also want to destroy me ...”.

Inherent in the act of suicide is a component of rejection. Thus, feeling rejected by the victim is a salient experience of suicide survivors. This differentiates the grief experiences of suicide survivors from that of other natural death survivor groups. The victim’s rejection of life is very often also interpreted as a concomitant rejection of the survivor. Additionally, a suicide sometimes leaves survivors behind to deal with memories of a last, angry interpersonal exchange. No wonder that survivors then interpret and perceive the suicide as intentional punishment; a deliberate and hostile rejection of their personhood that leaves them with a sense of intense guilt and anger (Bailley, Kral & Dunham, 1999:266; Henley, 1984:58; Van der Walt, 1988:5; Wertheimer, 1991:44, 173).
Some survivors are angry at the victims for **not confiding and sharing their problems in the trust relationship** that existed between them prior to the suicide. The intensity of this experience is evident from the following quotation from Shirley’s interview: “... we were very close ... I would have thought if he had a problem, he would have told me and we would have spoken about it ... so I didn’t understand when he did something alone and I didn’t even know it ... that’s why I think I resented him ... if he could talk to me about anything else, why couldn’t he talk to me about this ...”.

When the victims have never confided in the survivors about their problems and how desperate they felt, it is experienced as an intense betrayal of their trust relationship. In such a case the survivor may be angry or experience a sense of personal rejection due to not being trusted or given the opportunity to help. This is especially true in the case when the victim and survivor shared a deep companionship (Dunn & Morrish-Vidners, 1987-88:205; Helen, 2002:67; SIEC, 2001a; Silverman, Range & Overholser, 1994-95:49).

Another aspect that evokes anger towards the victims is located in the **emotional hurt, frustrations and unanswerable questions that the victims leave behind** for the survivors to deal with. This was described as follows by some research participants:

Ilze: “It is senseless that I had to go through all this pain because she didn’t think clearly for a moment ... she messed up the lives of everyone around her ... that is painful ... it is extremely senseless”.

Shirley: “Right now I am very angry ... because he put me through so much ... I’m not strong ... and he knew that ... and he still did what he did ... there was no proper goodbye ... we just found him hanging ... how could you put people you claim you love through so much pain?”

The emotional hurt and great deal of unfinished relationship business that survivors face after the suicide is based in the inherent betrayal and abandonment by the victim. Sadly, the survivors had no choice in the suicide act that left the loved one dead, but it is they who have to cope with the bewildering array of emotions, thoughts and questions (Jackson, 2003:2; Rando, 1993:525; Wertheimer, 1991:172).
Anger towards the victim is a common and normal component in the bereavement process associated with a suicidal death. The inner experience is one of “Why have you left me?”. For some reason the victim rejected or didn’t seek the survivors’ help. The origin of anger can be found in the experience of being rejected and abandoned by someone who did not consider the survivor important enough to remain living for, in the experience of being abandoned by someone he/she loved. Because the victim has deliberately and wilfully chosen to abandon, anger is pronounced and may at times be quite overwhelming. This makes it difficult to cope with anger (Calhoun, Selby & Selby, 1982:411; Demi & Howell, 1991:351; Hamilton & Masecar, 2001:47; Kinsella, Greeff & Poggenpoel, 1993:45; Lukas & Seiden, 1987:56; Raphael, 1984:42, 155; Van Dongen, 1991:376; Wertheimer, 1991:171-172; Wrobleski, 1984-85:178-179).

v) Doubt: “Maybe it was not suicide”

Doubt refers to a condition of cognitive dissonance. In this section it expresses the survivors’ cognitive difficulty to integrate their well-ingrained views regarding what constitutes a “real” suicide with the realities of the actual suicide events. It is different than outright denial as the reason for death as it is rather a cognitive struggle to review and reformulate their views regarding evidence of a suicide act.

A frequent maybe-it-was-not-a-suicide argument relies on the fact that the victim did not leave a suicide note. This is illustrated by the following quotation from Megan’s interview: “The thing is, he did not leave a suicide note ... that is why I thought it had not been a suicide ... usually, if I look at my own suicide attempt, people leave a note”.

A number of studies have found that only a minority of suicide victims leave notes. One source puts it at approximately 15%, while other sources estimate the figure at between one-fourth and one-third of all suicide victims. When victims do not leave a suicide note it can sometimes be difficult to determine whether it was a suicide or perhaps an accident (Helen, 2002:15; Jackson, 2003:14; Rudestam & Agnelli, 1987:212; Sue, Sue & Sue, 1994:393). [See section 4.3.2 (viii) for a discussion of “Suicide notes” as an aspect of
“Not knowing the reason for the suicide” during “Being shattered” post-suicide experiences.

Another maybe-it-was-not-a-suicide argument is sometimes based upon an autopsy report that fails to conclusively point to suicide as the reason of death. In Megan’s words: “... his mom told me that his stomach was sent for an autopsy ... and it came back with a report that nothing was found in it ... I accepted her word for it”.

vi) Changes in relationship patterns/dynamics

The death of a loved one almost always results in altered relationship patterns and changes in relationship dynamics. Relationships play a big role in our sense of meaning and purpose in life. Changes in relationship dynamics may in itself lead to an existential crisis. The bereavement process contribute significantly to the stress or conflict that may appear in relationships following the loss, as well as to the impairment of interpersonal relationships in general (Raphael, 1984:62; Ulmer, Range & Smith, 1991:280).

The research participants experienced a number of changes in relationship dynamics: Polarised needs for close interpersonal interactions; close relationships becoming superficial; increased conflict; active distancing from close relationships; losing trust in significant others; being rejected, blamed or mistrusted by significant others; concealing suicide-as-reason-for-death in social interactions; and self-identification with being in a “weird” survivor group.

Survivors may experience polarised changes in their need for close interpersonal interactions, ranging between an intense need for interpersonal closeness and an intense need for being on their own. Ilze experienced that an initial period of introversion was followed by a period of indiscriminate trust and sharing: “... in the beginning I didn’t want anything to do with anyone ... I was a lot on my own ... then I started to trust people too much and too easily, because I needed someone to talk to...”.
At some stages during the bereavement process, suicide survivors have an intense need to share their emotions, thoughts and experiences about their tragedy (Dunn & Morrish-Vidners, 1987-88:181).

Close relationships with significant others prior to the suicide may become superficial after the suicide. This is illustrated by the following quotations from the interviews:

Ilze: “We were very close, extremely close ... I think that I know everything about my dad, he knows everything about me ... but now ... we are not as close as we were”.

Megan: “… his mom ... our whole friendship has changed ... it just wasn’t as before ... when I visited them ... for a long time it was merely ‘Hallo, how are you, good, see you’ ... I still haven’t talked to her about it …”.

In some cases, survivors experience that close relationships with significant others are characterised by an increase in conflict in the aftermath of the suicide. Ilze described such experiences of increased conflict in her diary and interview: “My sister ... we started to fight ... she couldn’t understand what was happening ...” and “My boyfriend and I fight a lot ... he tells me that I have gained weight ...”.

More relationships with significant others, including family members and friends, become increasingly superficial and troubled after the suicide than those who deepen. Important factors that may contribute to this are intense mutual blaming, precipitation of problematic relational issues and feelings of guilt (Dunn & Morrish-Vidners, 1987-88:190).

Survivors sometimes make an intentional choice to actively avoid and/or distance themselves from close relationships. The following quotations provide clear examples of this specific experience:

Ilze: “… the first two months after my mom’s death ... I neglected my boyfriend ... and pushed him away ... finally I broke up the relationship”; “… I didn’t want to go home on the weekends …”; “… I decided that I only want to get married when I’m thirty ... I don’t want to be in a relationship where I will be bound because I saw what my mom
and dad did to each other ...” and “... in the beginning ... I didn’t want anything to do with anyone ... I was a lot on my own”.

Shirley: “... I push people away ... I don’t want anyone close to me ... because if they say they love you, like my brother did, they just leave you ... if people like that can put you through so much pain, what can stop a stranger ... I find it very difficult to have somebody very close to me ... so I keep by myself ... cause I don’t want anything to do with, especially male ...”.

Adolescent survivors often show marked avoidance and distancing from significant relationships after someone close to them has completed suicide. Suicide is the ultimate rejection and in order to prevent oneself from being rejected again, the survivor does the rejecting. The avoidance and distancing actions may be based in a fear of rejection, being hurt again or an expectation that loved ones will eventually abandon the significant relationship. This non-involvement with others boils down to an attempted restriction of one’s existence by closing off possibilities for anxiety and suffering. The victim’s desertion of the relationship may be interpreted as an indication to the survivor that their relationship was somehow not providing enough reason to prefer living above death, or not providing a safe enough and trusted interpersonal space (Kruger, 1988:81; Lukas & Seiden, 1987:94; Raphael, 1984:159).

Adolescence is a critical developmental phase for the consolidation of an adult sexual identity. In cases where adolescents are the survivors of a parental suicide, the death of the same-sex parent may deprive them of an important source of sexual identification. Also, it can lead to difficulties in the formation or maintenance of intimate relationships. It may be very difficult for them to trust someone close to them because of the fear that they will also leave them (Raphael, 1984:166; Rosenfeld & Prupas, 1984:71).

In the aftermath of a suicide, relationship trust is often challenged and threatened due to the way in which significant others handle the situation. Survivors often lose trust in a significant other, with a resultant breakdown in communication. Megan described such a change in relationship dynamics as follows: “... [his mom] never told me that he
committed suicide ... if she was open with me about what happened and why it happened from the beginning ... I wouldn’t have been so angry at her ... until today she hasn’t spoken to me about it ... we were so close and I want to know why she didn’t tell me ... all I want is that she be honest”.

The suicide of a loved one is often experienced as the ultimate betrayal. The victim has rejected the survivor, leaving him/her feeling abandoned. To trust significant others are no longer a given or taken for granted. Suddenly, the survivor can see no reason why such a betrayal could not come from anyone else. The result is that the loss can bring feelings of tremendous insecurity that deeply impacts on the survivor’s sense of trust. This sense of insecurity can make it hard for trust to be established in any of the survivor’s relationships. To avoid further existential insult the survivor withdraws from previously close and trusty relationships (Dunn & Morrish-Vidners, 1987-88:205; Dunne, 1987:205; Wertheimer, 1991:174).

Adolescent survivors may experience being rejected, blamed and/or mistrusted by significant adults. This is illustrated by the following quotations:

Ilze: “My dad has basically disappointed me with the lady he met ... now it is just about her and he forgets that I was there for two years ... I supported him through everything ... I was the one who pushed my mom away for him, and now ... she is everything for him and that hurts me because I was there”.

Megan: “His mom blamed me a lot ... she pushed me away ... the blaming started about two months after the suicide ... the people who meant a lot to me started to reject me”.

Maria: “... I thought my parents would be open after this, but they are completely the opposite after the event, they became ... very strict”.

Survivors sometimes intentionally choose to conceal suicide-as-the-reason-for-death in interactions with non-significant persons. It is a form of secrecy to cope with the pain. The following quotation from Ilze’s interview aptly describes this relationship pattern: “... no one knows that my mom committed suicide ... for me it is a suicide, but nobody else
knows ... my friends know that my mom died of cancer ... I don’t want them to know ... my dad’s family knows ... I won’t tell anybody else ... for me it is my own privacy ... I don’t want anyone to know it”.

Over many centuries, society has been intensely apprehensive of suicide. Even today, the whole subject of suicide largely remains a social taboo, probably since it is arguably the only truly antisocial act. The suicide victim has decided to abandon society at large, while society is left without any way to respond (Rosenfeld & Prupas, 1984:7).

The degree to which suicide survivors experience social discomfort and unease is most clearly evident in their concealment of the cause of death. Such a “secret” is often an attempt to avoid public scrutiny, guilt and pain of loss. If the death can be described as ‘an accident’ or due to ‘natural causes’, then no one is to blame, and no one need to feel guilty (Calhoun & Allen, 1991:102; Demi & Howell, 1991:352-353; Helen, 2002:61; McIntosh, 1993:153; Range & Calhoun, 1990:317; Solomon, 1982-83:385; Wertheimer, 1991:113).

The concealment of suicide-as-the-reason for death due to its social taboo and secretive nature can be better understood with reference to the “stigma” concept. This term refers to the phenomenon of shame or disgrace, whether visible or not, that potentially detracts from the character or reputation of a person. “Stigmatisation” refers to the belief in and an internalisation of negative attitudes towards the self. This leaves survivors to feel “different”. The way that stigmatised individuals relate to others in social interactions may result in restricted social support, increased social isolation and avoidance. They feel that disclosure poses risks to future interactions (Hamilton & Masecar, 2001:47; Helen, 2002:61; Seeber, 2002:94; Solomon, 1982-83:377).

A number of studies have found that suicide survivors, when compared to other natural death survivor groups, report more telling others that the cause of death was something different than suicide. The issues of perceived stigmatisation and feelings of shame, embarrassment and guilt play a definite role. This differentiates the aftermath

Any form of self-identification with being a member of the suicide survivor group has a significant influence on the social identity of survivors. They may perceive themselves as belonging to a “weird” group that is somehow different than everyone else in the “normal” group. In Shirley’s words: “... sometimes you are going to be with people ... they don’t know ... I feel, if I were with people who understand, then I wouldn’t have to feel so left out or so weird” and “... the little things that I appreciate in life ... those times with your friends ... things that normal people that haven’t been through any pain, don’t appreciate ...”.

Suicide is a socially unspeakable loss. The social taboo and stigma attached to suicide force survivors to retreat into a private sphere where they are socially and emotionally isolated in their grief. There they are left to deal with the aftermath of the loss without the benefit of effective social support. Generally, support systems tend to avoid survivors of stigmatised deaths such as suicide - a social “conspiracy of silence”. In this way, society underplays such a death as an existential crisis. Survivors who feel stigmatised view themselves as being categorised in a separate group from the rest of society, to such an extent that they may retain a sense of differentness for a long time. This differentness is enhanced by a perception of failure to meet society’s standards, of being socially or personally inferior (Dunn & Morrish-Vidners, 1987-88:195, 197; Dunne, 1987:202; Grant Kalischuk & Davies, 2001; Opperman & Novello, 2003:3, 8; Rando, 1993:531; Range & Thompson, 1987:197; Van Dongen, 1991:377; Wertheimer, 1991:175-176).

Survivors’ altered status in society may require adjustive tasks on their part. Due to stigmatisation, their status is often less favourable than before the suicide. A number of studies found that others view suicide survivors as more psychologically disturbed than individuals grieving deaths from other causes. A possible explanation for this is that
suicidal deaths may activate cognitive schemas that include assumptions regarding moral issues, blame and responsibility. Since adolescents are in an age group in which they are particularly sensitive to peer group norms, they may especially resent any perceived stigma associated with an altered social status and social identity (Allen et al, 1993-94:43; Raphael, 1984:57, 170).

vii) Sense a loss/restriction of “self”

The death of a loved one leaves individuals with feelings of loss of their past and future; it is not only the death of another person, but also the loss of a part of the survivor. In other words, more dies than just the person who completed suicide (Carter, 1989:356).

A significant loss of “self” that survivors experience is that of the suicide victim’s socio-emotional support, care and friendship. The intensity of this experience is frequently evident in its seemingly chronic and unending nature. This loss of “self” is illustrated by the following quotations:

Shirley: “I think a part of me died when my brother died ... a huge part of me, because I sort of looked after him ... he’s my big brother ... he comes pick me up after school ...”; “... I would never tell anybody ‘You hurt me’ because the one person I wanted to tell is not here ... so, I couldn’t tell ... so, I don’t tell” and “... its three years now, you will expect its better now ... but it seems as if it is getting worse because you think if he was here now, he’ll be doing this or we’ll be doing that ...”.

Maria: “I find it difficult to just communicate with other cousins ... I feel her presence is gone ... that she is not there ...”.

Erik Erikson’s psychosocial theory of human development identifies the predominant task of the young adult as that of intimacy versus isolation. The loss of an “intimate” friend during this developmental stage may result in feelings of depression, abandonment and despair. The primary loss of a significant person may be compounded by a number of symbolic losses - reciprocal intimacy, spontaneity and closeness. The loss is also in terms of a crisis of meaning. The survivor has to make meaning of the death and find meaning
A second important loss of “self” that survivors experience is a loss and/or restriction of significant personal emotions, thoughts and self-regard. The following quotations describe this experience:

Shirley: “... I was told by my aunties and my dad that I mustn’t cry, I must be strong ... everybody else was crying and I wasn’t allowed to cry, so I didn’t cry ... there’s a big part of me that just wants to cry ...”.

Megan: “… this picture [Figure 4.4, P6] ... she doesn’t have any clothes on or have anything with her ... that’s how I felt ... everything was taken from me ... I was absolutely naked ... my emotions were gone, my thoughts, my material worth, everything ...”.

The experiences of survivors following a suicide can be thought of as an amputation. It leaves them feeling as though a significant part of them is missing (Wertheimer, 1991:103).

Another loss of “self” that survivors experience is that of an accessible and meaningful future. This is evident in the development of an indifferent and fatalistic attitude regarding life and relationship. Shirley expressed this attitude as follows: “You don’t care anymore, cause I don’t care about half the things that happen ... I have this ‘don’t care’ attitude now, I don’t care ...”.

A fatalistic attitude may result from the survivors’ lingering sense of disillusionment regarding life. This attitude often adversely affects relational commitments to significant others and to life projects (Dunn & Morrish-Vidners, 1987-88:205).

A last prominent loss of “self” that some suicide survivors experience is that new social role expectations tend to be intensely restrictive and overwhelming of their personhood. This loss is clearly illustrated by the following quotation from Shirley’s interview: “... everybody just expects me to be this superhuman who can listen to you and
not have problems of our own, and tell you what to do and what not to do ... I feel its too much pressure for me at times and I can not handle it ... I’m expected to know how to deal with it, because I’m the big sister, I’m the star of the family ... I think they are expecting way too much from me ... they just see me as this ... I’m gonna do to do this in this year, and that in the next year ... and I can not ... and you have to go out there and pretend you’re fine ... now I feel like I have chains ...”.

When the suicide victim is a sibling of an adolescent survivor, the one left behind often becomes the focus of the family’s attention and unrealistic demands. All their expectations may now be projected and directed onto the remaining child. The survivor is then attributed with the idealised qualities, personal characteristics and unrealised potential of the suicide victim (Helen, 2002:67-68; Rosenfeld & Prupas, 1984:81).

The interactions we have with loved ones play an integral role in our sense of self and identity. Therefore, the physical and symbolic losses associated with the death of a loved one can pose an existential threat. This explains why so much of the crisis of bereavement for the survivor actually originates in the loss of so much of the self; a part of the survivor invariably dies with the loved one. The various roles that the victim fulfilled might be difficult to replace and compensate for. The victim may also have contributed a lot to the survivor’s sense of purpose and beliefs about the self. The greater the threat of the losses to the survivor’s sense of “self”, the more difficult it will be to adapt and establish a transformed identity (Opperman & Novello, 2003:12-13; Rando, 1993:59, 444).

viii) **Negative affect**

The research participants reported a number of negative affect experiences that lasted beyond or only started after the funeral rituals: Self-pity; marked fears; emotional hurt and a sense of derealisation.

Ilze experienced some **self-pity** during the initial period that followed on her mom’s suicide. She described it as follows: “In the beginning ... I didn’t want anything to do with
anyone ... I was basically very sorry for myself and blamed myself ...”.

Some survivors develop marked fears for a wide variety of situations, for example darkness and the death of another significant person. Ilze expressed a persistent fear of darkness: “It is something that hasn’t passed ... I am very afraid of the dark, incredibly afraid of the dark”. Megan described her intense fear of the death of another significant person as follows: “... I am still afraid that people around me may die, I am extremely afraid of it ... maybe because no one close to me has died since then ... I am afraid something similar will happen again ...”. [See section 4.2.3 (iii) for “Avoidance reactions” as an aspect of “Behavioural reactions” in the days directly following the suicide].

Survivors occasionally experience phobias in the aftermath of a loved one’s suicide. It is based in an intense loss of security and confidence in the world. The world is perceived as a frightening place. The content of the phobic fears are often associated with the possible sudden and unexpected death of another loved one, especially family members. These fears can be very intense, but in most cases it will gradually subside (Helen, 2002:75-76; Rando, 1993:554, 556; Raphael, 1984:173; Wroblewski, 1984-85:179-180).

Survivors may occasionally find it difficult to verbalise some experiences of negative affect. One research participant reported such a feeling of intense emotional hurt in terms of physical pain. Shirley made use of a pain-in-my-heart metaphor to verbalise and express her experience of emotional hurt: “... [the psychiatrist prescribed] medication for sleeping ... I never did use those ... I felt it was pointless cause the pain was in my heart, not in my head ... I don’t know how to explain this ... when I think about this whole thing, I feel ... like your heart, it is physically sore”.

A sense of derealisation is periodically experienced by some survivors in the aftermath of a suicide. Shirley described this experience by means of a “bad dream” metaphor: “... I’ve never ever accepted [the suicide events] ... sometime I tell myself ‘Maybe it’s just a bad dream, I’ll wake up’ ...”. This metaphor suggests that she is employing an escapist
The concept “depression” in this thesis does not imply a clinical diagnosis, but refers to the suicide survivors’ lived experience.

Attempts to hold on to the conditions prior to a traumatic event are an indication of ambivalence about the changes brought about by the event. Also, it points to an avoidance to accept the reality of the suicide events (Kelly, 1997).

When one deals with the issue of “metaphors”, it is imperative to recognise that they are narrative phenomena used by individuals to help them understand one domain of an experience in terms of another; a transfer of knowledge from a well-known “source domain” to a lesser-known “target domain”. Metaphoric portrayal allows the discussion of otherwise hard-to-address issues. It assists individuals in a specific socio-cultural context to describe the events in their lifeworlds. As a result these events are understandable to other individuals in the same context, sometimes even to individuals of different socio-cultural contexts (Barry, 1996:416-417; FitzSimmons, 1994-95:35).

ix) **Depression**

Depression appears to be a significant part of the response to a suicidal death. Mostly it can be described as a reactive depression, which is a valid and appropriate response in the case of a suicide death. In some cases it can develop into a clinical depression, for which therapeutic help is recommended (Calhoun, Selby & Selby, 1982:411; Seeber, 2002:34; Van der Wal, 1989-90:157; Van Dongen, 1991:376; Wrobleski, 1984-85:178).

A number of quotations from the research participants illustrate some of the physiological, somatic, cognitive and existential experiences associated with depression:
- Extended bouts of **crying**. Ilze (diary entry): “Today I am feeling very depro, my friend cry as much as I do”. [Also see Figure 4.1, P11].

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4 The concept "depression" in this thesis does not imply a clinical diagnosis, but refers to the suicide survivors’ lived experience.
- **Chronic nocturnal waking-and-crying episodes.** Shirley: “... there are times when I will wake up in the middle of the night, even this year, just wake up and cry ...”.

- **Weight gain.** Ilze: “I am falling into a deep depression ... my boyfriend tells me that I have gained weight ... I know that I have gained approximately eight kilograms ...”.

- **Decreased motivation** to engage in meaningful activities. Ilze: “... in the first two months after my mom’s suicide I didn’t care about anything ... I neglected my studies ... I did nothing ... I neglected my boyfriend ...”.

- **General perception that everything is getting worse;** small problems seem like big challenges. Ilze: “... after two years ... things didn’t get better, everything got worse ... every small thing becomes a mountain ... you don’t want to go over the mountain because there is another one, and another one”.

- **Interpret own life as a failure;** whole life seems completely negative, “dark” and not having an impact on the lives of significant others.
  
  Shirley: “My life has turned out to be one sad case ... it’s just sad”.
  
  Megan: “… in my matric year ... I just couldn’t see above me ... it was too dark for me ... I increasingly felt like a failure because I failed in school and my friends ... I really felt that I was a failure ... it wouldn’t have mattered if I was there or not ...

- **Recurrent depression episodes.** Megan: “… some time after that I again fell into a depression ... I was in a deep depression ...”. [Also see Figure 4.4, P8].

A number of studies on the reactions of university students to a suicide event report that depression was the most common emotional response. Feelings of apathy, fatigue, emptiness, despair, crying, irritability, sadness, headaches, insomnia and exhaustion were some of the other prevalent responses. Depression plays an important role in suicide survivors’ tendencies to lose weight or overeat, and to not form new relationships because of their low self-esteem. The duration of depression tends to be long lasting and deep. This reflects depression patterns similar to those of adults (Balk, 1983:154; Brent et al, 1992; Helen, 2002:75; Lukas and Seiden, 1987:39; Raphael, 1984:154; Van der Wal, 1989-90:157; Van Dongen, 1990:226, 1991:376). [See section 4.3.1 (xiii) for the themes of “Hopelessness”, “Sense of failure” and “Loneliness and social isolation” as aspects of
“Suicide tendency” during post-suicide experiences].

x) Cognitive experiences

The research participants reported a number of cognitive experiences that lasted beyond or only started after the funeral rituals: Rumination; memory difficulties; memory imprinting; flashbacks; memory suppression and suicide fantasy.

Survivors sometimes ruminate on various aspects of the suicide events and its consequences. This is illustrated by the following quotation from Shirley’s interview: “... sometimes I don’t want to be with anyone, so I keep by myself ... just leave me alone ... let me think about my stuff ... I think I feel, I think too much”.

*One study found that suicide survivors tend to spend a relatively large proportion of their time ruminating on certain aspects of the suicide, especially regarding the motivation of the individual who completed suicide (Bailley, Kral & Dunham, 1999:269).*

The research participants reported a number of cognitive experiences related to memory:

- **Memory difficulties.** Ilze was still experiencing an inability to remember everyday events that happened only a few days earlier: “... what I also see is that I easily forget things ... I very easily forget anything ... sometimes I cannot even recall what I had done a week ago ...”.

- **Memory imprinting.** Certain aspects of the suicide events may become imprinted on the survivors’ consciousness, so much so that it will apparently be remembered for the rest of their lives. Annie described a number of instances that illustrate this experience: “The trauma through which the school went for the following three days is something that I will never forget ... the emotions that others expressed ... it was five years ago, but I will definitely remember it ...”; “... when the Headmaster announced the suicide ... I remember precisely where I stood and where everyone around me stood, the sounds, you remember it ...”; “... the [schoolboy’s] suicide ... it is not something that you must forget ... it is actually impossible to forget it ...” and “... while
I was working for the police reservists, we saw photos of people who committed suicide ... I remember those pictures ...”.

- **Memory flashbacks.** Flashbacks can be highly disturbing for survivors. In some cases it may also be associated with concentration difficulties. Shirley reported it as follows: “... when I went to the psychologist ... I had flashbacks and I couldn’t concentrate ... and I couldn’t take it anymore”.

- **Memory suppression.** Survivors sometimes make an intentional decision to employ memory suppression as a way to cope with troubling and/or traumatic memories. This is illustrated by the following quotations:
  
  Shirley: “... sometimes I just think ‘If you tell yourself you never did have a brother, you won’t miss him as much’ ... you just learn to forget ... or you choose to forget ... I chose to forget cause that’s the only way I can deal with things”.

  Ilze: “... it is my body’s way to cut out the stuff that I don’t want to remember ... if I don’t want to remember it, I shut it out, then I cannot even recall it”.

An existential-phenomenological view of “memory” holds that it is a making present of the past, an openness for that which was. Individuals remember the important and salient things, events and interactions within their respective lifeworlds. In the case of traumatic events, memories of a past hurt facilitate the re-experiencing of its intense emotional pain (Kruger, 1988:114-115; Rowe et al, 1989:239).

In one study, Van Dongen (1991:376-377) found that a significant number of suicide survivors had experienced mental images or flashbacks of the death scene as they cognitively struggled to make sense and accept the reality of the suicide. It often resulted in disrupted sleeping patterns.

One of the research participants entertained a suicide fantasy that cannot be regarded as an explicit suicide ideation due to a clear accompanying intention to live. It seems to rather have been more of a curiosity triggered by a loved one’s suicide. Maria described her suicide fantasy as follows: “I’m this person who loves ... these rides ... like you see at the Pretoria Show ... that just pumps your blood ... sometimes it will be like, imagine ...
if I were on top of a building, and to just maybe trying to commit suicide, just trying to fall down … I’ll one day experience that flow of blood … but then sometimes I thought to myself ‘You’ll kill yourself’ … if only I could experience that … I don’t want to think about too much of those thing”.  [See section 4.3.1 (xiii) for “Suicide thoughts” as an aspect of “Suicide tendency” during post-suicide experiences]

xi) Escape into a fantasy/magic world

Survivors who struggle to acknowledge and cope with the aftermath of a suicide, may attempt to escape from their seemingly unbearable and overwhelming emotions and thoughts into a fantasy world. However, such a fantasy world merely provides a temporary relief until the survivor can enter the proper healing process.

Shirley described two fantasy/magic worlds into which she could or would like to escape when the “real” world’s emotional hurt threatens to overwhelm her, namely a fantasy world of music and a magical sleep world. Her fantasy world of music provided an escape context away from the “real” world into a non-threatening and “happy” world. The following quotation contextualise this fantasy world: “… music makes me happy … I just play music … and it’s much better … that’s the only thing that makes me happy … it makes me feel so much better because you can then go to some ‘world’ where I’m just me … and there is this one person that is just singing for me … I love it because I feel like I can just cut this world out and be alone … because when I come back to planet earth it’s just bad bad bad … nothing makes sense”.

Perschy (1997:91) reported the following remarks from an adolescent in a grief support group: “I don’t feel so alone when I listen to sad music … when I’m angry, I like loud music … it reminds me that there are a lot of frustrated people out there”. Music can play a very important role in the way that adolescents deal with grief feelings. It definitely exerts a powerful influence on emotions and physiological processes. A number of studies have found that listening to music results in a lowered heart rate and blood pressure. Also, it can significantly change negative emotions into positive ones. The implication
is that when the survivors’ lifeworlds seem to inhibit the expression of emotions, music can provide a gentle probe to facilitate its expression. As the music facilitates the expression of locked-up emotional pain and sadness, it may also release an existential vitality that revives a renewed sense of purpose and meaning in all aspects of life, studies and relationships (Perschy, 1997:91).

Shirley also expressed a wish to escape into a magical “sleep” world as a way to experience a temporary freedom or escape away from the “real” world’s emotional hurt. This wish is an indication of her reliance on miraculous and/or magical wish mechanisms to deal with emotional burdens, rather than accepting personal responsibility to actively deal with it. The “sleep” wish contains some implicit and explicit suggestions of suicide ideation [see section 4.3.1 (xiii) for “Suicide thoughts” as an aspect of “Suicide tendency” during post-suicide experiences]. The following quotation provides detail regarding her “sleep” wish: “... the hurt ... I’m hoping that someday it’s just gonna vanish, everything ... I was thinking ‘If I were to sleep and never wake up, I’ll be the happiest person’ ... sometimes I feel I don’t want to be here ... I don’t want to be living because there’s just too much pain ... I just want to sleep ... and never wake up ... I don’t think I’d actually take it to a point where I’d say ‘OK, I’ll kill my self now’ ... it’s just sometimes I wish I could just die, even if it was for just one week ... come back next week, maybe things will be much better, or never come back ... not that I’m gonna kill myself ...”.

xii) Ineffective behavioural coping patterns

The bereaved individual’s lack of effective coping skills can impede and inhibit an exploration of new behaviours appropriate to life without the loved one (Rando, 1993:441).

Survivors often engage in a variety of ineffective behavioural coping patterns in the weeks, months and years after the suicide events. These patterns are regarded as “ineffective” due to its implicit aim to avoid or escape from actually dealing with intense emotions and thoughts. Some survivors even express explicit doubt in the existence of
successful coping mechanisms in the aftermath of a suicide. In Shirley’s words: “I don’t know how to cope with it, because I don’t think there is a way ... I don’t think you ever cope with it, you never how to”.

The research participants resorted to three common ineffective behavioural coping patterns: Disrupted eating patterns, cigarette smoking and alcohol misuse.

The ineffective coping pattern of resorting to **disrupted eating patterns** is illustrated by the following quotations from Ilze’s diary and interview: “I must return to the university residence, it is a new year ... I feel overweight and ugly, I stopped eating, I put my finger in my throat when I do eat ... it lasts for a week” and “... for the first two months ... I didn’t want to eat ... I started to be bulimic”. [See section 4.3.1 (ix) for the theme of “Weight gain” as an aspect of “Depression].

**Cigarette smoking** is another ineffective coping pattern. It is often used in an attempt to deal with or to “erase” life stressors. Shirley described her motivation to start smoking after the suicide events as follows: “... and I started smoking, I just want something take that away ... because I’m thinking ‘If I can not take, I smoke away’, it doesn’t help, but just smoke it away”.

A last common ineffective coping pattern that survivors resort to is **alcohol misuse**. On the one hand, it can serve as a way to deal with **social isolation and peer rejection** after the suicide events, especially in the case of adolescents. Megan recalled such a context as follows: “... back at school ... my friends questioned the relationship I had with him ... it was a big negative thing ... then I started drinking ... so heavily that I was very drunk ... as in, I didn’t know what I’m doing ... I thought that I was becoming cool in doing what my friends did”. On the other hand, it can serve as a way to **forget and deny the impact of the suicide events**. This is indicated by the following quotations from the interviews:

Ilze: “I wasn’t someone who used alcohol ... but the first two months after the suicide ... I started drinking, excessively ... I went out with friends and partied ... we were drunk in class ... even when I wrote exams”.
Megan: “... I started drinking and never dealt with or accepted ... only going on with life without wanting to look back it ... I used alcohol as a crutch to carry me through ...

A number of studies have found marked increases in alcohol consumption and tobacco use among the bereaved. These potentially health-compromising behaviours may even become excessive. The use or abuse of alcohol and other substances is regarded as a risk and predictive factor for poor progress in the mourning process. It is used as a source of temporary comfort, defence, avoidance or escape from emotional pain. The “feeling good” effects provide a false sense of mastery and control over the mourning process. However, the long-term effects of alcohol misuse, cigarette smoking or drug use are often psychologically and physically self-destructive (Carter, 1989:356; Rando, 1993:194-197; Seeber, 2002:38; Watson & Lee, 1993:37).

xiii) Suicide tendency

One of the saddest ways in which survivors cope with the [suicide of a loved one] ... is when a person says ‘because you died, I’ll die too’ (Wertheimer, 1991:178)

One of the heartbreaking behavioural phenomena amongst suicide survivors is their higher tendency to engage in self-destructive behaviour, thoughts and emotions than for any other survivor group. In the aftermath of a loved one’s suicide they seem to be less concerned about protecting and continuing their own life. As a result, they then often engage in deliberate acts of self-injury or self-destructive behaviours (Silverman, Range & Overholser, 1994-95:48-49; Van Dongen, 1991:376).

Suicide survivors often experience suicide thoughts. This was clearly verbalised by Ilze during her interview: “I have thought about suicide a million times”. It seems that survivors’ exposure to suicide cases brings an acute awareness of suicide-as-a-coping-option for life’s problems. This is illustrated in the following interview quotations:

Megan: “... one of my motivations was that if he could do it, why can’t I ... he could
Annie: “I started to view suicide as an option because you are more aware of it ... people make such a great fuss about suicide nowadays ... that everyone is aware of it ... it is now a quick option”.

Suicide thoughts are not uncommon amongst suicide survivors during the early months of bereavement. This may be due to the fact that the loved one’s death makes the very idea of suicide more real in the survivor’s life. Fortunately, actual serious suicide attempts are less common (Jackson, 2003:6; Kinsella, Greeff & Poggenpoel, 1993:46; Rosenfeld & Prupas, 1984:87; Wertheimer, 1991:178).

Death is an individual’s extreme existential possibility right from the start of life; it is definitely not limited to the final stage of life. Once an individual becomes aware of this possibility, it is impossible for one’s life, behaviour, thoughts and emotions not to be influenced by it in some way. The awareness of death-as-an-existential-possibility may particularly be triggered by exposure to a loved one’s suicide. It tends to reframe the idea of suicide into a viable option in the event of great stress, difficulties or crises. This is especially true for adolescents and young adults. The very reality that a significant other has completed suicide can make the previously unthinkable and impossible idea suddenly seems possible. The proverbial “veil” of death has been lifted and the survivor is forced to come to grips with its existential reality. The aftermath of a loved one’s suicide forces individuals to be aware of the possibility of their own death and the potential of other significant persons’ suicide death (Dunn & Morrish-Vidners, 1987-88:209; Dunne, 1987:204; Kruger, 1988:75-76; Ness & Pfeffer, 1990:283; Wertheimer, 1991:178; Wrobleski, 1984-85:179).

Another experience that is closely related to the survivors’ suicide thoughts in the aftermath of a loved one’s suicide is a longing to be reunited with the victim. There is a belief and/or hope amongst some survivors that their own death will bring an opportunity to ask the victim about the reason/s for the suicide. In Shirley’s words: “… sometimes ... I was thinking ‘If I were to die, then maybe I would see him ... and I’d ask
Adolescents’ suicide thoughts may be triggered by a desire to be reunited with the victim. The fragility with which they deal with concepts related to the finality and irreversibility of death can in some cases result in an idiosyncratic belief that reunion with the victim may in fact be possible. The wish to rejoin a lost loved one is often also based in an identification with that person. This places the survivor at considerable risk for a suicide attempt (Balk, 1983:154-155; Raphael, 1984:150; Schuyler, 1973:316; Wertheimer, 1991:178).

The experiential contexts within which suicide tendencies occur in the aftermath of a loved one’s suicide are complex and varied. The research participants reported the following experiences that significantly contributed to their suicide attempts: Hopelessness; sense of failure in life; loneliness; lack of social support; and limited coping options.

A sense of pervasive hopelessness is often an integral part of depression. [See section 4.3.1 (ix) for a discussion of “Depression” during post-suicide experiences]. Annie described it as follows: “There are times that I still remember that hopelessness ...the face and emotions on this picture [Figure 4.5, P15] ... that hopeless feeling ... it felt as if you can just disappear and it would be better ... I hate it ... it is probably depression ...”.

Hope is a positive feeling and outlook about the future. An inability to discover existential meaning in life can result in experiences of hopelessness and depression. Such individuals are at risk for suicide attempts. Several studies found that hopelessness represent an important link between depression and suicide, as well as being associated with adolescent suicide thoughts and suicide attempts (Barlow & Durand, 1995:293; Helen, 2002:40; Stillion & McDowell, 1996:58-60, 106; Sue, Sue & Sue, 1994:393-395).

Closely linked to hopelessness as a factor in survivors’ suicide attempts is their sense of failure in life. This is illustrated by the following quotations:
Megan: “... about a year after his suicide, I tried to commit suicide ... it was in my matric year ... I just couldn’t see above me ... it was too dark for me ... I increasingly felt like a failure because I failed in school and my friends ... I really felt that I was a failure ... it wouldn’t have mattered if I was there or not ...”.

Annie: “... at that stage you feel as if life is continuing without you, the world doesn’t even realise that you are lost between the waves of life ...” and “... I just couldn’t escape from the grip of drugs, so I felt like a failure, a failure in my mom’s eyes, in everyone’s eyes”.

Loneliness, social isolation and a lack of appropriate social support are salient experiences that contribute to survivors’ suicide tendencies. They sometimes are merely longing for someone who can provide an authentic space for the expression of emotions and thoughts. Annie experienced it as follows: “It felt to me as if no one noticed my experiences, as if I was alone ... I am the only one who is experiencing it and nobody will understand what I felt ... it was as if I was completely alone ... that loneliness was the worst ... I just couldn’t reach out to others ... I wished someone could reach out to me ... all I wanted to do in that situation was to be able to talk to someone ... to just pour out all my emotions without being interrupted by that person ...”.

An ancient Egyptian text is the oldest known document that deals with suicide. Already in this text the experiences of loneliness and social isolation are recognised as important reasons for considering suicide. Today, social isolation and poor peer and family relationships are still regarded as risk factors that affect suicide ideation and suicide attempts in adolescents (Rosenfeld & Prupas, 1984:xi; Stillion & McDowell, 1996:113).

Another experience that contributes to survivors’ suicide attempts in the aftermath of a loved one’s suicide is a view that suicide is the only available coping option. This is closely associated with the “Awareness of suicide-as-a-coping-option” theme that is addressed at the beginning of this section. Annie expressed this view as follows: “I have also gone through a time in which I felt that suicide was the only solution”.
Individuals that consider suicide view it as a solution to problems, not as a problem in itself. Research indicates that they not so much long to be dead, but rather to be alleviated of some stress, emotional or physical pain, or seemingly unsolvable problem. In other words, the primary goal is then not to end life, but to end pain. They often perceive the solutions to any of these problems as an all-or-none (life or death) affair, but fail to recognise that suicide is a long-term solution to a short-term problem. The result is a restricted ability to work out any alternative solutions (Helen, 2002:29; Jackson, 2003:10; Perschy, 1997:129; Sue, Sue & Sue, 1994:396).

A number of factors may play an important role to reduce or inhibit survivors to follow through on their suicide tendencies:

- Perceived social support from significant others and God. [See section 4.3.3 (ix) for “Effective social support” during the healing process]. Annie described the importance of social support as follows: “... I had contemplated suicide ... but God has been there for me all the time ... I always had some caring people around me, and that’s the difference”.

- The realisation of a personal coping choice. [See section 4.3.3 (xi) for “Personal existential realisations” during the healing process]. This is illustrated by the following quotation from Annie’s interview: “I know that at that point I still had a choice ... everyone has a choice ... you can make or break yourself, it is your choice”.

- A realisation of the emotional hurt that it will cause significant others. In Shirley’s words: “I realise that if ... I also go away because I would die ... my mother couldn’t take it anymore”.

The realisation of the anguish that one’s suicide will cause others makes it no longer a feasible or attractive option. However, what remains in many cases is a struggle with the ambivalence toward continuing life. The prevalence of self-destructive feelings may stay for a long time despite the presence of realisations and other reasons that reduce or inhibit such action (Dunn & Morrish-Vidners, 1987-88:209).
xiv) Delayed confirmation of suicide-as-reason-for-death

This “falling apart” experience refers to a situation where the survivor only receives a definitive confirmation of suicide-as-reason-for-death a considerable time, at least a number of months, after the actual suicide events. The reason for this delay is not primarily the absence or denial of definitive suicide-as-reason-for-death information, but rather as a result of significant others’ seemingly deliberate efforts to conceal it from the survivors. A number of specific experiences are associated with this situation: Re-experiencing of grief emotions; emotional hurt in being misled; and sense of unfairness.

Survivors of any unexpected and sudden death of a loved one experience normal grief reactions that subside after some time. If the reason-for-death proves to be a suicide some months or years after the actual death events, survivors tend to **re-experience the initial grief emotions** regarding the victim’s death as if for the first time. Megan described such an experience as follows: “I was in grade 11 when he committed suicide, and only found out during my first year at university ... and that opened up many of the old wounds ... I thought that I had worked through it, but then suddenly it opened up the old wounds, as well as some new ones”.

Survivors may feel some resentment towards those individuals who have withheld the “real” reason-for-death from them for so long. In such a case they experience **emotional hurt in being mislead** and lied to by significant others. It often elicits a lot of questions and disillusionment. This is illustrated by the following quotation from Megan’s interview: “… that was very painful because she [Peter’s mom] never told me that he committed suicide ... Why didn’t she tell me? ... Why did she blame me? ... How could she lie to me? ... I couldn’t believe that she didn’t tell me ... that hurt me ...”.

One result of a delayed confirmation of suicide-as-reason-for-death is survivors’ **sense of unfairness**. They regard it as unfair that significant others, who knew the “real” reason from the start, do not reveal it from the outset. Megan experienced it as follows: “I was in grade 11 when he committed suicide, and only found out during my first year at
university ... she [his mom] told her school class and then I had to hear it from someone in the class ... the girl was in my residence ... and she told me ... I felt that was unfair”.

4.3.2 Experience cluster 2: “Being shattered”

It is as though the person who commits suicide puts his social skeleton in the survivor’s psychological closet (Shneidman, 1971:456)

This experience cluster describes the research participants’ experiences of “Being shattered” when they struggle to cope with a changed life. Their lives seem to have been broken into so many pieces that repair and healing seems to be an impossibility; they are merely struggling to survive each day. [See the story of the two flower vases in the first paragraph of section 4.3]. The degree to which emotional pain is experienced varies considerably, depending on the survivors’ acknowledgement of the loss. However, experiencing the pain is important, because it facilitates a recognition of the psychological injury (Hamilton & Masecar, 2001:18).

i) Merely living without actually dealing with the suicide experiences

Time can be empty even when we are engaged in numerous activities. It is empty in being a deprived form of time. In this case the future is not accessible and the past is not significant. The result is a mere passing of time without any actual existential progression (Kruger, 1988:69).

Suicide survivors may be merely living during their “being shattered” experiences without actually dealing with the suicide events on a psychological level - a form of “empty time”. On a superficial level it may seem as if these survivors are coping and moving forward with their lives, but on a deeper level they experience a sense of stagnation and stuckness. In Shirley’s words: “... you have to go out there and pretend you’re fine ... wake up in the morning, and be fine and smile ... and go to sleep, and you know you’re not fine ... but I pretend to be happy ... I think I can do that very well now, pretending, I just do it now ...
I pretend to be the happiest person”.

Many survivors engage in a variety of activities that serve several implicit and/or explicit purposes. It includes activities that redirect thoughts away from the memories of the suicide events, activities that the victim would have been proud of, and avoidance of specific activities. Activities that redirect the survivors’ thoughts away from the memories of the suicide events are illustrated by the following quotations from Ilze’s diary and interview: “I spend all my time on my dad and five dogs ... sometimes it feels as if I am forgetting mom” and “I went to a lady [for counselling], but it completely interfered with my coaching ... basically I do not have time for it; I coach and must attend class, and must also participate in my own sport ... I must, there is just not time for it, there is not time at all”.

Grief after a suicide is emotionally draining, to such an extent that one cannot dwell within it indefinitely. Survivors naturally seek comfort and temporary distractions which can provide distance and some chance for relief and renewal. Some individuals attempt to avoid the emotional pain by staying frantically busy (Demi & Howell, 1991:354; Carter, 1989:356; Clark, 2002; Sheskin & Wallace, 1976:234).

Activities that the suicide victim would have been proud of are sometimes engaged into by adolescent survivors. There is a suggestion that these activities might be motivated by the survivors’ attempts to compensate for guilt feelings [See section 4.3.1 (i) for “Guilt” during post-suicide experiences]. Ilze described such an activity as follows in her diary: “I must go back to the residence, the year must progress ... Mom would have wanted it” and “It is the final exam, I pass with two distinctions ... Mom will be so proud”.

Another way that suicide survivors are merely living without actually dealing with the suicide events is to avoid engaging in activities that may trigger thoughts and emotions regarding the suicide events. One potential negative consequence of this avoidance behaviour is an ever increasing social isolation. Shirley engaged in such avoidance: “... when I see a funeral on TV, I don’t watch that ... it just brings back too
much bad memories ... I don’t want stuff like that” and “... before that I could sit down with people for hours ... now I just sit there for an hour and I decide ‘No, I’m leaving’, because ... somebody will say something that’ll make me think about some thing that happened, and I cannot take it and I just go”.

Suicide survivors’ experiences of an inaccessible future (‘empty time”) may manifest in not having specific life goals, but to merely focus on living in the here-and-now. Shirley verbalised this experience as follows: “I don’t know [what keeps me going everyday] ... sometimes I just tell myself ‘You know, you cannot just keep doing this to yourself, just do what you have to do’ ... I just do what I have to do ... I don’t think there is a driving force that makes me happy, or whatever”.

The existential-phenomenological viewpoint holds that a chaotic past leads to an inaccessible future. On the other hand, an accessible future indicates a well-ordered past. When the future becomes inaccessible, the past becomes even more confusing. The past then seems to be as absurd and as aimless as the future. Life had become so confusing, aimless and unpredictable that only today, the here-and-now, really matters. For survivors, the victim’s sudden and unexpected death has caused time to be frozen in the present (Dunn & Morrish-Vidners, 1987-88:210; Kruger, 1988:67-68).

Survivors sometimes realise and acknowledge the ineffective nature of merely living and coping with everyday life without actually dealing with the aftermath of the suicide events. One reason for this might be their lack of knowledge regarding effective coping mechanisms. Shirley described it as follows: “... I don’t think I have coped with it ... I don’t think I want to do it ... I don’t think it is possible ... and some of it I don’t want to face, this is the big one that I don’t want to face I’m facing now ... and now I’m gonna have to live with that now ... I don’t think anything can be done about this ... till whenever I die ... I don’t know how to cope with it, because I don’t think there is a way ... I think I store stuff inside and sometime I can not take it anymore, and it becomes sore ... that’s the way I deal with it”.

Closely related to the “empty time” existential concept that was introduced in the previous section [4.3.2 (i)], is that of “frozen time”. Temporal stuckness refers to the phenomenon that time has “stood still” for the survivor since the suicide events. The research participants reported two different experiences of temporal stuckness:

- The first experience is that the time lapse since suicide feels like very recent despite being much longer ago. For Shirley: “It was in 1998 ... It feels like yesterday ... every time I think about it, it still feels like it was yesterday” [Note: The actual time lapse between the suicide events and the research interview was four years].

- The second experience is that of the survivor’s inability to continue with life and move on from the suicide events. This is illustrated by the following quotation from Shirley’s interview: “... everybody else seems to have moved on and I am still standing back there”.

Suicide survivors have to deal with an overwhelming array of existential challenges in the aftermath of a loved one’s suicide. One attitude that survivors seem to choose during their experience of “being shattered” is one of reluctant acceptance of the suicide events and its aftermath in their life contexts. [See section 4.3.3 (ii) for “Acceptance of what actually happened” during the healing process]. The research participants reported a number of situations that they reluctantly had to accept:

- To continue life without understanding the suicide events. Shirley described it as follows: “You just live ... that’s about it ... I hate my brother ... there’s nothing I can do about it ... If I were to have just one wish, I’d wish to go to where ever my brother is,
just ask him ‘Why?’ ... I don’t want to know anything else ... he went, I go on ... I’m not going to do anything now, I’m just gonna live”.

- To accept the victim’s suicide intentionality in the light of evidence that seemingly leaves no other conclusion. Megan’s reluctance to accept Peter’s intentionality is clear from the following quotation: “... the previous evening Peter was asking questions about the different medicines in the house ... so we suspect that he had taken medicine that causes a heart arrest ... I say that ‘We suspect it’ because there is so much around the story ... there were rumours that his stepfather killed him by swapping his medicine ... so that is one idea, but everyone said that it was suicide”.

- To accept the irreversibility of victim’s choice to abandon a close relationship. Shirley expressed it as follows: “He decided to kill himself, not me ... we were so close ... there’s nothing I can do about it”.

- To accept and adjust to the permanent absence of the suicide victim. This is illustrated by the following quotation from Shirley’s interview: “It just happens that you learn to adjust to things ... you learn to know that he is no more there”.

One of the hardest things for a suicide survivor to accept is that the loved one is irrevocably gone. The suddenness of a suicide is similar to that of an accidental death, but it is much crueler because of its intention. Its combined suddenness and cruelty makes it feel like a personal abandonment. However, the survivor somehow still feels connected to the victim in many spheres - emotionally, cognitively and spiritually. The biggest difference is that the relationship is now incomplete and the survivor is left with an unanswerable reply (Rosenfeld & Prupas, 1984:27; Seeber, 2002:37).

iv) Realisation of finality

A number of situations may sometimes quite unexpectedly, elicit an acute realisation of the suicide’s finality. The research participants reported four such situations: Objects cherished by the victim; noticing others’ relationships; reaching personal milestones; and music-elicited reactions. [See section 4.3.1 (x) for “Memory” as an aspect of “Cognitive experiences” during post-suicide experiences].
The presence of objects once cherished by the suicide victim can elicit painful memories and realisations. Shirley described one such context: “Every time you go home you see his bedroom, you see his favourite things there, and you think ‘Man, he is gone’”.

When survivors notice the positive relationships that exist between other individuals, it may serve as a reminder of the positive relationship they once had with a loved one. This is illustrated by the following quotation from Shirley’s interview: “... and you sometimes you feel so bad when you see brothers and sisters coming along and you think ‘I had a brother once, and now he is gone’”.

When survivors reach significant personal milestones (for example birthdays and anniversary of the suicide) it often serves as an acute reminder of the loved one’s absence; survivors are aware that they can experience it while the suicide victim can’t. For Megan, such a milestone was her birthday: “... this year it would have been Peter’s 21st birthday, and it was very sad for me that I could reach my 21st, but he couldn’t”.

Milestone events have a tendency to elicit painful feelings of guilt, sadness and a realisation of the loss. The result is often a re-experiencing of certain memories and grief reactions. It reminds survivors that their lives are moving forward without their loved ones (Jackson, 2003:5; Raphael, 1984:47). [See section 4.3.2 (x) for “Milestone events and dates” as an aspect of “Longing for a continued relationship with victim” during post-suicide experiences].

Sometimes a piece of music that was loved by the victim or somehow associated with the victim can trigger specific memories. Megan reported such a music-elicited reaction: “Every now and again, there is one song that always turns my thoughts to him ... Eric Clapton’s ‘Tears in heaven’ ... I cry when I hear that song”.

Music is well known to elicit intense emotional reactions and memories. These reactions may be elicited by different characteristics in a particular song or musical piece, such as the melody, rhythm, tempo and/or harmonics. The important aspect is the nonverbal
engagement of emotions related to the loss (Jackson, 2003:3; Rando, 1993:77; Van Dongen, 1991:377). [See section 4.3.1 (xi) for a discussion of the role of “Music” in dealing with grief emotions].

v) Emotional stuckness

Emotional stuckness is an integral characteristic of “being shattered”. It predominantly prevents one from exploring and opening up to new possibilities in life. As individuals suppress the normal flow and progression of emotions and thoughts, they are left in a heartbroken, dispirited and low motivation state. The result is little emotional energy to generate and accept new possibilities in life (Clark, 2002).

The research participants have experienced a number of emotions that can be regarded as an indication of “being shattered”. The “stuck” nature of these emotions manifest in overwhelming feelings that the negative effects and emotional hurt of the suicide events will never subside. The following quotation from Ilze’s interview provides a succinct description of this experience: “... it was really bad when someone told me ‘You will get over it’ ... how are you going to get over your mom’s death ... you are not going to get over it”. For Shirley, it was “… sometimes you get overwhelmed with feelings ... it’s too many feelings mixed up together ... and you don’t know what to feel”.

The typical progression of mourning for certain kinds of losses are sometimes significantly longer than for others, particularly when the death was sudden, unexpected and self-inflicted. In the case of adolescents, they often have never been submerged so deeply into painful emotions. Their control of emotions is overpowered and they now have to cope with new, strange and overwhelming emotional experiences. No wonder that they believe that there will be no alleviation, especially since an important source of comfort, strength and support are suddenly absent (Balk, 1983:155; Clark, 2002; Rando, 1993:181).
Survivors frequently experience a **reluctance, avoidance or fear to outwardly express and verbalise their deep-felt emotions**. This is illustrated by the following quotation from Shirley’s interview: “I don’t talk about emotions, I just answer your questions ... I don’t talk about my stuff ... I do not cry ... the last time I cried was ... my brother’s funeral ... the stuff is still there, it’s in bottles, I keep bottles in my heart ... that’s the type of person I’ve become, I just store stuff ... I’m just scared of facing it ... I don’t think I want to do it anytime soon, never ... it’s just too much and I know I won’t be able to handle this”. [See section 4.2.3 (i) for “Inability to express emotions” as an aspect of “Emotional reactions” on becoming aware of the suicide].

**Intentional emotional inhibition may be the survivors’ way of protecting their families and friends from the hurt they are experiencing.** Apprehension and fears about bringing emotional pain into the open most often than not introduce boundaries in significant relationships. The result is social distancing and separation (Dunn & Morrish-Vidners, 1987-88:202; Opperman & Novello, 2003:11).

Adolescents often have to deal with social sanctions against emotional expression, the inability of others to recognise their emotional needs and a lack of appropriate social support. This contributes significantly to making the process of mourning a private affair which extends the grief process and eventual resolution (Raphael, 1984:155-156).

The **inability to forgive** may focus on either the suicide victim or the survivor self. Shirley verbalised an acute inability to forgive the **suicide victim** as follows: “... my brother ... I can never, even if I was paid to, forgive him ... I don’t think I’ll be able to do it ... I don’t know how to”. Ilze’s inability to forgive **herself** for a perceived contributory role in the suicide events is illustrated by the following quotation: “... I cannot forgive myself ... because I now know, after everything, what happened to her ... I now know that she needed me and I pushed her away ... I just wasn’t there at the end ... I could have changed it, but I didn’t because I chose not to do it”. [See section 4.3.3 (iii) for a discussion of “Forgiveness”].
Hate feelings may be directed at either the suicide victim or the survivor self. **Chronic hate and anger** towards the **suicide victim** can be as a result of the emotional hurt caused by the suicide events and its aftermath. Shirley described it as follows: “Right now I am very angry ... because he put me through so much ... It’s there, it will never go away ... the pain, the anger, the hatred”. [See section 4.2.3 (i) for “Intense hate and anger towards the suicide victim” as an aspect of “Emotional reactions” in the days directly following the suicide, as well as section 4.3.1 (iv) for “Angry at victim” during “Falling apart” post-suicide experiences]. Hate directed towards the **self** may be based in survivors’ personal disappointment for being hateful towards the victim. This experience was verbalised by Shirley in the following quotation: “... I hate him, and I hate the fact that I hate my brother”.

Closely related to the above “inability to forgive” and “chronic hate and anger” themes are some survivors’ **reluctance to acknowledge the victim’s positive personal characteristics**. Different survivors may react in quite opposite ways when recalling a specific victim’s personal characteristics. This is evident in the following quotation from Shirley’s interview: “My mother ... she’ll talk about the good things he did ... she wants to make us realise that he wasn’t a bad person and she would still love him even though he is gone, but I find it very difficult”.

_Survivors frequently tend to have a distorted, restricted or one-dimensional image of the victim. As a result they see them as either all good or all bad. When the victim is viewed as all bad, the rest of his/her life, and particularly the more positive aspects, can be almost completely denied, ignored or overlooked (Wertheimer, 1991:191)._  

As a last “stuck” emotion, survivors often experience that **memory cues trigger emotional responses for a long time after the suicide events**. This experience is illustrated by the following quotation from Megan’s interviews: “... it’s been a long time, but I still sometimes cry when I hear Eric Clapton’s song ‘Tears in heaven’”; “... [Figure 4.4, P6] there are still times that I feel like this ... especially when I think about everything, it is as if everything is falling away ... that I expose myself for the whole situation ...
sometimes, but it is not that bad anymore” and “… [Figure 4.4, P1] at one stage while I was drawing it, I started to cry because that childlike unconditional hurt came out again ... you know, if a child gets hurt, he hurts very much ... I still get hurt, even if it happened five years ago ...”. [See section 4.3.1 (x) for “Memory” as an aspect of “Cognitive experiences” during post-suicide experiences].

vi) Insistence on the idiosyncratic nature of personal experience

Grief is at the same time a universal human phenomenon and a highly individualised experience. Grief’s idiosyncratic nature is based in its multidimensional character that includes behavioural, cognitive, emotional, social, somatic and spiritual components. The implication is that one should never interpret or respond to suicide survivors as if they belong to a homogenous group with little variability (Bailley, Kral & Dunham, 1999:256, 269).

One way that survivors affirm the idiosyncratic nature of their personal experience is to make use of a comparative evaluation of their hurt. Shirley described it as follows: “I think I’m the one who hurts the most, but they don’t realise that…”

Another phenomenon that supports the idiosyncratic notion of survivors’ experiences is their insistence that it is impossible or difficult for others to understand and identify with their experiences. As a result, survivors find it almost impossible to explain or share their experiences with others. Ultimately, it leads to social isolation and avoidance of any external support interventions. This is illustrated by the following quotations:

Shirley: “I don’t think anybody can understand what an individual goes through ... they can say ‘I feel I know your pain’, but they don’t know what you feel ... nobody ever, even your family ... I think the experience, it’s not the same, your pain is not the same ...” and “… I don’t want to talk to anybody ... because you feel they won’t understand”. Annie: “It felt ... I am the only one that experienced it and nobody will understand ... it was as if I was completely alone...”.
Coming to terms with the suicide of a loved one is a unique process for every survivor. It is not uncommon for survivors to feel as though they are the only persons who ever had to go through the experience. They feel that nobody will understand their experiences. The result is a sense of social isolation. Other persons are avoided or pushed away, often in spite of their concern. Alternatively, the survivors’ insistence to not share their experiences with supportive others may be a coping strategy to conserve energy and make time for their own grief process (Clark, 2002; SIEC, 2001b; Wertheimer, 1991:xviii, 69).

[See section 4.3.2 (xiv) for “Ineffective social support” during post-suicide experiences].

vii) Contexts that elicit frustrations

The research participants reported a number of situations and contexts that were quite frustrating to them. It included the following: An inability to provide answers to others regarding the reason for the suicide; being the “real victim” of the suicide; not being regarded as “adult” enough; and persistent jokes and stories.

A significant frustration for suicide survivors is their inability to provide answers to others’ questions regarding the reason for the suicide. Shirley expressed this frustration as follows: “... my little brother, my little sister, they keep on asking me ... and I don’t understand it myself why it had to happen cause he left a note, and the note was just like: ‘I’m sorry I had to do this. Bye’, and he didn’t explain ... so, I don’t know” and “... sometimes when you talk to people, like asking about ... sometimes I don’t have the answers, I never have the answers ... you can never ask him, because he’s not here and nobody knows”. [See section 4.3.2 (viii) for “Not knowing the reason for the suicide” as a “Being shattered” post-suicide experience].

The search for the reason the victim chose to die, is one of the worst frustrations to the bereaved friends and family due to its unanswerable and/or ambiguous nature. To add to this frustration, suicide survivors experience that they are more often than natural death survivors pressurised by other people to explain the cause of death. As a result they not only struggle with their own understanding of the events, but also have to cope with
the questioning attitude from other (McIntosh, 1993:153; Range & Calhoun, 1990:317; Rosenfeld & Prupas, 1984:5).

Closely related to the previous frustration is that of being the “real victim of suicide” due to someone else’s decision to complete a suicide. The following quotation from Shirley’s interview describes this frustration: “I think the victims of suicide, and not the people that kill themselves, it’s the family left behind ... because they go through pain maybe for like ten minutes and they’re dead and we have to live with that for the rest of our lives ... and we have to every day have to struggle, it’s a battle ... and that’s not my fault, that’s his fault, he decided to kill himself, not me”.

*Lukas and Seiden (1987:56)* describe suicide survivors as follows: “Taken as a class of people, survivors are victims. They appear angrier, guiltier and more grief-stricken than the general population”.

An important developmental task during adolescence is identity formation. Therefore, adolescent suicide survivors can be especially frustrated when not being recognised as emotionally mature enough by informed adults to be entrusted with sensitive information regarding the suicide events. This is illustrated by the following quotation from Maria’s interview: “I don’t know what’s in her letter that she wrote ... her parents, they know and my mother knows, my aunt knows, but then they don’t tell us, Why? ... we are old enough to handle anything, we can make sense of anything, just tell us what happened”.

*Adults need to recognise that it’s important to truthfully discuss a suicide with children and teenagers right from the start. That is the only way that they can reasonably make sense of things. If some facts or truths are hidden from them there are always complications, if not immediately then much later in their lives. Without truthful information, they tend to make up their own version of the facts which often proves to be a significant distortion of reality. Also, adolescents learn that they cannot trust the adults who are close to them and suppose to be truthful with them (Lukas & Seiden, 1987:172).*
[See section 4.3.2 (viii) for the “Inability to access information sources” as an aspect of “Not knowing the reason for the suicide” during post-suicide experiences].

Another context that elicited frustration in the research participants was that of persistent stories and jokes regarding the victim and the suicide events. [See section 4.2.3 (iv) for a discussion of the theme of “Stories, jokes and rumours” as an aspect of “Interpersonal reactions/experiences” in the days directly following the suicide]. Annie described it as follows: “... the stories afterwards that hurt a little bit ... how can people add things to such a tragic event ... that is unnecessary” and “... what hurts me a lot is if people make jokes ... I mean, they are speaking about a person that suffered and couldn’t cope with life ... I don’t understand why people do it ... it frustrates me”.

viii) Not knowing the reason for the suicide

*Suicide survivors often experience difficulty in understanding the rationale for a loved one’s death. A state of cognitive dissonance develops when current cognitive elements are inconsistent or in conflict with the perceived reality. As a result they tend to become anxious and confused, wondering about what actually triggered the suicide events. The loved one’s death shatters the survivor’s worldview regarding meaning, orderliness and predictability. This makes it very difficult to deal and recover from the loss (Helen, 2002:37; Rando, 1993:47; Van Dongen, 1990:226).*

Almost without exception suicide survivors have a deep personal longing and need to know the reasons for the suicide. This is illustrated with the following quotations from Maria’s interview and collage poem [Figure 4.3, P13]: “How?? I still wonder?! Who knows why” and “... I want to know what happened ... I think, to know the full reasons ... I will be able to just accept fully ... I still have that space that’s left ... that letter, if I read it that space will be fulfilled, it will be full and I will be like, it happened this way, and I’ll accept it”.
The deep longing for understanding why the suicide occurred is a significant component of post-suicide bereavement. This need to search for understanding and answers is a natural, albeit frustrating and one of the most difficult legacies that a survivor will inherit. The usual explanations that society offers to bereaved persons (for example ‘It’s God’s will’) are obviously not available to those bereaved by suicide. As a result suicide survivors are more likely to search independently for an understanding. They then spend a lot of energy and time searching for a definitive answer - a form of “agonising questioning” in the face of persistent cognitive dissonance. For some survivors this search for understanding becomes their reason d’être. Sadly, many do not find personally satisfactory answers as the real reason for the suicide will remain a mystery (Calhoun, Selby & Selby, 1982:412, 417; Dunn & Morrish-Vidners, 1987-88:184; Grant Kalischuk & Davies, 2001; Ness & Pfeffer, 1990:283; Seeber, 2002:39; Van Dongen, 1990:225-227; Watson & Lee, 1993:38; Wertheimer, 1991:80).

The search for answers and understanding is often motivated by the survivors’ feelings of guilt and responsibility; a need to rule out the possibility that they were the reason for the suicide. The most perplexing question that is asked may also be the one that lasts the longest: “Why?” The tragedy of this question is that survivors don’t get a chance to ask it to the one person who actually has the answer. The complexity of the question “Why?” is evident in its loaded nature: What was there in my loved one’s life that made it so unbearable? Was I partly responsible? What could I have done to prevent it? Could I have kept him/her from dying? The search for these answers can become an overwhelming and endless struggle to put together life’s pieces. It can so dominate survivors’ lives that it interferes with relationships and their ability to get on with life. The “answer” is a realisation that the pieces will never be perfectly put together, just as one will never find all, or any, of the answers (Alexander, 1987:115; Hamilton & Masecar, 2001:45; Lukas & Seiden, 1987:91-93; Rosenfeld & Prupas, 1984:27).

Dunne, McIntosh and Dunne-Maxim (1987:xv-xvi) describe their view regarding the complexity of the “Why?” question as follows:

“We have never seen an instance where multiple forces were not at work to bring
about this tragic scenario. Never has it seemed appropriate to attribute the death to a single cause, even such seemingly telling antecedent events as fights, arrests, or divorces. These events can increase the potential for suicide, but they are not sufficient in themselves to account for it. Never has it seemed to us that any single person, be it a parent, sibling, spouse, lover, friend, or therapist, could be appropriately singled out and blamed as the agent of a suicide. We do not believe in ascribing ‘responsibility’ for suicide to anyone other than the victim. The failure to choose life is the failure of the deceased, not of the survivors”.

Usually there is a number of factors that contribute to survivors’ experience of not knowing the reason/s for the suicide. The research participants reported the following factors: The victim’s non-typical behaviour and mood state prior to the suicide; a non-informative suicide note; and not being allowed access to sources that can reveal the actual reason.

Survivors’ inability to retrospectively understand the victim’s non-typical behaviour and mood state prior to the suicide contribute significantly to their sense of not-knowing-the-reason-for-the-suicide. Shirley described her brother’s non-typical behaviour as follows: “... we were very close ... I would have thought if he had a problem, he would have told me and we would have spoken about it, because everything we do, we do together ... I don’t think he had any troubles because he wasn’t that type of person, if he had any he would have talked about them ... he’d talk about them ... I don’t know ... I didn’t understand”. She also reported an inability to understand his non-specific negative mood state directly prior to suicide: “… it was Wednesday ... he decided to go to his room ... but he was very sad that day ... I don’t know what happened”.

The uncertainty of non-understanding motivates survivors to relive the time just prior to the suicide and to look for clues and evidence that might illuminate the motive for the suicide. As a result survivors spend a lot of time and effort to explain and understand the antecedents which may have precipitated the suicide events (Calhoun, Selby & Selby, 1982:417; Grant Kalischuk & Davies, 2001).
Infrequently suicide victims leave a suicide note. However, in many cases these suicide notes do not provide clarifying information regarding the reason for the suicide. This leaves survivors with the experience of still not knowing the reason/s for the suicide despite having access to a suicide note. This experience is illustrated by the following quotation from Shirley’s interview: “... he left a note, and the note was just like ‘I’m sorry I had to do this, bye’, and he didn’t explain ... the thing that irritates me the most, that the note didn’t say anything”. [See section 4.3.1 (v) for the “Absence of a suicide note” as an aspect of “Doubt” in “Falling apart” post-suicide experiences].

A suicide note should be regarded as a text in which the victim only tells the survivors what he/she wants them to know - a final goodbye, explanation, apology, blame, or written will. It should be kept in mind that the note merely represents the victim’s state of mind and thoughts at the time when it was written; it would be mistake to attempt extracting all the reasons of the tragedy from this document. Possible “positive” aspects of a suicide note are its role to help survivors gain clarity and accept the reality of the death. Survivors rarely get a chance to properly say goodbye to the victim; the note may then represents their only farewell. Research also indicates possible “negative” aspects of a suicide note. In one study it was found that survivors who had received suicide notes were more likely to experience intense emotional pain in the aftermath of the suicide than those who didn’t receive suicide notes. It seems that a suicide note in this case serves to emotionally draw the survivor deeper into the drama and tragedy of the suicide. The note may unequivocally indicate the victim’s suicide intent, or be just another confusing and ambiguous piece of the puzzle. Sadly, the suicide denies the victim any opportunity to respond to the suicide note’s message (Helen, 2002:40-41; Jackson, 2003:11; Rudestam & Agnelli, 1987:212; Wertheimer, 1991:74, 76).

Another factor that contributes to survivors’ experience of not knowing the reason/s for the suicide is their inability to access information sources that can reveal the actual reason for the suicide. In this case the reason is known to others who refuse to reveal the reason. This factor is described in the following quotations from Maria’s interview and collage: “This is just a little poem [Figure 4.3, P13] ... it goes like ‘How?? I still...”
wonder?! Who knows why. Seem powerless to tell. Still we wait patiently, that one day it will all be revealed”, “... still, I don’t know what’s in her letter that she wrote ... if I know, at least, I would have some guide ... they [victim’s parents] don’t want us to read it” and “... it will be much better if they just talked about it and just maybe told us about it ... I want to know what happened ... but then they do nothing about it”.

Sometimes close relatives of a suicide victim are reluctant to reveal information regarding the suicide events; they shroud the death in secrecy. As a result the restricted facts may become vague or distorted. Those not being entrusted with all the facts are likely to feel angry and excluded (Helen, 2002:60-61). [See section 4.3.2 (vii) for the “Frustration when not being recognised as emotionally mature enough to be entrusted with sensitive information regarding the suicide events” as an aspect of “Contexts that elicit frustrations” during post-suicide experiences].

Not knowing the actual reason for a suicide makes it difficult for survivors to progress in the healing process; they are caught up in a state of “being shattered”. Maria expressed this experience as follows: “... still, if you have that thing in you that, that you don’t understand why it happened, until it makes sense of what happened, then you can, you are gonna get better”.

All individuals have an inherent need to understand and cognitively make sense of their lifeworlds. It provides a sense of mastery, predictability, security and control. Even the death of a loved one is not excluded from this thought process in order to eventually cope and readjust to the changed situation. Suicide survivors engage in cognitive attempts to formulate for themselves an explanation regarding the cause and circumstances surrounding the suicide more frequently than any type of natural death survivor groups. Restricted healing and adjustment problems surface when a survivor is unable to sufficiently construct an account that explains how and why the death occurred. The inability to cognitively fit the loved one’s death into a logical framework leads to a sense of a meaningless, disorderly and unpredictable world. The survivor invariably becomes confused, anxious and fearful of his/her lifeworld (Bailley, Kral & Dunham, 1999:266;

ix) Suspected reason for death

Survivors usually have an idea or strongly believe that they know the reason/s for a loved one’s suicide. They rarely attribute the death to the victim’s loss of motivation to be alive or as the result of a deliberate intentional decision. Rather, it is often attributed to “external” factors such as difficult interpersonal relations, academic problems or negative life circumstances (Dunne, 1987:204).

The reason/s for a loved one’s suicide is very often not clear to those that are left behind, as indicated in the “Not knowing the reason for the suicide” section [see 4.3.2 (viii)]. As a result survivors attempt to offer some plausible, from their perspective, reason for the death. These may vary from highly improbable situations to subjective judgements of the victim’s personality. Other suspected reasons might very well be part of the “realistic answer”. The research participants’ views regarding the suspected reason/s for the victim’s death can be described as belonging to one of the following themes: Alternative reasons, excluding intentional suicide; negative circumstances; and personal characteristics.

Sometimes survivors will offer alternative reasons for the loved one’s death, excluding an intentional suicide. Such an alternative reason is often not a strong personal believe; the survivor will often, even in the same sentence, also recognise and express indications of an intentional suicide. During her interview Ilze described her mom’s death as an accidental death due to medicine use, but also as a suicide: “... she chronically used analgesics and other medicines ... that night she stayed at work ... she took pills, but not an overdose ... she fell asleep in the bathroom ... basically it is suicide because she knew that she was weak and couldn’t do it ... she didn’t mean it, but it happened ... for me it is just that she decided to go”. However, in her diary, Ilze ascribed her mom’s death to
cancer: “The pathologist says it is definitely cancer, not suicide ... thank you Lord, thank you so much”. Megan entertained a murder complot as an alternative reason, together with suicide: “... there is so much around the story ... there were rumours that his stepfather killed him by swapping his medicine ... so that is one idea, but everyone said that it was suicide”.

Sometimes the suicidal nature of a loved one’s death is denied. Even after the accumulation of evidence to the contrary, survivors may hold onto the notion that the death was accidental, caused by a life-threatening disease or foul play. In all these cases denial serves as a defence mechanism to protect them against the feeling of disgrace associated with a suicide. By keeping the alternative reasons alive, some survivors never get the chance to deal with their true feelings (Cain, 2002:132; Lamb & Dunne-Maxim, 1987:258; Rosenfeld & Prupas, 1984:12; Schuyler, 1973:319; Sheskin & Wallace, 1976:232; Van der Wal, 1989-90:156; Wrobleski, 1984-85:177).

One frequent set of suspected reasons for the victim’s suicide is to attribute it to negative circumstances. It seems to be an attempt to contextualise or even “justify” the loved one’s suicide. Also, it shifts the blame away from the victim to external circumstances.

One of the suspected negative circumstances reported by the participants was the victim’s perception of absent or inadequate social support. Ilze formulated it as follows: “I now know that when you are depressed and someone rejects you, then you do not think ... you do not care anymore ... you feel as if nobody cares ... on that moment, she felt like this ...”. In Maria’s words: “... maybe she felt more ‘I have nobody to lean on, even my best cousin, my best friend doesn’t call ... I have nobody to talk to’”.

Another suspected negative circumstance reported by the participants was the role of troubled family relationships. This is illustrated by the following quotation from Megan’s interview: “... he had a difficult life with his stepfather ... while others liked his stepfather a lot ... his own dad wasn’t good either ...”.
Sometimes the victim has suffered from prolonged physical pain and the suicide is then interpreted by the survivor as an escape from negative physical circumstances. Ilze described such an interpretation as follows: “I don’t know if it actually was suicide, but I know that she didn’t want to live because she suffered a lot of pain ... she had a lot of operations ... physically she was very weak ... she had a lot of pain, and I understand that”.

One study found that students evaluate any person’s suicide in response to chronic physical pain as relatively more acceptable than suicide in response to depression (Deluty, 1988-89:321).

Closely related to the previous “escape” reason for suicide, is the survivors’ view that suicide was the last remaining coping option for the victim to escape from overwhelming, intensely negative life circumstances. This is illustrated by the following quotation from Maria’s interview: “I think she was really burning inside ... loneliness was burning her ... she couldn’t take all the pressure that she was experiencing ... and then the last resort for her, it was death, that’s how I saw it .... she just couldn’t cope ... I would say her lifestyle forced her towards suicide”.

In the days and months leading up to the actual suicide, victims may have experienced intense confusion and bewilderment within a context of acute and unrelenting emotional pain. They may have been so overwhelmed by it that a suicide seemed more like an ending and escape from pain than an ending of their lives (Helen, 2002:38).

Survivors’ religious beliefs may significantly influence their contextualisation of the victim’s suicide. Some survivors then view the suicide as an escape from an emotional hurt context to a positive context in God’s presence. Annie described such a view as follows: “... it is as if her suicide, she perhaps just wanted to be with God, I don’t know, if I can put it in this way ... the person who committed suicide ... is in a better place ... I hope that person doesn’t experience pain anymore”.
Survivors sometimes base their views regarding the suspected reason/s for the suicide on one or more of the victim’s personal characteristics, for example an “unhappy” personality or insufficient coping abilities. This is illustrated by the following quotations:

Megan: “... when I was busy working through it .... I realised that he was very unhappy in his life since childhood ... he was unhappy ... he was a person who needed other people to be happy, he couldn’t do it himself ....”.

Maria: “... the captivity was too much for her to handle ... she couldn’t cope with everything ... she was really in a bad situation ... she couldn’t handle it ...”.

During their attempts to work out the motivation and reasons for a suicide, survivors need to be cognisant of its multidimensional nature. A combination of many factors are usually involved in the suicide. It includes the socio-culture environment in which the individual was raised, family environment, relationships the victim has experienced throughout his/her lifetime, inherited biological factors, physical and psychological health of the person, cognitive abilities, religious beliefs and views regarding the value of his/her personal existence (Stillion & McDowell, 1996:18-20, 38).

Even when survivors are able to offer plausible “causes” or “reasons”, they frequently remain unsure and ambivalent about why it happened. They find it difficult to formulate more than just partial or fragmented explanations, even after a long time of reflection on the tragedy. Every formulation attempts to establish plausible connections between the victim, the suicide, and relevant events in the person’s life, however ambiguous and unclear these connections might be. On the one hand, responsibility is attributed to the victim as part of the explanation. On the other hand, survivors seem to excuse the victim by ascribing the suicide to a weak personality, negative life circumstances or some other reason (Dunn & Morrish-Vidners, 1987-88:182-186; Rosenfeld & Prupas, 1984:38).

x) Longing for a continued relationship with victim

“Holding” refers to the bereaved person’s desire to selectively preserve and maintain that which was good from the loved one’s lost existence. It also involves continuing the
loved one’s presence through various means, such as talking aloud to the person, writing
to him/her in a diary, or feeling his/her presence from time to time (Carter, 1989:356).

The research participants experienced a number of “holding” phenomena that indicate a
longing for a continued relationship with the victim. **Milestone events and dates** are
frequently a point in time when a longing for the victim’s presence is salient and strong.
This is illustrated by the following quotation from Ilze’s diary: “It is Christmas, I hate this
day, it is my birthday and mom is not there, she will never again be at my birthday, never
again be at a Christmas, she will never be able to plan my wedding or dress, she will never
see when I become 20, 21 ... she will never see my children and never hold them”.

*The meaning and reality of a loss continues to emerge through experiences over time.*
*The intensity of grief may gradually decrease, but particular times, dates and events
associated with the person who has died can readily elicit memories and grief reactions.*
*Memories provide a lived continuity to the story of being with the one who is gone. It
holds one in place in the world, reorientates the experience of lostness, supports sense-
making and reshapes emotional pain until the loss are accepted. Memories allow the
dialogue of “being together” to carry on, except that it is now one-sided (Clark, 2002;
Helen, 2002:92; Kinsella, Greeff & Poggenpoel, 1993:45; Seeber, 2002:103; Witte-
Townsend, 2002:174). [See section 4.3.2 (iv) for “Reach significant personal milestones”
as an aspect of “Realisation of finality” during post-suicide experiences].*

Survivors can give **concrete expression** to their longing for a continued relationship with
the victim through various actions, such as writing letters and visiting the victim’s grave.
Megan expressed her longing through **letters**: “... for the first two years I wrote a letter
each year and released [it] in the wind with a hope that it will reach him”. Annie preferred
to express her longing by **visiting the victim’s grave**: “... sometimes I enjoy to visit her
grave and to talk to her ... ‘I hope that you are in a better place’ and to tell her what is
happening in my life”.

Rituals are often used to provide symbolic evidence of the loved one's continued existence in the life of the survivor. At the same time it recognises the reality of the death. Participation in rituals for a limited time may provide the survivor with an opportunity to interact with the memory of the victim without crossing over into pathological dimensions. It serves the important function of connecting the past with the present. Personalised rituals provide powerful facilitatory actions for transition, healing, continuity and affirmation of ongoing relationships (Conley, 1987:179; Rando, 1993:58, 316; Watson & Lee, 1993:41). [See section 4.2.3 (v) for a discussion of the “Ritual” concept; see section 4.3.3 (vii) for “Engaging in creative writing” during “Putting the pieces back together” post-suicide experiences; see section 4.3.3 (v) for “Role of a cultural ritual: Visiting the grave” during “Putting the pieces back together” post-suicide experiences].

Sometimes the longing for a loved one’s presence manifests in experiences of the victim's supernatural presence as a friend and carer. Megan described it as follows: “... he is there and he will always be there ... I know he watches out for me” and “... this picture [Figure 4.4, P1] where we are holding hands, it is that connection between us ... it will always be there, even if he is not here, he is always there with me ... at the top it says ‘Friends forever’ because that is so, we will always be friends ...”.

Although death has ended the biological life of the loved one, it does not necessarily end their relationship. A continuing sense of the victim’s presence as a constant companion is a common feature of mourning. Such a relationship is not regarded as psychologically pathological if it doesn’t significantly interfere with the survivor’s engagement in ongoing life. Additionally, two criteria should be met: 1) the survivor must recognise that the person is dead and understand the implications of the death, and 2) the survivor must continue to move towards adaptation and integration into the new life (Rando, 1993:55; Van der Wal, 1989-90:158).
An appropriate death is one which a person might choose for himself, had he an option. Death is therefore a harmonious end point. It is difficult ever to see suicide as an appropriate death (Shneidman, 1971:457)

The “Disappointed in victim” experience is closely related, but not identical, to being “Angry at victim” [sections 4.3.1 (iv) and 4.3.2 (v)]. Anger refers to an intensely negative emotion towards the victim. It is often based in some form of underlying blame or guilt. Disappointment refers to a reflective and tempered negative view of the suicide’s legacy, either for the victim (for a premature ending of life) or the survivor (for being on the receiving end of the victim’s choice).

In the case of an adolescent suicide, society at large and survivors directly are often intensely disappointed in the victims for prematurely ending their lives during the prime years of life. The survivors are left with the view that the victims had a lot of personal potential, resources and options still available. This is illustrated by the following quotation from Maria’s interview: “... she was young ... years to live her best life ... she had dreams, she had goals, she had the most perfect smile, she was so beautiful ... her road was still to begin ... she was yet to see a lot more to life than what she has done, and then she decided to cut it ...”.

One study found that suicide survivors more frequently report that the suicide was a senseless and wasteful loss of life than natural death survivors (Bailley, Kral & Dunham, 1999:266).

Another experience of disappointment in suicide victims is the survivors’ view that their choice to complete suicide was selfish. It is based on the notion that the victims didn’t have foresight and regard for significant others’ reactions, thoughts and emotions in response to a suicide. Megan expressed this disappointment as follows: “... to commit suicide, when I take my situation and his situation, is very selfish ... one must think before
you do anything like this”.

_A loved one's suicide is sometimes regarded as a selfish and thoughtless act, mainly due to the immeasurable pain it inflicts on family and friends (Helen, 2002:7)._  

xii) Changed relationship dynamics: Family and social roles

_The death of a loved one is probably the most destabilising event that families and close peer groups have to adjust to. A failure to adapt to and integrate the changes brought about by it increases the risk of dysfunctional relationship development. The number, quality and centrality of roles that the victim fulfilled in the family and social groups have an important influence on the extent of the functional impairment that the various groups are likely to experience (Helen, 2002:59; Opperman & Novello, 2003:4)._  

Almost without exception suicide survivors have to fulfill **new family roles** following the suicide of a direct family member. Adolescent survivors frequently experience being thrust into a new **emotional carer, advisor and parent role**. These survivors are then expected to fulfill parental functions while actually still being adolescents. As a result of these new roles, adolescent survivors often experience an unmet personal need for emotional support. This is illustrated by the following quotation from Shirley’s interview: “I was suppose to have the answers for the little ones because they didn’t understand … I have to listen to their problems now because we are a very close family … my parents couldn’t talk to them because they were going through so much pain themselves … I had to be the one with all the answers but nobody had the answers for me … I always felt like I’m taking care of everybody cause those time my mother got sick, she couldn’t take care of them … I had to take care of everyone but who was taking care of me?”

_Siblings often assume the responsibility for taking care of things after the suicide of a family member. The usual roles of parents and child as carer and cared for are then temporarily reversed. The parents may be so consumed in their own grief and emotional pain that they do not recognise or give adequate attention to the grief of the children._
whatever their ages might be. For this reason the children are often referred to as “the 
forgotten mourners”. The children may now “parent” their parents in an effort to bring
some order to the family’s disrupted functioning. They may feel a need to protect their
parents from further distress. When children “parent” their parents, they frequently
postpone their own needs to grief, to be comforted and to resolve their emotions and
thoughts regarding the suicide. As a result they may never actually mourn their loss.

Adolescents are so sensitive to social cues and expectations that they may perceive
themselves as being “expected” to act “grown up” and to comfort other family members,
such as younger siblings. On the one hand, it offers a sense of usefulness and a positive
role in the face of the irreversible tragedy. On the other hand, it may facilitate doubts
about their ability to fulfill such needs and expectations when they feel so helpless
themselves. Where the parents continue to be consumed in their grief for the dead child,
the surviving adolescent may eventually feel unloved and neglected (Demi & Howell,
1991:351; Dunne-Maxim, Dunne & Hauser, 1987:238; Helen, 2002:59, 67; Perschy,
1997:16; Raphael, 1984:151; Rosenfeld & Prupas, 1984:77; Wertheimer, 1991:122-123,
127-128).

Another new family role that some adolescent survivors have to deal with is an explicit
or implicit expectation from others to fulfill the family role previously held by the
suicide victim. Shirley described it as follows: “... I couldn’t talk to my parents because
I was now the oldest one” and “I think in a way they expect me to come in my brother’s
place because he’s not here anymore ... he was going to do some engineering stuff, so he
was going to be big ... now I have to be that one, I have to live up to his expectations ...
be the kind of person that he would have been if he was there ... for my little brother and
sister, and my mother and father”.

The death of one family member means that the family system has irrevocably changed.
The suicide has brought an end to the victim’s problems. For the family members that
stay behind, the tragedy and struggles are just beginning. The roles, relationships and
interactions within the family can no longer continue and be fulfilled as before, especially
if the victim has occupied a key role in the family. Sometimes one survivor will literally
take over the victim's role and functions in the family. Children are often the most likely to be significantly influenced by the changed role allocations and interactions that develop subsequently (Raphael, 1984:54-56; Wertheimer, 1991:101, 128).

In the case of a parental suicide, adolescent survivors may experience strong social pressures to fulfill the role of the absent parent in order to maintain family stability, especially if they are the oldest child. Such a new role as “parent” may have many negative implications for the adolescents’ personality development since it usually forces them towards premature identity foreclosure. Also, late adolescent survivors, especially if they are now an only child, may be torn between feelings that they should be around to support and care for their bereaved parents, while at the same time wanting to continue or embark on their own independent lives (Raphael, 1984:170; Wertheimer, 1991:123).

Suicide survivors often experience new or changed social pressures as a result of a loved one’s suicide. One such social pressure is that of being expected by others to provide answers regarding the suicide events due to a close relationship with the victim. Shirley verbalised such a social pressure as follows: “... I was expected to know everything ... I guess if I was in the position those other people were at, I would also expect me to know ... I didn’t know”. [See section 4.3.1 (vii) for “New social role expectations” as an aspect of “Sense a loss or restriction of ‘self’” during “Falling apart” post-suicide experiences].

Closely related to the above new family role of emotional carer, is a similar perceived social pressure to be a perfectly adapted person that can provide care and advise to others. This is illustrated by the following quotation from Shirley’s interview: “... everybody just expects me to be this superhuman who can listen to you and not have problems of our own ... and tell you what to do and what not to do ... they expect me to be such a wow person and I’m not ... even my friends they expect me to be this wow person ..."
AWARENESS OF IMPACT ON OTHERS

Suicide survivors are not always so absorbed with their own grief and emotional pain that they do not notice the impact of the suicide on other significant persons. Such an awareness manifests in sincere empathy for other survivors’ grief (Kinsella, Greeff & Poggenpoel, 1993:45).

Some survivors may display a sensitivity and empathy for the extreme emotional traumatic experiences and life crises that other survivors are experiencing after the suicide of a mutual loved one. This is illustrated by the following quotations from the interviews:

Maria: “... the day before she killed herself ... she was happy ... and [her parents] thought ‘Wow, OK, my kid is it getting better’, only to do the opposite the next day ... when you feel at comfort with your kids and then to experience that thing the next day, I think it is traumatising, it is trauma ... it’s bad when one think about it, I mean, her kid ... and it was her father’s gun”.

Annie: “... [the suicide] breaks others’ hearts ... I have seen that her mom didn’t know how to continue with her life, she couldn’t believe that she didn’t notice her daughter’s pain”.

INEFFECTIVE SOCIAL SUPPORT

“Social support” refers to a set of personal contacts and interactions with individuals or groups, through which the individual receives emotional comfort, material assistance and/or information. The effectiveness of social support depends on the perceived quality of the support received by the bereaved individual. It maintains the individual’s social identity and assures the individual that his/her emotions are understood and considered normal within the specific context. The different forms of social support can facilitate the processing of intense negative experiences or obstruct coping responses, be a source of comfort or result in increased stress, cushion survivors from or expose them to intense stress (Hauser, 1987:66; Vachon & Stylianos, 1988; Walker, MacBride & Vachon, 1977:35-36).
The proverb “beauty is in the eye of the beholder” is perhaps more true for the social support that survivors receive than many other aspects of the bereavement process. Caring others frequently want to support, comfort, help and assist grieving survivors in times of intense sadness. However, survivors often do not experience these well-meant actions and inclinations in the same positive way as in which it is offered. To the contrary, survivors often experience it as ineffective and unhelpful to a greater or lesser extend. [See section 4.3.3 (ix) for “Effective social support” during post-suicide experiences].

One reason for survivors’ sense of ineffective social support is their experience and/or perception that individuals who are not survivors themselves do not have insight in the intense emotional experiences in the aftermath of a suicide. Shirley described this experience as follows: “... sometimes you are going to be with people and they don’t know ... I feel if I were with people who understand then I wouldn’t have to feel so left out ... I’d love to be with nice ... ya, talking to people”.

Social and emotional support depends on a degree of similarity between the experience of the distressed individuals and their social networks. Where such a similarity of experience is lacking, the social network may be unable to provide effective and/or empathic support. Suicide survivors have an implicit or explicit sense that only someone who has experienced suicide bereavement can know what it feels like. They frequently insist that others who have not lost someone to suicide can never fully understand their reactions or situations (Wagner & Calhoun, 1991-92:71; Walker, MacBride & Vachon, 1977:36; Wertheimer, 1991:208).

Another reason for survivors’ sense of ineffective social support is their experience of perceived inauthentic social support; support that afterwards prove to have been for reasons other that the authentic and empathic support of the survivor. In such cases the survivors become disillusioned in others’ social support. This is illustrated by the following quotation from Ilze’s interview: “My dad’s friend supported me more than anyone else, but at the end she was basically only there to be close to my dad ... she only
was very nice and worked through us for my dad ... I only discovered it much later ... I wouldn’t have been as close to her from the start, because I became very close to her, but at the end I got hurt when I discovered it”.

*It is not uncommon for survivors to experience contrived and stylised behaviour in the social support offered by others (Dunn & Morrish-Vidners, 1987-88:191).*

Closely related to the previous experience of inauthentic social support is survivors’ disilllusionment and disappointment in others’ inability and/or reluctance to live up to expected support levels. They experience that others don’t recognise their need for social support. The following quotations describe this experience:

Ilze: “My boyfriend should have understood more what happened ... he shouldn’t have cheated on me ... he should have understood it ... people understand such things, I mean, I understood everything my dad did” and “... my family, I thought it was people close to me ... my dad has disappointed me with the girlfriend he met ... now it is just her and he forgets that I supported him for two years through everything ... it is now just her and that hurts me because I was there”.

Shirley: “There’s just too many things happening ... people don’t realise, even my friends don’t realise, there’s just too many things happening in my life and I can not deal with ... I think I’m the one who hurt the most, but they don’t realise that ... they always say I’m fine, even if I’m not fine ...”.

*Potential social supporters are usually capable of conceptualising a survivor’s need for helpful responses. Unfortunately, these responses are sometimes, for various reasons, not provided or are provided concurrent with non-helpful responses. Alternatively, bereaved individuals may simply only remember the most non-facilitative responses. Although survivors may understandably feel hurt when people who they thought should be helpful supporters, part of coming to terms with the loss involves acknowledging that others, even close friends and family members, are not always going to be able to provide the desired social support and understanding (Jackson, 2003:4; Thompson & Range, 1992-93:66; Wertheimer, 1991:141).*
Survivors often receive intense emotional and practical support at the time of the tragedy. After this initial stage, support networks return to their normal routines and the survivors are left to cope with the aftermath effects of the events. Suicide survivors, more than other types of survivors, experience the quality of social support as inferior. As a result, they often experience difficulties when their perceived needs for sustained support are not met. This is a form of secondary loss. The problems are exacerbated when survivors recognise that social support is available but for some reason not provided. This is worse than completely unavailable support because it tends to increase the secondary loss. Feelings such as depression, anger, abandonment, guilt and social withdrawal often accompany the secondary loss. The lack of effective social support may result in a perception that their loss is not being validated by others. Also, it is frequently accompanied by implicit or explicit messages that the survivors have to get on with their lives (Opperman & Novello, 2003:12; Rando, 1993:499; Range & Calhoun, 1990:312; Thompson & Range, 1990-91:257).

Survivors often experience that well-meaning social supporters offer advice that ignores here-and-now emotional experiences. Rather, these supporters offer advice that attempt to focus the survivors’ thoughts to future-directed changes of negative experiences. Ilze expressed this experience as follows: “... when somebody said ‘Don’t worry, you will get over it, you will forget it, it will get better’ ... it was very bad when someone said that you will get over it, even after two years ... how are you going to get over your mom’s death ... you are not got to get over it ... at that stage you don’t want to forget it ... ”.

Suicide survivors, in comparison to those bereaved from other causes of death, frequently experience that potential social supporters offer advice and information that are unhelpful. Typical unhelpful responses involve those that divert attention away from the death or statements offering unsolicited advice. Unfortunately, there are few good listeners available to bereaved survivors (Range, Walston & Pollard, 1992:26; Sheskin & Wallace, 1976:236; Thompson & Range, 1992-93:62-64, 67).
Families in which one member completed suicide often avoid using the word “suicide” in any interaction. They rather resort to euphemisms. As a result, the individual family members, especially children and adolescents, experience emotional loneliness within the family system, even if it was meant to “protect” them. This is illustrated by the following quotation from Ilze’s interview: “... we will not mention mom’s suicide at our house ... ‘Mom died from hypothermia’, or ‘Mom died from cancer’ ... everyone knows it but nobody wants to say it ... to protect me ... they spoke amongst each other but nobody wanted to mention it to me”.

In family conversations, taboo topics such as suicide are often treated with a narrative silence. Such a silence in family narratives makes it clear to its members, especially children, that a specific topic should remain unspoken and unadmitted. They avoid initiating discussions of the death or suicide itself, strengthening the silence around the event (Book, 1996:325; Rudestam, 1987:33).

Many times people will speak about “bad” experiences in terms of euphemisms. Euphemisms refer to words that substitute for other words whose meaning might be found offensive, unacceptable, harsh or distressing to specific individuals. They provide inexact descriptions of things, experiences and processes by being merely suggestive of the actual meanings. In the context of death, dying and suicide, the use of euphemisms is a way that people pretend that death is not part of the life cycle; it comes down to a “denial” of death or suicide (FitzSimmons, 1994-95:24, 35-36).

Ineffective social support can hinder the survivors’ gradual adaptation and readjustment to their changed context. The absence of support from positive relationships may restrict the survivors’ ability to deal with emotional pain, to express emotions and to progress with the complex processes of mourning (Rando, 1993:431-432; Range, Walston & Pollard, 1992:26; Rosenfeld & Prupas, 1984:17).
There is an awareness that everything has been thrown open to question, as if the bereaved is now peering into an existential abyss (Dunn & Morrish-Vidners, 1987-88:204).

All individuals base their view of the world on certain assumptions. These assumptions basically deal with meaning, trust, security, fairness, control, justice, predictability and invulnerability. The death of a loved one and the mode of death often challenge one or more of these assumptions, especially if the death is of a sudden and unexpected nature. Survivors may fear that their whole assumptive world can fall apart. If fundamental beliefs are perceived as not truthful, what is left? Some assumptions can be modified, while others must be discarded. The loss of fundamental assumptions may result in a cynicism that leaves survivors feeling insecure, directionless and frustrated. The “new” world is discovered to be incompatible with the “old” assumptions which had been meaningful at one stage. This lost sense of cognitive mastery has the potential to prevent the survivor from effectively integrating the death into their life world (Hamilton & Masecar, 2001:45-46; Opperman & Novello, 2003:14; Rando, 1993:427-428).

The research participants reported a number of existential questions in the aftermath of the suicide events. Most, if not all, of the questions had no obvious or clear cut answer. The following quotations from the interviews describe this experience:

Shirley: “There’s too many questions that you ask yourself and there is no answers; there’s way too many questions”.

Annie: “... there are so many questions left behind ... there is just questions that arise the whole time ...”.

The list of questions that survivors ask can be endless and the search for answers can be unending. The questions usually revolve around motives, interpretation and own contribution. Particularly in the early stages after the death of a loved one, this search for answers can become an obsession that tends to dominate every waking moment.
Survivors implicitly hope to reclaim a sense of control and alleviate fears that they were to some extent responsible for the suicide (Dunn & Morrish-Vidners, 1987-88:182; Kinsella, Greeff & Poggenpoel, 1993:46; Wertheimer, 1991:67-68).

Probably the most frequently and persistently asked question is “What is the actual reason for the suicide?” [See section 4.3.2 (viii) for “Not knowing the reason for the suicide” and section 4.3.2 (ix) for “Suspected reason for death”]. The centrality of this existential question is illustrated by the following quotations:

Shirley: “If I were to have just one wish, I’d wish to go to where ever my brother is, just ask him ‘Why?’ ... that’s the only thing I want to know ... I don’t want to know anything else ... right now, I would die just to know ‘Why do you had to?’”

Annie: “ ... the question marks ‘Why?’ [Figure 4.5, P4 and P11].”

Survivors may eventually have to accept that they will never understand why their loved one chose to die. It means acknowledging that they will never arrive at an answer to the question ‘Why?’ Survivors are left to their own ideas and interpretations, with no guarantee of ever formulating a conclusive explanation of the tragedy (Dunn & Morrish-Vidners, 1987-88:182; Wertheimer, 1991:27).

Many of the existential questions focus on the victim’s relationship with the survivor and other significant persons. Some of them deal with issues of relationship of trust [See section 4.3.1 (iv) for “Not confiding and sharing problems in a trust relationship” as an aspect of “Angry at victim” during “Falling apart” post-suicide experiences]. Shirley formulated it as follows: “He went, I go on ... ‘Why couldn’t you come to me and tell?’” In other words, “Why didn’t the victim trust me enough to share his/her problems?” Other “relationship” questions deal with feelings of abandonment and rejection [See section 4.3.1 (iv) for the themes of “abandonment” and “rejection” as an aspect of “Angry at victim” during “Falling apart” post-suicide experiences]. This type of existential question was expressed by Shirley as follows: “There was no proper ‘Goodbye’ ... we just found him hanging ... how could you put people you claim you love through so much pain? ... why did he have to put all of us through it if he loved us so much ... maybe he
didn’t love us?” Implicitly this question asks “Was our love not enough to keep him alive?”

Some existential questions focus on the victim’s personal characteristics. One such question deals with the victim’s apparent inability to cope with emotional pain. This is illustrated by the following quotations from the interviews:

Annie: “... for me it was ‘How can a person experience so much pain that he takes his own life?’”

Maria: “... she surprised us a lot, because I always saw her as this person who was tough, who could handle anything ... for her to do this was like ... wow, how can she?”

Other existential questions are related to the survivor’s retrospective evaluation of their own perceived role in the tragedy [See section 4.3.1 (ii) for the theme of “If only I had acted on the cues of the imminent suicide” as an aspect of “Self-blame/regret” during “Falling apart” post-suicide experiences]. The following quotations provide an illustration of such an existential evaluation:

Annie: “When a person commits suicide ... one tends to ask ‘Why wasn’t I there for that person?, Why didn’t I notice it?’ ... my friend, Lindi, shot herself through the heart ... two evening before that, at a dance, she said ‘You will never again see me cry’ ... that was words she gave us ... if you just thought about it, you could maybe become aware of it ... I didn’t take it literally because I never thought she would commit suicide ... I blamed myself ... ‘Why didn’t I listen, she made it so clear, why was I so stupid?’”

Maria: “But then, later, later after her suicide, I realised, maybe, those things made sense ... but why?, yea, afterwards”.

“Survivors only achieve understanding with hindsight” (Wertheimer, 1991:xv).

In cases where the survivor is a teenager and the suicide victim is a late adolescent or an older role model, existential questions regarding the challenges of adult life may arise. Such questions arose in Annie’s mind following the suicide of a grade 12 boy when she
was in grade 8: “... the standard sixes [grade eight learners] knew the matrics [grade 12 learners] well and looked up to them ... then one of them committed suicide ... and you start to wonder ‘Is life really so bad, is that what lies ahead for you?’ ... ‘Is that the reality?’ ...”.

Existential questions related to religious beliefs are not uncommon amongst suicide survivors, especially in the light of a long history in western culture of explicit condemnation of suicide by many religious traditions [See section 4.3.1 (iii) for “Blaming God” during “Falling apart” post-suicide experiences; see sections 4.3.3 (iv) and 4.3.3 (x) for religious sense making of suicide events during the healing process]. The following quotations provide examples of this type of existential questions:

Ilze: “... my mom was very religious ... so, for me the big question was ‘Will she go to heaven after everything that happened, or won’t she?’”

Annie: “... because I am a Christian, I asked ... ‘What will happen to that person’s soul?’”

Deep-seated religious beliefs about suicide which have been accepted and internalised by societies over many centuries, are not easily discarded. Frequently survivors, regardless of whether they subscribe to any formal religious beliefs, experience anxiousness that the act of suicide may have negative eternal consequences and punishment for their loved ones. The survivors’ concerns are usually not a search for definitive theological formulations on suicide. Rather, their direct concern is to have some sort of assurance that, in contrast to the victim’s emotional or physical suffering in this life, the person’s suffering has been replaced by a form of eternal peace (Seeber, 2002:94-95; Wertheimer, 1991:94-95). [See section 4.3.3 (iv) for a discussion of Christian thoughts regarding suicide since the 4th century AD].

Spiritual, religious, philosophical and existential viewpoints are critical components of an individual’s assumptive world. When survivors’ assumptive worlds are shattered, they can become embittered, cynical, mistrustful or experience a crisis of faith in previously held viewpoints. The death of a loved one, especially if it was a sudden and unexpected
When the search for meaning is successful, individuals have a sense of personal identity, direction in their life, and confidence in their ability to cope with painful but unchangeable situations... when the search for meaning is unsuccessful, individuals feel personally insufficient and lose joy in living and confidence in the ability to handle painful situations... (Ulmer et al, 1991:279-280).

4.3.3 Experience cluster 3: “Putting the pieces back together”

This experience cluster describes the research participants’ experiences of “Putting the pieces back together” when they experience healing and adaptation to their changed life circumstances in the aftermath of a loved one’s suicide. The pieces of their “shattered” lives are painstakingly being “glued” together in such a way that it eventually appears unblemished to all but the most experienced eye [See the story of the two flower vases in the first paragraph of section 4.3].

i) The process of healing

When the search for meaning is successful, individuals have a sense of personal identity, direction in their life, and confidence in their ability to cope with painful but unchangeable situations... when the search for meaning is unsuccessful, individuals feel personally insufficient and lose joy in living and confidence in the ability to handle painful situations... (Ulmer et al, 1991:279-280)

Healing in the aftermath of a suicide means to cope on a day-to-day basis with the reality of the suicide while at the same time reconstructing a new reality within changed circumstances and striving to live a fulfilled life. In essence, it is about re-defining oneself and the environment in terms of changed circumstances. The healing process begins as soon as the injury or loss has occurred (Hamilton & Masecar, 2001:18; Seeber, 2002:38, 89).
Coping is an integral part of the healing process. It involves cognitive and behavioural efforts to deal with specific external and internal demands on the person's resources and psychological adaptation. Not all demands can be explicitly controlled, but effective coping allows one to tolerate, minimise or accept that which you cannot control or change (Faure & Loxton, 2003:29; Nienaber, Adendorff & Wissing, 1998; Thoits, 1986:417).

This section deals specifically with the characteristics of the healing process. It is an introductory section to the ones that follow on it in this experience cluster. Those sections deal with the specific content elements of healing; with the content of “putting the pieces back together”.

Survivors frequently experience that the “true” healing process was initiated by a recognisable turning point in their lives. One such a turning point may be the realisation of their own behavioural patterns’ potential negative impact on the lives of significant others. This represents a focus shift away from the victim towards other significant persons in their lives. It is often accompanied by behavioural changes to let go of ineffective coping patterns and focus on positive activities. This is illustrated by the following quotations:

Ilze: “... my sister’s baby was born ... that basically changed me ... the baby’s birth changed everything ... he mattered a lot to me ... I stopped drinking ... I started eating again ... I resumed my studies ... repaired my broken relationship ...” and “I wish I was with mom, but I know that will cause a lot of damage to my dad, sister, boyfriend or godchild”.

Megan: [following her own suicide attempt] “... I told her [Peter’s mom] that it wouldn’t have mattered if I died ... she said ‘You are so wrong, it would definitely have mattered for your mom, dad and friends, the sadness and pain that you would have caused them’ ... the healing started there because I then started seeing a psychologist ... the turning point was when she talked to me ... it was a very big turning point in my life”.

Closely related to the above turning point in the healing process is survivors’ **explicit decision to take active responsibility for their healing and to live future-focused**.

The following quotations describe such decisions:

Ilze: “I thought that the least I could do was to ... pull myself together because my mom would have wanted it that way ... most people just give up ... you can not give up ... you will get stuck if you give up and then you will disappear ... now I experience a calmness and motivation to move forward ... it made a very big difference”.

Shirley: “... when I was doing it [making the collage for the research interview] ... I accepted it, because I don’t think I’d never accepted this whole thing before ... it has happened, deal with it ... I felt so much better because I had to face up to this whole thing ... now I feel like I’m willing to go on, I’m willing to, before I didn’t want to think about ...”

Annie: “… this picture [Figure 4.5, P19] is how you look back at life, it was sad ... I have lost friends, but you mustn’t let that get you down, you must continue ... be strong, learn from it and continue” and “... this picture [Figure 4.5, P20] is a plant, you must continue to grow …”.

The existential-phenomenological view holds that a chaotic past renders the future inaccessible, while an accessible future means a well-ordered past. Ultimately, it is for the survivor to choose whether or not they will become a “true” survivor with an accessible future that is filled with renewed meaning and purpose, or a victim with an inaccessible future, like the person who died (Clark, 2002; Helen, 2002:100-101; Kruger, 1988:67; Wertheimer, 1991:194).

Survivors cannot indefinitely continue to direct all their emotional and physical energy toward the victim who cannot return it. A gradual transition needs to occur away from a focus on the past, namely the victim and suicide events, towards the establishment and maintenance of rewarding investments in people, objects, activities, roles, pursuits, hopes, beliefs, ideals, goals and causes that can provide emotional gratification. It cannot compensate for that which was lost with the death of the loved one, but it can establish a gratifying readjustment and adaptation to a changed life. Survivors that tap into their
innate strengths and coping capabilities have the potential to heal in response to the decisions they make and the healthy relationships they establish (Grant Kalischuk & Davies, 2001; Rando, 1993:60, 448-449; Wroblewski, 1984-85:180).

Some survivors receive professional psychological or psychiatric interventions at one or other stage during the healing process. However, not all these interventions necessarily facilitate the healing process. A number of survivor characteristics may play a role in “unsuccessful” interventions: Merely complying with others’ insistence to engage in therapy; a non-willingness to share deep emotions and experiences; and an incompatibility with the therapist. This is illustrated by the following quotations:

Ilze: “I went to a lady for a short time ... then it was holiday ... I went there for a few times ... my dad and sister thought it would be a good idea, but I just didn’t have time ... I know it was necessary ... but I just work it out for myself”.

Shirley: “My mom and them tried to take us to a psychiatrist ... I told the guy I was fine and I don’t want to talk about it ... he accepted it and left me alone”.

Megan: “In [grade 11] the school referred me to a psychologist ... I didn’t have a good experience with her ... she just helped me deeper into the ditch “ and “... after my suicide attempt the school again referred me to a psychologist ... he felt that I didn’t open up because he was a man ...”.

Many suicide survivors merely need social support from friends and family members after the death of a loved one, while others might need professional therapy or counselling. The survivor’s readiness and positive attitude are important initial factors when professional therapy or counselling is considered. One needs to keep in mind that therapy involves a confrontation with painful realities, agonising memories and hurtful emotions. Ambivalent survivors may require a good deal of support and motivation for participating in therapy or counselling (Rando, 1993:356; Wroblewski, 1984-85:181).

In contrast to the above “unsuccessful” interventions, many survivors find great value in professional psychological or psychiatric interventions that facilitate significant intrapersonal growth and the discovery of personal resources to cope with life. For
some survivors, these interventions may be a critical healing component in their lives. Megan described her experiences of a “successful” psychological intervention as follows: “... a female psychologist started working with me ... we didn’t start with the problem because there was so many ... at first she attempted to build me up, to give my life more value ... she gave me the guts to do things I never thought I would be able to do ... then slowly we tackled every problem” and “... ‘Everybody needs a little miracle’ ... that’s what I got by going to a psychologist ... to talk to people who know about such stuff, that was my miracle...”.

Research evidence suggests that formal intervention programmes for bereaved individuals help them to proceed faster and more effectively through the grieving process. Family and friends are often so overwhelmed by their own feelings of grief that they cannot offer adequate and effective support to other survivors. Therapeutic interventions can be an important source of support and a means of working through some of the complex emotions and thoughts associated with the aftermath of suicide. Therapists prompt survivors to express their thoughts and emotions openly in a “safe” and facilitative context. They enable and empower survivors to explore their guilt and reality feelings in a non-judgmental atmosphere (Demi & Howell, 1991:354; Helen, 2002:91; Rando, 1993:335; Wertheimer, 1991:157-158).

One pervasive characteristic of the healing process is that it takes a long time and is never fully completed. This temporality characteristic of the healing process was described as follows by two research participants:

Shirley: “… that is difficult and it takes a lot of time ... learn to deal with it and go on with life, cause life will never wait for you to get over things ... it’s been three years ... it takes time ... and a month passes before its better than the last months ... I’m not saying you heal, but you’re much better than last month ... it’s a very long road ... at the rate I’m going, I don’t think I am going to be at the end very soon”.

Maria: “I think time for me helps a lot ... time allowed me to make sense of what’s happening”.

Bereavement after a loved one’s suicide frequently results in a lengthier healing process than most other types of death. Certain features of suicide bereavement can significantly lengthen the process: Survivors that become stuck in an endless search for definitive answers to unanswerable questions; survivors that experience intense anger towards the victim for perceived abandonment and rejection; and survivors that decide they were responsible for the death and get stuck in overwhelming guilt feelings (Range & Thompson, 1987:193; Wertheimer, 1991:169, 184).

Most suicide survivors describe their experience of the healing process as an ongoing event as opposed to a time-limited one. They recognise that at some future points they will need to deal with recurring memories and emotions. In one sense, the suicide is something that will remain a part of them forever. There is no finite period after which the survivor will automatically pick up the threads of “normal” living. One study amongst adolescents found that their grief symptoms after a sibling death had a lingering quality; at least two years after the death of their sibling, many of them still experienced the death as a source of emotional pain (Balk, 1983:152-153; Helen, 2002:95; Wagner & Calhoun, 1991-92:70; Wertheimer, 1991:184; Wrobleski, 1984-85:180).

ii) Acceptance of what actually happened

Authentic living implies that individuals take upon themselves that life which is theirs, including a being-unto-death. Such individuals are open and free to take on the possibilities of their relations with the world and others. It also implies an openness to the possibility of suffering. Being deeply involved in another individual’s life means a commitment to the unfolding possibilities of that relationship, even that person’s death (Kruger, 1988:80-81).

“Acceptance” is the key in the healing process after the loss of a loved one. It is a deceptively simple concept that refers to the acknowledgement and realisation of limitations, specifically with regards to the fragility of life, and the finality and irreversibility of death. Other areas include the realisation that one cannot exert total
control of others’ behaviour and decisions, completely understand their problems, or
determine their fate in life. In the case of suicide survivors, there is an added need to
accept the emotional hurt and to work through the legacies of suicide, such as dealing
with unanswered questions (Dunn & Morrish-Vidners, 1987-88:203-204; Helen, 2002:79;

Survivors have to accept a number of essential issues regarding the suicide events and
suicide victim during the healing process: The reality of the suicide events; the
irreversibility of the events; the intentionality of the victim’s acts and choices; and the
sufficiency of their own efforts.

One of the most profound aspects of a suicide that must be accepted is the reality of the
suicide events and the accompanying unanswerable questions [See section 4.3.2 (viii)
for “Not knowing the reason for the suicide” and section 4.3.2 (xv) for “Unanswerable
existential questions” during “Being shattered” post-suicide experiences]. This is
illustrated by the following quotations:

Ilze: “… basically [I had] to recognise that my mom committed suicide ... I just had to
... that is it, she didn’t meant to, but it came out as such, whether she meant it or not”.
Maria: “... later I realised it happened and you just have to make sense of everything
... even though you don’t understand everything ... you have to accept that it happened
... because if you are going to sit around with it, it’s gonna hunt you for long”.
Annie: “... do not look for what could have been, look for what actually happened in
that moment ... don’t tell yourself it could have been otherwise”.

Suicide survivors find it hard to accept the reality of a loved one’s suicide due to the
implied intentional choice to stop living and the realisation that some questions will never
be adequately answered. The “asking” of unanswerable questions is normal and even
critical for healing, but the insistence that answers are necessary for an effective
continuation of life is restrictive. It is only by asking these questions that survivors are
able to realise that they have no definitive answers. However many clues and suggestions
they may find in order to piece the events together, ultimately survivors will have to live
with something that they can only partially understand. Life is far too complicated to be captured in simple, straightforward answers (Grant Kalischuk & Davies, 2001; Helen, 2002:45, 99; Wertheimer, 1991:79-80).

Alexander (1987:109) expressed the difficulty she had to accept the reality of her mom’s suicide very eloquently: “‘She’s dead. She killed herself.’ I don’t know how long it took for the meaning of those words to register. Minutes, hours, weeks, even months.”

Closely related to the previous “reality” aspect of a suicide that must be accepted during the healing process, is that of the irreversibility of the suicide events. This realisation was described as follows by the research participants:

Maria: “... you have to accept that it happened ... you cannot turn back the hands of time, it goes on and life goes on ... her presence is gone ... she is not there any really now”.

Annie: “I made peace with it ... nothing that I do now will change it ... so, at first I had to accept and deal with it”.

Like other bereaved persons, suicide survivors have suffered a major loss. One important bereavement task is to accept the permanence and irreversibility of the loss. Part of it is the realisation that even if one could turn back the clock and do things differently, it wouldn’t necessarily change the outcome. The recognition and acceptance of the loss’ permanence makes it part of the individual’s personal history. The result is a more ordered past that allows survivors the possibility of an accessible future (Jackson, 2003:18; Kelly, 1997; Wertheimer, 1991:17).

The previous two “acceptance” experiences are related to the suicide event per se. However, suicide survivors also need to come to a sense of acceptance that the suicide victim made an intentional choice to complete suicide; no one else should take blame or be blamed [See section 4.3.2 (ix) for a denial of victim’s intentionality as an aspect of “Suspected reason for death” during “Being shattered” post-suicide experiences]. This is especially difficult when survivors are reluctant to ascribe responsibility to the victim.
Often they prefer to apportion blame on themselves, others or God [see section 4.3.1 (ii) for “Self-blame” and 4.3.1 (iii) for “Blaming others/God” as aspects of “Falling apart” post-suicide experiences]. The following quotation from Shirley’s interview describes her acceptance that the victim made an intentional choice: “... I’ve realised it’s never your fault, that person just had to do this ... they took it upon themselves to take their lives away ... you shouldn’t blame yourself for somebody else’s death ... they know what they’re doing ... you should never blame yourself ...

The recognition of autonomy and freedom of choice is fundamental to the phenomenon of personal responsibility and guilt. Without freedom of choice no individual could have been held responsible or be blamed for any behavioural act. While it is normal for suicide survivors to blame themselves or others, it is important in the healing process to recognise that the person who completed suicide made the decision to do so, not the survivor or anyone else. Ultimately, the responsibility for the suicide act must rest with the victim him/herself. Suicide is always a choice, admittedly not one that an individual would choose for a loved one. Naturally, it is difficult for survivors to accept the victim’s irreversible choice to end his/her life, together with the emotions and thoughts that such a choice leave them with (Allen et al, 1993-94:40; Healing, 2002; Jackson, 2003:17; Kruger, 1988:89; Lamb & Dunne-Maxim, 1987:258; Rando, 1993:503-504; Rosenfeld & Prupas, 1984:20-21; Wertheimer, 1991:167).

Another issue that is directly related to the survivors’ realisation of the suicide victim’s intentional choice to complete suicide, is that no one else should take blame or be blamed for it. However, survivors’ sometimes engage in extensive and unrealistic self-blame [See section 4.3.1 (ii) for “Self-blame” during “Falling apart” post-suicide experiences]. During the healing process they then need to accept that they have done what could reasonably have been expected from them in the specific context. This acceptance of the sufficiency of their own efforts is illustrated by the following quotations:

Shirley: “... I blamed myself for about two months ... but there was nothing I could have done, I’ve realised that”.

"BEING AN ADOLESCENT SUICIDE SURVIVOR"
Maria, regarding any regrets: “No, I don’t ... 80% I think I’ve done quite a lot, just that I was not keeping in contact”.

It can be difficult for suicide survivors to acknowledge that no matter how much they had done, perhaps it would never have been enough to keep the other person alive. Such a realisation of personal limitations challenges them to come to grips with feelings of impotence. On the positive side, it allows for a cessation of self-blame and enables the realistic assessment of responsibility; survivors cannot predict the future and did the best they could with the knowledge they had (Dunn & Morrish-Vidners, 1987-88:205; Helen, 2002:25, 45; Jackson, 2003:25; Wertheimer, 1991:174).

iii) Seek forgiveness

Forgiveness is a process that serves to change the significance of past deeds, omissions or thoughts. It is experienced as interpersonal within the context of a specific event and/or relationship. Forgiveness takes place in a context of understanding and compassion. When you experience and recognise that there is compassion and understanding within a specific context, then you can forgive yourself. Forgiving yourself brings about a change in the way you look at yourself, no longer with eyes of self-blame and guilt, but with eyes of understanding (Fourie, 2003:3-4).

Pervasive feelings of guilt and self-blame form the basis of survivors’ need to seek and receive forgiveness from others, the victim and God [See section 4.3.1 (i) for “Guilt and punishment feelings” and section 4.3.1 (ii) for “Self-blame” during “Falling apart” post-suicide experiences; and section 4.3.2 (v) for the “Inability to forgive” as an aspect of “Emotional stuckness” during “Being shattered” post-suicide experiences]. The following quotations from Ilze’s diary and interview provide a description of the different relationship contexts that she sought forgiveness in:

- **Other significant persons**: “... sorry Dad, it is my fault, we had an argument ... sorry Dad, sorry Dad”.
- **God**: “I prayed a lot for forgiveness and calmness ... suddenly I experienced an
  indescribable calmness ...” and “[in a prayer] ... dear God, it is all my fault ... please
  forgive me for what I’ve done to my mom ... take this guilt burden from my shoulders
  and let me live in You ... I wish that I could give her one last embrace and tell her that
  I’m sorry.”

- **The victim**: “Mom was in my dreams last night ... I told her that I was sorry ... she
  held me ... said that she understands and had forgiven me a long time ago” and “... the
  knowledge that my mom had forgiven me, basically pulled me through”. In her diary
  she recalled the nature of the dream as follows: “The dream was very realistic ... this
  morning I can still taste her lipstick and smell her perfume on me”

_Dreaming is a mysterious but powerful tool in the healing process. It can be regarded
as a way that the unconscious guides a bereaved individual through the process of
mourning (Wertheimer, 1991:183)._

_Forgiveness is a complex and multidimensional process that has the potential to take
bereaved individuals from a context of hurt, anger and confusion to one of acceptance,
restoration and readjustment towards oneself and others. The need for forgiveness arises
in the perception that someone has acted unjustly, or when someone has acted in a way
that the integrity one’s life and identity has been disrupted or violated. Forgiveness
changes one’s relationship to the past and brings about a renewal of an irrevocably
changed future; it restores the disrupted and violated order. It frees up oneself, the world
and the future in new ways. The critical dimension of forgiveness is that it facilitates a
shift in one’s understanding and relationship to the other person, oneself and the world.
It allows one to continue your life without overwhelming emotional pain, anger, blame,
guilt, harshness, resentment and misery. The future is again available. The past is no
longer a crippling, heavy burden. Lastly, it facilitates an acknowledgment that our
personhood and relationships aren’t perfect (Helen, 2002:99; Rowe et al, 1989:233, 235-
236, 239-240, 242)._
Suicide survivors often respond negatively towards caregivers’ attempts to negate or explain away guilt feelings. This will frequently make survivors feel worse and misunderstood. Ultimately, survivors need to be allowed to find personally appropriate ways for finding a sense of atonement. Caregivers can facilitate the healing process by providing a space in which the survivor can ask and/or receive forgiveness from the victim, God or other significant individuals (Fieldnotes, 27 November 2002; Gibbons, 1994; Rando, 1993:487).

iv) Role of religion

Religion and culture play an integral part in society at large and in the personal lives of individuals. It provides belief systems that enable individuals to make sense of lifeworld situations and to establish a sense of purpose and order in both life and death. In situations such as the death of a loved one, religious and cultural guidelines and beliefs are mobilised to allow an interpretation and understanding that cannot be adequately explained by logic. Personal pietism facilitates adjustment to a loss by means of active participation in and by attaching importance to specific religious principles and doctrines (Kinsella, Greeff & Poggenpoel, 1993:45; Opperman & Novello, 2003:4-5).

From an existential-phenomenological viewpoint, an authentic faith holds that being-in-the-world is not the totality of human existence. In this sense death does not constitute an ultimate ending, but rather an entrance into an alternative existence which is largely unknown, but none the less meaningful (Kruger, 1988:73).

Religion can perform different functions in the lives of suicide survivors. In essence its functions are to provide a way to cope with the aftermath of the suicide, to make sense of the events, and to deal with ambivalence.

Religion plays an important role in suicide survivors’ ability to cope with guilt and as a source of personal comfort. The following quotations from Ilze’s diary and interview illustrate how religion allows forgiveness and healing when coping with guilt [See
section 4.3.1 (i) for “Guilt” as an aspect of “Falling apart” post-suicide experiences and section 4.3.3 (iii) for “Seek forgiveness” as an aspect of healing]: “Lord, please forgive me for what I’ve done to my mom ... take this guilt burden from my shoulders and let me live in You” and “I prayed a lot for forgiveness and calmness ... for how sorry I was ... suddenly I experienced an indescribable calmness ... basically my faith pulled me through ... I know that God had forgiven me”.

As a source of personal support, religion brought an experience of calmness, care, comfort, peace and healing for the research participants. They experienced it as follows:

Ilze: “I prayed every night and spoke directly with God ... I prayed a lot for calmness ... I turned a lot to God and received words that calmed me down ... it was an indescribable calmness ... He had forgiven me ... my faith means a lot ... it was the only thing pulled me through”.

Maria: “[in the poem] ... the love from above reassured us”; “He can only make things better”; “... my spiritual level did a lot ... it just comforted me in a way, peace ... cause I remember, I was damaged”.

Annie: “... God has always been there for me ... there is always a way out ... if God closes one door, He opens another door”; “... when I’m in a bad situation, I will always read [Psalm 121] that says ‘Where will my help come from, my help comes from the Lord’”.

One study amongst teenagers found that religion had been a source of help after the death of a sibling (Balk, 1983:151).

Apart from being a way to cope with the aftermath of the suicide, religion can play an integral role in making sense of the suicide events. Firstly, survivors may find comfort in God’s omnipotent knowledge within their context of not knowing the full reason for the suicide [See section 4.3.2 (viii) “Not knowing the reason for the suicide” during “Being shattered” post-suicide experiences]. This is illustrated by the following quotations from Maria’s interview and collage: “Only God knows [Figure 4.3, P12]” and “I know only God knows why and when ... what pushed her really really really hard ...
why it happened and what’s gonna happen”.

Secondly, survivors make sense of the suicide events by accepting that all positive and negative life events are part of a bigger Godly plan that is for the good of everyone. One can speculate that such a “Godly plan” view indicates that survivors implicitly attempt to transfer the responsibility for the suicide choice from the victim onto God. Also, it helps to explain why God didn’t prevent the suicide. The following quotations describe this aspect of sense making:

Maria: “I think maybe God allowed it to show us something, or maybe to show her parents and us something ... maybe the way they were going to be were not good and then He needed just wake them up a little bit”.

Annie: “The way I view death is to accept that God had a plan and purpose with everything that happened”.

Thirdly, survivors make religious sense of the suicide events by accepting that the victim’s earthly life was a negative experience, while a heavenly existence is much happier and better. Implicit in this view is the belief in a form of afterlife. The research participants formulated it as follows:

Megan: “… now, after I’ve worked through everything, I realises that he was a very unhappy person throughout his life ... where he is now, I believe he is in heaven, he is much happier ... everything happened so that his difficult times could end”.

Annie: “… it is as if her suicide, she just wanted to be with God ... I hope that that person doesn’t have pain anymore”.

Hope is an integral component of all the major religions. The implication is that survivors’ grief for loved ones who have died by suicide, is tempered by the hope of a tranquil existence in an afterlife away from earthly sorrows and suffering (Rubey & Clark, 1987:153).

Lastly, religion helps survivors to deal with spiritual anxiety and ambivalence. One source of spiritual anxiety is the possibility that the victim has ended up in a state of
eternal condemnation ("hell") and not in a state of eternal peace ("heaven") for completing suicide rather than waiting for God to decide on their death date. Survivors then resort to contextual excuses that, in their own minds, might be valid reasons for the victim to receive God’s forgiveness. This is illustrated by the following quotations:

Ilze: “... my mom was very religious, a very big Christian ... so, for me it was a big question ‘Will she be in heaven after all that happened, or not?’ ... at the end it is who you are and how you believe”.

Maria: “... we just hope you went to heaven ... personally I think she is in hell because you don’t decide when to stop your life ... but I think maybe the reasons why she killed herself might get her forgiveness from God”.

Megan: “God says in his Word that if you take your own life you will go to hell ... but I feel that the circumstances determine it ... Peter was a very strong religious person, God was important to him ... that’s why I believe he is with God”.

Survivors frequently seek reassurance and comfort in the aftermath of the suicide events. If they value some religious principles and guidelines in their own live, they will often strive to integrate their religious beliefs with the tragedy of a loved one’s death. One potential outcome of this strive is an experience ambivalence between the acontextual and condemning religious rule of suicide-as-unforgivable-sin, and their contextual and forgiving attitude towards a loved one’s suicide. (Rubey & Clark, 1987:154). [See section 4.3.2 (xv) for a discussion of “Deep-seated religious beliefs about suicide” as an aspect of “Unanswerable existential questions” during “Being shattered” post-suicide experiences].

Since the time of Augustine (4th century AD) the Christian church has regarded suicide as forbidden and an unforgivable sin. Those completing suicide were thought to be condemned to hell. The church commonly refused them rites of burial. In some cases the body were intentionally scarred to deter others from considering suicide. Over the following centuries this view influenced thoughts, legislation and attitudes throughout the Western world. In the middle of the 17th century, rigid church teaching regarding suicide left no doubt that suicide was considered one of the worst sins that anyone could commit.
No wonder that the result was intense stigmatisation of the suicide act and suicide survivors. When the church openly called suicide a sin, it invited the rest of society to also view it as a shameful act motivated by some kind of insanity or demonic possession. Today, there is an increased acceptance of suicide as less of a sin and more akin to a human tragedy (Hamilton & Masecar, 2001:48; Helen, 2002:7; Lukas & Seiden, 1987:19-20; Rubey & Clark, 1987:152; Stillion & McDowell, 1996:8; Strydom, 2002:108, 110-112, 115).

v) Role of a cultural ritual: Visiting the grave

Symbolic cultural rituals are a way in which appropriate roles and emotions are articulated. It helps to define an individual’s sense of identity in relation to the larger community. Rituals provide a structure to deal with losses and stressful times (Hamilton & Masecar, 2001:12; Opperman & Novello, 2003:5). [See section 4.2.3 (v) for a discussion of “Rituals”].

The ritual of visiting-the-victim’s-grave provides survivors with an opportunity for personal closeness to the victim. The victim’s grave may also serve as an important concrete memory symbol during the healing process [See section 4.3.2 (x) for visiting-the-victim’s-grave as an aspect of “Longing for a continued relationship with victim” during “Being shattered” post-suicide experiences]. The participants described their experiences of visiting the victim’s grave as follows:

Shirley: “You learn to know that he is no more there and if you want to see him you go to the graveyard now”.

Megan: “... when I go to his grave ... just that physical memory is important for me”.

Annie: “... sometimes I enjoy it to visit her grave and to tell her that I hope she is in a better place ... to tell her what is happening in my life”.

Rituals provide survivors with a way to keep their loved ones “alive”. It allows them an opportunity to interact with the memory of the loved one without crossing into pathological dimensions. Also, it provides symbolic evidence of the continued existence
of the deceased in the life of the survivor. At the same time rituals recognise the reality of the death and its implications (Demi & Howell, 1991:354; Rando, 1993:58, 316).

vi) Identification with art objects

As part of the healing process, art objects play a facilitatory role in eliciting emotional responses and as memory triggers. The implication is that art objects can be useful as therapeutic tools to facilitate the expression of emotions when people find it difficult to verbally express and experience their emotions.

Art objects performed different functions for Shirley to deal with the aftermath of her brother’s suicide. On the one hand it facilitated the expression of personal sadness: “...things I identify myself with ... when I’m watching a movie or going to an art exhibition, is the sad stuff ... the very sad stuff I can relate to, cause I think somehow I feel that pain” and “If I’m feeling very sad ... like when I was [creating the collage], I was listening to Tracey Chapman ... that make me feel so bad but I felt much better after that”. On the other hand it facilitated the memory recall of positive pre-suicide family interactions: “... my Dad, when I was small he’d make me and my brother sit up until late and had the habit to force us to listen to that music ... I ended up loving it because when he was not home we would like wake up and go play the music ... it means a lot to me ... [take me back to] the good times, not the bad times”.

vii) Engaging in creative writing

The blank pages of a notebook or diary are always available to the writer, will not be judgemental, and allows the freedom to write and “say” whatever needs to be jotted down. For grieving persons it is a powerful and effective way to recall the good times

5 “Art objects” in this section refer to any form of artistic expression, such as art exhibitions, movies and music.

6 “Creative writing” in this section refers to the act of writing letters, poems and journal entries.
and the bad times. It can provide opportunities to bring closure and deal with unfinished issues (Perschy, 1997:89).

Creative writing allowed Ilze to deal with the aftermath of her mom’s suicide in the following ways:

- It facilitated the ordering of thoughts: “I love writing letters and poems ... I have a diary that I made for my mom ... most evenings I write in it ... after my mom’s death I started to write down my thoughts, ‘Why?’, ‘Where?’ ... somewhere things must have gone wrong ... I just wanted to see where things went wrong”.

- It allowed control over the recall of memories: “It is my way to forget about the past, but if I want it back, I can recall it”.

- It facilitated the externalisation of emotions: “… I am very fond of writing ... it is my way to externalise it and then not recall it”.

The act of creative writing provides a way to overcome the experience of helplessness after a tragic death. It is a way to exert control over what may otherwise appear to be uncontrollable; a way to organise chaotic thoughts and emotions. Two important advantages of keeping a diary are the following: Hidden and disturbing aspects of the survivor’s relationship with the victim can be safely expressed; and private expressions of emotions and thoughts are safeguarded from others’ potential censure or criticism. The expression of thoughts and feelings on paper puts them at a distance from oneself - an externalisation process. Through self-expression, individuals can identify and explore the significance and meaning of experiences for themselves (Clark, 2002; Demi & Howell, 1991:354; Hamilton & Masecar, 2001:64; Wertheimer, 1991:167).

The process of externalisation allows individuals to view problems more objectively since they have gained some distance from it, especially when they have become so overwhelmed by the problem that a solution or alternative interpretation seems impossible. It promotes the process of dialogue rather than monologue with regards to the problem. Eventually it may result in new insights regarding their feelings, fears and concerns. Another positive outcome of externalisation is that it makes it possible for
Suicide sensitizes all of us to the extreme precariousness and preciousness of life, urging us to cherish and savor the life that we have, the relationships we enjoy, as much as we can for as long as we can (Rubey & Clark, 1987:158).

viii) Interpersonal relationship dynamics

Suicide sensitizes all of us to the extreme precariousness and preciousness of life, urging us to cherish and savor the life that we have, the relationships we enjoy, as much as we can for as long as we can (Rubey & Clark, 1987:158).

_A loved one’s absence and the associated loss of interaction patterns and role-fulfilling behaviours, challenge survivors to invest in new or modified roles, behaviours, relationships, hopes, expectations, experiences, attitudes and ways of being. The result is changes of the survivors’ image of themselves since the interactions with loved ones help define a sense of self and identity. In the healing process it is important to recognise and mourn that which has changed, to affirm that which continues, and to integrate that which is new. The changes in the intrapersonal, interpersonal and external worlds contribute to a new image of self and bring about a new identity (Rando, 1993:59-60)._  

Survivors experience a number of changes in interpersonal dynamics that facilitate and accompany the healing process in the aftermath of a loved one’s suicide. These are in stark contrast to the changes in relationship dynamics that were part of the “falling apart” experiences [see section 4.3.1 (vi)].

Sometimes survivors experience an _increased and fulfilling closeness to significant family members_. It is frequently associated with an open sharing of personal information between the members. This experience is illustrated by the following quotations:

_Ilze: “My sister is four years older than me ... we couldn’t stand each other since we were small ... but after my mom’s death we became very close to each other ... she knows just about everything about me ... I talk to her about everything ... basically she_
is now like a mom to me ...” and “... my dad and I are very close to each other ... we were always a close family, but never as close as since my mom’s death”.

Maria: “... I just want to be close to my brothers ... that if they go tomorrow I would have had the chance to tell them everything ... I’m very close to them ... something good came out of this because it brings us together ... it made me realise that you have so much ... it just brought together ... we are so close now ...”.

*An important indication of adaptive family grieving and healing is the mutual expression and sharing of both negative and positive emotions. A tragedy may draw the family closer together than before the suicide (Helen, 2002:59; Opperman & Novello, 2003:11; Van Dongen, 1991:377).*

Adolescent suicide survivors often experience that the suicide events facilitate marked **increases in personal emotional maturity and independence**. Ilze described this experience as follows: “I now know that it is important to stand on my own legs because my dad isn’t there anymore ... he is still there, but not as much as before ... I am now on my own, I must be mature and continue on my own”.

Closely related to the above “facilitation of increased personal emotional maturity” is the **growth in social insight** that survivors experience in the aftermath of a suicide. Some of the research participants discovered that it **takes time to really know other individuals’ social support motives**. As a result, they learned to **use discretion** with regards to trust in relationships. The following quotation from Ilze’s diary and interview illustrate this experience: “Many things became clear to me ... a friend was not what I thought she was ... why was I so blind not to have seen it? ... at the end of the day you discover that people are not always what you thought ... I learned from that to not trust people all that easy anymore ... I don’t tell her everything as I did before ... now I am stronger as I trust people only up to a point, don’t tell them everything ...”.

The brevity of life, together with the unexpected nature of a suicide, can elicit an awareness and **appreciation of the little things in life** that make relationships worthwhile.
- things such as a smile and enjoyable times. In Shirley’s words: “It’s the little things that I appreciate in life, those smiles, those time with your friends ... things that [others] that haven’t been through any pain don’t appreciate ...”.

One of the harsh lessons in the aftermath of tragedy is that appreciation of what one has today is of paramount importance. It provides meaning and purpose to everyday life. One feels more contend with life when you make conscious efforts to appreciate others and yourself (Helen, 2002:102-103).

Survivors of traumatic and/or life-threatening experiences sometimes actively engage in the support of other individuals that have suffered a similar experience as they did in the past. They experience this as a chance to transfer what they have learned and experienced in their own lives into a positive and satisfactory opportunity for personal growth. This is illustrated by the following quotations:

Ilze: “I’m a good listener because I know what it feels like to be not listened to ... many people come to me with their problems because I always listen and give advice ... 90% of the time I have been through the same stuff ... when you have been through it yourself, you can help”.

Megan: “... because I have worked through it, I can comfort and help others that are in a similar situation ... I enjoy helping others”.

Annie: “... through that which happened, I can now help others ... I never understood others’ pain before I experienced it myself ... now I understand it ... that what I have experienced can make a difference in others’ lives”.

Frank (2003b) uses the concept “survivorship” to refer to individuals’ craft and skill to live in a creative way following a life crisis. It is the process of finding some meaning in a traumatic occurrence and then finding ways for making that meaning to change one’s life. The initial response after such a traumatic occurrence is often a stuckness to continue with life. Survivors then merely live from one day to the next without a clear future perspective. The craft of “survivorship” comes to the fore when a choice is made to actively turn disaster and negative outcomes into opportunities. These individuals start
living future oriented without using the trauma events as an excuse. They respond to others’ suffering with a first-hand self-consciousness of their own vulnerability. Survivors transcend their own tragic circumstances by reaching out to others in meaningful ways, to make a difference in the world. In short, their own suffering is interpreted as a call and preparation for works of further service; a conviction of the need to help people. This represents a precipitation of altruism that stems from a newly discovered appreciation of life and others (Appel & Wrobleski, 1987:220; Dunn & Morrish-Vidners, 1987-88:208; Fieldnotes, 8 and 12 January 2003; Grant Kalischuk & Davies, 2001; Helen, 2002:98; Moldeven, 2001).

ix) Effective social support

“Social support” refers to the functions performed for a distressed individual by others. It is a stress-resistance resource that serves to temper, reduce or buffer the negative impact of stressful life experiences. Social support must be experienced and appraised as helpful by the recipient in order to be supportive. When someone has experienced the death of a loved one, the consolation and comfort offered by supporters can meet the need for belonging and facilitate the bereavement and healing process. It can help the bereaved individual to accept and express grief emotions, to review the positive and negative aspects of the lost relationship, and to mourn the loss satisfactorily. Effective social support will enable this person to gradually review the lost relationship and encourage an investment in ongoing life and relationships. However, when the social milieu is unsupportive, poor outcomes in the bereavement and healing process is a likely consequence (Opperman & Novello, 2003:11; Raphael, 1984:47-48, 154-155; Thoits, 1986, 416-417; Vachon & Stylianos, 1988:177-178). [See section 4.3.2 (xiv) for “Ineffective social support” as an aspect of “Being shattered” post-suicide experiences].

An important prerequisite for effective social support is that survivors need to recognise and accept that no one has to solve all their problems on their own. They need to acknowledge that other persons are available to help. Megan expressed this recognition as follows: “... there are other people who can help you ... now that I know that I can ask
for help, I think that I will be okay ... I will try to be less stubborn and to rely on my support systems, even if I’m so vulnerable ...”.

The aftermath of a loved one’s suicide can threaten anyone’s coping strategies. It is especially difficult for someone who has always been able to cope on their own to recognise and acknowledge their need for social support (Wertheimer, 1991:159).

Effective social support requires an empathic interaction space where survivors can verbalise thoughts and express emotions. On the one hand, this “space” should be characterised by the supporters’ unconditional acceptance and recognition of the survivors’ emotional hurt. On the other hand, supporters should refrain from prescribing or forcing a way of coping onto the survivors. The following quotations illustrate the research participants’ experience of such an empathic interaction space:

Ilze: “In the university residence I shared a room with Susan ... she was someone I could talk to and share everything with ... when my mom died she helped me through it ... when I was crying in the evenings, she talked to me ... she meant a lot me ...”.

Megan: “... [my parents] supported me a lot ... even though Peter was not a family member ... they didn’t really know what I went through but they saw the hurt I experienced ... they didn’t pressurise me ... they were just there for me ... I could go to my dad with my problems ... they supported me up to point ... when I wanted to be alone they retreated”.

Annie: “It means a lot to me to tell someone what I went through because it is a way to deal with it ... the first time I talked to you [the interviewer], I opened up and cried ... afterwards I felt better...”.

The most helpful comments to a recently bereaved person are expressions of personal willingness to help and listen. Talking is the process by which most people focus on what things mean to them. It facilitates cognitive assimilation, the transformation of the relationship to the deceased person and an integration of the loss in their lives. In short, effective social supporters create a space for survivors in which they can explore and create new meanings (Clark, 2002; Demi & Howell, 1991:354; Hamilton & Masecar,
Supporters should listen and respond to survivors in a way that communicates trustworthiness and acceptance. Disclosure to self and others requires a sense of safety and confidence in the supporter. Survivors need to express their difficult and intense emotions in a non-rejecting atmosphere. When they talk about their sadness, anger, blame, guilt, abandonment, fears and loneliness, they are already learning to cope with these feelings. Lastly, they need supporters who can reassure them that their emotions are normal grief feelings and who can acknowledge that they need solitude at times (Hamilton & Masecar, 2001:54; Rando, 1993:405-406; Rosenfeld & Prupas, 1984:87-88; Raphael, 1984:154-155; Schuyler, 1973:319-320; Walker, MacBride & Vachon, 1977:38; Wertheimer, 1991:25).

Talking about traumatic experiences harbours a paradox. Language communicates, but it also brings a distance from the traumatic events as it was experienced. Supporters will never fully understand what the survivors experienced, in part because the impact of the traumatic events cannot be adequately captured in words. The survivors’ trauma narratives are not simply about facts, it is probably more about the impact of those facts on their lives. The lived experiences tell us more than facts can about how individuals attempt to live their lives after such a trauma. One needs to keep in mind that there cannot be a final and complete “reconstruction” of trauma in retelling it. Each telling reflects the survivors’ progression or regression with the trauma material (Gobodo-Madikizela, 2003:85-86, 165).

Closely related to the above empathic interaction space that provides a context for effective social support, is the need for supporters to be good listeners who only provide advice after having listened closely to the survivor. Such a supporter approach will facilitate the survivors’ sense and perception of being effectively supported. This is confirmed by the following quotations from Ilze’s interview: “... [the most important thing that others can do] when you’re mom has just committed suicide .... is to listen ...
you can slowly begin to give advice after a month or two months, but don’t do it immediately ...” and “... they listened as if they understood ... my dad listened, he listened for hours and hours ... my sister also listened ... my boyfriend listened all the way ...”.

Most survivors have a deep-seated need for others to take the initiative of reaching out to them. However, they are often too scared, too depressed or too unsure of themselves to actively elicit the help of others. A key task of effective social supporters is to give survivors the opportunity to tell their stories and ventilate their feelings. To tell your story is a powerful act in the healing process. Survivors need to talk about what is important, meaningful, confusing, conflicting or painful for them. The best way to offer help to someone who needs to talk is obviously to be a willing and active listener. Survivors need someone who will listen to all the “I remember” experiences. Since each one’s story will be different, supporters need to recognise and support the uniqueness of each survivor’s story. This includes respect for each survivor’s way of thinking and organising ideas (Dunn & Morrish-Vidners, 1987-88:193-194; Helen, 2002:86; Lukas & Seiden, 1987:147-148; Rosenfeld & Prupas, 1984:88; Seeber, 2002:40-41, 90; Wertheimer, 1991:208; Wrobleski, 1984-85:177).

Survivors sometimes experience tremendous and very effective support from a specific friend or committed supporter who allows them to tell and re-tell at length what happened. Usually, these persons are prepared to sit and listen, and to not be embarrassed or frightened by the survivor’s distressing story - ‘Good listening permits good talking’. It allows the survivors to freely express their feelings rather than inhibiting such expressions. These supporters listen to the survivor’s story without feeling obliged to make comments or offer advice (SIEC, 1999; Wertheimer, 1991:146, 149; Vachon & Stylianos, 1988:182).

Anyone that wishes to provide effective social support need to recognise that they don’t have to “fix” things for others. Rather, survivors need help and support to work out their own interpretations, answers and solutions; only these answers are ultimately the relevant ones. The supporters’ personal views regarding the morality and ethics of suicide are not
the issue at stake (Wertheimer, 1991:140).

Suicide survivors frequently have an intense need to talk to and be supported by others who have themselves experienced the suicide of a loved one. This preference is evident from the following remarks by Ilze during her interview: “... someone who hasn’t been through it themselves cannot talk to you about it because they don’t know what it’s all about ... they don’t know exactly how you felt ... they don’t understand it ... they give cheap advice that you don’t want ... for me it is important that they understand what you go through ... you can help if you have experienced it yourself”.

Survivors often experience that it is invaluable to share their intense experiences with others who have had to deal with a suicide themselves. It involves a personal interaction that is based on a common identification and shared status. It provides survivors with an opportunity to share and compare their experiences and feelings with someone who really understand the unique nature of their loss. There is a sense that their deep and vulnerable emotions are understood from the inside. The interaction allows them to divulge their emotions without being ridiculed, judged or alienated; to discover that others have experienced similar emotions (Appel & Wrobleski, 1987:218-219; Carter, 1989:357; Clark, 2002; Jackson, 2003:4; Ness & Pfeffer, 1990:284; Rando, 1993:445; Rosenfeld & Prupas, 1984:47; Thoits, 1986:420-421; Wagner & Calhoun, 1991-92:70; Wertheimer, 1991:70, 162).

Wertheimer (1991:162) described the encouraging aspect of sharing suicide survivor experiences with similar others as follows: “It’s nice to meet somebody who says ‘OK, we’ve been through it, and look, we’re still alive’, and I didn’t think I would live through it”.

Alexander (1987:114-115) described her longing and need for understanding and comfort after her mom’s suicide as follows:

“Above all, I wanted to talk with others who had gone through this experience and survived. I wanted to be told that it could be survived and that my world would
eventually assume familiar contours again. The common emotional threads that bound us as survivors, and the connection that we felt with one another was both healing and empowering”.

Suicide survivors are in need of different types of social support at different times. It may include one or more of the following:

- Socioemotional support refers to expressions of empathy, caring, listening, love, intimacy, encouragement, valuing and reassurance of worth;
- Validational support refers to an acknowledgement of the mourner’s loss and suffering;
- Instrumental support refers to the provision of material goods or services such as financial support or the performance of specific tasks; and

x) Intrapersonal growth

... psychic strength ... is (the) capacity to cope with suffering and adversity (Crites, 1986:171)

A study amongst adolescent survivors found that they have experienced significant existential growth in coping with the crisis of a sibling’s death. They perceived themselves as “more grown up” or “more mature” than most of their peers. Also, they have learned to value each day and its opportunities, and to accept that irreversible traumatic things can happen to teenagers (Balk, 1983:152; Helen, 2002:65).

Growth and acceptance does not imply forgetting the deceased or the crisis events. It means gaining freedom from restricting emotions and thoughts; to cease being and behaving like victims. It means continuing with life as it is, not as one would like or wish
it to be. There is recognition that one cannot always control what happens to you, but one can decide on how to respond to it (Bolton, 1987:93; Helen, 2002:80).

Intrapersonal growth can occur in various areas of survivors’ lives in the aftermath of a loved one’s suicide. One such area is the realisation and recognition of their own emotional and physical vulnerability. This is illustrated by the following quotations:

Megan: “... before I saw myself as a very strong person and that nothing could really hurt me ... now I’ve realised my own vulnerability ... things can hurt me no matter how strong I am, or want to be ... I can still get hurt”.

Annie: “... I realised that life is actually only a heart that beats ... if your heart doesn’t beat, you’re not alive ... and anyone can take that life away from you ... your life is so valuable, but it is still determined by a heartbeat ... sometimes I listen to my own heartbeat ... you actually appreciate the chance to live” and “... the fact that blood runs through your veins and that you can get hurt ... this life is so hard and you are so vulnerable ... life can hurt you so much ...”.

Another area of growth is a realisation and recognition of the need and personal freedom to express emotions [See section 4.3.2 (v) for “Reluctance to outwardly express deep-felt emotions” as an aspect of “Emotional stuckness” during “Being shattered” post-suicide experiences]. Megan described this aspect of personal growth as follows: “I’m not scared anymore to show my sadness ... the psychologist showed me that it was okay to have those feelings ... many people go through life with the idea that you’re not allowed to show your emotions when you’re angry or sad ... now it is as if I’m not any longer behind that bars [Figure 4.4, P10], I’m now in front of it ... I can now show my feelings”.

Survivors’ often experience personal growth and emotional healing when they realise their own life’s meaningfulness. This realisation is evident in the following quotation from Maria’s interview: “I feel that the road ... made us feel better ... made us realise we’ve got so much to live for” and “Sally [psychologist] showed me ... there’s so much to live for ... even though something was taken away from you, doesn’t mean it’s the end ... you have to go on, that’s life”.

Adolescent suicide survivors may experience an increased ability to cope and understand adulthood’s challenges in the aftermath of suicide events. This aspect of personal growth is expressed in the following quotation from Ilze’s interview: “... now I understand things better because I’m older, I’m not a child anymore ... I became a strong person, not physically stronger ... basically I have risen above my circumstances ... I became very strong in everything that happened ... I know it is important to now stand on my own feet ... I must go forward on my own”.

Lastly, some survivors experience a significant growth and deepening of personal religious beliefs when dealing with the impact of the suicide events in their lives [See section 4.3.2 (xv) for “Questioning religious beliefs” as an aspect of “Unanswerable existential questions” during “Being shattered” post-suicide experiences; see section 4.3.3 (iv) for the “Role of religion” during the healing process]. In Megan’s words: “... [at the time of the suicide] my faith was not as strong as it is now ... I have learned that to have the Lord in your life is very important, but I never realised it”.

A sense of personal faith allows individuals to question God in times of difficulty, to be angry at God when the assumptive world seems to collapse altogether, and to eventually affirm your belief in a loving God who gives people a free will to choose the life they want to take up as their own (Bolton, 1987:91).

Suicide survivors often experience positive personal growth in the aftermath of a loved one’s suicide. They are more sensitive and tolerant of others’ needs and problems; have a positive outlook on life; experience spiritual growth and closer family interactions; recognise the relative unimportance of material objects; and explore new life meanings. In short, they have been able to reframe the tragic loss as an opportunity for personal development (Dunn & Morrish-Vidners, 1987-88:206-28; Wertheimer, 1991:187-188).
xi) Personal existential realisations regarding “life” and “suicide”

Being on the edge between the arriving future and the disappearing past makes life tolerable because there is a future. That future makes even my death tolerable. People will remember me. This anticipation softens the uncompromising inevitability of death (Keen, 1986:188).

Dealing with the death of a loved one is at the nexus of human meaning. The experience of being confronted with the brink of non-existence brings us to the core of our living as human beings. It touches and challenges our deepest motivations for living (Clark, 2002).

The assumptive world of suicide survivors is intensely challenged in the aftermath of a loved one’s suicide. Sometimes they have to rethink existing assumptions, while at other times they have to formulate new assumptions [See section 4.3.2 (xv) for a discussion of individuals’ assumptive world]. This section deals with the participants’ personal existential realisations regarding “life” and “suicide” that have precipitated in the aftermath of the suicide events. It provides a glimpse in the participants’ assumptive world after having struggled to make sense and meaning of a changed life. Obviously, it is not the final existential realisations; life is dynamic and constantly changing.

“Life is gift” - it should be accepted and lived in a positive way. In Annie’s words: “...you actually appreciate the chance to live ... I also see the positive from it ... you actually received a gift from God, the chance to live”.

After having been confronted with a significant loss, life and its problems can become more valued for some survivors. The realisation of their own lives’ finiteness brings a renewed appreciation and will to live (Dunn & Morrish-Vidners, 1987-88:208; Rosenfeld & Prupas, 1984:33).

“Life is not fair” - sometimes life brings intense emotional pain to people who doesn’t deserve it. Shirley expressed it as follows: “No ... I don’t think it’s fair, but life is not fair”.

Balk (1983:149) found in a study amongst adolescent survivors of a sibling’s death that one of the lessons they learned was that irrevocably bad things can happen in life. Most people express feelings of unfairness when confronted with misfortune. Everyone wants to believe that life is fair, but when a suicide defies explanation, you have to acknowledge that that’s not the way things have worked out (Helen, 2002:76).

“A significant loss is not the end of your life, you should continue to live” - individuals share their lives with others, but they shouldn’t be so dependent on another individual that they cannot live authentically in the absence of that person. This realisation is illustrated by the following quotations:

Shirley: “… just let life go on … that is difficult and it takes a lot of time … learn to deal with it and go on with life cause life will never wait for you to get over things”.

Maria: “… there’s so much to live for … even though, something was taken away from you, doesn’t mean it’s the end … you can not turn back the hands of time, it goes on and life goes on”.

Annie: “… [the most positive picture on the collage] is this one [Figure 4.5, P19] … if you are looking back at life it is sad … I have lost friends, but you are not going to let it get your down … you can learn from it … you must continue …”.

The reality of death and the impact of a loved one’s death bring about a realisation of life as being a finite existence. Life can only be lived in terms of such an existential boundary. Moving forward in the acceptance of this reality is the very best we can do. It doesn’t imply that you have to forget the loved one as if he/she never existed or had not been an important part of your life. Cherish what you have learned from it, take the memories of the person and the relationship with you, but also let go of that which must be relinquished. Continue to invest emotionally in other people, goals and dreams. In short, live your present and future life authentically without denying the past (Helen, 2002:81; Kruger, 1988:74; Rando, 1993:42-43).

“Life is never as dark as it seems” - life’s problems are never as overwhelming or without alternative solutions as it might seem in the specific situation. The following
quotations describe this realisation:

Megan: “... everything is not as dark as it seems ... to commit suicide is very selfish ...
”.  
Annie: “... I know there is still a choice at that point ... there is always a way out of it ... there must be another option than suicide ... you must get up from failures and continue ...”.

_In a study amongst adolescent survivors of a sibling’s death they indicated that one of the lessons they learned from it was that there are different ways to cope with adversity (Balk, 1983:149)._  

_“Life is not an egocentric activity”_ - no person lives only for him/herself, but as part of social systems; the meaning of life can be found in social interactions and mutuality; egocentric choices affect all the members of the social group, not just the individual that make it. Megan expressed it as follows: “Your life doesn’t only revolve around yourself ... to commit suicide is very selfish ... you must think before you attempt anything like it”.  

_“Suicide victims have been persons in their own right”_ - suicide victims should not only be remembered for the suicide, but for the complete persons that they were in the years prior to the suicide. This realisation was described as follows:  
Megan: “I love the person, but it doesn’t mean that I accept what he did ... it didn’t really fit in with my ideas ...”.  
Annie: “... he should actually be respected for what he was, because he was a good leader and he was good in sport ... he was good in many things ...”.  

_“Everyone is responsible for their own choices and its consequences”_ - freedom of choice implies that all individuals act autonomously and that each one must accept the responsibility and consequences that accompany the choices. This was eloquently expressed by Annie in the following words: “... I feel that everyone has a choice ... what you’ve done can make or break you, it’s your choice ... your choice today can make a difference tomorrow ...”.
Survivors need to realise that they had no choice in the victims’ decision to end their lives. However, they do have a choice on how they make sense and integrate this experience in their own lives. It depends on whether they accept the freedom, responsibility and consequences of their choices in the aftermath of a suicide (Hamilton & Masecar, 2001:61).

4.4 CONCLUSION

This chapter extensively described the results of the situation analysis’ phenomenological research component that focused on the research participants’ experiences, meaning-making and coping patterns in the aftermath of “being an adolescent suicide survivor”. In essence, it found that the experiences of late adolescents can be described in five experience clusters. The first two clusters describe their short-term experiences in the period directly around the suicide events, namely “immediate reactions” (see 4.2.2) and “reactions in the first few days following the suicide” (see 4.2.3). The other three clusters describe their long-term experiences in the weeks, months and years that follow the suicide events. The “falling apart” experiences (see 4.3.1) encompass those aspects of their lives that seem to be getting worse as time progress, as if being in a downward spiral. The “being shattered” experiences (see 4.3.2) cover those aspects of their lives when they struggle to cope with a changed life; they are merely struggling to psychologically survive each day. The “putting the pieces back together” experiences (see 4.3.3) refer to those aspects of their ultimate healing and adaptation to a changed life.

The results and insights gained from the phenomenological situation analysis in this chapter provided the material that was used to address the programme development stage of this study (see Chapter 6). However, before I focus on the conceptual framework for the psycho-educational programme, I would like to focus in the next chapter on the research participants’ experiences of using collages as narrative facilitators during phenomenological interviews.