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Attempted suicide in the family: the sibling's experience

Portfolio submitted for the fulfilment of the Professional Doctorate in Counselling Psychology (DPsych)

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City University

Department of Psychology

Submitted: February 2010

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Acknowledgements

Firstly, I would like to thank my supervisor, Dr Maggie Mills for her guidance and emotional support through the challenge of this research process. I am also grateful to my initial supervisor, Dr Dee Danchev, who supervised me from the start of the research until the transcription stage (2008). Thank you to my peers for keeping me going, in particular, Nikki, who has been a fantastic support for me. I would also like to thank my patient and understanding husband, who has become very adept at cooking and housework during this time! I couldn't have done this without him. Above all, I'd like to express my gratitude to all my research participants, who were brave enough to share their personal experiences with me. I hope that I have done justice to their stories.

Declaration

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Section A: Preface

Preface

The preface outlines the three elements of the thesis, which are related by a shared theme of suicidality. Firstly, there is an original piece of research of the experiences of siblings of people who have attempted suicide. The second component is a client study, describing clinical work undertaken with a client experiencing post-traumatic stress disorder (PTSD), who attempts suicide through the course of therapy. Finally, there is a critical literature review of some of the risk factors related to adolescent suicidal behaviour. It is hoped that each component illustrates competency in working as a Counselling Psychologist, and that collectively they demonstrate an ability to incorporate theory, research and practice, as needed in Counselling Psychology. The preface ends with a discussion of the relationship between these components, the motivation underlying the pieces of work, and a reflection on how they connect on a personal level.

B) Research

The portfolio begins with an original piece of research which aims to explore the subjective experience of siblings of people who have attempted suicide. In particular, the intention is to explore the emotional impact of the suicide attempt for the sibling, alongside the influence on the family dynamics and the quality of the sibling relationship. Furthermore, interest is paid to the sibling's experience of professional help following the attempt. A review of the literature revealed a paucity of research on the impact of families following attempted suicide, in particular on the siblings. The study therefore aims to address this deficit in the literature, with the hope that it may draw attention to this neglected family member and to encourage further research. A sample of eight adult siblings of people who had attempted, but not completed suicide were interviewed using semi-structured interviews. Their accounts were then analysed using the qualitative methodology of Interpretative Phenomenological Analysis (IPA). The findings are discussed in relation to the existing literature, and implications for Counselling Psychologists are considered. It is hoped that this component of the portfolio fulfils the Research Dimension criteria required of Counselling Psychologists (BPS, 2008), showing the "ability to design, conduct, critically evaluate

and report on a research project" (p. 11.) Although the aim is not to generalise the research findings, it is hoped that Counselling Psychologists will be stimulated to reflect on how a suicide attempt could possibly impact on a sibling, thereby enhancing their therapeutic work with their clients.

C) Advanced client study

The second part of the portfolio consists of an advanced client study, describing professional practice as a Counselling Psychologist in a trauma service. The client was an adult woman experiencing PTSD following a violent assault during an abusive relationship. The aim of this work is to show clinical competence and formulation of the client's difficulties within the selected therapeutic model, which in this case is cognitive behavioural therapy (CBT).

There are various reasons why this piece of work was selected. Firstly, it demonstrates the complexities of working with PTSD following domestic violence, and the efficacy of trauma-focused CBT, when a collaborative therapeutic relationship is established. Since the client attempted suicide during the course of therapy and was at risk of harm from her ex-boyfriend, it also demonstrates the challenge of working with risk and the importance of flexibility, issues of which are pertinent to Counselling Psychology. With this in mind, it is hoped that the author demonstrates an ethical way of working, and fulfils the criteria "to respond appropriately to the complex demands of clients" (BPS, 2008, p. 12.). Furthermore, the issue of suicidality in this client study resonates with other components of the portfolio. Finally, this piece of work illustrates the importance of recognising resilience in a client, and how this can facilitate the therapeutic progress, despite these difficulties. Again, it is hoped that the evaluation of the therapeutic interventions within this work evidences "the ability to reflect critically on your practice and consider alternative ways of working" (BPS, 2008, p. 12).

D) Critical literature review

This section aims to present a critical evaluation of the literature on a subject pertinent to Counselling Psychology. In doing so, it seeks to demonstrate "the ability to analyse critically and evaluate published research relevant to Counselling Psychology" (BPS, 2008, p. 11), required of Counselling Psychologists.

The topic of risk factors for adolescent suicide was partly chosen since youth suicide is an increasing problem in global terms. Furthermore, it is relevant to Counselling Psychologists since suicidality and adolescents are typically encountered in our work. Moreover, we have a responsibility to assess clients for risk of harm to self and others. Due to the extensive literature on a myriad of risk factors in an area with such complexity, the review focuses on a selection of these risk factors, and is restricted to empirical literature within the last 12 years. The appraisal briefly explores the epidemiology of youth suicide, alongside risk factor studies related to psychiatric disorders, familial factors and other psychological characteristics. Consideration is also given throughout the review of the implications for Counselling Psychologists, such as the need to elicit comprehensive information from the adolescent, and the importance of awareness of risk factors for adolescent suicidality. The review argues that although undoubtedly adding value to our understanding of youth suicide, the mainly quantitative research is in danger of reducing a complex issue to a set or risk factors. Furthermore, there should also be an equal focus on factors that *protect* adolescents from suicidality, so that Counselling Psychologists also foster resilience within clients.

Personal reflections and associations between themes

I have had a long-standing interest in suicidality, partly borne out of a curiosity as to what motivates a person to forsake in my opinion, the most fundamental gift we are given - life. I have therefore wanted to gain an understanding of suicide, coupled with a deep empathy for people who feel such pain that they believe that this is the best option available to them. I have also become aware through my work as a Counselling Psychologist of the frequent encouragement within families to suppress feelings,

which in my opinion can contribute to distress and suicidality. Therefore, I am keen to help break this taboo and bring the subject of suicide into the open. Furthermore, as a Counselling Psychologist undertaking risk assessments with new clients, my experience is that previous suicidal behaviour frequently occurs during adolescence. Therefore, these are some of the factors that inspired me to undertake the critical literature review on adolescent suicide risk factors, which examines what may predispose young people to engage in suicidal acts.

The client study continues the theme of suicidality, replacing theory with experience, since the client attempted suicide during the course of our therapeutic sessions. Although this was a challenging situation as a Counselling Psychologist, this experience deepened my understanding of suicide and of the client's distress, as I realised impulsivity and the perception of being in an inescapable circumstance were also factors in suicidality. I began to realise that the subject of suicide is highly complex, that does not involve a simplistic wish to die. I have also reflected that in working with this client, I had been forced to face my fear of a client's suicide attempt rather than in the abstract of considering possible risk factors in the critical literature review. Paradoxically, what emerged unexpectedly for me was the client's resilience during her difficult circumstances, and I realised the importance of Counselling Psychologists recognising and fostering this characteristic within a client. Resilience in this section also overlaps with the critical literature review, since the latter critiques the lack of emphasis on protective factors and resilience within adolescents.

The theme of resilience also imbues the empirical study, although to a lesser extent than the continuing motif of suicidality. The research was inspired by several factors. In working in an acute mental health ward, I frequently encountered people who had attempted suicide and I was struck by the scant attention paid to the families who came to visit their relative. Therefore, my desire to understand suicidality expanded to interest in significant others of those who attempt suicide. I had a curiosity about the family's experience of the suicide attempt, and what happened after the patient was discharged from the hospital. In particular, I was interested in the sibling's experience, since they were typically not present in clinical meetings regarding the patient's aftercare. As mentioned previously, this inattention to the sibling's experience is also reflected in the paucity of research. What emerges from my study is that suicidality

can have a profound and far-reaching impact on a sibling. Furthermore, there is an overlap between the research and the critical literature review, in that the majority of siblings who had attempted suicide in my study were adolescents at the time of the event, whilst the issue of complexity and ambiguity threads through all three components. The research impacted me in that I was led to reflect on my own experience of a suicide attempt in my family, therefore I was experiencing a parallel process to the participants.

I have realised that alongside my quest to understand suicidality, I have also been on my own personal journey; from taking a *theoretical* stance with a focus on prevention through the literature review; to facing and actually experiencing my *professional* fear of suicidality of a client within the client study; to reflecting on my *personal* experience of familial suicidality, prompted by my research. Furthermore, the issue of resilience threading throughout the portfolio is also reflected in my journey to becoming a Counselling Psychologist.

Therefore, I believe that in undertaking all the components of this portfolio, there has been a growth and development within me, both in a personal and professional sense.

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Section B: The research

Attempted suicide in the family: the sibling's experience.

Supervised by Dr Maggie Mills

Abstract

Research on the impact of attempted suicide on siblings is scarce, with studies tending to focus on the attempter, on the parents or on the impact of *completed* suicide. In particular, there are few qualitative studies that solely explore the sibling's experience of attempted suicide. To address this gap in the literature, this study examines the subjective, lived experience of eight adult siblings aged 22-39 years of people who have attempted, but not completed suicide. In particular, the intention was to explore the emotional impact of the suicide attempt for the sibling, alongside the influence on the family dynamics and the quality of the sibling relationship. Following semi-structured interviews, the qualitative methodology of Interpretative Phenomenological Analysis (IPA) was used to analyse the data, with the emergence of four masterthemes: *Feelings of grief & loss*; *Resilience*; *Family communication, roles and changes*; *Experience of professional help*. The findings reveal a profound impact on the sibling and family relationships that is analogous to that of *completed* suicide. What emerges is the complexity and ambiguity of the subject matter, with a sense of 'unfinished' business, manifested particularly through feelings of grief and loss. Furthermore, emotions of shame and guilt interweave the accounts, with a sense that the families' lack of communication perpetuates the distress from the suicide attempt. In addition, there appears to be a lack of professional support offered to siblings. Despite the negative impact, there also appeared to be resilience within the siblings, and some positive changes possibly result from the suicide attempt. The findings are discussed in relation to the existing literature, and implications for Counselling Psychologists and other professionals are considered.

Literature review

Suicide is one of the most enduring and complex human issues that we face, generating a wealth of literature and art throughout the ages. Due to the scope of this report, the focus for this literature review is on empirical studies rather than theoretical literature. For more philosophical and sociological discussions, please refer to work such as *"Suicide: A Study in Sociology"* (Durkheim, 1951).

In the last 45 years, global suicide rates have increased by two thirds, with an estimate that figures could be twenty times higher for attempted suicide due to under-reporting (World Health Organization [WHO], 2009). Clearly, this is a growing problem which needs to be addressed. Furthermore, the number of people affected by suicidal behaviour is likely to be even higher when considering the estimate that six people experience severe grief for every suicide (Shneidman, 1969).

In reviewing the literature on the impact of suicidal behaviour, it appears much research has been concentrated on completed, rather than attempted suicide (Hawton & van Heeringen, 2000), involving risk factors and prevention. Studies on attempted suicide are mainly focused on the suicide attempter, with comparatively little regarding the effect on families (Beautrais, 2004), and even fewer related to siblings. Consequently, this review has been widened to include literature on the effects on families of people who have enduring mental illness, since people who attempt suicide often have mental illness (Beautrais, 2004). Due to the scope of this report however, this area cannot be exhaustively investigated. Additionally, there is a review of the literature concerning the impact on families who have been bereaved by a completed suicide. This is because it would seem reasonable to expect some similarities in the experiences of attempted and completed suicide.

There is considerable debate in the literature regarding the definitions of 'self-harm', 'deliberate self-harm' and 'attempted suicide', due to the frequent difficulty in ascertaining the true intention of the action. Favazza (1998) uses the term 'self-mutilation', distinguishing self-harming behaviour as a form of self-help to obtain relief from distressing feelings, as opposed to the intention of suicide to end all

feelings. Indeed, Favazza (1998) asserts that self-harm can be viewed "as a morbid form of self-help that is antithetical to suicide" (Conclusion, para.1). He therefore views self-harm as a way of continuing life, in contrast to suicide as a way of ending life. Accordingly, this review is based on literature which relates to suicidal behaviour as a perceived intention to die, as opposed to self-harming as a coping behaviour.

Impact of attempted suicide on families

A study of the literature reveals a dearth of studies assessing the impact of suicide attempts on other people. Hawton and van Heeringen (2000) assert that there is a genuine need for such research, whilst Talseth, Gilje and Norberg (2001) highlight the neglect of the subjective experience of family members such as siblings. Tzeng and Lipson (2001) also note the lack of research into the quality of life after a suicide attempt, whilst Beautrais (2004) criticises the lack of focus on the needs of families of people who attempt suicide. Instead, the predominantly quantitative studies focus on risk factors, the person who has attempted suicide or familial factors underlying the attempt. There is also current interest in the genetic components of attempted suicide (e.g. Willour et al., 2007). The few studies that have been undertaken on the impact of family members tend be focused on parents and significant others, and are mainly quantitative. Concerns were raised at the '12th European Symposium on Suicide and Suicidal Behaviour', that researchers are overly focusing on suicide and suicide prevention, with little attention paid to postvention and the impact on families following suicidal behaviour (personal communication, August 29, 2008).

Much of the literature appears to originate in the U.S.A., New Zealand and Europe, particularly Scandinavia, with less undertaken in the U.K., the Middle and Far East, Africa and Eastern Europe.

In a quantitative study, Wagner, Aiken, Mullaley and Tobin (2000) found that adolescent suicide attempts tend to lead to a combination of contradictory feelings within parents. This study has been selected since it one of few that addresses both a suicide *attempt*, and the impact on the family, which is of interest to the author. However, its constraints include a lack of representation of fathers and a restriction to

clinical settings, thus limiting generalisability of the findings. Furthermore, interviewees were paid for their participation, therefore the possibility of response bias and its influence on the findings should be considered. Additionally, since participants were interviewed approximately within a month of the attempt, the study would benefit from a more longitudinal examination, to explore any changes in feelings. Nevertheless, this study is important as it could lead to parents being more willing to acknowledge any angry feelings that they have about their suicidal offspring and to realise that this is common, thus helping them deal with any guilty feelings. It also shows the range of conflicting emotions a parent may feel when their child attempts suicide. It may be logical therefore to wonder if another family member, such as a sibling would experience similar complex feelings towards the suicidal relative.

The importance of recognising and normalising powerful feelings in families experiencing a relative's suicidality is also reflected in other studies, (e.g. Mishara, Houle & Lavoie, 2005). In a quantitative study, James and Hawton (1985) conducted semi-structured interviews of self-poisoners and relatives. They found that some relatives conveyed strong feelings about the event, and that there were disparities in interpretations for the overdose between them and the self-poisoners. Limitations of the research include unequal numbers of family subgroups, and female participants being under-represented. The fact that only one sibling was included underlines the author's argument that this family member is under-represented. Nevertheless, this study has important clinical implications, particularly for Counselling Psychologists, and is another reason it has been selected in this discussion. As some relations conveyed strong feelings, the facilitation of communicating these and their normalisation may lead to families being able to provide more help to the person attempting suicide. Furthermore, Hawton is arguably one of the U.K.'s most respected suicide researchers, adding further rationale for the inclusion of his work in this review. However, Hawton can be criticised for being overly focused on quantitative research and risk factors, rather than seeking richness of subjective experiences through qualitative studies. In addition, the emphasis of this study, like much of the literature, still remains on the patient, rather than the family member. This could be further developed to look at the beneficial effects of opening up communication for specific family members.

A quantitative Swedish study of relatives of psychiatric inpatients revealed feelings of worry in family members of suicide attempters, with a negative effect on their mental health and social life (Kjellin & Östman, 2005). Like the quantitative findings of Mishara et al. (2005), this research suggests that relatives of suicidal family members experience feelings of burden and have a need for support. However, the relatives in this study were selected by the inpatients, raising issues of bias in participant selection and responses that were given. Furthermore, participants gave yes or no responses to questions; therefore it could be argued that the findings were defined by these structured questions. This study is valuable in highlighting the impact of suicide attempts on family members, is one of few that include significant numbers of siblings, and is one reason that it has been selected for this review. Additionally, it is argued that it could be improved by adopting a qualitative approach, giving a richer and more detailed picture of this experience.

The family's need for professional support is also echoed in a Swedish quantitative study of significant others in the immediate aftermath of a suicide attempt (Magne-Ingvar & Öjehagen, 1999b). They reported that participants expressed a strong desire for counselling, with many people experiencing a sense of burden with their suicidal relatives. Furthermore, in a valuable follow-up study one year later, the number wanting counselling had only slightly decreased (Magne-Ingvar & Öjehagen, 1999a). This research is included for several reasons. It has a strong focus on the professional needs of families, which is one of the author's interests. It is also a rarity in that again it pertains to a suicide *attempt* rather than completed suicide, and it also includes a follow-up study, which is valuable in understanding how families' needs and experiences change over time. However, in their original study, participant selection was based on patients' suggestions, which could engender bias in the findings, and the study was largely focused on thoughts about the *attempter* and *their* needs. Nevertheless, this research is important in highlighting the professional support needs of significant others of suicide attempters. It would benefit from replication in a more qualitative way such as more in-depth, open-ended interviews conducted in person, rather than by telephone. Any non-verbal cues could be captured, thus enriching the data collected. Additionally, very few of the participants were siblings. Therefore, extending this research to include these neglected family members would be useful.

The value of receiving support, trust and collaboration with professionals is also reflected in a Norwegian qualitative study of relatives of suicidal inpatients (Talseth et al., 2001). Using a phenomenological hermeneutic method, they reported that being viewed as a *person* and receiving emotional support from professionals helped to reduce feelings of helplessness and engendered hope in family members. Limitations of the study include the use of a small sample, thereby limiting generalisability, and the findings involving interpretation and therefore subjectivity. Nevertheless, the research is a welcome addition to the literature, adding in-depth findings to this field, whilst also focusing on the helpful aspects of professional services. Indeed, the richness of the data illustrates the value of a qualitative methodology, and the concern with professional needs of family members of suicidal people is something that requires further exploration through research. However, this study fails to specify which family members participated. Therefore, it could be improved by focusing solely on one family member such as siblings, which would illuminate their experience instead of amalgamating it with other family members, as in this research and other studies.

There is also a need for more qualitative studies that highlight the religious, ethnic and cultural aspects of attempted suicide. Tzeng and Lipson (2004) describe how completed suicide is regarded as shameful in China, but a suicide *attempt* is even more stigmatising for both suicide attempter and the family. This is because of the cultural view that one should not harm one's body since it is inherited from the parents; attempting suicide is seen as damaging the parents. Their Taiwanese ethnographic study revealed that the reason for the attempted suicide appeared to be overtaken by the immense sense of societal disgrace and denial felt by the family and patient, hindering their subsequent communication (Tzeng & Lipson, 2004). This study gives an invaluable insight into how culture and religion can influence the impact of attempted suicide and the resulting family dynamics, and this should be borne in mind in future studies. For example, it would be interesting to undertake a similar study involving families who are Roman Catholics or Muslims. However, this research did not specify which family members participated, although it appeared to be mainly parents. Therefore, extending this to other family members, including siblings would be valuable.

Impact of completed suicide on families

Much of the research on completed suicide is historically quantitative, and concerns the risk factors leading to the behaviour, and the subsequent increased risk in suicidality in family members (Beautrais, 2004). Therefore, studies have been previously focused on prevention, epidemiology and on the person who has completed suicide. Clark (2001) speculates that postvention research has previously been neglected due to many issues such as difficulty in measuring grief, and reluctance to approach potential participants at a time of great distress.

However, in more recent years there has been increasing interest in suicide bereavement. This initially tended to be quantitative and focused on predictors of bereavement outcomes, but has increasingly been concerned with grief interventions. Research has indicated an intense impact of suicide on families (e.g. Van Dongen, 1991), however more recent studies examining differences between suicide grief and that from other modes of death has yielded mixed findings (Jordan, 2001). Recent studies suggest other factors, (e.g. increased frequency of familial mental illness), rather than the mode of death influences the bereavement response, and that these could account for any differences between suicide bereavement and grief from other circumstances (Clark & Goldney, 2000).

More recent qualitative studies have drawn attention to the emotional impact of suicide bereavement (Clark & Goldney, 2000). Although there has been increasing interest in the family's needs following suicide (Clark, 2001), further research is needed on the effects of suicide on family dynamics (Beautrais, 2004; Ceral, Jordan & Duberstein, 2008; Wolfe & Jordan, 2000).

In particular, there appears to be a lack of investigation into the effects of completed suicide for non-heterosexual partners, siblings and grandparents of people who complete suicide. The importance for further exploration after a suicide in the family (postvention) is perfectly summarised in the following statement: "Postvention is

prevention for the next decade and for the next generation" (Shneidman, 1969, as cited in Hawton & van Heeringen, 2000, p. 481).

Since there appears to be few studies, especially qualitative that focus solely on siblings following suicide, this review discusses studies that include other family members as well as siblings. Indeed, it appears that the only study on child siblings of people who have completed suicide is that of Brent et al. (1993).

One finding across the limited studies appears to be that people are profoundly impacted by a sibling's suicide (e.g. Begley & Quayle, 2007). In an American quantitative study by Brent et al. (1993), findings showed that 25 adolescents, whose sibling had completed suicide were more likely than a control group to experience a major depression within six months following the event. However, in their follow-up study three years after the suicide, siblings did not show a greater risk of depression or other psychological problems, and appeared to recover better than mothers. However, this did not apply to siblings who were younger than the suicide completer, and siblings also appeared to experience continuing feelings of grief (Brent, Moritz, Bridge, Perper & Canobbio, 1996). This study is important since it has drawn attention to siblings following suicide and shows the value in longitudinal research. Limitations include fewer follow-ups in the sample of mothers, making it difficult to accurately compare their progress with that of the siblings, and the use of questionnaires, restricting the richness of data. Furthermore, it does not tell us in any depth about the experiences of these siblings, which could be elicited from a qualitative approach.

Dyregrov and Dyregrov (2005) also discuss the scant research on children and adolescents whose sibling has died from suicide. They performed a Norwegian study involving parents and people aged over 15 years, whose sibling had died by suicide, which revealed a strong need for surviving siblings to receive more support. Using questionnaires with participants and in-depth interviews with some of the siblings, they discovered that younger siblings living at home had the most difficult time after the suicide, supporting work by Brent et al. (1996) and Lindqvist, Johansson and Karlsson (2008). Guilt and burden was increased when some siblings did not disclose to parents serious triggers for suicide, along with a reluctance for both sibling and

parent to discuss the death so as not to 'upset' the other. A sense of isolation in the sibling's grief was often experienced due to parents being so engrossed in their own loss, with many siblings then experiencing over-protectiveness from their parents. The study also revealed a lack of professional help for siblings, with only 6 per cent receiving individual support more than three months after the suicide. Although covering a wide range of psychological, familial and social factors, the research was undertaken using questionnaires with yes/no answers or ranking, which one could argue would restrict the information gained. However, some of the participants were also interviewed in-depth, which deepens the quality of the data, and could be extended to more participants. However, this study is important as it highlights the need for more research and help to be given to siblings of suicide completers. Furthermore, it has been chosen for this review because it is a rare study focused solely on siblings, describing family dynamics and experiences of professional help, which are all areas which the author is interested in exploring. Given the complexity of emotions and resulting family dynamics in this Norwegian research, it prompts the question of how siblings are affected by a brother or sister that *attempts*, rather than completes suicide.

Feelings of guilt and shame in the above study have also emerged in other research on family members following completed suicide (Begley & Quayle, 2007; Dyregrov & Dyregrov, 2005; Lindqvist et al. 2008). A qualitative study using hermeneutic phenomenology was undertaken in New Zealand by Fielden (2003). In-depth interviews were conducted concerning the lived experiences of family members of people who had completed suicide. Themes of blame, stigma and guilt were revealed. However, nearly all of the participants were parents, a group that has been more frequently studied, with only one sibling participating. Therefore, this study which yielded rich data would benefit from replication with other less studied family members such as siblings and grandparents.

The ongoing need to make sense of the suicide is also a prevalent theme in literature on siblings following suicide (Fielden, 2003; Lindqvist et al., 2008; Wertheimer, 2001). In an Irish study, Begley and Quayle (2007) undertook research with four parents and four siblings following completed suicide, using IPA methodology. The need to make sense of the suicide was a powerful emergence from this research,

having significant effects on their lives. For example, many of the participants described beliefs that only people who had undergone the same event could understand their experience. Consequently, support groups became a place for sense-making and were often the only place where they would share their feelings about the suicide, resulting in distancing from other people in their lives. Limitations of the research include the length of time elapsed since the suicide (3-5 years ago), which could distort the accuracy of the participants' recall. Furthermore, most participants were recruited from a voluntary support network. Therefore, it could be argued that findings would be biased since these people may be more negatively impacted by the suicide than others, if they sought help from that source. Nonetheless, this research has yielded detailed accounts of the experiences of siblings and parents bereaved by suicide. A further rationale for its inclusion is that it employs the same methodology that may be used in the author's study, adding a richness to previous quantitative and qualitative studies. Furthermore, it is fairly unique for a study of this kind to be based close to the UK, which is to be the demographic basis of the author's study, and could offer interesting comparisons. This research could be given extra depth by replicating it longitudinally and by focusing on one family member, such as siblings to continue addressing this gap in the literature.

Another reoccurring theme across the research involving siblings is that of being overlooked, and a lack of professional help provided to siblings (Dyregrov & Dyregrov, 2005; Fielden, 2003; Wertheimer, 2001). This is particularly evident in a Swedish mixed method study, which was undertaken with 10 families to describe the psychosocial consequences of teenage completed suicide (Lindquvist et al., 2008). Findings suggest that long-term professional support was particularly lacking, especially for younger siblings who need to be given time and patience before they can communicate their feelings. This lack of inclusion appears to be reflected in the interviews described in the study, since the authors described the siblings as merely 'present' but not actively participating alongside their parents in some of the interviews. Furthermore, the ages of these siblings are not specified. Interestingly, subsequent follow-up conversations revealed that it was these siblings who most benefited from the interviews, despite their reluctance to articulate their experiences. It therefore appears that future studies should consider how best to build trust and

facilitate communication within these siblings, since clearly they want their experiences to be heard but they have difficulty in articulating them.

Impact of mental illness on families

There is substantial literature regarding the impact on family members related to someone with a severe mental illness. However, due to the constraints of this review, only selected studies can be discussed. The dominant methodology has traditionally been quantitative, with schizophrenia and parents being the most studied groups. Rose (1996) reports that relatives other than parents, and illnesses other than schizophrenia need to be studied, and the author concurs with this assertion.

Encouragingly, in recent years there has been an increased focus on qualitative studies and on siblings in their own right. Furthermore, there has been a move away from attributions of mental illness purely to 'dysfunctional' families, particularly mothers, to a consideration of other possible factors. Additionally, there appears to be an increased interest in strengths in families with mental illness, with the concept of 'burden' viewed more in terms of 'coping strategies'.

- Burden and coping strategies

In an earlier study that focused solely on siblings' qualitative experiences of mental illness, Gerace, Camilleri and Ayres (1993) conducted an American study of 14 siblings of people with schizophrenia. A content and thematic analysis suggests that participants engaged in collaborative, crisis-oriented or detached ways of coping with their sibling's illness, and that there was an impact on their lives ranging from discrete to pervasive. This study was valuable since it highlighted the variability of effect of mental illness on siblings and it generated further research. However, limitations include a sample of mainly white, well-educated females, thus limiting generalisability. Furthermore, recruitment through support groups could have biased findings. For example, the groups could have taught participants alternative coping techniques or minimised the impact of mental illness. Alternatively, seeking support from these groups could represent distress in the sample that may not be so prevalent

in other siblings. Furthermore, some of the questions were based on the assumption that there would be difficulties in having a sibling with schizophrenia, possibly influencing participants to consider mainly negative views of their circumstances.

Similar findings were also revealed in a qualitative study by Kinsella and Anderson (1996), which showed that adult children and siblings of people with mental illness exhibited a range of coping skills such as 'constructive escape' and self-censoring behaviour. This study is important in many ways. Firstly, it suggests that younger siblings or children of people with mental illness may be more susceptible to feelings of burden. Furthermore, it highlights the needs of the participants, such as their need for information and inclusion in the treatment of the ill family member. In addition, it discusses strengths that had been largely neglected in past literature, such as an increased independence and empathy within the participants. Finally, its influential place within mental illness literature, and the focus on siblings' coping strategies, which is of interest of the author, also add rationale for its inclusion in this review. This study could be improved by widening the sample to include other ethnicities, and mental illness other than schizophrenia. Furthermore, the authors acknowledge that large age differences between the two types of family members made comparison difficult, and therefore it would be preferable to examine offspring and siblings separately.

The themes of burden and coping patterns has also been illustrated in a small Grounded Theory study of siblings of people with schizophrenia (Stålberg, Ekerwald & Hultman, 2004). Their findings had similarities with Gerace et al. (1993) and Kinsella et al. (1996), with siblings describing coping strategies such as avoidance and care-giving. However, other interesting emergences were the strength of the sibling bond, mixed feelings, and the fear of inheriting schizophrenia. These findings, alongside the burden of stigma and uncertain obligations have also arisen in subsequent studies, lending weight to the value of this research, despite its small sample.

The issue of burden is examined more cross-culturally by Horwitz and Reinhard (1995). Their American research illustrates that ethnicity is a feature of caregiving, after controlling for other variables. In their quantitative New Jersey study of parents

and siblings of psychotic patients, white parents described more caregiving burden than black parents, despite having equivalent duties. Furthermore, white siblings reported more caregiving burden than black siblings, despite the latter having more duties. Limitations of the study include the small sample size, particularly of black participants, meaning comparisons are problematic, and findings cannot be generalised to other populations. Furthermore, the quantitative measures reduce the richness of the experiences of the family members. Nevertheless, this research is important in highlighting the need for further qualitative exploration of ethnicity and of the experiences of parents and siblings who care for a person with mental illness.

- Grief and loss

Some literature has found that some family members 'grieve' for their mentally ill relatives (Jones, 2002; MacGregor, 1994; Marsh & Dickens, 1997; Osborne & Coyle, 2002). In an American study, Riebschleger (1991) conducted semi-structured interviews with 20 adult siblings of people with chronic mental illness. Findings revealed that they experienced a range of emotions akin to a grief response for their sibling, including mourning the loss of the 'healthy' person, and anger towards the sibling and family.

A sense of loss is also echoed in findings by Lukens, Thorning and Lohrer (2004). Their Grounded Theory study revealed multiple losses experienced by 19 siblings of people with mental illness: loss of a 'normal' childhood; loss of boundaries and family roles; loss of communication in the family; loss of freedom etc. In contrast to historical literature on families and mental illness, it also presented protective factors, thus providing 'balance' to the accounts so that they were not painted as wholly negative experiences. This represents the change in focus within psychology towards resilience within people, providing further rationale for its inclusion in this review. Furthermore, its exclusive focus on siblings and the use of a larger sample size than many others studies provide a broader account of this experience. However, asking participants to think of a minimum of five negative and positive ways that a sibling's mental illness has impacted their lives could be seen as too 'leading'. Furthermore, the sample was predominantly white, middle-class females. Therefore, this research would benefit from widening the sample to males and other ethnicities and socio-

economic classes. Focus groups in the study can be viewed as facilitating openness within the participants, whilst minimising interviewer bias. However, it can also be argued that there is a possibility that they could induce social desirability bias. Nevertheless, it is a thought-provoking study, and is important in illuminating in an in-depth way the profound impact of mental illness on siblings.

Stein and Wemmerus (2001) took a life course perspective and gained personal stories of adults with schizophrenia, their parents, and siblings from six families. The dominant theme appeared to be 'loss of family life' but contrastingly, there was also a sense of hope. One could critique this study for being small-scale and involving families in which members have close relationships, thereby possibly biasing the findings. Furthermore, the participants were paid $30, which one could argue could influence the participants to respond in a way to 'please' the researcher. Nevertheless, this research is very important as it demonstrates the uniqueness of each family experience, and it shows the danger in generalising across large populations. It would be useful to replicate this study involving relatives who have been less studied, such as solely focusing on siblings, and to examine mental illnesses other than schizophrenia.

Summary

In reviewing the literature, although the effects of mental illness and completed suicide in families have been moderately explored, the sibling's in-depth experience appears to be lacking.

This neglect is even more apparent in the area of attempted suicide, where the largely quantitative research has tended to focus on risk factors. Hawton and van Heeringen (2000) assert that there is a real need for further exploration of the impact of suicide attempts on other people. The limited studies that exist regarding the effects of attempted suicide have tended to concentrate on parents and on the attempter, with siblings given less attention. Furthermore, the sibling relationship in general has been under-researched in comparison to other family relationships, yet it is one of the most significant and enduring bonds that one ever has (Sanders, 2004).

Any suicidal behaviour can have serious repercussions in a family, with increased risk factors for future suicidal behaviour (Beautrais, 2004). Therefore, exploring the sibling's experience of a suicide attempt in an in-depth way may reveal findings that are not only currently lacking in the literature, but may also be important for prevention of future suicidality. Furthermore, 95 per cent of the research participants in the study of significant others of suicide attempters described feeling pleased that they were interviewed (Magne-Ingvar & Öjehagen, 1999b). This suggests that some siblings of people who have attempted suicide may welcome the opportunity to discuss their experiences in a study.

It is hoped that by contributing to the under-developed literature on attempted suicide and siblings, that it will increase our understanding of their experiences and encourage further research to be undertaken. In the future, siblings of people who attempt suicide may then receive more recognition and support, both in a personal and professional sense. This is particularly pertinent to Counselling Psychologists, since they will frequently encounter suicidality and siblings in their work. Therefore, gaining an insight into these experiences may help inform them of more effective ways of supporting these clients.

The current study: Research question and aims

The research question is to explore the thoughts, feelings and experiences of people whose sibling has attempted, but not completed suicide.

In particular, the aims of the research are to explore the following areas:

1) How does the person feel when the sibling has attempted suicide?
2) What does the person think when the sibling has attempted suicide?
3) What is the impact on the person's life when the sibling has attempted suicide?
4) How are the family dynamics affected by the attempted suicide?
5) How is the relationship affected with the sibling who has attempted suicide?

The research aims have been shaped by the deficits in the literature and the areas requiring further exploration, such as the emotional impact of the suicide attempt on the sibling, the influence on the family interactions, how the participant experiences the sibling relationship, and their experience of professional services.

Methodology

Research Design

A qualitative methodology was selected for this study.

Rationale for adopting a qualitative approach

For Smith (2003), the aims of qualitative research are the exploration and description of how participants experience their world. Using naturalistic methods such as interviews, which are then subject to interpretation, rather than testing pre-defined hypotheses, qualitative methodologies seek to elucidate participants' views of the world. Such research typically involves a small number of participants rather than a large number of people, and it uses language to access participants' internal worlds (Smith, 2003).

After consideration, a qualitative approach was chosen for several reasons. From a personal point of view, inspiration was gained through working as a health-care assistant on an acute mental health ward, and observing families visiting their relatives who had attempted suicide. In contrast with the patients, there appeared to be little support or aftercare available for the families. The emotional needs of siblings, in particular were generally overlooked. Over time, the author's interest in gaining a deeper understanding of the lived experience of siblings of suicide attempters developed into the focus of the research. Since a qualitative approach is suited to creating rich detailed accounts of the meanings people attach to their experiences,

rather than focusing on causal relationships (Willig, 2008) or testing hypotheses, it seemed the most appropriate methodology for the present study.

As discussed previously in the report, there is a scarcity of research on the impact of attempted suicide. In particular, there is a lack of attention paid to siblings and their subjective experience of the attempt. The present study contends that a qualitative approach will best address this gap in the literature, adding depth to the quantitative studies, and 'give voice' to this neglected member of the family. This seems particularly pertinent since any suicidal behaviour can have serious repercussions in a family, with increased risk factors for future suicidal behaviour (Beautrais, 2004). It is hoped that this project will encourage further research, and lead to increased social and profession recognition for siblings of people who attempt suicide.

It is argued that a qualitative approach is 'the best fit' for Counselling Psychologists, due to the shared nature of an interest in the subjective experience of an individual. Morrow (2007) asserts that "Counseling psychology practitioners, in particular, may find qualitative inquiry more congruent with the narrative perspectives of their therapeutic work" (p. 211). This is also formalised in the BPS Professional Practice Guidelines (Division of Counselling Psychology, 2008) which state that the aims of practice and research are to:

> engage with subjectivity and intersubjectivity, values and beliefs; to know empathically and to respect first person accounts as valid in their own terms, and to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing. (pp. 1-2)

Rationale for adopting Interpretative Phenomenological Analysis (IPA) and methodological considerations

There are various reasons underlying the methodological choice of IPA for this study. As the research aims to study and interpret how a person experiences, thinks and feels about their sibling's suicide attempt, IPA's focus on capturing and understanding

participants' experiences distinguishes it as the most appropriate methodology for the present project. The lack of qualitative research in this area further supports the use of IPA, specifically as Smith and Osborn (2003) assert IPA's suitability for research topics that are novel or that have been largely neglected.

It is argued that the richness of an IPA interview depends in part, upon empathy, building rapport, and drawing out the client's experiences, qualities that define the practice of Counselling Psychology. Supporting this, Smith, Flowers and Larkin (2009) highlight that IPA attracts those who are interested in the human experience, which it is argued is also at the heart of Counselling Psychology. Moreover, they point to the growing numbers of Counselling and Clinical Psychologists who are employing IPA methodology for their research (Smith et al., 2009). Furthermore, it is contended that IPA researchers and Counselling Psychologists both aspire to 'step into the shoes' of the client or participant, a process which demands a high level of reflexivity (Willig, 2008). It is argued that IPA holds an intuitive appeal for Counselling Psychologists, who are trained to develop reflexivity and receive supervision in this area. Furthermore, the assertion of Smith and Osborn (2003) that there is no formal prescription of 'how to do' the analysis offers a flexibility that is both personally challenging and appealing.

In deciding on possible methodologies, Grounded Theory was also considered. Willig (2008) describes the similarities between IPA and the shortened version of Grounded Theory, observing that both are concerned with showing how individuals view their world, involve the classification of data into themes, and start with individual cases which are incorporated so that the final representation provides a richer description of the experience. However, the distinctions between the two methodologies highlight the reasons for selecting IPA for the present study. Whilst acknowledging that Grounded Theory seeks to elucidate the social processes that underlie the phenomena being examined, Willig (2008) emphasises that IPA seeks to uncover the essence of the experience and was purposely created for psychological research. Since the intention was to gain an understanding of the participants' psychological world, which was partly influenced by the author's work as a Counselling Psychologist, it seemed that IPA was a better fit for the aims of the research. Furthermore, Creswell, Hanson, Clark and Morales (2007) discuss how Grounded Theory is concerned with generating

a model from the author's abstractions and interpretations. Since the intention was not to create a theory, and instead to focus on the participants' unique experiences, it seemed that again, IPA was better suited for this research. Moreover, it was felt that the nature of the topic being investigated was so emotive and personal that there was a reluctance to theorise or 'dilute' these subjective experiences, particularly since they have been so previously neglected by researchers. Finally, Willig (2008) discusses the ongoing debate regarding the different versions of Grounded Theory, and indeed what constitutes this methodology. In pragmatic terms, it was felt that there was insufficient time to give these complex issues the full consideration that was needed, in order to be able to select an appropriate version.

IPA also shares a similarity with Discourse Analysis, in that both recognise the importance of language in the qualitative examination of experiences (Chapman & Smith, 2002). In Discourse Analysis, language is the predominant focus, with the view that it constructs the participant's reality, and an interest in social structures which it asserts unfold in the participant's text. Contrastingly, IPA's focus is to gain an insight into the participant's lifeworld, and views language as a means of gaining access to this (Eatough & Smith, 2006). Since the author's aims were to explore the subjective experience of the participants, rather than a focus on how they talk about their experiences or on the social processes, it was felt that again IPA, rather than Discourse Analysis was more appropriate for the research question.

Another reason that IPA was chosen over other qualitative methods concerns the issue of epistemology. Willig (2008) discusses the importance of researchers clarifying their epistemological position, that is, specifying the type of knowledge that they hope to attain from the study, whilst also ensuring its congruence with the chosen methodology. At the same time, Willig (2008) acknowledges the frequent ambiguity of epistemological perspectives and that the terminology used can be problematic. Nevertheless, it is this point to which the author now turns.

An epistemological position of a critical realist is taken; the belief in an external reality that exists outside of our mental world, but that our understanding of it is dependent on our perceptions. Madill, Jordan and Shirley (2000) assert that a critical realist considers that one's beliefs influence this knowledge, and the author concurs

with this. IPA is not confined to one single epistemological position. Indeed, Larkin, Watts and Clifton (2006) assert that IPA has an "epistemological openness" (p. 114). However, Willig (2008) comments that IPA is in part founded on a realist position, in that it attempts to elucidate how and what people think of an experience, which is compatible with the author's stance. Furthermore, like IPA, the author is more concerned with the participant's experience of a phenomenon, rather than whether or not their experience is 'true' (Willig, 2008). This is partly motivated by the author's work as a Counselling Psychologist, which values the client's subjective experience and views the meanings that they attach to their experiences as the primary focus for therapeutic work, rather than concerns about an objective reality.

This study also embraces the principles that inform the contextual constructionist position. That is, the belief that knowledge is subjective and will vary according to the person and their context (Willig, 2008). According to Willig (2008), IPA is also established from a contextual constructionist standpoint, which is compatible with the author's stance.

The author's recognition that one cannot directly access the participant's reality is also shared with IPA, which asserts that a researcher can never completely access a participant's psychological world (Willig, 2008). Indeed, Smith et al. (2009) describe that IPA can only hope to reveal *something* about an individual's way of being in the world, and how they make sense of it.

Introduction to IPA

Developed by Jonathan Smith in the mid 1990's for use in psychological analysis, IPA has since been widely adopted by other disciplines across the social sciences (Smith et al., 2009). Focusing on the inner psychological world of the individual, IPA attempts to explore and understand people's lived experiences (Smith et al., 2009). It is an inductive, bottom-up, (as distinct from theory-driven) process that generates data through the use of open questions, typically semi-structured interviews or diaries.

In his account of phenomenology, Smith et al. (2009) traces its evolution from Husserl to Heidegger. In developing IPA, Smith incorporated Husserl's focus on the intrinsic essence of phenomena, ("go back to the things themselves") and the individual's experience of them (Smith et al., 2009, p. 12). Inspired by Husserl, Smith's IPA aspires to set aside pre-existing assumptions, in order to consider the fundamental qualities of the experience. It achieves its "phenomenological attitude" through its attention to the individual's perception and consciousness, thus providing the descriptive, subjective basis of IPA (Smith et al., 2009).

Smith adopts Heidegger's interpretation that the nature of being in the world is always situated in historical and social contexts (Smith et al., 2009), and similarly embraces a descriptive view of the world over Husserl's more interpretative stance. Smith's endorsement of Heidegger's emphasis on the individual's connectedness with the world leads to the second theoretical foundation of hermeneutics (Smith et al., 2009) This hermeneutic approach within IPA views people trying to make sense of their world. A double-hermeneutic occurs since the IPA researcher is attempting to make sense of the participants trying to make sense of their world, leading to final account that is created by both participant and the researcher (Smith & Osborn, 2003). Smith et al. (2009) assert that a good interpretation is grounded in and develops from the participant's text. Similarly, Willig (2001) emphasises that the researcher's dynamic engagement with the participant's account promotes reflexivity and deepens the level of interpretation. Expanding upon this, Smith & Osborn (2003) contend that IPA should combine empathic and questioning hermeneutics. This means that in line with its phenomenological roots, the IPA researcher adopts the participant's viewpoint. At the same time, in drawing on Heidegger's postulate that a phenomenon may lie hidden but is nonetheless connected to what is visible, the researcher steps back and thinks critically, looking beneath the surface account to get at underlying meaning.

Smith et al. (2009) highlights the concept of the hermeneutic circle, and underscores the importance of the iterative nature of the analysis, a process in which the researcher reads and re-reads the texts, and constantly revises the emerging themes.

IPA's idiographic approach privileges the individual's account and aims to provide detailed, meaningful insights into his or her subjective experience, before moving on

to other cases. It contrasts with the nomothetic approach, in which probabilistic claims are generalised to a large population, and may therefore be criticised for failing to provide rich insight into people's experiences. Indeed, Smith et al. (2009) argue that is only through this meticulous analysis that the complexity of human psychological processes can be fully appreciated. Furthermore, they describe IPA's focus on the 'particular', both in terms of the detailed analysis, and also the 'particularity' of the phenomena being understood from the perspective of 'particular' participants (Smith et al., 2009). Through the use of small and homogenous samples, the objective of IPA is to reveal experiences that pertain both to the individual and to the sample as a whole, whilst also showing differences (Smith et al., 2009). Therefore, IPA is able to reveal aspects of divergent experiences that would normally be overlooked in quantitative studies (Smith et al., 2009).

Countering criticism about the lack of generalisability of the findings from IPA studies, Smith et al. (2009) also argue that the particular and the general are not so separate; what is revealed in the particular on a deeper level may also reflect meaningful themes that relate to us all, thus taking us nearer to the universal. Indeed they believe that these micro analyses are valuable in their own right; they aim to illustrate "actual slices of human life" (p. 202), but they may also "enrich the development of more macro accounts" (Smith et al., 2009, p. 202).

Personal reflexivity

Morrow (2005) discusses the custom of qualitative researchers explicitly disclosing to the reader their preconceptions and biases, so that their position in relation to the research is made evident. Furthermore, Willig (2008) discusses the different roles of reflexivity; that of personal reflexivity, when consideration is given to how one's own beliefs have impacted the research, and epistemological reflexivity, when reflecting on how issues such as the research question and methodology have influenced the findings. Accordingly, a reflective diary was kept (Morrow, 2005), to capture thoughts and feelings throughout the research process. Excerpts from the diary are interspersed throughout the report, to try to convey the author's reflexive process, and to help the reader understand the factors that may have influenced her interpretations

of the participants' accounts. These reflexive comments are written in the first person and italics, to distinguish the author's subjectivity from the participants' experiences.

The following is an extract written prior to the start of the research process, in which there is an attempt to identify possible biases and assumptions:

Having experienced the attempted suicide of a family member, I view myself as coming from a position similar to that of the participants. Therefore, I am mindful that my own experience could influence my research. For example, my own experience was upsetting and I therefore have the assumption that the suicide attempt of a sibling could have a strong emotional impact on the participants. Furthermore, through my experience of working in a mental health ward, I am aware that I have fairly strong feelings that siblings are neglected within the National Health Service, following a suicide attempt. Since my interpretations will automatically be influencing my analysis, I will need to monitor myself whilst simultaneously seeking to meet the research aim.

In an attempt to bracket my feelings as much as I am able throughout the research process (Smith et al., 2009), I intend to undertake several strategies. For example, I will keep a reflective diary of my own feelings that come up during the research process, and reflect on any differences, and not just similarities between my own feelings about my relative's attempt and those of the participants. At the same time, I hope that my personal experience will deepen my empathy and commitment to giving voice to the participants

Interview schedule and pilot interviews

The literature shows that most families have appreciated interest in their experiences of suicidal behaviour or mental illness, and have found it beneficial to talk about them (Kiev, 1975). In their study of families of teenagers who have completed suicide, Lindqvist et al. (2008) assert that the families, and in particular the siblings, described the interview method as beneficial for them. Smith et al. (2009) also recommend interviews as an effective way of capturing rich, personal accounts, and point to their

congruence with IPA's concern with individual experiences. Therefore, the author used a semi-structured interview schedule (appendix A). Questions were based on literature on families and mental illness (e.g. Lively, Friedrich & Buckwalter, 1995), and adapted to explore the impact on areas of the participant's life, such as mental health, family relationships, and personal relationships. The questions were open-ended, to allow for flexibility and exploration of the participant's experience. In this way, the interview schedule acts as a guide rather than something to be slavishly followed. This allowed the interview process to become more fluid and collaborative, as the researcher had a sense of what area to explore, but at the same time the participants were free to introduce any issues that were important to them. Smith and Osborn (2003) discuss how this method can facilitate our understanding of the client's world, often yielding richer information than may be produced from other quantitative data-collection methods

In line with the recommendations of Smith and Osborn (2003), the questions moved from the general to the specific. Therefore, the initial question regarding participants' general views on suicide served as a way of 'opening up' the topic, allowing the participants to become more comfortable as more sensitive information was elicited. Furthermore, there was an opportunity towards the end of the interviews to expand upon anything they wished, or to bring in anything else related to their experiences that they wanted to discuss.

Two pilot interviews were undertaken before conducting the research. This was to pre-test the interview schedule, by assessing the suitability, phrasing and quantity of the questions, to gauge the approximate length of the interview, and to receive feedback on the manner in which the interview was conducted. It could be argued that the piloting process demonstrates rigour, which is a form of validity for qualitative research (Yardley, 2000), and is discussed later on in the report. Since the feedback was that the interview style and schedule were appropriate, no refinements were made. However, the author learned that the subject area appeared much more complex than she had anticipated, with other factors appearing to complicate the experience of the suicide attempt. None of the participants in the research participated in the pilot interviews, and the pilot interviewees fulfilled the criteria set for the main study.

Sampling and participants

The criteria for the study were that a participant should be aged 18 years and over, be fluent in English, with a sibling who had attempted but not completed suicide a minimum of two years ago. Although the length of time since the attempt could have possibly affected the accuracy of participants' recollections, it was decided that the ethical considerations and ensuring that the memory was not too 'raw' had to take precedence, thereby minimising potential distress to the participant. Furthermore, Tejedor, Diaz, Castillón and Pericay (1999) describe an elevated risk for a further attempt or completed suicide within the first two years after a first suicide attempt. Since the author wanted to avoid interviewing vulnerable participants who could possibly be in the middle of another family crisis, the two year time period seemed appropriate. Furthermore, since the interest was also in any impact over time, this was a further reason why the interviews were not conducted closer to the time of the suicide attempt. Other inclusion and exclusion criteria based on ethical factors are detailed in the 'ethical considerations' section of the report.

The literature discusses the difficulty in determining intentionality to take one's own life during a suicide attempt. Indeed, Kerkhof (2000) asserts that a suicide attempt should not necessarily be viewed as a failed suicide, due to the complexity and differences involved in the action. Therefore, for the purpose of this study the definition of a suicide attempt was that it was the *participant's* perception that the sibling had seriously intended to take their own life.

Due to the volume of literature concerning schizophrenia, the initial preference was to recruit participants whose sibling did not have this mental illness. However, in line with research demonstrating the prevalence of mental illness in people who attempt suicide (e.g. Beautrais, 2004), it was anticipated that this may be problematic, therefore this criterion was not implemented.

Smith et al. (2009) discuss how the sample should be homogenous and purposive, and that an acceptable sample size for an IPA study is around three to six participants.

However, for professional doctoral research they suggest four to ten participants, to generate sufficient convergence and divergence in findings (Smith et al., 2009). However, this is dependent on the subject area to be explored, the richness of the participants' accounts and the recruitment criteria being followed (Smith et al., 2009). Furthermore, due to the idiographic nature of this methodology, the aim is not to make broad generalisations across the population, but instead to help deepen our understanding of a specific group of individuals; "the issue is quality not quantity" (Smith et al., 2009, p. 51).

In line with these recommendations and due to the stringent nature of the recruitment criteria, the intention was to recruit a minimum of six participants. Fifteen people made initial enquiries about participating, all via e-mail contact. In total, eight participants were recruited, excluding two pilot interviewees. Six of the participants were female and two were male, with none being paid for their participation in the research. Half of the sample had some form of psychological training for their occupations (please refer to appendix B for the demographic questionnaire, and appendix K for full demographic information of the participants).

Although the intention was to recruit participants who had only experienced one suicide attempt by the sibling, the nature of the subject matter and the restrictive criteria meant this condition could not be met in all cases. Two participants had experienced more than one suicide attempt by their sibling. However, one participant did not believe that his sibling intended to take his own life with the second attempt, and expressed that he would prefer to focus on his sibling's first attempt during the interview, which he perceived as a serious suicide attempt. Similarly, the other participant stated that she would like to focus on her experience of the second attempt, as she expressed doubt that her sibling's other attempts were serious intentions in taking her own life. Following discussions in research supervision, it was decided that it would be acceptable to interview these participants.

Seven of the eight participants were British and all were fluent English speakers. It was decided in research supervision that the non-British participant was eligible to participate since he was a fluent English speaker and he was living in the U.K.

Recruitment

Since much of the research in this subject area involves a clinical sample, it was decided to recruit participants from a variety of non-clinical settings. Initially, recruitment flyers (appendix C) were issued to local counselling agencies, therapists and carers groups, and postings were placed on several carers' online discussion forums. However, possibly due to the nature of the research topic and the stringent recruitment criteria, there were difficulties with recruitment. Consequently, it was agreed in research supervision to broaden the recruitment catchment area. Flyers were then placed at a university, and paid advertisements were placed in a regional newspaper, a therapy publication, and a student newsletter, which was also available online.

Eventually, the participants were recruited via the therapy publication, the online student newsletter and a carers' online discussion forum. Full inclusion and exclusion criteria were detailed in the therapy publication. In the newsletter and regional newspaper, selected criteria were detailed due to advertisement costs. In both instances, the researcher's telephone and e-mail details were given. Potential participants were invited to enquire about the study and were then given the full criteria and the opportunity to ask questions.

All initial enquiries were made via e-mail. Participants then received an e-mailed reply, with full details of the study, along with an information sheet (appendix D). They were asked to e-mail confirmation if they were still interested in participating, along with their contact details and a suitable time for them to be contacted. Telephone contact was then made to verify that the recruitment criteria had been satisfied, and to provide the opportunity to discuss the study and to ask questions. An interview date and location were then mutually agreed, if the participant was happy to proceed with participation.

The recruitment procedure was time-consuming, and the choice to use non-clinical settings undoubtedly made the process more difficult. At times I felt despondent,

however it was ethically important for me to adhere to the recruitment criteria as much as possible. Widening my recruitment catchment area and paying to advertise in several publications certainly generated responses. It was during this time that my research supervision was especially valuable in helping me to exercise ethical judgement in assessing suitability of applicants for participation. These ethical issues were unexpected, and I started to realize the complexity to the research area.

Interview procedure

In order to make the participants as comfortable as possible and for their convenience, the majority of the interviews were conducted at the participants' homes. For the remaining participants interviews took place in a neutral, private setting, which was mutually convenient. Time was spent before the interviews establishing a rapport with the participants, to allow them to feel as comfortable as possible. The interviews lasted between approximately sixty minutes and ninety minutes, and were audio-taped on a digital voice-recorder.

All the participants appeared pleased to have the opportunity to discuss their experiences and I was satisfied with how the interviews progressed. I felt very privileged that the participants were so forthcoming in sharing their personal and painful experiences with me, and I felt encouraged that they expressed finding the interviews a useful and cathartic experience.

However, I initially underestimated how draining the interviews would be, due to the emotive subject matter and the challenge of conducting a satisfactory interview. Therefore, although I had to schedule the interviews close together due to recruitment difficulties, I made the decision not to undertake more than one interview in a day, to allow myself time to process the interview experience.

I was also struck by the differences in the presentations of some of the participants. For example, some became quite emotional during the interview, whilst others were more composed. I reflected that this could be due to a myriad of factors, e.g.s., different expressive styles or coping strategies, the intensity of the impact of the

suicide attempt, the time elapsed etc. I found that my experience as a Counselling Psychologist helped me to tolerate any upset that the participant showed. However, as a researcher I had an ethical duty to ensure that they were happy to continue with the interview and that it was not causing undue distress.

I was also aware that I shared other elements of 'sameness' with many of the participants, such as being a British, white, well-educated female of a similar age group. Furthermore, I shared a similar occupation to some of the participants, and I reflected on whether this facilitated an openness with them. For example, one of these participants commented that she had decided against giving the 'perfect' interview responses, and was instead very candid, which provided fascinating and rich data. Conversely, my title of 'Counselling Psychologist' could have been a barrier to openness. For example, some participants could have possibly feared that they would be negatively judged if they expressed signs of 'not coping well'. This raises the issue of bias, and of participants providing a 'socially desirable' response. I have also considered that the psychological training that some of the participants received for their occupations may have facilitated an increased self-awareness, thereby influencing their accounts.

Ethical considerations

- Approval for the study

Ethical approval to undertake the research was sought and granted in November 2006 by City University Psychology department (appendix E) The sources from which the participants were recruited already had an advertising facility for research recruitment, and therefore did not require separate ethical approval. None of the research process began until written permission had been granted by City University. The researcher abided at all times by the BPS Code of Ethics and Conduct (BPS, 2006, updated 2009).

- Ethical decisions

In an effort to minimise possible harm to the participants, the criteria for the study was that participants should not themselves have depression, nor current or historical suicidal ideation or behaviour. This criteria was based on the participant's self-disclosure. Although there was the possibility of biasing the findings, it was again decided that the ethical considerations had to take precedence. Furthermore, the participant should not have witnessed the attempted suicide, nor be receiving trauma counselling at the time of the interview.

Of the people who made initial enquiries, two were unsuitable for the research due to a current diagnosis of depression, and one person was not accepted as she was currently undergoing trauma counselling, which was related to the suicide attempt. In these circumstances, their applications were politely declined, with the recruitment criteria reiterated, and they were thanked for their interest.

Of the eight participants who were finally recruited, six fully satisfied the recruitment criteria, with the remaining two participants reporting mild depression in the past. However, they stated that they were willing to participate in the study, that they were not currently receiving psychological help, and that they did not believe that they were at risk of harm from participating. Following research supervision, it was decided that they would be acceptable to interview, providing that they were briefed about the nature of the interview before it took place, that their informed consent was given throughout the research process, that a resource list was provided after the interview, and that follow-up contact be made to ensure that they had not been left distressed by the process. This process was followed by the researcher, as it was for all the participants.

One participant disclosed that her sibling's most recent attempt occurred within the last two years (outside the minimum time specified in the recruitment criteria), but since she doubted that it was a 'serious' suicide attempt, she did not believe that the interview would cause her undue distress. Again, after thorough discussions with the research supervisor and with the participant, it was decided that it would be

acceptable to conduct the interview, providing that there was adherence to the other ethical guidelines.

- Safeguarding the participants and the researcher

For the interview to be held at the participant's home, the criteria was that it should be quiet and private, and that the sibling who had attempted suicide should not be present, since this could inhibit the participant's responses, and cause conflict or distress within them or the sibling. These criteria were met by all the participants.

The majority of the interviews were conducted in the daytime, during weekdays, so that there was availability of support resources following the interview, should the participant require them. For the remaining participants, when it was more convenient for them to be interviewed either in the evenings or at the weekend, their assurance was sought that they did not believe the interview would leave them in any state of vulnerability, when they would require professional emotional support. Nevertheless, they were all provided with details of 24 hour support services, should they require them.

Since the majority of interviews were held at participants' homes, the author also took precautions to ensure her own safety. This involved leaving details of the interview location in a sealed envelope with a trustworthy person. The anticipated time of the finishing time for the interview was written on the outside of it, and the strict instruction was given that it should only be opened in an emergency. However, after each interview, the author telephoned this person to confirm that she was safe and the unopened envelope was destroyed.

- Consent and managing distress

Participants were again provided with an information sheet outlining the nature of the study (appendix D), prior to the interviews being started. All the interviewees completed forms for their consent to participate, (appendix F) and for their agreement for the interview to be audio-taped (appendix G). Participants were invited to raise

any queries that they had, and their consent was again sought both before and after the interview. If there appeared to be any distress during the interview, they were also asked if they wanted to cease participation. However, any participants who became upset during the process recovered their composure and stated that they wanted to continue with the interview.

None of the participants at any stage of the research process expressed a wish to withdraw their consent to participate. Furthermore, the majority of participants reported that although elements of the interview had raised some upsetting feelings, they felt the interview process had been a valuable and cathartic experience.

- Confidentiality

The participants were assured of confidentiality, but were informed that it would be waived if they disclosed an intention to harm themselves or others.

All interview recordings were coded and retained in a locked filing cabinet. The key listing the identity and code numbers was kept in a separate, secure place, with data to be destroyed upon completion of the research.

With regards to the interview transcripts, pseudonyms were assigned and any identifying details changed. Following confidentiality and ethical guidelines, and for reasons of sensitivity, only brief transcripts are appended to this report (appendix M).

- Debriefing

The final interview question asked how the participants felt taking part in the interview, with time given for them to debrief (appendix H) A comprehensive self-help resource list was provided after the interviews (appendix I), including both local and national helplines, along with contact details of the author and her research supervisor. Furthermore, a follow-up e-mail was sent to all participants within a day of their interview, to confirm that they had not been left in a state of distress, and to give them the opportunity to withdraw their consent if so required (appendix J).

At the end of the interview, participants were asked if they would like a copy of the study's final conclusions, following completion of the study. All the participants stated they would like to receive this in the future.

Transcription

All interviews were transcribed verbatim, including pauses, false starts etc., as recommended by Smith and Osborn (2003). Each interview was transcribed in chronological order.

Due to the difficulties in recruiting participants and the second wave of advertising, the majority of the interviews were undertaken closely together, in a short period of time. This left insufficient time to transcribe one interview before interviewing the next participant. However, each interview was listened to before the next one was conducted, to try and inform the author of areas that may require further exploration.

The transcription procedure was one of the lengthiest elements of the research process. However, it helped me to stay grounded within the text, and to start noticing both the differences and similarities between participants' experiences. I was also surprised at the extent to which my own emotions were aroused by listening to the interviews. Keeping a reflective diary alongside the transcriptions was useful in capturing this process.

Analytic process

Larkin et al. (2006) discuss the flexibility of the analytic procedure involved in IPA, describing it as more of a perspective than a dogmatic sequence of stages to be followed. Smith et al. (2009) assert that "there is no clear right or wrong way of conducting this sort of analysis" (p. 80). However, they do offer guidelines, particularly for novice IPA researchers, whilst also encouraging creativity in their process. Accordingly, the author has followed the framework that they have recommended.

Each interview was analysed in chronological order in an idiographic way; that is, the analysis was completed on one transcript before moving onto the next one. Based on Smith et al.'s (2009) guidance, the steps of analysis are detailed as follows (see appendix L for a summary):

Step one: Reading and re-reading

After listening to the audio-recording of each interview, the author initially read through each transcript several times. This was "to ensure that the participant becomes the focus of the analysis" (Smith et al., 2009, p. 82). Any initial thoughts on the transcript, or recollections from the interview were also noted in a reflective diary, in order to try and set these aside for a while.

Step two: Initial noting

This stage was mainly descriptive, with unfocused notes and preliminary ideas written in the left hand margin of the transcript. These included comments on the content of the text, repetition, contradictions or connections within the account and the participant's use of language. Although Smith and Osborn (2003) had previously suggested that these initial notes should be made on the left-hand margin of the transcripts, more recent recommendations advocate that that they instead be made on the right-hand side (Smith et al., 2009). Initial guidance was based on Smith's left-handed way of working. However, in realising that the majority of people are right-handed and therefore their most natural way of working would be moving from the right side of the text to the left, it is now suggested that one should start from the right-hand margin (Smith et al., 2009). Since the analysis had already been started before these new guidelines were published, the previous guidance was followed, hence the initial noting in the left-hand margin. However, Smith et al. (2009) emphasise working in whichever way is suitable for the individual, and it seems clear that what is important is that the initial noting and the emergent themes are written in separate margins, irrespective of which side of the transcript.

Step three: Developing emergent themes

The notes made during step two of the analysis were then reviewed, with a summary made of the important core of each set of notes, so that tentative themes started to emerge in the right-hand margin. The author attempted to use labels that were both psychological in nature, but were also still grounded in the text. Furthermore, this stage also involved identifying slightly higher level concepts and being more interpretative (see appendix M).

I found this part of the analytic process challenging, one reason being that I found it difficult to capture the participant's words in concise psychological statements. I also felt uncomfortable with breaking up the participant's narrative through the process of identifying emerging themes, and I was concerned with being too reductive with the accounts. However, I was reassured by Smith et al. (2009) who discuss that this is a common response within researchers. Furthermore, my worries were also eased by their assertion that this splitting up of the participant's experience is only one part of the 'hermeneutic circle'; that these parts would form more of a coherent whole again, through the narrative, within the writing-up stage (Smith et al., 2009).

Step four: Moving to the next case

Although many researchers may then decide to begin searching for associations across the emergent themes within the first transcript, Smith et al. (2009) discuss that this may be more appropriate when working with very small sample sizes, when *all* emergent themes should be detailed. However, when working with a larger sample, they state that the aim is to capture the *key* themes that pertain both to the group, but also to the individuals. Therefore, it is suggested that the researcher may delay searching for patterns until emergent themes have been identified for each transcript, after which the accounts can be scrutinized altogether (Smith et al., 2009). Since the author had a sizeable sample, the latter procedure was followed, and therefore steps one, two and three were repeated for each transcript before moving on to the next one.

In accordance with guidance from Smith et al. (2009), an idiographic focus was maintained as much as possible, by setting aside any emerging views from the

previous transcripts before moving onto the next account. Although recognising that one will be undoubtedly influenced by previous findings, Smith et al. (2009) draw attention to the importance of remaining open to new ideas that may appear in subsequent transcripts.

In trying to manage this delicate balance between having existing assumptions and themes and remaining open to new ideas, I have used several strategies. One of them was to write down any thoughts or ideas about one account onto that transcript, and also in a reflective diary, to try and 'get the ideas out of my head' as much as possible. I also found analysing transcripts on separate days helpful in trying to look at accounts with 'fresh eyes'. Furthermore, delaying the search for connections between themes until all the transcripts had been analysed helped to minimise the assumptions made during the earlier stages of the analysis.

<u>Step five: Searching for connections between emergent themes and patterns across cases</u>

Once identified emergent themes had been identified throughout all the transcripts, they were written down in chronological order as they appeared, underneath each participant's name, along with the reference and line numbers. Due to the vast amount of data and the constraints of the doctoral research requirements, decisions had to be made as to which data would be excluded from the subsequent part of the analysis. In accordance with recommendations by Smith et al. (2009), decisions were made according to the recurrence of a theme across cases, the salience and richness of quotations constituting a theme, and its relevance to the research question. Since it is at the researcher's discretion to decide the frequency that defines recurrence of a theme (Smith et al., 2009), it was decided that a theme had to occur in at least four of the transcripts, or contain rich/interesting data, or be pertinent to the research question for it to be retained in the analysis.

The author looked for connections between the themes and the patterns across cases by looking for similarities and meanings that they shared, with some grouping naturally together. At the same time, differences were also sought, since Smith et al. (2009) espouse the importance of divergence as well as convergence within the

themes, to illustrate the 'particular' of the individual's experience. Sometimes the clustering was not so clear, and other strategies were used such as asking oneself questions such as "are these themes saying the same thing?", "what might be the consequence of experiencing that emotion?", looking for polarisation within themes, and grouping themes under the temporal elements that were identified (Smith et al., 2009). Since the author was interested in three types of relationships that the participants experienced, (experience of self, experience of the sibling relationship and experience of the family relationships), these also had to be accounted for within the themes. This often involved collapsing the themes into sub-ordinate themes to distinguish these differences, adding further complexity to the process.

During this process, a computer spreadsheet was created, in which each transcript extract was cut and pasted under the tentative themes, along with the details of the page and line number for each quotation (see appendix O). One reason was that in seeing all the data physically next to each other, the author felt it was easier to check that they clustered together, and to also decide on theme labels that represented the group as a whole, but also captured the essence of the individual (Smith et al., 2009). Furthermore, it helped to ensure that the themes remained grounded in the text (Smith et al. 2009). At the same time, the author worked in an iterative way, continuously checking interpretations with the participants' original transcripts to ensure that the clustering of themes made sense in terms of the individual accounts, as well as in the group as a whole.

Although the process of assembling all the quotations under the tentative theme labels on the spreadsheet was time-consuming and the document was then very large, I felt that the process was beneficial in refining theme labels and connections between themes. There was also another pragmatic advantage; having the quotations and reference points close-at-hand would help their location later on, when writing up the findings.

Once tentative themes and masterthemes had been identified, a map was created detailing these (appendix N). This was necessary since there were still many sub-ordinate themes and a lot of data. The researcher also experimented with schematic diagrams to try and view the data in a fresh way and to look for connections between

themes (appendix P). This was helpful in clarifying the participant's perception of family dynamics following the sibling's suicide attempt, however at the same time it also illustrated the complexity and non-linear nature of family interactions.

This process of integrating themes continued (see appendix Q) until the author had a final summary table of masterthemes constituting themes that captured and organised, both the key themes of the individual accounts, but also the group as a whole (see appendices R and S). This table continued to be adjusted even during the writing up of the findings, demonstrating that the double-hermeneutic was still ongoing. Since the writing-up often involves abstracting the themes further and being more interpretative (Smith et al., 2009), this adjustment and even elimination of themes seemed a natural part of this process.

I found that this stage of the analytic process very time-consuming and I often felt overwhelmed by all the data. I realised during this time that I actually like to have a prescriptive way of working, and although the flexibility of IPA analysis appealed to me, it also meant that I felt lost in the analytic process at times. It took time for me to accept that there is no 'right way' of doing the analysis. Indeed Smith et al. (2009) assert that "as long as the interpretation is stimulated by, and tied to, the text, it is legitimate" (pp. 89-90). During this time I was frequently seeking reassurance from my supervisor and peers, and I learned that I needed to have confidence in myself and my decisions. Indeed, Smith et al. (2009) reminds us of the importance of the 'interpretative' part of IPA, and the need to be brave with this part of the process. I also recalled the advice of a past supervisor in my work as a Counselling Psychologist, about focusing less on 'getting it right', and instead trusting the therapeutic process, and I tried to apply this to the analytic process.

I was aware that my analysis was taking me in a different direction to the one that I anticipated. The experiences seemed to often focus on the participants' perceptions of the family dynamics, and I found that I was being led to consider family systems, mental illness and grief, more so than suicide. I was unsure as to what extent my themes should be influenced by the existing theoretical literature, however Larkin et al. (2006) discuss how interpretation can be guided by existing theories.

The issue of interpretation was also challenging for me. I was mindful of staying grounded within the participants' texts, and that they had all requested to see my final conclusions. Ethically, I felt uncomfortable at the possibility that the participants would see findings that contained my interpretation of their experience, which may be dissimilar from their own insights. I discussed this with my supervisor and we agreed that I need to be clear that it is my interpretation when disseminating my findings. Nevertheless, this issue is one to which I need to give further consideration.

Validity

Willig (2008) argues that qualitative research has higher ecological validity than some quantitative studies, since it elicits data in naturalistic settings, rather than in an artificial experimental environment. Due to their wide variety of theoretical positions, there is increasing recognition that it is inappropriate to assess qualitative research for validity in the same way as quantitative studies, however there is considerable debate as to how this can be reconciled (Smith, 2003).

Yardley (2000) asserts that despite this incompatibility, it is vital that there is some form of quality appraisal, and she proposes a set of criteria which could be followed. However, in the spirit of qualitative methodologies, it is emphasised that these are not a rigid set of rules to be followed, but are adaptable and serve purely as a guideline. Smith et al. (2009) support this criteria, citing its applicability to a wide range of theoretical models and in particular, its compatibility with IPA's creative approach. Therefore, it is these principles upon which the author bases her efforts for validity for this research.

The first standard that is proposed is that of sensitivity to context, which encompasses many features. One of these is demonstrating an understanding of the existing theory and literature that is pertinent to the research (Yardley, 2000). As demonstrated previously in the report, the author has conducted a thorough literature review, identifying a paucity of qualitative studies regarding the effects of attempted suicide on the family, and in particular on the sibling. Since the research aims to address this deficit, and the findings are also discussed in relation to the literature within the

Analysis and Discussion and Synthesis sections, it is proposed that this demonstrates a commitment to the aforementioned criterion.

Yardley (2000) also discusses the sensitivity to the participant's socio-cultural setting. Smith et al. (2009) comment that this can be illustrated through good interview skills, such as showing empathy and building a good rapport with the participants. It is proposed that the rich data that was elicited through the interviews, particularly with such a sensitive subject matter demonstrates that these skills were being implemented. This rich disclosure could also have been influenced by the majority of the interviews taking place in the participants' homes if they so wished, so that they felt comfortable in participating in the interview, thereby causing them minimum inconvenience. Furthermore, the criterion that the sibling who had attempted suicide should not be present in the interview setting suggests an awareness of the discomfort this could cause the participant, as well as an inhibition in their disclosure. It is also argued that the strict recruitment criteria that was set in order to minimise possible harm to participants, may also satisfy the principle of ethical matters (Yardley, 2000). Yardley (2000) also cites sensitivity to the participants' perspectives. Like the comments made by Smith et al. (2009), it is argued that the fact interpretations are grounded so firmly in the participant's words, evidenced with the verbatim quotations in the Analysis and Discussion section, implies great attention has been paid to presenting the participants' authentic experiences.

The second criterion that Yardley (2000) discusses is that of a commitment and rigour, which again can relate to various issues. The author asserts that the close involvement with the participants' words, both during the interviews and during the lengthy analytic stage could be viewed as an illustration of this commitment. It could also be argued that the decision to address issues around suicidality, a subject that is often viewed with discomfort and shunned by society, also displays commitment to challenging this taboo and bringing it into the open.

The issue of rigour can relate to matters such as the diligence of the analysis undertaken and the suitability of the participants to the research question (Smith et al., 2009). It is hoped that the latter has been adequately demonstrated by the justification

and description of the selection of a purposive and homogenous sample, despite the recruitment being impeded by the strict criteria. Furthermore, relevant demographic details of the participants have been provided, illustrating the suitability of the sample to the research question. The author also proposes that the undertaking of pilot studies prior to conducting the research interviews, and the feedback that the interview questions were appropriate to the research question, may also be an illustration of the rigour that is required.

The thoroughness of the analysis involves showing a methodical process, with the resultant findings demonstrating sufficient interpretation and themes that pertain both to the individuals and to the group as a whole (Smith et al., 2009). Again, it is left to the reader to decide the extent to which this criteria has been met, but it is hoped that the transparency of the analytic process and the final themes illustrate the depth required.

The third principle is that of transparency and coherence. Transparency refers to the clarity of the presentation of the research stages, whilst coherence relates to issues such as the presentation of a persuasive narrative, and the congruence between the finished research and the underlying philosophical assumptions (Yardley, 2000). Elliott, Fischer and Rennie (1999) discuss the importance of providing extracts to enable the reader to evaluate the correspondence between the data and the researcher's understanding. Accordingly, the researcher has endeavoured to explicitly demonstrate her entire research process and show an audit trail. In particular, it is hoped that the description of the analysis, with the accompanying extracts and tables clearly demonstrates her analytic process.

Transparency can also take the form of reflexivity; that is, considering how the author has influenced the research (Yardley, 2000). Elliott et al. (1999) refers to this as "owning one's perspective", when the researcher openly acknowledges their own assumptions so that the reader can consider other understandings of the data. Again, the author has attempted to integrate statements of her reflexivity throughout this study, and in line with Willig's (2008) recommendations, elements of both personal and epistemological reflexivity have been incorporated

With respect to coherence, Smith et al. (2009) advise that themes should be categorised in a plausible way, and that any inconsistencies between participants' accounts should be acknowledged and clearly addressed. It is hoped that the author's thought process in determining themes is clear and understandable to the reader. Furthermore, it is believed that the differences within themes have been readily embraced and reflected upon, with the hope that this has been successfully conveyed to the reader. The author has also endeavoured to combine both the phenomenological aspect of the methodology, i.e. the experience of the siblings, with the hermeneutic quality of tentative interpretation, and it is hoped that this is adequately reflected in the narratives.

The fourth dimension that Yardley (2000) suggests is that the research should convey something that is important or useful to the reader. The intention was to capture something of the participant's subjective experiences following their sibling's suicide attempt, particularly since this has previously neglected by researchers. It is hoped that the reader's interest in this topic is stimulated by the research, and that it encourages further exploration of the sibling's perspective on familial suicidality. Furthermore, through the insight gained of some siblings of suicide attempters, it is hoped that there may be increased understanding, empathy and inclusion for this important family member, both in future clinical work and in a general sense.

Further reflections

In addition to statements of reflexivity that are interspersed throughout the report, the following commentary presents further reflections on the research process:

My biggest learning from this research experience is the complexity involved in the subject area, and I have realised that I underestimated this at the beginning of the process. In hindsight, I was naïve in my assumptions about the impact of a suicide attempt, not realising that suicidality is a convoluted and ambiguous area, which is complicated by mental illness and family dynamics.

Furthermore, my surprise at some of the positive findings that emerged suggests that I continued to hold negative assumptions about the impact of a suicide attempt, despite trying to bracket these. I also realised that my position as a Counselling Psychologist could have also possibly influenced me into expecting that participants would want therapy following the suicide attempt. However, the fact that unanticipated, positive findings and other unexpected themes did emerge from the analysis suggests that I did manage to bracket these assumptions to some extent. I believe that this was aided by discussing my research with my supervisor and with my peers, which helped me to 'step back' from my analysis at times, alongside constant checking of the participants' experiences against mine, and taking regular breaks away from the analysis.

On a personal level, the research process has undoubtedly been challenging for me. It has caused me to reflect on my own experience of a familial suicide attempt, bringing up feelings that were both shared and different to those of the participants. Furthermore, reading the literature regarding family dynamics has been enlightening and sometimes painful for me, in leading me to reflect on my personal situation. I have coped with this process by at times seeing a therapist, exploring my own feelings to try to differentiate them from those of the participants, keeping a diary of what has emerged for me, and speaking to my supervisor. One advantage of this affinity with the interviewees is that I believe it has further deepened my empathy, leading me to feel even more connected to the study, and passionate in wanting to convey the participants' experiences.

One final reflection is that in hindsight I would have preferred to interview fewer participants, so that I could have presented an even more in-depth study. Having the accounts of eight participants alongside the academic restrictions naturally led to me having to discard some themes, in trying to capture something that pertained to the group as whole, but also to the individuals. This has felt difficult, but I hope that I have managed to capture something of each participant's experience.

Analysis and Discussion

Smith and Osborn (2003) do not offer a definitive guide to presenting findings, and instead assert that the researcher may choose the most appropriate way to convey them. Since the analysis is presented as a thematic narrative, it seems natural to interweave the literature, providing a more coherent account of the findings. Therefore, the author integrates the literature with the analysis section, and presents a separate synthesis to elucidate the main findings.

As described previously, interviews were transcribed verbatim, and the reader is directed to appendix M for an explanation of the key used in transcription. However, in presenting the analysis, some alterations have been made to quotations. An explanation of how these quotations are presented is as follows:

- Pseudonyms have been assigned to the participants; other names or identifiable details are replaced by ****.
- Quotations are followed by the participant's name, page number of the transcript, and line number of the start of the quotation. For example, 'Fiona. 3. 2' refers to line 2 on page 3 of Fiona's transcript. If the participant's name is explicitly mentioned in the introduction of the quotation, it is not repeated so that the quotation is only followed by the page and line number.
- The researcher's utterances such as 'mmm' and 'yeah' have been omitted from the analysis to avoid distraction from the participants' dialogue.
- Laughs, pauses etc. are retained (in parenthesis), since they are viewed as adding interpretative value to the spoken words.
- A three-point ellipsis (...) denotes text that has been omitted from the extract if it was considered that the text was too cumbersome for easy reading, or if it deflected from the thrust of the participant's dialogue.

Overview of the themes from the analysis

A) FEELINGS OF GRIEF & LOSS	**B) RESILIENCE**	**C) FAMILY COMMUNICATION, ROLES & CHANGES**	**D) EXPERIENCE OF PROFESSIONAL HELP**
A.1 - Shock, numbness & difficulty remembering **A.2 - Sadness and distress** **A.3 - Guilt and shame** **A.4 - Anger and resentment** **A.5 -Helplessness** **A.6 - Worry**	**B.1 Trying to make sense of the attempt**	**C.1 Secrecy & caution** C1.1 - Collusion & conflict in maintaining secrecy C.1.2 - Sibling's reluctance to explain C.1.3 - Suppressing versus expressing feelings C.1.4 – Caution around the sibling	**D.1 Barriers to seeking help** D.1.1 - Stigma and shame D.1.2 - Doubts about the value of therapy
	B.2 Continuing life as normal	**C.2 Roles** C.2.1 – Continuing versus redefining roles C.2.2 – Reclaiming roles	**D.2 Feeling judged and excluded**
	B.3 Looking for hope and change	**C.3 Pay-offs**	**D.3 Unmet needs of the family** D.3.1 - Emotional support & psychotherapy D.3.2 - Information and guidance
	B.4 Acceptance	**C.4 Changes in the family** C.4.1 – Negative C.4.1.1 – Self and sibling C.4.1.1.1 – Imbalance and ambivalence C.4.1.2 – Self and family C.4.1.2.1 – Criticism of parents' behaviour C.4.2 – Positive C.4.2.1 – Improvement in relationships & redefining boundaries C4.2.1.1 – Uncertainty about reasons for changes	
	B.5 Personal changes		

Table 5. Mastertable of themes: The sibling's experience of the suicide attempt

Mastertheme A: Feelings of grief and loss

A) Feelings of grief and loss
A.1 Shock, numbness & difficulty remembering
A.2 Sadness and distress
A.3 Guilt and shame
A.4 Anger and resentment
A.5 Helplessness
A.6 Worry

Table 6. Mastertheme A: Feelings of grief and loss

This first mastertheme concerns the participants' responses to the suicide attempt. It has been distinguished from family responses (mastertheme C), as although one of the research aims was to explore the family dynamics, the primary focus was on the *sibling's* experience of the attempt.

The emotions depicted by the participants following the attempt collectively resonate with the grief reaction described by Worden (1982), including feelings of sadness, anger, guilt, anxiety, helplessness, shock and numbness. Although each participant does not necessarily express all of these emotions at the same time, their experience of their sibling's suicide attempt nonetheless resonates with experiencing loss.

A.1 Shock, numbness and difficulty remembering

Consistent with a study of significant others of people who have attempted suicide (Magne-Ingvar & Öjehagen, 1999b), initial feelings of shock upon hearing about the suicide attempt is a strong theme within the participants' narratives:

> *I think the best way to describe it is (pause 2 secs) shock* **Fiona. 3. 2.**

it was quite shocking...shocking news to hear...so at that time of year in particular, it was like Christmas time, November, December **Ella. 4. 13.**

For Ella, the timing of the attempt appears significant and contributes towards the feelings of shock that she experienced. An image is conjured up of Christmas time, generally regarded as a happy, unifying time, contrasting starkly with the suicide attempt, a deeply distressing and potentially divisive event.

An excerpt from Lucy's story, although succinct is rich in meaning:

I was just sort of you know...shell-shocked **5. 15.**

Her use of military rhetoric, *"shell-shocked"* evokes an image of someone who has been involved in heavy combat and witnessed something horrific, leaving her almost in a state of numbness. In using "shell-shock", Lucy's response resonates with findings by Dyregrov and Dyregrov (2005), who discovered that some siblings experienced post-traumatic reactions following an attempt.

However, although Lucy and Lee comment on feelings of shock following the attempt, they also describe their siblings confiding their depressive feelings before the attempt, thereby linking depression with suicidal behaviour. For example, Lee says:

While I'm not saying I predicted it (...) I guess...on a certain, possibly subconscious level I'd got a better handle on what...on...on his mental state than...than other people around because he talked to me about it **1.17.**

Lee's possible denial could be also be interpreted in Lucy's following excerpt:

Although with hindsight it was bleeding obvious that he was high risk um...I just never contemplated it **18. 8.**

The reason for this possible avoidance is also strengthened by her earlier comment that prior to the attempt, the subject of suicide:

Was just so horrific, I just didn't go there **Lucy. 17. 16.**

Similarly, in reflecting on the high occurrence of suicidal behaviour in her family, Jane also says:

I guess I'd say it was almost inevitable **20. 4.**

In contrast to the general consensus, James expresses little shock about his sibling's attempt:

My brother had...had emotional problems for years prior to that...so it certainly wasn't a surprise **4. 20.**

Like Lucy and Lee, James knew of his sibling's *"emotional problems"* prior to the attempt, and for him this minimised his feelings of shock.

A less common, but interesting theme in the narratives is that of indistinct memories of the immediate aftermath following the suicide attempt. James discusses spending time alone with his brother in hospital directly after the attempt, but can recall little of what he was thinking and feeling at the time:

But it's very strange that I don't remember what I was feeling and that sort of was significant... um...but it's very much a blur... very...very much a blur (...) I don't want to sort of amateur psychoanalyse myself but um... I was doing something **5. 21.**

James seems perplexed at his difficulty in recalling what he was feeling. His comments *"that sort of was significant"* and *"I was doing something"* suggest an awareness of a possible psychological defence mechanism preventing his recall, however he seems reluctant to state this. Similarly, Lucy says:

It's a real blur to me now **5. 13.**

Like James, she also acknowledges that her lack of memory is meaningful:

> *You know I'm actually (Lucy laughs) really shocked how little I can remember, which perhaps in itself says a lot* **Lucy. 5. 6.**

Lucy also describes an overwhelming emotional effect but difficulty in recalling details following the attempt:

> *It's difficult to remember actually what thoughts um (pause 10 secs) I think just this flooding of emotion really* **3. 18.**

A psychodynamic interpretation of James and Lucy's comments would suggest that they were repressing their memories of the aftermath, due to the painful feelings that they would arouse. Difficulty recalling significant elements of a trauma can also be a symptom of post-traumatic stress disorder (PTSD) (*DSM-IV,* American Psychiatric Association [APA], 1994). This interpretation is strengthened by James' presentation during the interview, during which he expressed a clinical response to the attempt, and Lucy who stated that she was *"shell-shocked"*, as mentioned previously. Although there is no suggestion that Lucy and James experienced PTSD, these findings lend weight to those of Begley and Quayle (2007), who discovered that adults bereaved by suicide shared responses similar to PTSD. Although these suicide attempts happened some time ago which could affect recall of their experiences, the fact that both James and Lucy comment on the *significance* of their indistinct memories suggests that the psychodynamic interpretation may be appropriate.

Sophie describes a numbing of feelings following the attempt:

> *For a large portion of it it was a sort of numbness...you couldn't think about it, even if I'd wanted to sit down and really analyse my feelings about it, they weren't accessible...they were locked away before I'd had a chance to even realise they'd come up* **13. 3.**

There is the sense that some form of automatic detachment from her feelings was taking place, possibly as a self-protection mechanism. Emotional numbing is one of

the symptoms of PTSD (*DSM-IV*, APA, 1994) and again, although there was no suggestion that Sophie had experienced PTSD, her response suggests that her sister's suicide attempt was traumatic for her. This is also echoed by James, who suggests that his feelings were buried but:

> *Were probably there somewhere* **4. 21.**

Worden (1982) has also described numbness as a grief response. Sophie later talks about crying to her boyfriend but suppressing her feelings to her family, suggesting that her emotional affect fluctuated and was sometimes context-bound, like other participants.

A.2 Sadness and distress

Consistent with literature (Wertheimer, 2001), sadness was experienced following the suicide attempt, ranging along a continuum from feeling upset to feeling distraught, and for some participants still persists over time. Ella's words characterise the accounts, commenting that she was:

> *Obviously upset and quite sad that he'd tried to do such a thing* **4. 11**

Whilst Jane says:

> *I was distraught...absolutely distraught* **4. 7.**

An even stronger sense of sadness is conveyed by Lee:

> *Desolation... it's my brother... I've grown up with him you know and to see ... to know that... that he could have been hurting so much and so desperately unhappy with his life ... (um) that he would want to kill himself... that tore me apart* **5. 19.**

"Desolation" implies a sense of complete devastation for Lee in seeing his brother's emotional turmoil, also reflected by the tears in his eyes. His comment *"It's my*

brother" evokes a sense of protectiveness and his physical metaphor, "that tore me apart" could be interpreted as a painful destruction of his own sense of self. This powerful extract seems to show a shared pain, of Lee's pain mirroring that of his brother.

Contrastingly, although feeling upset, Sarah also describes an element of relief and satisfaction upon hearing that her sibling had attempted suicide:

> *A bit glad it wasn't me that had done it... (Sarah laughs slightly) um (pause 2 secs) kind of (pause 3 secs) I suppose there's that competition thing... I mean this is an odd... I'm just thinking on reflection now... but there was a little part of me that kind of... thought "well I've managed not to do that up until now" (Sarah laughs)* **3. 9.**

A theme of sibling rivalry pervades this extract, with her comments *"that competition thing"* and *"I've managed not to do that"*. One is left with the impression that suicide is something that Sarah herself had contemplated, and the pauses and laughter suggest a sense of shame in revealing her thoughts. She goes on to say that her views have since changed and that she now experiences guilt when reflecting back on these thoughts that she experienced in the aftermath of the attempt. Since Sarah also describes feeling upset at the time of the attempt, these conflicting emotions show the complexity of feelings involved in a sibling's suicide attempt.

Lucy, Lee and Sophie describe a profound impact of sadness on their mental health following the attempt (Magne-Ingvar & Öjehagen, 1999b). Lucy says:

> *I think I went quite low for quite some time* **2. 15.**

However, Lee describes a more severe impact, experiencing insomnia and depressive symptoms, necessitating anti-depressant medication:

> *I was never exactly diagnosed as depressed... I think it... realistically it's probably situational depression you know? It's... it's not an underlying... it sounds like I'm trying to justify (Lee laughs) it* **7. 3.**

Lee's last sentence and laughter suggest a possible sense of shame in admitting to experiencing depression. Moreover, he appears keen to emphasise that his possible depression was related to the suicide attempt, rather than an inherent cause.

Similarly, although Sophie attributes the depression that she experienced to various causes, she expresses a firm belief in a connection with her sister's attempt:

> *I would strongly link the two together in my mind* **6. 7.**

When asked about current feelings about the attempt, several participants express continuing feelings of sadness:

> *The suicide attempt is...is something which I...I don't think I will ever feel anything...other than absolute (pause 2 secs) tragedy about* **Lee. 23. 1.**

Whilst Jane describes increased sadness over time, particularly for her family:

> *Sadness mostly and actually sad for all us...you know... we've all... it feels like...having callipers on... or having some sort of handicap being born to the...you know our birth family really* **18. 22.**

Pervading this excerpt is a sense of loss, of what her family could have been. Jane's rhetoric such as *"callipers"* and *"handicap"* suggest that being a member of her family has felt like a debilitating and disadvantageous experience, and this has contributed towards her sibling's suicide attempt. Her words *"birth family"* suggests that she perceives that there are influential biological factors, particularly since she mentions other familial suicidal behaviour elsewhere in her deterministic account. This sense of an external locus of control is also underlined when she says of her brother's attempt:

> *I guess I'd say it was almost inevitable* **20. 4.**

A.3 Guilt and shame

Feelings of guilt and shame are pervasive, although the words are used interchangeably by the participants. Tangney and Dearing (2002) also discuss the widespread inconsistency in the use of these terms, and the considerable debate regarding their differences. Put succinctly, they define shame as a painful emotion, relating to the global self and concerned with how the self perceives that it is judged by others. Guilt however, pertains to the *action* and its consequences, and the individual's wish to make amends for the behaviour (Tangney & Dearing, 2002). Therefore, it is these definitions that the author uses in distinguishing guilt from shame in the analysis.

Guilty feelings were powerful following the suicide attempt, with participants mentally replaying events preceding it, and reflecting on how their actions and/or words may have triggered the attempt. This resonates with literature on guilt, and a sense of responsibility experienced by loved ones following completed suicide (Worden, 2009). Lucy says:

> *I remember then thinking... just some stupid things thinking... "perhaps something I'd said had caused it or something"* **10. 12.**

Similarly, Sophie attributes her feelings to a fight that she had with her sibling prior to the attempt:

> *I particularly felt guilty (...) I remember feeling terrible... for...not being more tolerant being the older sister and having you know, lashed out when I knew she was vulnerable* **3. 6.**

Sophie seems to attach responsibility to the role of *"the older sister"*, implying that she should endure her sister's behaviour since she is *"vulnerable"*. Sophie's suppression of feelings, (discussed elsewhere in her account) could indicate that she feared 'losing control' as she did during the fight that she describes.

Jane's guilt appears to be motivated by the belief that in working for a mental health organisation, she should have recognised the 'warning signs':

> *He was saying all these things and why didn't I pick this up?* **15. 20.**

Like Jane, Lee also expresses guilt at what he did *not* do, but his is connected to his parents rather than his sibling. In agreeing to maintain secrecy of his brother's use of anti-depressants he says:

> *I felt guilty as hell because...uh...I knew that he had them...and I'd kept that from my parents* **5. 6.**

These findings support those of Dyregrov and Dyregrov (2005) who describe siblings' guilt in having knowledge of something which they believe could have prevented the suicide.

In contrast to these participants who describe guilty feelings at the time of the attempt, Sarah talks of a *new* feeling of guilt that has emerged over time:

> *But I think now that I'm older I think there's more guilt that maybe (pause 2 secs) maybe there were limited resources in my family, maybe because I was the oldest...I don't know...I kind of have this idea of you know like those birds in a nest? (Sarah laughs slightly) that I was the big one that managed to get...what I needed but maybe there was less left over for her* **7. 5.**

Sarah's metaphor *"birds in a nest"* evokes a powerful image of 'survival of the fittest', of two siblings competing for scarce praise in the family. Her response is consistent with literature such as Stålberg et al. (2004) which revealed that siblings of people with schizophrenia experienced guilt at 'being healthy'. Sarah's extract is also evocative of guilt that a survivor of a multiple-fatality trauma might experience (Scott & Stradling, 2006).

There is also a strong pattern of shameful feelings following the attempt:

I can remember talking to somebody and...yeah...talking about sort of shame **Lucy. 2. 16.**

Resonating with literature on families and mental illness (e.g. Marsh & Dickens, 1997), shame appears to relate to feelings about the family, with the attempt appearing to symbolise the dysfunctionality of the family for Sarah, Jane and Lucy:

I thought "Well that's all of us then" and ...um... you know... how ...um... dysfunctional... how abnormal... how terrible that is **Jane. 12. 6.**

In Jane's extract she refers to the fact that all of the siblings had now engaged in suicidal behaviour at some point in their lives, with her words *"dysfunctional"* and *"abnormal"* indicating feelings of shame regarding her family. Echoing this, Lucy says:

What are we as a family? What's the dynamic? **2. 20.**

Stigma is an implicit theme throughout the accounts. Jane's following comment typifies the subject of suicide and how it is regarded as a taboo topic in general conversation (Fielden, 2003):

It was suicide and it's not you know... you don't generally (emphasis) talk about it over coffee **14. 15.**

The sense of taboo is again illustrated by Jane, when she discusses talking to empathic work colleagues experienced with suicidality:

I was allowed to talk with those words in that situation **14. 7.**

This suggests a perception that discussing suicide is 'forbidden' in society, and that the only context where she felt that she could discuss the topic was in a professional mental health setting.

Contrastingly, James denies experiencing any significant stigma of attempted suicide, due to the existing stigma of his brother's mental illness:

> *The stigma was never that big a deal, maybe because whatever stigma was attached had already attached* **18. 14.**

James' experience of stigma resonates with the concept of 'courtesy stigma' (Goffman, 1963), and literature such as Ostman and Kjellin (2002), which revealed that participants felt stigmatised through being related to their mentally ill relative.

Generally, participants describe receiving supportive reactions when they disclosed the suicide attempt. However, disclosure appears to be restricted to people who would understand or had experienced a similar event themselves, supporting many findings on completed suicide, (e.g. Begley & Quayle, 2007):

> *It helped, the ones I was most open with had their own siblings who had mental illnesses right?* **James. 16. 18.**

> *I did actually speak to one person and that was a...a friend of mine from school whose sister had done basically the same thing* **Fiona. 8. 9.**

Although participants do not explicitly state reasons for their restricted disclosure, Goffman (1963, as cited in Kawanishi, 2006), suggests that limiting disclosure is a strategy to evade feelings of stigma or shame.

Ella discusses how her disclosure facilitated her friend's admission of her own past overdose, saying:

> *That made me realise obviously it's not just my bro, there's other people* **15. 5.**

There is a sense that her friend's disclosure eases a sense of isolation and shame within Ella, feelings which are also reflected in some other narratives.

Sarah's narrative differs greatly in terms of shameful feelings. Although she perceives that the suicide attempt symbolised family dysfunctionality, she also believes that it gained her a certain cachet within her peer group:

> *All these things I'm talking about that I'm not proud of (Sarah laughs slightly) but there's kind of a weird sort of kudos about it... (uh huh) it would have been different if she'd been successful (pause 1 sec) but that it was almost like (pause 2 secs) I don't know what it did for her but if you say your sister's had a suicide attempt to a friend then that then becomes shorthand for all the other things you might imagine that it was like in my family (pause 2 secs) whereas if she'd... if she'd succeeded then it would have been absolutely awful*
> **13. 8.**

Furthermore, she expresses a feeling of pride at her sister's attempt to show her unhappiness, albeit causing much distress:

> *She knew that something wasn't right and... even though she didn't go about it in the right way (pause 4 secs) she didn't keep it all in... maybe that was the pride of it* **15. 10.**

From Sarah's first extract it seems that a suicide attempt in the family brings some form of status with her friends, an instant way of revealing the family difficulties that she too is experiencing. However, there appears to be an unspoken demarcation between attempted suicide and completed suicide; the latter event would take on a different meaning and *"it would have been absolutely awful"*. Note the paradox of the 'success' of a completed suicide with the 'awfulness' of it. Sarah's pauses and comment *"all these things I'm talking about that I'm not proud of"* indicate a sense of shame in revealing this aspect of her experience.

A.4 Anger and resentment

Anger is a strong theme throughout the accounts and ranges along a continuum of resentment to fury. Few participants directly state feeling angry towards their sibling

for attempting suicide. However some suggest an increased anger over time, following their sibling's ongoing disruptive behaviour:

> *I am angry about it* **Lee. 22. 6.**

Lee continues:

> *It would have been easier in the long run if he died... uh...even my mother's said that* **21. 10.**

Although he does not specifically mention anger in this extract, Lee's occasional wish that his sibling had died suggests strong anger and powerfully illustrates that enduring his brother's self-harming behaviour over time has been difficult and painful for him and his family. For his mother to relinquish the unconditional, caring role determined by societal norms and to occasionally wish death on her own son illustrates the deep anger which has been evoked by his brother's behaviour. Introducing his mother's view could also be seen as a way of 'legitimising' Lee's anger, since he also mentions that his other sibling has similar thoughts.

Sophie is one of the few participants to express anger with her sibling about the attempt. This is revealed whilst discussing a need for a professional outlet for her feelings in the aftermath:

> *I think, initially, getting over the shock factor on a one to one basis where you vent all the somewhat more, socially unacceptable feelings of anger, and you're wanting to throttle the person and knock some sense into them* **24. 12.**

Like Lee, Sophie's words *"throttle"* and *"knock some sense into"* suggest aggressive, angry feelings towards her sibling, although her anger pertains to the attempt, rather than the sibling's ongoing behaviour. Indeed, she indicates wanting to kill her sibling for attempting to kill herself. Wanting to voice these *"socially unacceptable feelings"* outside of a family therapeutic environment suggests a sense of taboo and shame in feeling angry towards her sister. Sophie's use of the second person could also be viewed as a way of distancing herself from these angry feelings. This is reminiscent of

studies such as Dyregrov and Dyregrov (2005), who describe siblings feeling guilty at their anger following the suicide. One could speculate that this 'forbidden anger' (Lindqvist et al., 2008) could be a reason why few participants directly describe anger towards their sibling, or minimise this emotion in relation to the suicide attempt:

> *I'm not sure I'd call it anger although probably I've certainly been angry with him about his mental illness many times...um...resentment is probably a little more accurate.* **James. 5. 12.**

James differentiates between resentment and anger, relating the first emotion to the suicide attempt and the latter, stronger feeling to the behaviour accompanying the mental illness that his brother has subsequently experienced. His words *"probably I've certainly"* appear contradictory and hesitant, and objectifying the anger to the illness rather than to his brother could be viewed as further distancing the feeling of anger from his sibling. This echoes Kinsella & Anderson (1996) who describe differentiating between the family member and the mental illness as a strategy of maintaining a bond with the person, whilst simultaneously experiencing negative feelings.

At the same time, James and Lee express difficulty in attributing blame to the sibling for their behaviour over the long term (discussed later on in the report), which also seems to inhibit their angry feelings. For example, Lee questions whether or not his sibling's behaviour can be externalised to mental illness, or whether he is responsible for his behaviour:

> *But it's...at the same time...if in order to feel really angry about something I've...I've gotta feel that it's somebody doing it out of choice you know? And a lot of what he's done I don't think it is...some of it I do* **22. 11.**

It seems Lee feels that his anger towards his sibling can only be justified if be believes that his brother has control over his behaviour (Smith & Greenberg, 2008). However, the ambiguity about this locus of control makes it difficult to admit this anger, possibly creating an internal conflict between his feelings and how he believes that he

'should feel'. Lee's tapping of his pen on the table whilst speaking could also be interpreted as an indication of angry feelings.

Similarly, Jane, Lucy and Sarah do not recall angry feelings towards their sibling about the suicide attempt, but suggest that their anger was possibly misdirected towards other family members, concurring with suicide studies (e.g. Wertheimer, 2001). For example, Jane discusses anger towards her mother following the attempt for her inadequate mothering skills:

> *I don't think I ever felt angry with ****...I don't think I did...but if I did I can't remember that...I remember the anger being directed at my mother... now whether that was displaced anger or...I don't know (Jane smiles)* **19. 13.**

Jane's smile could be seen as a psychological defence mechanism against her anger, and her use of the psychological term 'displacement' could reflect her psychological training within her work. Lucy has the same occupation and also comments on her misdirected anger towards her parents following the attempt:

> *I suppose with hindsight...I think I just had to go somewhere with my feelings* **3. 4.**

And:

> *I was furious (emphasis) at my parents, absolutely livid (emphasis) with my parents* **Lucy. 3. 1.**

Jane and Lucy's psychological training may have facilitated a heightened awareness of the possible displacement of their angry feelings, which is not apparent in the other accounts.

In describing her anger at the psychiatrist involved in her brother's care after the attempt, Lucy says that she felt:

Frustration at the mental health system I suppose um...they're sort of anonymous **16. 14.**

Lucy's feelings of anger were initially directed at a specific source, i.e. the psychiatrist, however in this excerpt, her anger dilutes to frustration and becomes directed more generally towards the mental health system. Her word *"anonymous"* suggests difficulty in identifying a target for her anger, and resonates with unfocused anger that is sometimes experienced during a grief process. Tangney and Dearing (2002) theorise that externalising anger is a way of evading shameful feelings. Therefore, since Jane and Lucy also discuss feelings of shame and guilt in their accounts, another interpretation could be that their angry feelings were being displaced from *themselves.*

A.5 Helplessness

Feelings of helplessness following the attempt is another collective theme. For example, Lee describes:

Feelings of my own helplessness to...to have any kind of influence on the situation **8. 4.**

Similarly, Jane talks of the suicide attempt evoking a distressing childhood memory of witnessing an attack on her brother:

And also it reminded me of a time when he was a baby (...) and he was crying and screaming... trying to get through this gate to me... and I was trying to get to him... and I couldn't reach him... and it really... really brought that back **4. 13.**

The imagery described by Jane is powerful and a sense of impotency pervades this extract. The prompting of her childhood memory suggests that she perceived her brother's vulnerability and defencelessness following the suicide attempt as analogous to that of a baby. The protective nature of their relationship is palpable, and her words

"I couldn't reach him" suggests an attempt and failure in easing her brother's emotional turmoil.

Contrastingly, Lucy discusses feelings of helplessness in helping her sibling *prior* to the attempt:

> *It was evident that he was going into a real despair (...) we couldn't actually help him* **2. 18.**

Lucy's experience is reminiscent of the 'immobilisation response' experienced by people encountering other people's suicidal behaviour (Litman, 1970: 441, as cited in Wertheimer, 2001).

The theme of powerlessness more commonly occurs when participants talk of the impact on their family and in witnessing their parents' distress. For example, Fiona says:

> *It's horrible seeing your parents cry when there's no (pause 3 secs) um...no...I mean the mother cries in films but it's horrible watching her upset as she was* **12. 11.**

There is a suggestion that the reality of the situation does not match the 'script' of how it 'should be' for Fiona. It is distressing for her to undergo the role reversal of comforting her parents, shown by her repetition of *"it's horrible"*. The words *"seeing"* and *"watching"* implies a passivity which emphasises her sense of helplessness. This sense of impotency is common in the stories, with participants often dealing with their helpless feelings by providing practical help to their families.

A.6 Worry

Worry pervades the accounts, with the predominant concern being that the sibling will reattempt suicide. This concurs with findings by Magne-Ingvar and Öjehagen (1999a), who found that a year after the attempt, 77 per cent of significant others of

suicide attempters expressed worry of a re-attempt. This concern is reflected by Lucy in the immediate aftermath:

> *I remember thinking as well (pause 2 secs) you know... "I've got to face the reality of this...that there's a very strong likelihood that ****'s gonna try again and be successful" um (pause 2 secs) so I suppose there's a lot of thinking about that* **3. 19.**

It seems that Lucy was forcing herself to confront the possibility of future loss, which can be viewed as a form of self-protection and is discussed later on in the analysis. Tidemalm, Långström, Lichtenstein and Runeson (2008), amongst others, suggest that there is an elevated risk of someone repeating a suicide attempt. Lucy's knowledge of this could have been gained through her mental health training, and may have contributed to her worry. This knowledge is also apparent with Jane who had received similar training:

> *For quite a few months after he attempted suicide... I would say "oh" (...) "have you heard those voices?"...because I was... I was actually quite obsessed with that...because that to me was really... you know... his age... the effects you know ...um... really set off alarm bells for me* **21. 18.**

Jane's preoccupation with her sibling hearing "voices" suggests that this preceded her brother's suicide attempt, and would serve as a 'warning sign' for future suicidality. Her words *"alarm bells"* evokes an image of emergency services, and illustrates the sense of urgency and significance that she attaches to her sibling hearing *"voices"*. The fact that Jane was *"obsessed"* suggests that at the time her fear was all-consuming. However, her introduction of time, *"for quite a few months"* suggests that although this worry still exists, it has diminished somewhat over time, which is comparable to many of the accounts. With both Lucy and Jane, there is a sense of needing to be prepared for a future loss, which is also representative of other participants' stories. However, Jane's narrative implies that she can somehow actively try to prevent her sibling's reattempt, whilst Lucy's account implies a more helpless attitude.

The persistence of this worry runs through the narratives:

> *I always worry that she'll do it again um (Fiona sighs) (pause 7 secs) I am always aware of what she's doing* **Fiona. 16. 4.**

> *I guess there is that worry...that's always there in the background (...) you change internally because you know something negative's happened, so you don't know if it would...would happen again, so it puts you on edge slightly* **Ella. 15. 20.**

Ella describes a profound and lasting impact on her internal world, *"you change internally"* due to this persistent fear. Her metaphor *"on edge"* evokes an image of being on the brink of disaster, with the disaster being another suicide attempt.

The alertness described by these participants could be seen as analogous to the hyper-vigilance that is often present following a trauma, when one is overly alert to any possible future threats to oneself (*DSM-IV,* APA, 1994).

Sophie perceives that the impact of worrying about her sister has had a lasting impact on her mental health:

> *Anything that requires me to think and concentrate...sort of studying became almost impossible* **Sophie. 8. 2.**

Furthermore, she describes increased anxiety in both herself and her mother which persists to this day, possibly due to her sibling's repeated suicide attempts:

> *My mother and I both had panic attacks, occasionally since my sister started attempting suicide (...) I get more physically anxious than I used to* **30. 3.**

Ella discusses that although the worry is still present, it has diminished to some extent over time, which is akin to other participants. For example, Jane says:

I do have an undercurrent of...um (pause 1 sec) worry about him in the future **21. 12.**

Sarah and James describe how the level of fear is contingent upon the sibling's ongoing behaviour:

As he proceeds in treatment and is a successful person, he calms down, I calm down in my own worries about him **James. 22. 4.**

Another worry that surprisingly is only explicitly discussed by James but is worthy of mention is that of genetic concerns regarding the sibling's mental illness:

I mean sort of this idea of mental health being at least partially genetic, there's always a sort of thought in the back of your mind too, like "do I have it?" **James. 32. 11.**

Various studies such as Stålberg et al. (2004) suggest that siblings of people with mental illness fear also becoming mentally ill. Therefore, the lack of expressed concern in this study may challenge that view.

James, Lucy and Ella also describe the impact of worry on their relationships outside of the family. For example, James reveals that his former girlfriend's resentment at the time he spent with his brother in the aftermath of the attempt resulted in considerable conflict:

She would leave or she would be frustrated or sort of yell at me if my brother was coming over **7. 9.**

This resulted in him having to make a 'forced choice' about who to spend time with:

I remain completely unwilling to sort of um...to cut back on my brother (uh huh) right... because in my mind at that time spending time with my brother was at least in my mind a matter potentially of life or death ...spending time with my girlfriend was not (...) she wasn't one to go kill herself so it wasn't

really about spread…I felt guilty and frustrated but it wasn't really a contest **James. 7. 14.**

James' fear of his brother re-attempting suicide pervades this extract: *"life and death"*, with his choice based on who was more likely to kill themselves. He appears to experience a great weight of responsibility for his sibling's actions; that if he makes the 'wrong' choice his brother could die. This sense of emotional burden is also echoed in findings by Lukens et al. (2004), regarding siblings of people with severe mental illness. There is also a strong sense of loyalty to his sibling: *"it wasn't really a contest"* suggests that his brother will always unequivocally 'win' the 'competition', whilst sharing his attention is not an option; *"it wasn't really about spread"*. Furthermore, his first sentence suggests that his loyalty persists to this day.

Similarly, emotional burden and worry is illustrated by Ella, who describes a slight sense of detachment when socialising with her friends following the attempt:

> *It does make you just feel just slightly different to… to not want to put a hundred percent in to everything you do away from the family, cos you've got that energy that you need to reserve… to come back to the family and help them out* **17. 3.**

Contrastingly, Lucy and Sophie describe the attempt as having a bonding effect on their personal relationships. For example, Lucy considers that there was an intensification of the relationship with her new boyfriend, which was not detrimental. Since the attempt happened shortly after they began dating, and he was immediately involved in the family 'crisis', she describes worry as unifying them, as he sought to support and reassure her:

> *It made it a far more serious relationship very quickly* **13. 20.**

Mastertheme B: Resilience

B.1 Trying to make sense of the attempt	B.2 Continuing life as normal	B.3 Looking for hope and change	B.4 Acceptance	B.5 Personal changes

Table 7. Mastertheme B: Resilience

This mastertheme is named 'resilience' to encapsulate the participants' endurance of the suicide attempt and its aftermath, along with the unexpected positive outcomes described by the interviewees. This mastertheme also resonates with a more recent research focus on strengths, rather than purely burden in families who experience mental illness. This resilience is encapsulated by Lucy, who says following the attempt:

> *I remember saying then that "I want to be the best psychotherapist (Lucy laughs slightly) I can ever be"... I do remember thinking "I want to make something out of this"...you know? Something positive* **3. 16.**

B.1 Trying to make sense of the attempt

Confusion about the motivation for the attempt is a common occurrence, with Fiona's following comment typifying the accounts:

> *I couldn't understand why she'd done it* **3. 13.**

Consequently, a need to understand the sibling's motive and trying to make sense of the attempt was a dominant theme. The sense-making often took the form of replaying events prior to the attempt:

> *I remember racking my brain and going through all her movements during the week (...) trying to find some sort of logic to what happened* **Sophie. 4. 11.**

Although accounts implicitly suggest fear of another attempt as a factor in sense-making, Sarah is the only participant who explicitly states this:

> *I really wanted to know why?...because I thought if I knew why then I could make sure it didn't happen again* **3. 15.**

For Sarah, understanding the reasons behind the attempt will help her to gain a sense of control in trying to prevent her sibling re-attempting suicide. A sense of responsibility pervades this excerpt, with an interpretation being that her response is a defence against feelings of helplessness and future loss.

Similarly, Lucy describes the importance of sense-making to enable her to tolerate her emotional pain:

> *When I look back at sort of...notes and things that I made at the time...I think "gosh, (Lucy laughs) I was in quite a black period" um...(Lucy sighs) trying to make some kind of sense (emphasis) I think of...of it...and also how I could deal with it in a way that (pause 2 secs) um...made it more bearable really...sort of make some kind of sense of it and move forward with it* **4. 15.**

The repetition of *"make some kind of sense"* underlines the importance of this process for Lucy in coming to terms with what her sibling has done. There is a time element of feeling 'stuck' with this pain; it is so unbearable that she needs to understand the reasons for the attempt, so that she can *"move forward"* and continue with her life. Making notes appears to be an active and necessary part of this process. There is a parallel between Lucy's excerpt and research by Fielden (2003), who describes that following completed suicide, families need to make sense of the event to enable them to process their grief feelings.

In Sophie's story, her sense-making involves discussions with her family, with an agreed understanding that her sibling's behaviour could be attributed to several losses in a short period of time:

> *That is the marker that the family uses, as to when things got serious* **8. 19.**

The collective sense-making process in Sophie's excerpt is comparable to the "consensus view" in families, which sometimes occurs when there is no explicit explanation for mental illness in their family member (Terkelsen, 1987, p. 157).

In a phenomenological study of families bereaved by suicide, Begley and Quayle (2007) assert that sense-making is a complex and fluid process, to which people may return at different points throughout their grief process. This is reflected by some participants who to this day still wish to make sense of the suicide attempt, despite continuing with their lives. This sense of not knowing is illustrated by Fiona who says:

> *I still don't know why she did it* **3. 13.**

The lack of resolution, (discussed later on in the report) is due to the attempter's avoidance in discussing their motivation, which appears to perpetuate feelings of uncertainty, fear and frustration within participants. What emerges from the narratives is that suicidality is a complicated and ambiguous subject. In discussing his brother's long-term therapy to uncover reasons for his attempt, Lee highlights the complexity saying it's:

> *Like peeling an onion...there's so much shit going on in his head that...that it's difficult to know where it starts* **24. 17.**

B.2 Continuing life as normal

There is a strong theme of participants trying to continue with life as normal following the suicide attempt, despite any upsetting feelings being experienced. This accords with Begley and Quayle (2007), who describe a temporary suspension of feelings whilst continuing daily routines, following a sibling's completed suicide. Although Lucy took a small leave of absence from her job, she says:

Probably work was always kind of a way for me to actually get some sense of normality you know? (Lucy laughs) It was quite nice in a way to go back to that **5. 16.**

The *"normality"* of work suggests that for Lucy, the situation following the suicide attempt felt abnormal and uncomfortable, from which she was glad to escape at times. Indeed, she describes her visits to her brother in the psychiatric unit as disturbing and *"bizarre"* (8. 3.). In discussing the impact of the attempt on her life at the time, Lucy also says:

Things sort of... seemed a bit trivial and a bit mundane when you're sort of...I was facing that um...I don't know that it (pause 6 secs) I think I made a quite conscious effort to kind of keep doing things you know...and keep...keep a certain amount of routine **17. 7.**

Lucy's first sentence illustrates her perception of the enormity of the attempt, whilst her hesitant speech may reflect her difficulty in articulating this experience. She appears to start saying that the attempt had little effect on daily life, when she pauses before stating that she made a deliberate effort to keep a routine. This suggests that she was attempting to minimise the impact on her life, and that continuing with life as normal was a helpful coping strategy for her.

Ella's situation was common, in that she was at university and she set aside her feelings in order to carry on her with her studies:

And then being at college I just...kind of was more focused on trying to do the best that I could academically, and just continuing having a good time with friends and then just pushing it aside again, just thinking "it's a one-off", so hopefully everything will be good" **16. 1.**

It seems that for Ella, avoiding thinking about the attempt, *"pushing it aside"* (physical metaphor) and minimising it, *"it's a one-off"*, was necessary for her to be able to successfully continue her studies. Like Lucy, she describes supporting her

family when she was with them, but also deliberately attempting to minimise the impact on her life when outside the family. This is also echoed by Fiona who says:

> *It's almost like a filing system...I can put things in my head and shut them out until I want to think about them (...) in terms of my university experience and my friends (...) I've always just sort of slotted that away and (...) carried on with my life* **15. 16.**

The metaphorical language of *"slotting away"* and *"filing system"* conveys an image of a filing cabinet, representing the compartmentalization of her feelings. Being controlled with her emotions appears to be the most effective coping strategy for Fiona to be able to continue with her life. This seems even more necessary when considering her context of adopting the parental role in the immediate aftermath of the attempt, *"to hold a family together"* **(12. 19.)**. Interestingly, Sophie who also discusses being *"the strong one"* **(7.3)** in the family uses similar terminology, such as *"shelve"* when describing continuation with her life:

> *I had to sort of shelve...to go back to my room (...) and carry on with my studying* **5. 6.**

Whilst a psychoanalytic interpretation might be that participants were disavowing their traumatic experience, Marsh and Dickens (1997) recommend these coping skills, and assert that keeping a daily routine is an effective way of dealing with a sibling's mental illness. Since the author in this study argues that participants were experiencing grief-type emotions, Stroebe and Schut's (1999) dual-process model of grief may also be appropriate. They assert that oscillating between feeling grief emotions and distracting oneself from them is a healthy part of the bereavement process, providing that there is no excessive or continual denial of feelings. Since the accounts indicate that the universities and employers were generally accommodating and supportive, it seems that they also contributed to the participants' maintenance of daily life.

Contrastingly, Lee describes a significant impact on both his university and social life:

I lost about six months of my life (...) I stopped attending a whole bunch of lectures **8. 17.**

Lee's description of loss suggests that the suicide attempt had a profound impact on his life for six months. During this time he contemplated postponing his studies but decided against this, and in common with the participants, he decided to continue with his life as normal. Like Lee, James, Fiona and Sophie describe successfully completing their studies, despite the attempt. However, like Lee, Sophie says:

My studies were affected...quite considerably **8. 13.**

B.3 Looking for hope and change

Consistent with research on mental illness and families, (e.g. Kawanishi, 2006), there is a moderate theme of hope and looking for positive changes in the sibling over time. In the immediate aftermath of the suicide attempt, Lucy recounts a discussion with her boyfriend who described a relative's positive progress following a similar traumatic experience:

There was a discussion about... maybe we can get through this... um...oh yeah, and talking about how sometimes perhaps it needs to get to absolute rock bottom before anyone can really pick up again **11. 1.**

It appears that Lucy and her family were reassuring themselves that they could survive the trauma, and that her brother's emotional problems would improve. It seems that the suicide attempt represented *"rock bottom"*, and one could interpret that hoping the situation would improve was a way of tolerating helpless feelings and making a painful experience more bearable.

In other interviews, participants discuss hope in the context of their sibling's behaviour over time. Ella discusses the importance of:

Little units of...of family that...that I have for...for different supports **23. 10.**

who share her sense of hope for her brother's progress with his mental illness. She says of her grandmother:

> *She can be quite um...pessimistic which is just not pleasant to be around (...) and I'm just... "oh you know, you've gotta hope for the best and I'm sure things will change" which is the only way to...I (emphasis) think you can be* **23. 13.**

It appears too painful for Ella to consider anything other than the possibility that her brother will improve over time, resulting in avoidance in discussing him with relatives who do not share her optimism. Sophie also discusses:

> *Focusing on the positive things or the less (emphasis) negative thing* **19. 7.**

When reflecting on her sister's current behaviour, Sophie also says:

> *I think my feelings have moved towards...just looking for signs of change* **18. 8.**

There is a sense of movement and adaptation in Sophie's emotional response over time to her sibling's ongoing psychological difficulties, which has been a necessary coping mechanism. She goes on to describe hope for her sister's progress and for their relationship in the future:

> *There's a slight glimmer of the idea that we can build this into something that functions as a you know fairly good relationship (...) we're not (emphasis) there yet but you can see that it could happen in the future* **19. 12.**

Sophie invokes a strong sense of process in describing the status of her relationship with her sibling. The word *"build"* suggests that developing a good relationship with her sister is gradual and ongoing, and her last sentence and *"glimmer"* suggest that she is hopeful that they will be closer in the future. However, her emphasis on *"we're not there yet"* implies that this optimism is *cautious,* perhaps as a form of self-protection due to repeated past pain from her sister's behaviour.

The importance of caution with hope is also present in Lee's account. However, opposing the other extracts, he expresses little hope that his brother's emotional problems will improve in the future:

> *Nothing would make me happier if he would phone me up and say "you know what, I'm really happy about stuff" (...) I don't hold out any hope that it's going to happen necessarily because (pause 2 secs) hope can be a dangerous thing (pause 3 secs) I mean, hope's the most important thing in the world but it (pause 2 secs) it's got to be realistic* **26. 19.**

Hope for Lee appears to create some internal conflict; whilst acknowledging its importance, it also carries risk since it *"can be a dangerous thing"*. Like Sophie, it seems that having *"realistic"* hope is a form of self-protection against future pain, with his frequent pauses possibly reflecting his hesitation in expressing hope. The importance of retaining realistic hope is also described in a study of families experiencing mental illness (Lefley & Wasow, 1994).

B.4 Acceptance

Consistent with the acceptance stage of grief outlined by Kübler-Ross and Kessler (2007), some participants express some form of acceptance of their sibling's suicide attempt and mental illness over time. However, this does not necessarily mean that their feelings of grief have been resolved, but rather that they have found some way to tolerate their pain. Indeed, although they list the last stage of the grief process as 'acceptance', Kübler-Ross and Kessler (2007) assert that these stages are not necessarily sequential and may not pertain to everyone. In trying to make sense of the attempt and *"move forward with it"* (Lucy. 4. 18.), Lucy says:

> *I eventually sort of came to the conclusion, "ok, I don't like ****'s choices always but I will respect them"* **4. 18.**

It seems that for Lucy to be able to continue with her life, she has had to accept her brother's behaviour. There is a temporal aspect, with *"eventually"* and *"conclusion"*

suggesting that reaching acceptance has been an active process for her. The sense of process is also echoed by Lee who says of the attempt:

> *I mean right immediately after it happened (...) I wouldn't have been able to talk about it without breaking down in tears but time and just generally dealing with it means that...that I can...I can... I can put it in perspective I guess* **35. 18.**

Lee also expresses an acceptance of his sibling's choice to take his own life in the future, whilst Lucy describes being prepared for another attempt:

> *I'd say I reconciled myself to the fact a fairly long time ago that...there may well come a time when he kills himself and there's not really gonna be much I can do about that... and it's...it's not a nice thing to think but it's self-preservation you know?* **Lee. 26. 12.**

> *"I suppose I'm more confident I could handle it now if it were to happen...I think there's a certain psychological preparation gone on* **Lucy. 18. 5.**

For both participants, there is a sense of relinquishing control and responsibility for the sibling's actions, with the implication that this is necessary for defending against future pain. This is reminiscent of anticipatory grief, when one experiences grief feelings before an expected loss (Humphrey & Zimpfer, 1996).

Sophie however, conveys passivity and weariness in her response to her sibling's ongoing psychological problems:

> *I think there's a greater sense of resignation nowadays. I think certainly because of the recurrent behaviour you...sort of accept it as the status-quo* **18. 3.**

In her account, Sophie describes her sister's multiple suicide attempts and ongoing problems, and it seems that her *"resignation"* is her way of coping with these

difficulties. This resonates with the 'resigned acceptance' of mental illness in families described by Karp and Tanarugsachock (2000, p. 22).

Contrastingly, James and Sarah describe the *progress* over time of their sibling which has facilitated an acceptance of the suicide attempt. It therefore appears that acceptance for them is contingent upon the stability of the sibling's behaviour, and could therefore be temporary:

> *Well, it's easier looking back on it now to know that she's steady*
> **Sarah. 3. 16.**

> *Seeing my brother become slightly more stable at least um has been, has made it easier to look back on that time as an illness (...) I suppose I can see it even more clinical...clinically than I did back then* **James. 20. 13.**

James' attribution of his brother's suicide attempt to mental illness appears to be a way of detaching his feelings about the attempt and finding some form of acceptance of it. The word "it", (*"I can see it"*) suggests that he views the attempt as separate from his sibling, further underlining a sense of detachment. This increased clinical view is also echoed by Lucy and Lee:

> *I've moved on from there* **Lee. 30. 7.**

B.5 Personal changes

An unanticipated but strong emergence is the positive changes that participants personally experienced, either from their sibling's suicide attempt or from their mental illness. This corresponds with an increasing recognition of resilience in families who experience mental illness, (e.g. Kinsella & Anderson, 1996), rather than the historic focus on purely negative experiences. Sarah for example, describes how the attempt validated and drew attention to her own experiences of her family:

> *I can't remember if people actually said this but this was the kind of the sense of "oh I hadn't realised things were like that in your family" or "I hadn't*

realised things had been...were so hard" and then kind of maybe it prompted more of a discussion of what things were like for me (emphasis) in my family **13. 17.**

She describes how this in turn created an internal change, facilitating an acceptance of affection from her others:

So actually maybe it was a sort of learning opportunity for me to actually...you're allowed to get T.L.C. when your sister attempts suicide **Sarah. 15. 7.**

There is a sense of personal growth for Sarah through her *"learning opportunity"*, with her perception that the attempt 'permitted' her to receive care from others, which she would otherwise find difficult to seek out. However, *"learning opportunity"* could also be considered analogous to James' perception of the attempt, viewing it *"clinically"* (**James. 20. 15**). This suggests Sarah also experiences a sense of detachment from her sibling.

Ella discusses having to confront the subject of suicide following the attempt, when she gained an increased understanding and empathy for people who had experienced suicidal ideation:

I've definitely become more understanding of suicide and just more respectful of it as a as a subject...and I do feel more inclined, like to want to help people that do...have experienced it **17. 19.**

Similarly, Sophie describes a profound internal change following her sister's ongoing suicidal behaviour:

It's changed me as a person because I've become far more just accepting of certain things **30. 19.**

Sophie's experience is echoed by Lucy, who relates the positive impact to her sibling's mental illness as a whole, rather than just to the attempt:

*I think ****'s illness has been a bit of a wake-up call for me right? (...) It's sort of... made me think about other things that I just wouldn't have done previously* **19. 7.**

Lucy's metaphor *"wake-up call"* suggests that her brother's mental illness has acted as a stimulus for some form of positive internal change and reflection. This sense of individual growth and change is also detailed in research of families' experiences of mental illness by Marsh and Lefley (1996). However, an alternative understanding of the metaphor could be that it represents an implicit sense of alarm within her.

Mastertheme C: Family roles, communication and changes

C.1 Secrecy & caution	**C.2 Roles**	**C.3 Pay-offs**	**C.4 Changes in the family**
C.1.1 Collusion & conflict in maintaining secrecy C.1.2 Sibling's reluctance to explain C.1.3 Suppressing v expressing feelings C.1.4 Caution around the sibling	C.2.1 Continuing versus redefining roles C.2.2 Reclaiming roles		C.4.1 Negative C.4.1.1 Self & sibling C.4.1.1.1 Imbalance & ambivalence C.4.1.2 Self & family C.4.1.2.1 Criticism of parents' behaviour towards Sibling
			C.4.2 Positive C.4.2.1 Improvement of relationships & redefining boundaries C.4.2.1.1 Uncertainty about reasons for change

Table 8. Mastertheme C: Family roles, communication & changes

This mastertheme relates to the perceived familial response and communication following the attempt, often involving secrecy, suppression of feelings and cautious behaviour around the attempter. This mastertheme also encompasses the roles undertaken in the family, the secondary gains resulting from the attempt, and subsequent dynamics and changes in family relationships. The sense of interdependence and familial patterns of interactions is succinctly captured by Jane's comment:

Here we are again, doing this dance together **11. 4.**

C.1 Secrecy and caution

C.1.1 Collusion and conflict in maintaining secrecy

Consistent with many studies of completed suicide (e.g. Ratnarajah & Schofield, 2008), a powerful theme is that of family secrecy related to suicidal behaviour. This appears to be motivated by shame, fear and protectiveness, and was often prompted by the families, preventing open communication.

Following his attempt, Jane's brother asked his family not to disclose the event, which she attributes to feelings of shame:

We weren't to tell absolutely anyone **14.17.**

And:

He was very ashamed (...) he didn't want anyone to know **7. 7.**

Shame is also implicitly indicated as a reason for secrecy:

I think my parents were embarrassed **Fiona. 14. 5.**

I don't think my parents wanted their…go around town and have everyone know their son had tried to commit suicide **James. 18. 12.**

Similarly, Ella was discouraged from disclosing the attempt, with her mother saying:

Don't speak, don't tell anyone **5. 9.**

Furthermore, she did not want Ella to disclose to her brother that she knew of his attempt. Echoing literature on completed suicide (e.g. Clark & Goldney, 2000), there appears to be residual fear, with Ella's mother believing that discussing the subject will prompt her brother to re-attempt:

So she just said, yeah "don't speak to him about it"…she doesn't want him to…to think about it and do it again or put any more thoughts in his head **8. 21.**

Like Ella, keeping the attempt secret from other family members is also commonly found in other accounts, with the secrecy typically requested by the parents:

We didn't tell anybody outside of our...outside of the three of us what happened either (...) mum and dad made that decision and I went along with it **Fiona. 13. 9.**

This experience resembles the 'internal secrets' described by Karpel (1980, as cited in Rosenblatt, 2009) and Jaques (2000), who discuss how the rules of some family systems oppose the disclosure of information outside of the family. James and Ella discuss being particularly forbidden to reveal the attempt to their grandparents:

My parents were very explicit about this right, "don't talk about any of the details in front of your grandparents" **James. 17. 6.**

In both interviews, the reason given for this non-disclosure is one of concern, to protect their grandparents from feeling upset and anxious, *"it wouldn't help them"*

(Ella. 11. 12.). This is also the reason cited by Jane in the family decision to initially conceal the attempt from her mother, and is reflected in research by Dyregrov and Dyregrov (2005). However, Rosenblatt (2009) contends that secrecy in families can be a way of preventing relatives from raising issues that are painful for the secret-holders to think about.

A common consequence of maintaining secrecy is the internal conflict that this collusion creates. For example, Ella says:

> *I felt a conflict within myself* **14. 1.**

This is also strongly illustrated by Jane, who in discussing the difficulty in maintaining her brother's request for secrecy says:

> *And I also wanted to say (emphasis) what had happened and... but I didn't want to betray him and...perhaps I felt like I had to honour...um... what he wanted but also I felt like I had to honour what I wanted too...and.. and they actually were quite... opposite* **15. 2.**

Jane's words *"honour"* and *"betray"* evoke an image of allegiance to an army or team. This is analogous to a family unit, whereupon betrayal, in the form of secret-telling could equate with being viewed as a 'traitor' (Potter-Efron, 2002). In discussing mental illness, Kawanishi (2006) suggests such secrecy is linked to family dysfunctionality, and is a way of preventing disintegration of the family system. Therefore, an interpretation could be that Jane feared making her brother angry, which could result in losing their emotional tie and ultimately being rejected by her family.

Fiona, in common with other accounts, reveals that her collusion was not passive, but rather one that entailed actively lying to relatives, intensifying her discomfort and sense of powerlessness:

> *We just had to say that **** was really ill um...and that was (emphasis) hard, it was really hard because people wanted to know what was wrong with her... and you had to...lie (emphasis) really* **13. 16.**

Despite the family request for secrecy, participants tended to disclose the attempt to people outside of the family who were mainly friends, suggesting that the need for support was greater than their sense of shame or loyalty. However, their disclosure was restricted to only those who would be empathic and could be trusted, and this is discussed further elsewhere in the study. For the relatives who maintained secrecy, one could assume that this resulted in feelings of isolation for them.

The collusion of secrecy elsewhere in the family also features strongly in the narratives. Some participants express suspicion but uncertainty of whether other relatives, particularly grandparents had deduced that the sibling had attempted suicide:

> *Maybe they're not even oblivious to it, maybe they have some inklings in their own...own ways, you never know* **Ella. 11. 12.**

This suggests some form of denial in the families, thus maintaining an unspoken 'conspiracy of silence'. This is also reflected in Jane's extract, who says of her relatives' failure to query her brother's 'illness':

> *Something isn't there? Something...going on* **15. 16.**

For James, Jane and Lucy, there is a sense that this possible response of denial was an existing relational pattern within the families. For example, in describing another relative's past suicide attempt, Jane says:

> *They had covered it up* **15. 10.**

Likewise, Lucy talks of the "revelation" (12.18.). of a relative's suicidal behaviour that only emerged following her brother's attempt. Since there is a family history of suicidal behaviour in some of these accounts, it could be surmised that there is a form of generational shame, with families perceiving that they are 'tainted' by suicide (Clark & Goldney, 2000).

C.1.2 Sibling's reluctance to explain

Compatible with findings by Magne-Ingvar and Öjehagen (1999a), there is a strong perception of the sibling's reluctance to discuss the suicide attempt, and to offer an explanation for it. Since the need to make sense of the attempt, even years later is a powerful theme within the accounts, this evasiveness frequently left interviewees with feelings of confusion, frustration and concern that the sibling would re-attempt suicide.

The sibling's avoidance is illustrated by Jane, who when broaching the subject of his attempt with her brother says:

> *He quite carefully...steered that away* **9. 6.**

However, Jane is the only participant who explicitly attributes his reticence to feelings of shame:

> *He didn't want to talk about it (...) he was very ashamed* **7. 7.**

Her following excerpt, although succinct, uses powerful language to describe her perception of her sibling's suppression of feelings:

> *He (pause 1 sec) wouldn't speak about his feelings...and he chose to try and kill that part of him I think* **7. 20.**

Jane perceives that after failing to kill his *physical* self, her brother then deliberately sought to destroy his *emotional* self. This suggests a sense of loss within Jane, that although her brother did not *physically* die, she experienced his *emotional* death.

Relating to the sibling's suppression of feelings about the attempt, Sophie also says of her sister:

Often how she was feeling was a fairly dead-ended conversation, she wouldn't want to talk about it **10. 14.**

There appears to be a paradox in the accounts of the suicide attempt; the attempter was communicating a powerful message of distress through the suicide attempt, whilst simultaneously suppressing communication following it. It could be surmised that this suppression of feelings is representative of the sibling's normal communication style, and perhaps the suicide attempt was the only way they believed that they could communicate their distress or needs. This is also suggested by Sarah, in reflecting on her sister's possible reasons for the attempt:

If that was her best way of getting what she needed **15. 9.**

The theme of the sibling's avoidance in discussing the attempt is also demonstrated in Fiona and Sarah's stories:

Whenever I've broached the subject she very quickly dismisses it **Fiona. 6. 14.**

We went out a coffee and talked around it a bit and I (inaudible word on the recording) trying to be kind of tentative about it, and she was like (Sarah adopts a groaning voice) "oh no, don't, let's have some more cake"...um...just really dodged it, and I said "well if you want to talk about it" **Sarah. 6. 11.**

Fiona and Sarah's tentativeness in seeking answers from their siblings is again a common occurrence throughout the accounts, and could be attributed to fear of provoking another attempt. The participants' need for explanations and the sibling's avoidance of discussing the attempt, (*"dismiss"*, *"dodge"*) could also be interpreted as an unconscious strategy by the siblings to gain power within the family. Combined with some of the attempters' ongoing emotional problems, it appears that this perpetuates an atmosphere of uncertainty and concern, ensuring that this balance of power in the family is retained by the suicide attempter. This possible power dynamic is encapsulated by Sarah:

I did really want to know why she done it, I thought she was kind of holding back on me **9. 13.**

Alternatively, in considering findings by Wiklander, Samuelsson and Åsberg (2003), one could surmise that feelings of shame, or the difficulty for the siblings themselves in understanding their motivation could be the reason underlying their avoidance. This is evidenced by Fiona:

I don't know whether she doesn't know herself **6. 5.**

In contrast to these accounts, James recounts how his sibling was very communicative about his attempt and emotional problems. Indeed, his expressiveness led to James feeling both awkward and scared:

He was happy to talk about it...it didn't make him feel awkward or embarrassed which I suppose is great...um...for me though it wasn't so easy right? I...it does make me feel awkward towards my brother...it does (emphasis) make me feel...not embarrassed but scared **8. 12.**

Opposing the other participants who were seeking information from the sibling to make sense of the attempt and to possibly assuage their fears of a repeated attempt, it seems that knowing details of his brother's emotional difficulties actually *induced* fear within James, evoking a sense of burden in his account.

C.1.3 Suppressing versus expressing feelings

There is a sense across the narratives of a familial communication style of suppressing feelings following the suicide attempt. Some of the participants recall suppressing their feelings from their family:

For me it was very necessary to not show my family that it was upsetting me **Sophie. 6. 20.**

I suppose...I didn't really um...talk to them very much about how I was feeling because it seemed much more important to look after them (emphasis)
Fiona. 8. 6.

Fiona's excerpt suggests that she perceives that looking after her family's needs were more important than her own feelings following the attempt. Since both she and Sophie described adopting the role of *"the strong one"* (Sophie. 7. 3.) in the family shortly afterwards, it seems that suppressing their feelings felt a necessary part of this role. Since Fiona describes an emotional response from her parents and says *"I felt that my family was falling apart"* (8. 8.), it could be assumed that this was her coping strategy to prevent a perceived disintegration of the family unit. This accords with Lukens et al. (2004), who describe siblings of people with mental illness being controlled with their emotions to balance the family turmoil.

Likewise, James, Jane and Sarah describe a pragmatic familial response to the attempt:

I don't think we're so good at talking about thoughts and feelings
Sarah. 10. 18.

Whilst James says that the attempt:

Was talked about in sort of a logistical sense **11. 4.**

James continues:

I...we never sort of cried about it or shouted about it or anything like that... we just sort of dealt with it ...as a problem to be solved **4. 22**

It seems that James and his family were unexpressive with their emotions, instead coping with the attempt in an objective manner. This could be viewed as a way of avoiding painful feelings; James' change of perspective from "I" to "we" could be seen as a way of further distancing himself from these emotions. It could also be

surmised that perhaps the family *did* want to *"cry"* or *"shout about it"*, but felt unable to.

Similarly, Sarah describes an avoidance of discussing the attempt, perceiving that her family's anxiety has been displaced onto her sister's physical condition:

> *The thing that's focused on with my sister is her epilepsy...so I think that kind of becomes a kind of socially acceptable challenge... so "oh I wonder how" "is she, is she all right?", "has she had a fit recently?" so...all this anxiety about that might be around for other things...becomes focused on her epilepsy* **21. 8.**

Her words *"socially acceptable challenge"* implies a sense of stigma, that a suicide attempt or mental illness in socially *unacceptable* for the family.

Fiona and Lucy describe how styles of emotional expressiveness led to them assuming a role of mediator in the family. For example, Fiona perceives that the differences in emotional expressiveness between her parents caused a temporary emotional separation within their marriage, leading her to adopt a mediator role:

> *She expressed how she was feeling but my father didn't, he just would just get very upset and be almost embarrassed to cry in front of us* **12. 14.**

Contrastingly, Lee and Lucy's accounts suggest that feelings were expressed more freely within the immediate family following the attempt. For example, in discussing her parents in the immediate aftermath, Lucy says:

> *I really lost my temper with them and they lost their temper with me* **9. 9.**

Lee describes how he and his parents cried in a telephone call, after discovering his brother's suicide attempt:

> *I called them back and we just...talked on the phone for probably an hour or so...the vast majority of which we were both in tears* **6. 4.**

This open communication is apparent over time, when Lee discusses his feelings about his brother's ongoing behaviour:

> *I have at times wished he'd died (...) my sister's felt the same (...) even my mother's said that* **21. 7.**

The frank admission of occasionally wishing death upon a family member is generally regarded as a taboo topic of conversation and is discussed elsewhere in this report. Disclosure of these angry feelings between Lee and his family, suggests that this is a family environment in which it feels acceptable to express difficult feelings. Later on in his narrative, Lee describes how the sufficient support from his friends and family meant that he did not feel the need for psychotherapy, suggesting that this expressive style was beneficial to him. Similarly, although Lucy described expressed anger in the family in the aftermath, she also says *"we have just stuck through it together"* (13. 10).

C.1.4 Caution around the sibling

Consistent with findings such as Beautrais (2004), a significant theme throughout the narratives is that of suppression of feelings and cautious behaviour around the sibling following the suicide attempt. This occurred both in participants and within the families, in the immediate aftermath and over time.

Whilst James says that his behaviour around his sibling following the attempt was:

> *A little bit less joking, a little bit less...um relaxed* **9. 14.**

Sophie describes becoming *"more guarded"* **(11. 8.)** around her sibling:

> *Before...it was as you feel at the time, completely spontaneous, whereas I think...once...she had attempted suicide, it was almost like she was constantly looking for little bits of normal, little bits where you could have a laugh and a*

joke or discuss something normal (...) and you'd sort of try and draw out of those bits, but the rest of the interaction was very stilted **11. 10.**

Sophie describes a sharp contrast between her relaxed behaviour around her sister prior to the attempt, and her self-conscious interactions following it. Repetition of the word *"normal"* suggests that the situation felt abnormal and uncomfortable to her. Her attempt to *"draw out"* some form of normality and humour from her sibling suggests that this was an effortful process in avoiding her uncomfortable feelings.

Sarah's account also reflects similar behaviour, with repetition of *"careful"* and the pauses in her speech suggesting caution:

I was more careful to be in touch...um (pause 5 secs) and to be nice to her I suppose...just to be a bit more (pause 2 secs) careful with her **8. 4.**

Lee's story differs from many, in that he describes talking to his sibling to a limited extent about his feelings following the attempt:

I remember a couple of... of fairly brief conversations where I...where I told him that I...the way I've been made...I felt about it **12. 11.**

Lee's hesitations in his speech could be interpreted as mirroring the tentative conversations with his brother. His change from *"I've been made"* to *"I felt"* shows an ownership of his feelings, but could also be viewed as a curtailment of angry feelings towards his sibling.

There is also a strong perception of the family's caution around the sibling in the immediate aftermath, which appeared to be motivated by a fear of a reattempt. For example, Fiona discusses her family's effort to prevent any future suicidal behaviour from her sibling:

After that they didn't keep any medicines or tablets in the house so we...we considered other options that she might use **18. 2.**

This response resonates with considerable suicide literature. In particular, a phenomenological study revealed that mothers of suicidal adolescents acted more cautiously around their child (Daly, 2005). Sarah describes her father curtailing his joking, whilst Sophie's family suppressed their feelings to avoid causing her sibling further distress:

> *We sort of agreed as a family not to mention that it was affecting us because the last thing we wanted to do was to appear that we were heaping guilt onto her* **Sophie. 10. 11.**

One of the strongest themes throughout the narratives is the perception of inhibited behaviour around the sibling that still continues to this day. This is illustrated when Lee says:

> *The back of your mind concern you might have about entering into an argument with him* **22. 16.**

Fiona says when challenging her sister:

> *You end up backing down* **20. 16.**

In the following excerpt, Sophie discusses the reduced but continuing suppression of negative feelings towards her sibling:

> *The guards have come down a bit more, and I am much more willing to show when she upsets me um...I still try and sort of restrain things to a moderate level if she makes me angry* **20. 9.**

Although Sophie describes now being less inhibited around her sister, she still censors her feelings at times, illustrated by her last sentence. There is a sense of vulnerability to this excerpt; her use of the word *"guards"* suggests self-protection from her sibling. This is also reflected in her account, in which she describes adopting an unemotional manner to cope with her sister's ongoing problematic behaviour.

In the same way, although James describes being slightly less cautious around his sibling over time, he still monitors his interactions around him:

> *It's very (emphasis) uncomfortable... it's very stressful to be tense and to be thinking about what you're saying...how you act around your own brother... um...it's exhausting frankly* **10. 5.**

The feeling of tension and discomfort is evident in James' excerpt. His words *"how you act around"* suggest a conscious 'performance' rather than a natural interaction with his sibling, which is commonly reflected in the accounts.

It is worthy of note that the participants who describe the strongest and most enduring caution around the sibling are generally those who also describe the continuing nature of their sibling's problematic behaviour. Therefore, it seems that this is a coping strategy in response to their sibling's mental illness. Nevertheless, fear of another suicide attempt still appears to be the concern underlying the cautious behaviour.

Comparable to findings of parents' reactions to their child's self-harming behaviour (Raphael, Clarke & Kumar, 2006), a recurrent theme is the perception of the parents' continuing guarded behaviour around the sibling, despite time elapsing since the suicide attempt, or an improvement in the sibling's behaviour. This suggests that the pain of the suicide attempt has had a lasting effect on the family, and that their caution is a way of preventing repetition of this painful event. However, there is also the possibility of secondary gains from these interactions, which is discussed elsewhere in the report. The former interpretation is reflected by Fiona who says:

> *And mum and dad avoiding talking about him because they think it would upset her and they don't want to upset her in case... you know, something else happens* **21. 18.**

The implication here is that upsetting the sibling could lead to a further suicide attempt, therefore a compliant stance is adopted by the parents. Similarly, Lucy also perceives that her parents are still yielding to her brother's demands. In discussing her

father's agreement to undertake activities with his son, despite finding them mentally and physically difficult, she says:

> *But he hasn't...sort of taken the viewpoint that it would be okay to say "no" to* **** **21. 3.**

In the same way, James also views his parents as passive in their interactions with his brother:

> *There's the total deference to my brother's desires and opinions (...) sort of the desire that he be pleased all the time and that everything go perfectly* **22. 11.**

There is a strong sense in this extract that James' brother has a powerful position in the family, with the parents focused on appeasing his sibling. This accords with Gerace et al. (1993), who describe perceptions that the sibling with schizophrenia is given too much power within the family. The last sentence suggests that James perceives that his parents are trying to control situations, as if they are desperately trying to avert another disaster. Therefore, this concern with avoiding upsetting his sibling leads to consequential tension within the family:

> *So he's just very tense all the time around my brother...um, anything my brother wants my brother gets (emphasis) um...then more eggshelly than anyone, supereggshells with my father* **11. 1.**

James uses the metaphor "eggshells" and prefixes it with *"super"* to emphasise his perception of his father's overly cautious behaviour around his sibling. His brother is analogous to something so fragile that he has to be handled delicately or he will 'shatter', which could be interpreted as his mental state or volatility. James' emphasis on *"gets"* suggests anger at this family dynamic, which is shared by some other participants.

C.2 Roles

In being asked about roles following the attempt, participants reflect on either the continuation or redefinition of roles in the family. An overwhelming finding is that the attempt either reinforced or established the attempter in the 'sick role', around which family dynamics were anchored.

C2.1 Continuing versus redefining roles

James, Jane and Ella discuss a continuation and reinforcement of existing roles in the families after the suicide attempt. For example, Ella says:

> *My mum just continued being...being the mother figure of the household kind of thing* **11. 17.**

James describes his brother as being *"the stereotypical sickly child"* (12. 1.), following childhood illness. Therefore, there had been a long-standing role of him as the 'well' child versus his sibling as the 'sick' child:

> *Needy, unbalanced second child and the sort of successful on his own first child* **12. 13.**

However, although James believes that this familial perception is inaccurate, he perceives that it was strengthened by the attempt:

> *It was definitely reinforced by the suicide attempt and it sort of continued on. I'm not sure that it would have lasted so long if the attempt hadn't happened* **12. 15.**

James' account reveals that the implication of this is that his sibling's *"centre of attention role"* (**12. 2**) was reinforced and that his parents became even more overprotective towards his brother, leading to tension and frustration within the family.

More commonly, participants describe a change in family roles following the suicide attempt. This is strongly illustrated in Fiona's account, where she discusses taking on the parental role in the immediate aftermath. This entailed providing both practical support to her parents, to the point of *"cooking them meals"* (**11. 1.**), and emotional support, particularly to her father who became suicidal:

> *My relationship with him changed in that we've...we've always been very close but I ended up (pause 2 secs) almost looking after him as well afterwards* **7. 8.**

Fiona's experience resonates with Humphrey and Zimpfer (1996), who describe offspring frequently assuming a parental role as a way of easing their parents' grief after the death of their sibling. Although Fiona says of this role, *"I was quite happy to do that"* (12. 18.), a sense of isolation and burden pervades in her excerpt:

> *It was really difficult to hold... to hold a family together by yourself* **12. 19.**

Similarly, isolation appears in Lucy's story. However, this pertains to her mother who was banned from hospital visits by her son who had attempted suicide, creating a 'split' in the family and forcing Lucy into her mother's role:

> *Of course my dad and I can share that talk of what it's like at the hospital and how **** is and blah-de-blah, and my poor mother is not seeing him and then um...yeah, it's not...not a comfortable dynamic cos that sort of (Lucy laughs) stuff I feel like I'm going into this sort of wife (emphasis) role almost, you know?* **11. 11.**

Fiona, Lee and Sophie also describe being *"the strong one"* in the family after the attempt:

> *My instinctive reaction was to be the strong one* **Sophie. 7. 3.**

Sophie equates this role with offering practical help and material support for the family. Therefore, it could be inferred that providing this support felt easier for her

than being emotionally involved, whilst still allowing her to be involved in the family situation.

Lee also describes a similar role. However, resembling the 'collaborative participation' family approach described by Gerace et al. (1993), this role has been shared over time since the attempt, conveying a sense of mutual support in the family:

> *It's not a rota system... we don't have a person who has to be strong on a particular day you know? It's just organic...and sometimes it's been (pause 2 secs) sometimes it's been my father who's been the strong one or my mother... sometimes it's been me... it's just the way it goes* **27. 15.**

Some interviewees also describe adopting a new role akin to confidant or mediator in the family following the attempt. Endorsing Bank and Kahn's (1975) description of siblings as 'peacemakers' to defend against family discord, Lucy describes *"kind of smoothing out the path"* **(15. 9.)** between her parents and other relatives. Similarly, in discussing the difficulties of her parents' different coping responses, Fiona says:

> *My relationship with them changed because I became the person in the middle... and trying to bridge the gap between the two of them* **7. 13.**

In their accounts, both Fiona and Lucy describe simultaneous parental and diplomat roles, suggesting several roles could be occupied concurrently in these families following the suicide attempt. Therefore, there appears to be a complexity to roles, in that they can be fluid and overlapping, rather than being discrete and fixed (Lukens et al., 2004).

Some participants describe their role of confidant or diplomat as continuing to this day:

> *I think the diplomat is what (Lucy laughs) I have become in the family a lot of the time (...) I've definitely taken on the (...) you know diplomat and um...be terribly (Lucy whispers) sensitive about this and...* **Lucy. 12. 3.**

Lucy's terms *"diplomat"* and *"terribly sensitive"*, alongside her whispering voice tone conveys a sense of fragility and tension within the family, suggesting that Lucy tries to appease everyone.

Opposing this, Sophie talks of *losing* her confidante role following the suicide attempt, which she also attributes partly to being away at university:

> *I think my sister to a certain extent replaced part of the role that I'd had in the family, of being my mum's confidante* **15. 11.**

C.2.2 Reclaiming roles

Some participants also describe their parents reclaiming their roles over time after the attempt. For example, Fiona says of her father:

> *He's back in his role and he's doing that again* **10. 17.**

Sophie discusses how, in seeing her mother's resilience following the suicide attempt, she relinquished the parentified role for her mother to reclaim:

> *Seeing my mum's emotional resilience in coping with this, the suicide attempt has made me perhaps slightly more likely to offload onto or to not offload her my problems onto her, but to see her as capable of coping with hers without making them my problems...so I think that's (emphasis) changed since the suicide attempt* **21. 13.**

And:

> *Sort of going "actually you're an adult, I think you can deal with this"* **21. 18.**

In the same way, James expresses satisfaction that his mother has reclaimed her parental role over time, after challenging his brother's perceived selfish behaviour:

She's finally stepped, stepped back into that role, and it made me very happy to see her do that **14. 19.**

In all these extracts there seems to be a sense of relief that the parents have regained their original family roles. This suggests that there is a sense of security when family members return to their established roles, and the status quo of the family system is restored. This is reminiscent of Shapiro (1994), who describes the importance to family members of reinstating the family equilibrium following familial death.

C.3 Pay-offs

A strong emergence from the participants' reports is possible intrinsic rewards for the family as a consequence of the suicide attempt or the sibling's ongoing behaviour.

Sarah's candid account is unique in that she is the only participant to explicitly acknowledge the personal gains that she received in the immediate aftermath of the attempt. In the following extracts, she describes the special allowances and attention she gained:

This is a terrible thing to admit... I had a new boyfriend who...I turned out to be with a long time but um...I got to go round...I got to leave work...got to go round to see him...got lots of attention **3. 13.**

And:

It's quite a dramatic thing...quite a dramatic thing to tell other people...it's like "oh gosh...lots of drama"...um (pause 2 secs) Yeah so that's kind of...the part of me that I'm less proud of I suppose **14. 18.**

Her words *"terrible thing to do admit"* and *"less proud"* indicate shame in admitting that she enjoyed these benefits from the attempt. Similarly, following the attempt, Fiona describes a gain which still continues to this day:

I'm (emphasis) much closer to my mum and dad (pause 2 secs) I think in a way mum and dad and I are almost like a little team and (Fiona laughs slightly) um...my sister's the um...the game that we're playing um...and (pause 2 secs) I think she's...I think she feels that she's an outsider even though she's very much part of our family... I definitely think she feels like that **22. 19.**

Fiona's powerful metaphor, with rhetoric such as *"game"*, *"play"* and *"team"* suggests that this shared focus provides an alliance, from which she gains a closeness to her parents. The paradox of her sister being the *"game"* whilst also being an *"outsider"* suggests that her sibling is excluded from the *"team"*, and therefore she cannot 'win' the battle for the parents' affections. This sense of sibling rivalry is underscored when she emphasises "*I'm* much closer to my mum and dad". This resonates with Bank and Kahn (1975), who describe siblings aligning themselves with the parents against the 'sick sibling', resulting in the latter's isolation.

Sibling rivalry is also illustrated when Sarah says:

I was pleased that I got to be the healthy one and that she...she's anorexic, she self-harmed, suicide attempt...that...that she maybe wasn't coping so well...I was kind of pleased about that **7. 3.**

Since Sarah was *"the healthy one"*, it can be inferred that she perceived her sister as 'the sick one' in the family; listing her sibling's emotional difficulties serves to underline her perception. There is a sense that for Sarah, her sister's attempt reinforced her own position in the family as the *"healthy one"* who could cope successfully with her own difficulties, and this felt satisfying for her.

This sense of power and alliance in the family is again illustrated by Sarah, when she describes her ongoing role of confidante following the attempt:

I suppose it's quite a powerful position...and quite a trusted position because I (pause 4 secs) I don't think it would help...to tell...to pass on my sister's information onto my parents...I don't think that would be...I think maybe my sister wouldn't trust me in the future...but also it did cross my mind "shit if

something does happen in the future and I've not (emphasis) told them, it's gonna come down on me" that "well why didn't you tell us?" **23. 1.**

This is the only time that the issue of power is explicitly mentioned; however it is implicit in many of the narratives. Like Fiona, it could be inferred that assuming this role provides a way for Sarah to gain power and to feel included in her family, particularly as she mentions that after the attempt *"it was the first time I'd sort of been able to be involved in a family crisis as an adult"* (**11. 6.**). It appears Sarah gains power in the family by being entrusted with secrets. However, this is also burdensome: *"if something does happen in the future"* implies her sister re-attempting suicide. It could also be argued that her sibling also has power, in that she is 'splitting' the family and making Sarah accountable in the event of a re-attempt.

Some accounts reveal a perception that the siblings who had attempted suicide had subsequently experienced some form of gain from the familial response, often motivated by the family's fear of another re-attempt. This emanates strongly in James' account, who perceives that his brother is now indulged by his father:

> *So he's just very tense all the time around my brother...um...anything my brother wants, my brother gets (emphasis)* **11. 1.**

James perceives that his father capitulates to his brother's demands to avoid provoking his volatility and a possible suicide re-attempt. The emphasis on the word *"gets"* suggests anger at this family dynamic, which he discusses elsewhere in his narrative. The inference that the suicide attempter benefits from the family's compliance with their requests is also exemplified by Lucy, who says of her father's response to her brother:

> *He hasn't...sort of taken the viewpoint that it would be okay to say "no" to* ****** 21. 3.**

The accounts also strongly reveal that the attempter received increased attention and became the focus of family dynamics following the attempt. It could therefore be interpreted that the sibling benefits from this increased concern, as illustrated by Lee:

I don't think he's above... using people's sympathy and caution around him to his own benefit **22. 13.**

It could also be surmised that the attempt was a way of facilitating closeness to family members for the attempter:

I'm kind of glad it happened because now we keep a much closer eye on her **Fiona. 16. 5.**

I haven't had that intimacy with him since he was very young (...) it demonstrated very clearly how much he... he meant to me **Jane. 20. 19.**

In discussing their sibling's continuing psychological problems, Lee and James comment on the difficulty attributing blame for their behaviour. Therefore, in line with Terkelsen's (1987) clinical observations of mental illness in families, it could be inferred that the sibling benefits from being absolved of responsibility for their actions. For example, James discusses time-consuming tasks his father assumes on behalf of his brother. In describing his sibling's resultant poor coping skills, he portrays an infantilised view of his brother:

So it's always difficult, difficult to blame him about that right? He's never had to sort of grow up **15. 13.**

Some interviewees also perceive that their parents received some form of internal reward. Jane perceives that her mother enjoyed the attention that she gained from her son's attempt:

"Oh isn't it terrible you know that my son tried this and you know... it's awful for me" **10. 21.**

Similarly, Sarah suspects that her mother enjoyed the attention created by the suicide attempt:

We didn't know why she'd done it but for my mum's own reasons...she was kind of hinting....quite awful things that may or may not have happened... almost (emphasis) like she was getting off on it **5. 3.**

The term *"getting off"* has sexual connotations and alongside her mother's insinuations, implies that Sarah perceives that her mother was gaining sadistic pleasure at the uncertainty and concern created by her comments. This again raises the issue of power and the word *"almost"* suggests shame in admitting this thought.

Contrastingly, Lucy perceives that her parents' ongoing concern for her sibling, despite his progress, is a way of diverting attention *away* from their potential marriage problems:

I think there's (pause 2 secs) quite a pay-off for them to keep worrying about him **21. 9.**

And:

I think it's a nice focus for their marriage um...they've always got to have something to worry about so that's quite good (...) I think "yeah, you don't want to see your son get better cos..." (Lucy laughs) "you're gonna have to look at yourselves a bit more **21. 12.**

Lucy suggests that her parents are gaining from keeping their son 'ill' as a distraction from their own problems, which is reminiscent of the 'identified patient' discussed in family systems theory. Furthermore, it concurs with Nichols and Schwartz (1991), who describe that without the diversion of the child's behaviour, parents would have to communicate about their marital problems, which could lead to the collapse of their marriage.

Similarly, Fiona's rhetoric such as *"manage"*, *"communicate"* and *"feedback"* in the following excerpt suggests that her sibling is the 'project' being worked on in the family, benefiting both her and her parents:

We have to manage my sister so we all sort of...you know...communicate a lot more about her and what she's doing and I get feedback from my parents as well **17. 19.**

C.4 Changes in the family

Although some participants deny a large impact on family relationships following the attempt, they nevertheless do describe both negative and positive significant changes. Like much of the analysis, ambiguity imbues this theme, with Lee's following comments regarding the attempt encapsulating this complexity:

It almost brought us closer together **15. 2.**

But also:

It's damaged our relationships with each other some...and with him **15. 20.**

C.4.1 Negative

C.4.1.1 Self and sibling

C.4.1.1.1 Imbalance and ambivalence

A strong theme amongst the accounts is that of a one-sided and conditional nature of the sibling relationship following the attempt, which still persists. Fiona discusses her increased effort in maintaining contact with her sibling since the attempt:

I think more regular contact is probably beneficial to her (emphasis) even though she wouldn't ever make the contact back but that's fine **6. 6.**

There is a strong sense of inequality, with Fiona's comments *"that's fine"* and *"that's just who she is"* (5. 20.) mentioned elsewhere, implying a minimisation and acceptance of her sibling's behaviour.

Fiona's story also shares a commonality with other narratives of suppressing feelings towards the sibling, despite the sibling expressing their feelings or behaving unpleasantly:

> *We get along quite well as long as, as long as he's not upset about anything, (...) I'm not as totally open with him as he is with me* **James. 21. 4.**

> *Just generally he'll ring up and say quite unpleasant things that you don't want to hear, how he's feeling, but you have to just take it on the chin*
> **Ella. 19. 15.**

Like James, Ella appears uncomfortable with her sibling's openness about his emotional difficulties. Her metaphor *"take it on the chin"* suggests someone who stoically endures an attack, while the physicality of the words suggests that listening to her brother is painful for her. Like Fiona and James, she believes that being supportive to her sibling involves tolerating unpleasant or unfair behaviour at times. This concurs with qualitative findings by Barnable, Gaudine, Bennett and Meadus (2006) who describe siblings of people with schizophrenia feeling that they could not rebuke their siblings.

Contrastingly, Lucy discusses how her sibling relationship has acquired a more reciprocal quality over time. Ironically, in refusing to yield to unfair demands on her time, she describes how her sibling now makes an effort to sustain their relationship, resulting in more of a *"two-way process"* **(20. 14.)**. Since Lucy expresses realisation that she cannot control her brother's possible future suicidal behaviour, it could be surmised that this acceptance liberates her from feeling that she must always placate her sibling, resulting in her brother assuming more responsibility for his actions.

Ambivalent and conflicting feelings towards the sibling characterise the narratives, supporting findings by Kristoffersen, Polit, Mustard and Min (2000). Features of the relationship include love and protectiveness, resentment, sibling rivalry and distancing from the sibling.

The consensus of protectiveness towards the sibling following the suicide attempt is shown by Fiona:

> *I do feel quite protective of her* **6. 6.**

This feeling however, is often combined with frustration or anger, as shown by Sophie who says of her sister:

> *"Could you stop screwing everything up for everyone else (...) you know you've taken a year's worth of university experiences away from me, and you can't give those back"...but at the same time she's lost four years of her childhood and you'd much prefer to give her those* **29. 7.**

The first half of this extract suggests anger at her sibling for her behaviour since the attempt; however her last sentence suggests love and protectiveness towards her. There is a sense of loss for both Sophie and her sibling, and ambivalence in how she perceives her sister's behaviour: *"you've taken"* versus *"she's lost"*.

Similarly, James describes feeling resentment at this brother for the attempt, and anger over the long term:

> *I've certainly been angry with him about his mental illness many times* **5. 12.**

At the same time, James also conveys a sense of protectiveness for his sibling and for himself:

> *There's sort of at least two competing emotions going on...at the one time I want to help him (uh huh) and prevent this sort of thing from happening in the future to the extent that I can...but on the other hand I want to defend myself from being worried all the time (...) frankly I don't want to know everything that upsets my brother...um...because that drags me down and makes me unhappy* **8. 15.**

Like Marsh and Dickens (1997), James perceives that there is a discord between wanting to support his brother and the desire to protect himself from the unhappiness and worry that this entails. It appears that in order to preserve his own happiness, he perceives that there is a need for detachment from his sibling. However, his sense of responsibility and his belief that he can actively 'prevent' another suicide attempt makes this distancing difficult for him.

Feelings of competiveness and jealousy of the attention the sibling received after the attempt is also present in some of the narratives, as illustrated by Lucy:

> *A bit of sibling rivalry probably, cos then **** is becoming the focus of attention for my cousins' attention and "isn't **** wonderful?"...and then sort of think (Lucy adopts a child-like voice) "oh, hang on, I'd like some attention or something" probably...(Lucy laughs) (...) but (Lucy adopts a child-like voice) "what about me?" (Lucy laughs) you know?* **15. 16.**

A sense of jealousy pervades this extract, reinforced by the child-like tone Lucy uses. Her question *"what about me?"* suggests feelings of abandonment in being overlooked for her brother, whilst her laughter indicates embarrassment or shame at admitting to these 'child-like' thoughts.

Similarly, one could interpret Sophie as feeling ashamed for wanting attention, since she is keen to distinguish that hers was not a child-like need:

> *The attention's taken away from you and not in a childhood-grabbing "I want attention" kind of way, but perhaps attention that's needed simply in order to address the situation you don't get* **28. 21.**

Like Lucy, Sophie also felt overlooked, *"my feelings were secondary"* (**28. 19.**), consistent with much literature on siblings of people with illness, psychiatric or otherwise (e.g. Lefley & Wasow, 1994). This sense of limited attention available from the family, and competitiveness is echoed by Sarah, in reflecting on the possible reason for the attempt. In describing herself and her sibling as *"birds in a nest"* (**7. 6.**), she says:

I was the big one that managed to get…what I needed but maybe there was less left over for her **7. 7.**

Consonant with Barnable et al.'s (2006) study of siblings of people with schizophrenia, James says:

There's definitely some jealousy and um…resentment there **13. 13.**

However, he relates these feelings to the perceived favourable treatment that his brother has received since the attempt:

It doesn't seem totally fair **13. 8.**

Some of the participants express a distancing in the sibling relationship at some point following the suicide attempt, which Stålberg et al. (2004) term as an avoidant coping pattern. However, Chess (1989) asserts that this distancing is adaptive, allowing a child to separate itself from dysfunctionality in the family.

Some interviewees discuss distancing in the immediate aftermath. For example, James says that his sibling relationship was *"a little bit more distant"* **(9. 17.)**, since his fear of a re-attempt led him to acting cautiously around his sibling. This distancing is also echoed by Sophie in the following extract:

Immediately after the suicide attempt there was a very big emotional distance, and I would not show any signs of weakness in front of her **20. 6.**

Sophie's response to her sister's attempt was to 'shut down' her feelings, suppressing them from her family and adopting a clinical manner. Her last sentence implies that showing her feelings equates with weakness and vulnerability, suggesting that her distancing was to protect herself against further pain from her sibling. Since Sophie describes in her account her sister's frustration at her unemotional response to her behaviour, it could be surmised that a possible factor in her sibling's ongoing problematic behaviour was to gain some emotional connection with Sophie. The irony

would be that her sister sees her behaviour as a facilitator to closeness with her sibling, whilst Sophie perceives it as a barrier.

Ella and Lee also echo the theme of detaching from their sibling as a form of self-protection, but for them it was a *physical* distancing. Ella describes discomfort in seeing her brother after the attempt, therefore limiting her time with him to *"very short stints"* (**10. 14.**). Likewise, Lee decided against living with his brother in the aftermath, fearing that it would aggravate his own depressive symptoms resulting from the attempt:

> *It wasn't choosing to be...separate from him...it was...(Lee sighs) I don't know...maybe not even...maybe subconsciously thinking it would be a good idea not to be with him* **10. 19.**

Lee attributes his distancing to an instinctive self-preservation, *"maybe subconsciously"*, rather than a deliberate choice on his part. It could be interpreted that his attribution to unconscious forces indicates feelings of shame that he did not want to live with his brother. Later on in his account however, Lee describes a more conscious detachment from his sibling over time, fuelled by his brother's ongoing problematic behaviour:

> *In order to be able to continue my life, I've had to harden my heart in places and at times...and that means that probably no you know I...the relationship with him is not as good as it was (ok) pre-suicide...but...that's inevitable you know?* **28. 4.**

Lee's first sentence confirms that his withdrawal is a form of self-preservation, which has negatively impacted the sibling relationship. This is akin to James' narrative, who says of the distancing over time:

> *The self-protection part gets bigger...um...over time* **9. 2.**

Distancing as a form of self-preservation against future loss has also been shown in a study of mothers' experiences of suicidal adolescents (Daly, 2005). In a similar way,

Lucy also discusses detachment over time in her sibling relationship. However, unlike Lee and James, she describes the distancing as mutual and beneficial for both her and her brother:

> *I think there's in a way a sort of clearer definition of boundaries yeah... yeah. But it works... it works better for me and I...I hope for him as well* **7. 11.**

The *"clearer definition of boundaries"* suggests that Lucy's sibling relationship was possibly enmeshed before the attempt. Since Lucy also perceives an improvement in her sibling's relationship with her parents over time, *"there's a much more sort of... independent relationship there"* (**19. 20.**), it could be inferred that there was a general, existing enmeshment within the family, and perhaps the attempt served as a way of changing this dynamic.

C.4.1.2 Self and family

C4.1.2.1 Criticism of parents' behaviour

A powerful theme across the accounts is that of perceived differences between the participants and parents in their responses to the attempt and behaviour over time, resulting in feelings of frustration. This accords with Barnable et al. (2006) who describe siblings' frustration with parents following their responses to their schizophrenic siblings. For example, Ella says *"it's frustrating"* (**23. 9.**), when discussing her father's avoidance of coping with her sibling's mental illness over time:

> *I just kind of keep my distance as much as possible because it's kind of...(Ella coughs) not really beneficial or necessary to me, unless my dad's gonna put his...his...get his hands dirty and do something properly* **22. 2.**

Ella's response to her father's perceived avoidance is to also withdraw in their relationship, which appears to be self-preservation: *"not really beneficial or necessary to me"*. Her description *"get his hands dirty"* implies that involvement with her sibling is both an active process, but is also unpleasant and difficult.

Lucy also expresses frustration, but her source of irritation is her parents' persistent acquiescence to her brother, despite the suicide attempt being some time ago. This perception is also shown in Fiona's account, who says of her parents:

> *They don't want to upset her in case... you know, something else happens...so it's rather ridiculous* **21. 18.**

The implication is that *"something else"* is another suicide attempt, and this concern underlying the parents' behaviour is implicit in many of the stories.

Likewise, James' narrative strongly illustrates frustration at his parents' overly cautious behaviour around his sibling, which still persists a long time after the suicide attempt:

> *The eggshells have gotten less with me (emphasis), they haven't totally gotten less with my parents and that frustrates me* **11. 14.**

James' stress on the word *"me"* emphasises the difference between his behaviour and that of his parents, with *"eggshells"* conveying the careful behaviour around his brother. Indeed, he suggests that it is the tension caused by his parents' persistent cautious and overprotective behaviour towards his brother, more so than the suicide attempt or mental illness that is damaging family relationships, saying:

> *It's been the overwhelming effect of my brother's attempt* **22. 8.**

James goes on to describe the profound impact of the tension on family interactions, perceiving that each relative is silently focusing and worrying about each other. Note the sense of rigidity, as if their interactions are fixed and stuck in time in the following excerpt:

> *So we're all sort of looking at each other you know um...and these...and these sort of um ways they get frozen right, every time um...whereas if my brother's*

not around, we sort of interact with each other you know, in a more fluid way I suppose **24. 1.**

Furthermore, James describes how his parents' continuing caution around his brother causes friction between him and his wife when they are visiting his family:

My wife's and my relationship is very (emphasis) good every other time, and not as good when we're there together **25. 17.**

Consistent with a study by Jones (2002) who discusses the impact of mental illness on family members' relationships, James goes on to say:

It never really occurred to me that it would make me act differently even towards my wife right, when she's around, um (pause 3 secs), so it's not just siblings of suicide attempters, it's those who have relationships with siblings of family members **31. 10.**

C.4.2 Positive

C.4.2.1 Improvement in relationships and redefining boundaries

There is a strong theme among the reports of positive changes in some family relationships over time, although it was sometimes difficult to attribute these solely to the attempt. These changes resonate with the suggestion that a suicidal relative's 'sick role' may unify the family following a suicide attempt (Aldridge, 2008, as cited in Wong et al., 2008). Supporting findings by Sin, Moone and Harris (2008) of increased closeness with siblings who had experienced psychosis, Jane describes a deeper emotional bond with her brother following the attempt:

I think because I shared in an experience in his life... and I haven't had that intimacy with him since he was very young...it demonstrated very clearly how much he...he meant to me (...) I do feel slightly more connected to him **20. 19.**

There is a strong sense of affection in this excerpt, with the attempt viewed as an opportunity for Jane to recapture the closeness she had with her brother and to demonstrate her love for him. There is also a powerful temporal element with this *"experience"* connecting Jane and her brother with both past and current intimacy.

Similarly, Sarah describes the attempt as initiating more open communication with her sibling:

> *I think that without the suicide attempt...I would never know that things weren't okay (...) maybe that kind of opened the door in some ways... to sort of keep communicating* **19.15.**

In the same way, there is some perception of an improvement in other family relationships, for example, Fiona says:

> *We call each other all the time, we talk a lot more* **17. 5.**

Lee, like Fiona also describes a release of emotional expressiveness within his father, saying:

> *It almost taught him that it was (emphasis) okay for him to be emotional* **15. 10.**

Lee goes on to discuss his perception that although his parents' marriage suffered due to his sibling's long-term behaviour, overall there has been an improvement in family relationships since the attempt:

> *I know up here (Lee points to his head) this is how it's happened and...and I know that...families becoming stronger in relationships with parents and things improving is not a logical by-product of a sibling's attempt at suicide but...this is the way it's worked out* **29. 5.**

In pointing to his head and using scientific rhetoric such as *"logical"* and *"bi-product"*, there is a suggestion that Lee perceives that there is an irrationality to an improvement in family relationships following a suicide attempt; that a potentially divisive event has actually had a unifying effect. This sense of surprise is also echoed by Fiona who says:

> *I think it strangely has brought our family closer together again now (emphasis)* **16. 8.**

Lucy and Sophie also refer to a redefinition of boundaries within family relationships over time, which they view as a positive change. Lucy perceives this as happening both with her brother and across her family as a whole, describing her relationship with her parents now as *"perhaps slightly less controlling of each other"* **(19. 5.)** This sense of reduced burden and enmeshment in the family is also reflected by Sophie. In witnessing her mother's resilience following the attempt, Sophie is now able to:

> *See her as capable of coping with hers without making them my problems* **21. 15.**

C.4.2.1.1 Uncertainty about reasons for changes

Despite discussing changes following the suicide attempt and over time, James, Lucy, Lee and Sophie express difficulty or reluctance to attribute these solely to the attempt. Although Lucy describes her brother's mental illness as *"a bit of a wake-up call"* (19. 8.), she also expresses uncertainty that changes in the family are related solely to the attempt:

> *I'm not sure it wouldn't have happened anyway* **19. 7.**

Similarly, in reflecting on a closer relationship with his father since the attempt, Lee says:

*It's difficult to know because I've only got this one take of it... and I can't rewind it and play out if **** had never tried to kill himself and see where we ended up* **15. 13.**

This uncertainty in participants' narratives illustrates the complexity involved in suicidal behaviour, mental illness and family dynamics. Furthermore, it suggests that simple causal attributions cannot and should not be made when reflecting on these issues.

Mastertheme D: Experience of professional help

D.1. Barriers to seeking help	**D.2. Feeling judged & excluded**	**D.3. Unmet needs of the family**
D.1.1.Stigma and shame		D.3.1. Emotional support & therapy
D.1.2. Doubts about value of therapy		D.3.2. Information & guidance

Table 9. Mastertheme D: Experience of professional help

When asked about their experience of professional help following the attempt, participants generally express a lack of support from services, but also describe their own psychological barriers to seeking help. Combined with a perceived lack of inclusion or guidance from professionals, there is a sense of abandonment and isolation within these families, with mental health services primarily focusing on the suicide attempter.

D.1 Barriers to seeking help

Corroborating many findings such as Raphael et al. (2006), there is a strong theme in the accounts of barriers preventing the participants and their families from seeking professional help following the suicide attempt.

D.1.1 Stigma and shame

For James and Sophie, the stigma of seeking therapy prevented them from seeking professional help. In discussing the wide range of university resources that were available, James says:

> *It had all been there if I wanted it (...) in retrospect I probably wish I...I'd used it um but frankly I felt a stigma attached to it (uh huh) um...and so I didn't do it* **27. 11.**

James felt stigmatised in seeking professional help, which is also shown elsewhere in his narrative by *"admitting that you um needed help in that way"* **(27. 16.)**. Stigma is also cited by Sophie in preventing her from seeking help with her depression following the attempt:

> *And partially because I didn't want the stigma of entering into the mental health profession myself having had a mental illness, I didn't seek treatment when I had depression* **32. 2.**

In Jane's narrative however, it is her sibling who had attempted suicide who was deterred from seeking professional help, due to concerns of a breach of confidentiality and the resulting stigma surrounding suicide:

> *He would not (emphasis) go to the doctor ...um... because... he... they live in a...a village in ****... and it... and it... he would say well the receptionist would know I was there and it would go round the village* **8. 10.**

Jane's brother's response commonly appears in the literature. For example, a qualitative study of self-harmers aged 14 and 16 years, reported that feelings of shame prevented them from seeking help after their actions (Fortune, Sinclair & Hawton, 2008).

D.1.2 Doubts about the value of therapy

Lee, Fiona, Sarah and Ella are doubtful about whether or not psychotherapy would have been beneficial to them following the suicide attempt. Lee discusses receiving sufficient emotional support from his family and friends, and says of professional help:

> *I don't know that I...how much benefit it would have been to me* **30. 2.**

However, when asked if he had experienced a need for professional support, Lee comments:

> *I don't think that...the way that in which I've dealt with...with **** suicide attempt has been...bad...I think for the most part I think I'm doing pretty well* **29. 14.**

One could interpret a defensiveness in this statement; that the meaning for Lee in seeking help is that he is not coping well with the suicide attempt, arousing possible feelings of shame and inadequacy. Similarly, Ella says:

> *I am quite sceptical about um...just in nature, about support and counselling...and I know it's beneficial to an extent but I don't know how much) it really can... can help because it...the...it's got to come from within you* **24. 9.**

Like Lee, an inference could be made that for Ella, receiving professional support represents some inadequacy. Her words *"it's got to come from within you"* suggests the importance she places on self-reliance, and it could be surmised that she perceives receiving professional help as an indication of dependency or weakness. On the subject of psychotherapy, Fiona also expresses doubt of its benefit for her:

> *The way I handle things, no it wouldn't have helped me um (pause 2 secs) I do think it would have helped my mum particularly to try and understand* **25. 15.**

Although Fiona sees a value in psychotherapy in helping her mother to *"understand"* the depressive responses in her family, she perceives an incompatibility with her own coping style. In her account she describes *"blocking things out"* **(15. 15.)**, so that she could be *"the stronger person"* **(3. 15.)** in the family, to look after them. It could therefore be inferred that facing emotions during psychotherapy could have felt too overwhelming for her, threatening her "strong" status in the family and risking a potential collapse of the family system.

Similarly, Sarah also doubted the usefulness of psychotherapy at the time of the attempt. However, her opinion has changed over time following therapy for issues unconnected to the attempt:

> *It was only when I began to have it that I realised how helpful it was* **24. 12.**

Although she did not want therapy to discuss the suicide attempt, and it was debatable whether she would have accepted it if it had been offered to her, she says that it may have been an earlier means of *"opening a door"* **(24. 1.)** to explore other issues.

It therefore seems that the meaning participants attached to receiving professional help and psychotherapy influenced their decision to seek out and accept these resources. However, it could also be argued that protective factors, such as having supportive friends or family provided sufficient emotional support that some participants required following the attempt.

D.2 Feeling judged and excluded

In general, the accounts reveal a lack of professional support for the siblings following the attempt and over time. Although participants were asked about *their* experience of professional help, they tend to include their parents in their dialogue, suggesting the sense of abandonment by professionals was a shared experience.

In a phenomenological study, siblings of people with schizophrenia described feeling excluded by professionals (Barnable et al., 2006), which is representative of much

literature on mental illness and families. Similarly, some participants describe feeling judged and excluded by mental health staff following the suicide attempt:

> *It doesn't feel very warm and opening for the family* **Lucy. 22. 20.**

This isolation is also illustrated by Sophie, in discussing the arrangement of clinical meetings concerning her sibling:

> *They were terrible at scheduling them for when I was actually available* **25. 3.**

And:

> *We weren't given sufficient information about what was going on, or what support was available to us* **22. 12.**

Sarah also perceives that her mother was excluded from being given information about her daughter in the inpatient unit:

> *Just that my mum was very angry...and very threatened I think...and angry with the hospital staff for not telling her what was going on... she felt that my sister was still her daughter and she...she was entitled to information that she wasn't being given* **26. 3.**

Sarah's narrative reflects the anger that she perceives her mother experienced towards the staff. The words *"threatened"* and *"still her daughter"* is evocative of a battle for her sibling, who has acquired the identity of a patient and now 'belongs' to the hospital. This sense of 'them and us' also resonates with Lucy, in discussing her experience of the staff on a psychiatric ward:

> *The mental health professionals are you know...cos of client confidentiality etc., won't really speak (emphasis) to the relatives um...and that's quite correct that it's like that but the message (emphasis) that's very often received I think on the...from the family side is like "oh, we're...we're bad and..."*

(inaudible word on the recording) "and they're against us" and this isn't what's really... but it's not helpful that sort of image I think **22. 12.**

Lucy believes that professionals conveyed a negative perception of the family, and like Sarah she attributes this experience to the boundaries of confidentiality to which staff must adhere. This is also evidenced in both suicide and mental illness literature. For example, in a New Zealand study, Fielden (2003) describes that families of suicide completers perceived that information that they were given was severely restricted by confidentiality regulations.

This sense of being judged following her sister's ongoing psychological problems is echoed by Sophie who says:

And while they never... well obviously they didn't try and make you feel like you were the cause, often you were made to feel guilty or something by the professional involved (...) They expected us to have something wrong with us and they projected the idea that they were expecting to have something wrong with us **22.15.**

Sophie perceives a negative evaluation from the professionals involved in her sister's care, with the implicit assumption that her family was to blame for her sister's behaviour. Sophie's perception is indicative of literature that has traditionally viewed families as responsible for mental illness in relatives. Her experience also resembles studies such as Jones (2002), who discusses families of people with mental illness feeling judged by staff involved in their relative's care. However, Sophie's use of the word *"projected"* is interesting. Although one could assume that she uses the word in the sense of the message being conveyed to her, a psychoanalytic interpretation might be that it is Sophie who is projecting her own feelings of shame and guilt onto the professionals. Supporting this, Tangney and Dearing (2002) describe how ashamed people may ascribe the cause of their feelings to those who they believe are disapproving. This view could be supported by Sophie's rhetoric such as *"cause"*, *"guilty"* and *"something wrong with us"*, alongside her comments regarding guilt mentioned elsewhere in her narrative.

In contrast to these accounts, Jane was already receiving psychotherapy when her sibling attempted suicide. Furthermore, she also describes herself as fortunate in accessing information and emotional support from the mental health organisation in which she worked at the time of the attempt. Consequently, unlike Sophie and Lucy who felt judged by professionals, Jane's experience was one of empathy, in which she felt comfortable revealing her feelings:

> *I was allowed to talk with those words in that situation* **14. 7.**

D.3 Unmet needs of the family

D.3.1 Emotional support and therapy

A strong theme amongst the narratives is the unmet need for emotional support and reassurance following the suicide attempt. More specifically, a desire for therapy, in particular family therapy is expressed by some participants. In their study of significant others of suicide attempters, Magne-Ingvar and Öjehagen (1999b) also describe how participants overwhelmingly expressed a wish for therapy in the immediate aftermath of the attempt. In the following extract, James discusses how family therapy should be standard practice so that shame does not prevent acceptance of this resource:

> *In those sort of first early days um after the attempt (...) it certainly would have been good if there'd been kind of, not mandatory but just sort of matter-of-course family counselling as well* **28. 20.**

James perceives that this early intervention could also be a form of education. Like Kinsella and Anderson (1996), he believes that it could have improved the family's subsequent coping skills with his brother:

> *Cos I think some of the stuff could have been headed off (...) but it wasn't so these patterns were sort of going on and on* **28. 2.**

A strong image of isolation within each family member and a need for unity pervades his following excerpt, when discussing his wish that family therapy had been offered:

> *Just so we're all on the same page...and just to point out that we're all sort of going to be dealing with this together, as opposed to each of us dealing with it poorly on our own* **30. 5.**

In the same way, Sarah, Sophie and Fiona also express a need for reassurance that they were responding in the 'right way' to the sibling:

> *If you're kind of given the information initially...that almost like you know you...you've done everything right* **Sarah. 25. 8.**

Lucy also fervently concurs with the need for family therapy following a suicide attempt, but she believes that participation should be optional:

> *They don't have to take it up, that's fair enough um...but when one of their relatives is in psychiatric, to offer therapy for the whole family would be fantastic* **22. 10.**

Sophie however, discusses a need for *individual* therapy in the immediate aftermath:

> *Where you vent all the somewhat more socially unacceptable feelings of anger* **24. 13.**

Followed by:

> *A sort of family oriented forum, where we can see and discuss the impact it has on each other might have been really useful* **24. 14.**

Sophie's comments suggest discomfort in revealing her strong, angry feelings to her family, preferring family therapy to be offered later on, once the strength of her feelings have abated. Her response can be likened to a study of siblings of people with

psychosis (Sin et al., 2008), which revealed siblings' inhibition of their feelings in family support groups, to avoid upsetting their parents.

D.3.2 Information and guidance

Receiving practical information or education about how best to respond to a suicide attempt, and how to manage the sibling's ongoing behaviour appears important to some of the participants. This is also persistently reported in literature regarding mental illness and families, (e.g. Sin et al., 2008). Sarah would have welcomed some data, which appears to have been motivated by fear of another attempt:

> *I'm sure there must be some statistics about the number of people who attempt once who then go on to succeed* **25. 7.**

Whilst James would have liked information about his brother's mental illness:

> *I don't know a whole lot about his um mental disorder or um...what he's gone through in therapy or otherwise um (pause 2 secs) and I think that would be good to know right?* **28. 13.**

Since there is a strong perception in the accounts that families feared another suicide attempt, some participants wanted some prescriptive guidance on how to prevent this:

> *And also some guidance on um how to deal with him when (...) things do get bad (...) and noone ever told us how to deal with that* **James. 29. 13.**

There is a perception of abandonment by the mental health services in James' account, which is also reflected by Sophie:

> *You're left to flounder, knowing all the while that everything you're doing could be making things worse* **23. 14.**

Sophie goes on to say:

What I would have wanted most was for someone to sit down and say "look, this is how to respond in this situation" (...) and to guide me through, just sort of getting through it **23.16.**

Similarly, Fiona also describes a lack of guidance in how to respond effectively to her sister's ongoing behaviour:

Nobody said you know, "this is what you need to do, this is how you can help her" **24. 4.**

These findings support those of Magne-Ingvar and Öjehagen (1999a), who describe siblings' unmet needs for guidance in effective communication with the attempter following the suicide attempt.

Synthesis

Introduction

The research aims were to explore the thoughts, feelings and experiences of people whose sibling has attempted, but not completed suicide. Ambiguity permeates the accounts, generating a complexity to the analysis. For example, it was difficult at times to distinguish the impact of the suicide attempt from the sibling's ongoing psychological problems or mental illness.

This ambiguity also pervades the feelings that participants experienced, and the roles and changes in their family. For example, some participants expressed difficulty in attributing changes solely to the attempt, or denied that they were significant, but then went on to describe noteworthy differences following the attempt. Since this was not a controlled study, it is difficult to know whether families were functioning in a similar way previously, and therefore if the attempt marked little difference to family circumstances. This illustrates the complex relationship between suicide, mental illness and family dynamics, and indicates that in such a multifaceted subject, simple

causal attributions cannot and should not be made. As a consequence, there is some overlap between themes.

IPA is committed to the exploration of the phenomenological experience, aiming to capture the meanings of participants' lifeworlds, rather than seeking to generate explanatory models and theories. Nevertheless, a schematic representation of the key themes from the analysis is presented to clarify the findings (see appendix S). However, it should be borne in mind that in line with IPA, this is a representation of an interpretation of how the participants typically *construed* their experiences, rather than claiming to be a definitive reality.

Grief, loss and 'unfinished business'

It is argued that a sense of 'unfinished business' threads through the accounts, largely reflected in the unfinished nature of the grief feelings. However, this lack of completion is also mirrored in the suicide attempt itself, in the communication within the families, and in the professional help that the participants received. There is a sense that they were left with their difficult feelings, with no guidance about how to manage or resolve them. The participants' sense of isolation and abandonment from professionals also mirrors that of incomplete grief feelings.

The experience of unfinished grief feelings resonates with Worden's concept of complicated mourning, when successful adaptation to loss is hindered (Worden, 2009). This assertion of ongoing grief is strengthened by the presentation of the participants during the interviews, with many becoming tearful when describing their experiences, despite the suicide attempt typically happening a long time ago. Furthermore, their comments after the interviews suggested that they were still trying to understand their experiences.

As previously mentioned, one influential theorist in the field of grief and loss is J. William Worden. Worden (2009) criticises stage theories of grief (e.g. Kübler-Ross, 1969) for being overly rigid and prescriptive, and phase theories (e.g. Parkes, 1972) for suggesting that mourning is passive, with little control over the process. Instead, Worden was originally influenced by Freud's concept of mourning, which involves

working through grief, and drew on a range of theories, such as Bowlby's theory of attachment and loss, which views grief as an innate response to the loss of an object of attachment (Bowlby, 1980). Worden (1982) proposed that bereaved people need to work through four 'tasks of mourning', in order to be able to adapt successfully to the loss. Countering criticism that his model was no more than an outdated series of stages and in keeping with research developments, Worden argues that critics lack understanding of his model and its subsequent refinements, and has provided further clarification since his original formulation (Worden, 2009).

Knowing when grief is 'finished' is in many ways an unanswerable question (Worden, 2009). Some theorists suggest that this occurs when the grief phases have been completed (e.g. Parkes, 1972), whilst Worden asserts that it happens when the tasks of mourning have been accomplished. At the same time, he acknowledges the sense that mourning is never-ending (Worden, 2009). Nevertheless, Worden (2009) posits that failure to work through all four tasks of mourning results in complicated grief, of which he identifies four types. One of these, the notion of 'chronic grief', described as a process of prolonged mourning with no adequate conclusion, particularly resonates with the findings in this study. Furthermore, Worden (2009) suggests that loss to suicide often involves complicated grief.

There has been considerable cogitation and debate over the nature of unresolved grief in the last couple of decades (Humphrey & Zimpfer, 1996). Worden (2009) describes the difficulty of reaching a diagnostic consensus of complicated mourning for the upcoming Diagnostic and Statistical Manual of Mental Disorders (*DSM-V*), and even the label it should be assigned (complicated grief, unresolved grief, abnormal grief, pathological grief?). The author concurs with criticism of the manual's generalisation of grief and its failure to appreciate its individuality (Worden, 2009). Furthermore, it is argued that the current criteria (*DSM-IV*, APA, 1994) pathologises grief, and is restrictive, overly focusing on depressive symptoms.

There are various reasons why Worden's theory of grief has largely been chosen to contextualise the study's findings. Firstly, Worden's assertions resonate the most strongly with the findings, in particular his description of complicated grief, of which he provides a detailed explanation. In addition, he pays significant attention to losses

such as suicide, with his work drawing on a broad range of theories, providing a comprehensive basis. Furthermore, he is widely respected in the field of grief and loss, with his model grounded in both clinical and empirical studies. It is argued that this provides a sound evidence-base, unlike other theorists such as Kübler-Ross and Freud, whose assertions were based on subjective interpretations from their work. Moreover, Worden has kept abreast of emerging research and subsequently refined his model to reflect these developments, which in the author's opinion demonstrates an adaptability which is necessary in theoretical work. Finally, Worden's model aims to provide a practical framework for bereavement counselling (Humphrey & Zimpfer, 1996). Since one of the purposes of the research is to consider how it can contribute to knowledge for Counselling Psychologists and to better inform their work, it is argued that Worden's model appears even more relevant for contextualising the study's findings.

Grief feelings relate to many losses that the participants experienced following the attempt, which is also reflected in research on siblings of people with mental illness (Lukens et al., 2004). The loss of the taken-for-granted assumption that their sibling will go on living was predominant, evoking persistent feelings of worry, permeating the communication and relationships within the family. Unlike literature that reveals families fear that they may experience their own feelings of suicidality following the completed suicide of loved ones (e.g. Wertheimer, 2001), the prominent worry for the participants in this study was that their sibling may re-attempt suicide in the future, and this time be successful. This resembles literature such as Wertheimer (2001) who posit that those who experience completed suicide fear a further suicide within the family. Worden's (2009) assertion that ongoing anxiety hinders the processing of task II of mourning (to process the pain of grief), therefore suggests that participants experienced difficulty in moving through the grieving process.

Worden (2009) also posits that relational factors, such as an ambivalent relationship with the deceased and unexpressed resentment indicates difficulty in adjusting to loss, which also strongly resonates with the research findings. Indeed, a volume of literature suggests that ambivalence with the lost person is a key characteristic of complicated grief (Humphrey & Zimpfer, 1996). Consistent with studies showing ambivalent feelings in families following mental illness or suicide (e.g. Jones, 2002),

participants described conflicting feelings regarding their sibling, with a double-bind of worry and wanting to protect them, but also wanting to shield themselves from further emotional pain. Bound up in this ambivalence were unacknowledged feelings of anger towards the sibling. In their study of siblings of people who had completed suicide, Tekavcic–Grad and Zavasknik (1992) found initial repressed feelings of anger, and like Worden (2009), suggest that unless angry feelings are acknowledged and explored following a suicide, feelings of grief cannot be fully worked through. Since it appears that participants were largely reluctant to acknowledge or express their angry feelings towards their sibling, with anger instead directed at other people (such as parents or professionals), this lends weight to the argument of the unfinished nature of their grief. Furthermore, Jones' (2002) qualitative study of relatives of individuals with severe mental illness describes a complex loss response, partially attributable to feelings of anger and to the relative still being alive, also resonating with the findings of this research.

Echoing a common response to completed suicide (e.g. Wertheimer, 2001), perhaps the most significant factor in these unresolved grief feelings is the lack of explanation to the question "Why did my sibling attempt suicide?", which often persists to this day. Although with completed suicide the deceased is not alive to give their reasons for their actions, in this study the attempters were still alive but were generally unwilling or unable to provide explanations, which impeded the participants from making sense of it even years later. This resulted in the same sense of 'unfinished business' and secrecy around the attempt. Furthermore, fear that the sibling would re-attempt suicide perpetuates this uncertainty and lack of resolution. This resonates with 'ambiguous loss' (Boss, 1999) when the ambiguity and uncertainty about whether a loss is temporary or final inhibits the ability to make sense of it, resulting in unresolved feelings of grief. The attempter's lack of communication is also reflected by Magne-Ingvar and Öjehagen (1999a), in a rare follow-up study of significant others of people who had attempted suicide. Worden (2009) posits that finding meaning in the loss is an important part of task III, and failure to do so contributes to difficulty adjusting to loss, which gives further credence to the author's argument.

Connected to this lack of explanation for the attempt were feelings of guilt and shame within the participants and their families, (discussed more fully further on in the synthesis). Whilst it is generally accepted that these emotions are common within grief experience, many theorists believe that they are particularly intense or prolonged in families with completed suicides (e.g. Kaslow & Aronson, 2004). Worden (2009) discusses how guilt and shame can result in complicated grief responses, and similarly, Boss (1999) also discusses how loss involving stigma hinders the grief process. Suicide is arguably a stigmatised topic, an 'unspeakable loss' (Lazare, 1979), and since guilt and shame pervade the accounts, it can be reasoned that the strength of these feelings also points to an interrupted mourning process within the participants.

The third task of mourning concerns an adjustment to a world *without* the deceased (Worden, 2009), and it is argued that this is even more difficult for the research participants since they have had to adjust to a world of losses in which the attempter is still *alive*. External adjustments that need to be made include adapting to roles and finding something positive from the loss (Worden, 2009). In this study, the attempter frequently gained or maintained a powerful position in the family as the 'sick one', around which family interactions and roles revolved, which appeared to be frequently perpetuated by his or her ongoing psychological problems. Although these roles led to secondary gains and improvements in family relationships for some family members, such as increased allegiance or power within the family, it is argued that these dynamics reinforced the cautious behaviour and maintained the unhelpful familial status quo. In his influential theory of family systems, Bowen (1978) asserts that the family is a homeostatic unit in which all members are interdependent, resisting change in its effort to maintain equilibrium. It is therefore surmised that a fear of loss of these new roles could also account for this sense of impasse within the families. Furthermore, the change in family roles following the attempt can also be viewed as a loss of normalcy, which still continues and inhibits feelings from being resolved. Nevertheless, some participants expressed some positive consequences of the attempt, which suggests that elements of Worden's task were accomplished by some of the individuals.

Worden (2009) discusses the commonality of distorted thinking in families of people who have completed suicide, in which the suicide is denied, creating a family myth in which anyone who voices the true cause of death must endure the family's anger. If these dynamics continue over time, it is unhelpful and impedes adjustment to the loss. It is argued that this reluctance to address reality is similar to the findings of this study, in which the families' common reluctance to discuss the attempt in emotional terms, or to challenge the attempter appeared to be motivated by a fear that it would prompt a re-attempt, analogous to 'magical thinking'. There was a perception that parents in particular were so fearful of future loss that they were psychologically frozen in time, yet this was seldom discussed. Their struggle to make internal adjustments influenced their sense of self-efficacy and self-identity, maintaining a sense of helplessness and preventing a successful working through of the third task of mourning (Worden, 2009). The perception of the parents' continuing capitulation to the attempter led many participants to feel frustrated with their parents, and resentful of their sibling. Furthermore, some participants found themselves caught in a double-bind; collude with the sense of unreality and denial in the family to maintain the status quo, or speak out against it and risk isolation or frustration. It can therefore be argued that the participants experienced a further loss; loss of the power to speak out about what is going on in the family, and this lack of communication and expression of feelings maintained the loss of reality in some of the families. Furthermore, it is surmised that the common suppression of feelings and reluctance to accept support from others shows a lack of active coping style within some of the families, impeding the adjustment to the loss (Worden, 2009).

Additionally, Worden (2009) cites studies showing how unresolved loss and grief from previous generations can hinder the current grief process (Paul & Grosser, 1965; Walsh & McGoldrick, 1991). Since the attempt prompted revelations of hidden suicidality in previous generations in some of the families, this further strengthens the argument for unresolved grief in the research.

In contrast to discussing grief as a *response* to a sibling's suicide attempt, it is argued that it could also be a possible *cause* of an attempt. The reasons for the suicide attempts are unknown in the accounts and the focus is on the sibling, rather than the attempter. However, Zisook and Lyons (1990) revealed that feelings of unresolved

grief were related to attempted suicide in a sample of psychiatric patients. Furthermore, several participants in the current study speculated that experiences of loss could have possibly contributed to their sibling's suicide attempt. Therefore, it can be surmised that grief and loss are connected to a suicide attempt, both in the sense of impact and cause.

Despite considerable resonance with this study, elements of Worden's model do not adequately account for some of the findings. His assertion that in chronic grief, the individual is conscious that they are not moving through their grief is not borne out in this research. It is also argued that occasionally Worden's assertions seem dogmatic, such as suggestions that loved ones of suicide completers act in self-punishing ways, experiencing social problems such as alcoholism. In the author's opinion, this does not fit experiences of the participants in this study, who despite the difficult circumstances, showed considerable resilience following the attempt.

An example of their resilience is the perception that occasional avoidance of feelings was necessary to continue with daily lives, or to withstand the sibling's ongoing problematic behaviour. In his original model, Worden (1982) however, describes cutting off painful feelings as contrary to the second mourning task. The author challenges Worden's previous view that temporarily avoiding feelings of grief is dysfunctional, and that grief occurs in a vacuum. Instead, it appeared that sometimes compartmentalising their feelings was a necessary strategy for the participants, so that they could successfully continue with their university studies and work, and was therefore a form of resilience. Indeed, it seems that a dual process model of coping with bereavement (Stroebe & Schut, 1999) is more relevant in this aspect. They propose that people engage in both loss-oriented coping (facing and working through their grief), and restoration-oriented coping (adjusting to secondary losses, involving coping with the practicalities of daily life). Stroebe and Schut (1999) assert that whilst there is some overlap with Worden's model, the bereaved person also needs some respite from their painful feelings. Therefore, they consider that dynamically oscillating between the two coping strategies is an adaptive process, which enables the bereaved person to continue with practicalities of daily life, providing avoidance is not excessive or relentless (Stroebe & Schut, 1999). This theory challenges previous bereavement models, and instead asserts that grief is a fluid process, varying between

genders and cultures. A further strength is that it has been subjected to empirical testing and refinement, and continues to generate exciting developments (Carr, 2010). However, it does not determine what comprises oscillation, nor does it identify the optimum balance between the two coping strategies (Carr, 2010).

Worden (2009) claims that that there is now little difference between his assertions and those of the dual process model, but that the latter is too rigid in its assertion that one cannot engage in both loss feelings and everyday coping simultaneously. Although the models of both Worden and Stroebe and Schut are particularly useful in considering this study's findings, the author contends that the loss experiences of siblings are complex and overlapping. There is no one theory that completely captures the grief experiences of the participants, and although there is some literature on the effect of completed suicide on siblings, there is no theory that is specific to that of *attempted* suicide. This suggests that although the subject of attempted suicide and siblings should be an area for future research, the uniqueness of this experience does not and should not be confined to one single theory.

Shame and guilt

Feelings of shame pervade the participants' narratives, and like the nature of the emotion itself, it often seems hidden and is seldom articulated, but is nonetheless implicit within the accounts. Indeed, it is argued that some participants were ashamed of their shame.

Despite the existence of considerable literature on shame and guilt across all disciplines, there appears to be a lack of universal agreement about what constitutes these emotions. Terms have frequently been used interchangeably, which is also reflected by the participants in the current study. Tangney and Dearing (2002) assert that although early psychoanalytic theorists gave consideration to shame and guilt, they frequently overlooked the distinction between the two emotions. In Freud's earlier work, shame was viewed as a defensive reaction against sexually exhibitionistic impulses, whilst his later focus on guilt viewed this emotion as developing from a conflict between id or ego impulses and behaviour and the superego (moral standards) (Tangney & Dearing, 2002). Freud's work has drawn

criticism from a number of sources. For example, Tangney and Dearing (2002) argue that his later work overly focused on the emotion of guilt at the expense of shame, and that this preoccupation with guilt caused him to wrongly identify his patients' shame experiences as guilt experiences (Lewis, 1971). Following an increasing interest in the emotion of shame, it is argued that more recent psychoanalytical theorists are now overly focusing on shame rather than guilt, so that once again the differences between the emotions are becoming obscured (Tangney & Dearing, 2002).

In 1971, a psychoanalyst, Helen Block Lewis published an immensely influential piece of work concerning this topic. She sought to distinguish guilt from shame, with her assertions based on empirical studies and clinical observations. Lewis (1971) described shame as developing from a negative self-evaluation of the *self*, whilst guilt emerges from the self's negative appraisal of a particular *behaviour*. Opposing the anthropological view of shame as a public experience versus guilt occurring privately (e.g. Benedict, 1946), Lewis (1971) asserted that it is one's understanding of the situation rather than the situation itself that gives rise to these emotions. Furthermore, reviews and empirical studies appear to corroborate Lewis' definition of guilt and shame (Tangney & Dearing, 2002). Drawing on attribution theory, and comparable to characterological versus behavioural self-blame in trauma theory (Janoff-Bulman, 1979), Tangney and Dearing (2002) contend that guilt feelings are likely to be more adaptive and helpful than those of shame, since they relate to specific behaviour that can be changed in the future, and not viewed as representative of one's character.

The author argues that the works of Lewis (1971) and Tangney and Dearing (2002) are particularly persuasive to contextualise the discussion of the findings. Firstly, the findings of the current study resonate with their distinction between guilt and shame. Furthermore, it appears that there is substantive empirical work (both quantitative and qualitative) that also supports their theories. In addition, the work of both Lewis and Tangney and Dearing are highly regarded in this field, with the latter in particular drawing on a broad range of perspectives. Nevertheless, there are criticisms, such as the failure of Tangney and Dearing (2002) to sufficiently explore gender, class and cultural differences (Clark, 2003).

In this study, guilt and shame were a significant response to the attempt, with some participants blaming themselves and experiencing a sense of dysfunctionality as a family. This accords with much research (e.g. Kaslow & Aronson, 2004) which shows that these feelings are particularly prominent in families after a member has completed suicide. Participants' narratives appeared to support the distinction of guilt relating to a behaviour and shame relating to the self (Lewis, 1971). For example, the word 'guilt' was used when they discussed what they *did* or *did not do* as *individuals* in events leading up to the suicide attempt, whilst describing a sense of regret and preoccupation with their actions. Contrastingly, when the participants described a sense of shame, it was normally in their discourse of *family* identity. It is therefore argued that the interpretation of 'self' and shame in this study concerns not the individual self, but is in the context of a family unit as 'self'.

There also appears to be an underlying undercurrent of shame imbuing mastertheme C, where alongside worry, feelings of shame appeared to underlie the secrecy and hindered communication in the families. It was unclear whether the attempters' common reluctance to discuss the attempt was due to shame, pain or power. However, Wiklander et al. (2003) suggest that suicide attempters experience feelings of guilt or shame at their actions. Although only one participant directly attributed her sibling's reticence to this emotion, (the word 'embarrassment' was occasionally used by others), it could be inferred that shame was possibly a barrier to the attempters' communication in the families, and that this silence was a way of escaping the shameful situation (Lewis, 1971). Unfortunately, this unacknowledged shame resulted in a lack of explanation for the attempt, impeding the participant from making sense of it, and preventing a resolution of grief feelings including worry, shame and guilt. Although it can be speculated that the attempters also experienced guilt at what they *did*, the argument that shame was more prevalent than guilt is strengthened by the perceived lack of desire for reparation for their actions (Lewis, 1971).

Keeping the attempt secret from other family members was common in the accounts, and was partly attributed to a desire to protect other family members from distress. However, it is suggested that the families' silence and denial is analogous to the desire to hide or escape after being 'exposed' (Lewis, 1971), and that therefore shame was also a contributing factor in this secrecy. Furthermore, secrecy related to other

relatives' avoidance of questioning the circumstances surrounding the attempter, echoing the 'shared obliviousness' sometimes found in families (Rosenblatt, 2009). However, the price that is paid for colluding with this secret is the internal conflict that it created in some participants, with a familial division between those who know 'the secret' and those who do not (Imber-Black, 1993). Since the attempt prompted a disclosure in some of the families of previous suicidality in other relatives, it is also suggested that shame was intergenerational in this study.

Interestingly, there appeared to be less secrecy outside of the family, with many participants confiding in friends about the attempt. However, they described limiting their disclosure to those who would be empathic to the situation, such as friends who had undergone a similar experience. Hastings, Northman and Tangney (2000) theorise that people experiencing shame are frequently preoccupied with concerns of other's negative judgements. Furthermore, they suggest that the shame and stigma related to suicide may cause others to shun the family left behind (Hastings et al., 2000). Therefore, although the attempter had not completed suicide, it could be interpreted that both participants and their parents could have feared a rejection from others, prompting their silence and limited disclosure to empathic friends. This response also resonates with 'information control' and the sociological viewpoint of 'courtesy stigma', which is experienced by people connected to stigmatised individuals (Goffman, 1963). Therefore, maintaining secrecy about the suicide attempt was a possible means of avoiding courtesy stigma, and therefore shame, resonating with mental illness literature (e.g. Jones, 2002). The irony is however, that the isolation that participants and their families feared then became the reality that they experienced. Furthermore, it is proposed that the helplessness that accompanies feelings of shame (Lewis, 1971) was reflected in the continuing impasse in families that emanates from the accounts.

The theme of hidden anger frequently appeared throughout the narratives, particularly concerning the participants' feelings towards the attempter, and also towards their parents for their perceived acquiescence to the attempter. However, this anger was rarely verbalised to the appropriate individual, which was partly due to the worry that it would prompt a re-attempt, and was also perhaps indicative of the communication style in some of the families. Since some participants seemed reluctant to even name

their anger in the interviews, it could be speculated that participants were ashamed of their angry feelings, comparable to those bereaved by completed suicide (Wertheimer, 2001). Tangney and Dearing (2002) theorise that unacknowledged shame can transform into anger, in that externalising blame may be a way for a shamed individual to preserve their ego defence and retain some power. Based on this interpretation, it could be construed that the anger directed at others, present across the accounts could perhaps be masking underlying feelings of shame.

Shame also permeated the mastertheme of experience of professional help. It prevented the seeking out of resources for several individuals, which resonates with research of mental illness and families (Jones, 2002). More implicitly, shame appeared to negatively influence the views of receiving psychotherapy for some participants. Tangney and Dearing (2002) theorise that people who experience shame may ascribe their feelings to those who they believe are disapproving. Therefore, an alternative interpretation of some participants' experiences of feeling judged by professionals could be that that they were projecting their *own* feelings of shame onto mental health personnel. Nonetheless, shame in seeking help, alongside the stigma of suicide appeared to be barriers to utilising professional support services, and concurs with Hastings et al. (2000) who assert that shame may cause family members who are bereaved by suicide to rebuff potentially supportive others. However, like secrecy, shame appeared to lead to families being isolated in their difficulties.

Tangney and Dearing (2002) and Lewis (1971) describe shame as a more painful emotion than guilt. In contrast, the participants' narratives and their emotional presentation when reflecting all these years later on their behaviour before the attempt, (guilt) challenges that assertion. However, the view that guilt can be maladaptive when combined with shame (Tangney & Dearing, 2002), could account for the continuing pain that is implied in the participants' narratives. It could also be argued that the lack of explanation for the attempt could contribute to the participants' inability to 'make amends' and therefore resolve their guilt feelings, which could also contribute to the sense of pain interpreted in their accounts. The immense familial efforts to maintain secrecy described in the accounts suggests that shame is a very painful emotion, against which they must be shielded.

Since Lewis (1971) suggests that shame induces a wish to escape the self, for some people suicide could signify the greatest escape (Hastings et al., 2000). On this basis, although the reasons for the suicide attempts were largely unknown in the study, it could be surmised that shame was a possible contributing factor in the siblings' suicidal behaviour. Therefore, the author suggests that like unresolved grief, shame is both a possible consequence and contributory cause of the suicide attempts in this research.

Conclusion

The findings of the research suggest that there is little difference between the impact of attempted suicide and that of completed suicide for siblings of suicide attempters. Indeed, it could be argued that attempted suicide generates greater distress due to its unresolved and ongoing nature, and indeed, feelings of grief, guilt and shame appeared just as comparable.

The study suggests overwhelmingly a lack of professional support was offered to siblings and their families, with an identified need for family therapy and psychoeducation. Despite this difficult situation, resilience imbued the narratives, with some participants identifying positive consequences of the attempt. Indeed, it is proposed that some siblings appeared to have reached some form of acceptance of the suicide attempt, whilst their families struggle to adjust to the losses, suggesting that they are at different points of the grief process. Therefore, it is posited that it is often the family's *continuing* response that causes friction and leads to a negative impact on the family. This accords with Dyregrov (n.d.), who asserts that asynchronous responses following grief or trauma can lead to family discord.

Although factors maintaining unresolved grief and negative changes have emerged from the analysis, the factors for positive change following a sibling's suicide attempt are somewhat more complicated, and present a challenge to Counselling Psychologists. What emerges from the accounts is the ambiguity and complexity of this subject area. Whilst there are similarities between participants' experiences, there are also differences, underlining that there is no one size that fits all. Therefore, a

reductionist stance which seeks to generalise sibling's experiences of attempted suicide should be avoided.

The study's contribution to existing academic research

Due to the paucity of qualitative postvention research on siblings and attempted suicide (Beautrais, 2004), this study contributes novel findings to an under-researched area and adds depth to quantitative findings. Consistent with the structure throughout this report, the author contextualises the findings alongside literature on attempted suicide, completed suicide and mental illness in families. Since a lateral perspective has been taken to locate the findings, it is beyond the scope of this report to describe all literature in these areas, including that of family systems theory. Therefore, the author presents a selection of this literature for discussion, based on some of the main outcomes of the findings of this report.

Findings from this study resonate with literature on mental illness in families, and particularly strongly with the impact of completed suicide in families. It also challenges some of the historical literature that views mental illness in families as a wholly negative experience.

The theme of unresolved grief echoes literature on mothers of suicidal adolescents (Daly, 2005), mental illness and siblings (Marsh & Dickens, 1997), and mental illness and family members (Jones, 2002). The findings also support the study by Riebschleger (1991) which revealed that participants grieved for their siblings with mental illness.

The stigma, guilt and lack of family communication present in the accounts is also illustrated by Vuokila-Oikkonen, Janhonen and Nikkonen (2002), in discussing patients and attempted suicide, and reflected in qualitative research on completed suicide and families (Fielden, 2003). Similarly, Dyregrov and Dyregrov (2005) described guilt and communication problems in siblings of people who have completed suicide, whilst content analysis of German caregivers of people with

mental illness also revealed feelings of shame and stigma (Schmid, Spiessl & Cording, 2005). Research by Tzeng and Lipson (2004) which suggested strong stigma experienced by families of suicide attempters in Taiwan, is also supported by the current study.

Strong feelings and the emotional impact of attempted suicide also supports research on the effect of attempted suicide and parents (Daly, 2005; Wagner et al., 2000), and significant others (James & Hawton, 1985; Magne-Ingvar & Öjehagen, 1999b; Mishara, Houle & Lavoie, 2005). An American quantitative study six months after adolescent suicides also found that siblings were more likely to experience depression (Brent et al. 1993), and this is borne out in the current study to a moderate extent.

The sense of being overlooked and isolation within siblings is also present in qualitative research on completed suicide and siblings by Dyregrov and Dyregrov (2005). They found that siblings often felt isolated since their parents were preoccupied with their own grief, which is also echoed by literature such as Wertheimer (2001).

The participants' need for more support from professionals supports many studies. For example, Magne-Ingvar and Öjehagen, (1999b) found that siblings of people who had attempted suicide expressed a need for counselling, as did other relatives (Talseth et al., 2001; Wagner et al., 2000). Continuing with the theme of attempted suicide, James and Hawton (1985) and Mishara et al. (2005) also suggest that emotional support and normalisation of feelings can benefit relatives of suicide attempters. The findings of this study also resonate with Schmid et al. (2005), who found that a lack of information was given to caregivers of people with mental illness, and with Dyregrov and Dyregrov (2005), who revealed that siblings need more support following completed suicide of their brother or sister. The findings of this study are also borne out by the mental health charity Rethink, who recently established a support service for people affected by the mental illness of their siblings, following an overwhelming response to their survey of siblings' needs (Rethink, 2007).

Despite lending weight to many studies of attempted and completed suicide, and of mental illness in families, the findings of this research either challenge some studies,

or there is difficulty in locating them within some research. For example, Wertheimer (2001) discusses family members' common fear of heredity of suicide. Similarly, Schmid et al. (2005) describe caregivers' concern of heredity of mental illness, and Stålberg et al. (2004) suggest siblings of people with mental illness fear also becoming mentally ill. Although some participants in the current study discuss familial suicidal behaviour, only one participant explicitly expresses genetic concerns, thereby challenging this literature. This is particularly pertinent since a recent study of attempted suicide in families with bipolar disorder suggests a possible link with suicidal behaviour (Willour et al., 2007).

It is also difficult to contextualise the findings with literature on the relationship between familial expressed emotion and mental illness, due to the complexity of the phenomenon, and the difficulty assessing family functioning from one family member's subjective opinion.

The resilience and positive changes described in this study also challenge some of the traditional literature that claims mental illness in families is a wholly negative experience. Moreover, this research partially supports an increasing focus in psychology on resilience in individuals, and literature which demonstrates strengths in siblings of people with mental illness (Kinsella & Anderson, 1996; Marsh & Dickens, 1997; Sin et al., 2008).

A final point that is worthy of note is that many of the suicide attempters in this study were male. This challenges the literature which states that more females than males attempt suicide (e.g. Cantor, 2000). Whilst this is an interesting observation, it should be remembered that the sample in this research was not representative, and therefore this finding cannot be generalised.

Implications for Counselling Psychologists and other professionals

Whilst it is tempting to be prescriptive with the outcome of the study, the complexity of the findings suggests that there are no easy answers for Counselling Psychologists.

It is impossible to do a controlled study with which to assess the best therapeutic outcome. However, one clear clinical implication is that following a suicide attempt, the needs of the sibling appear to be overlooked and should be addressed. In keeping with the ethos of Counselling Psychology, clinicians should view a sibling's suicide attempt as a unique and personal experience for those clients.

Although almost all of the suicide attempts in this study were reported to professionals, many go unreported (Kerkhof, 2000). This can be largely attributed to feelings of shame and guilt, therefore many siblings and families are not identified by professional services. This presents a challenge to Counselling Psychologists. One proposal is that further research and education should be brought into the public domain, with the aim of reducing the stigma associated with suicide. If the impact of suicide attempts was more prevalent in the literature, this could also increase families' knowledge of who may be at risk of suicidality in the family. Nevertheless, there is no short-term solution to this problem.

When a new client presents for therapy, Counselling Psychologists should pay great attention to mental illness in the family and be fully aware of suicidal behaviour, including that of siblings, by undertaking a thorough family history and risk assessment. Since guilt and shame are prevalent in the study, the therapist should initiate the enquiry into familial suicidal behaviour, to overcome possible reticence on the part of the client.

Another implication could be that when health care professionals do see someone who has recently attempted suicide, a full family history should be taken, including details of siblings. Similarly, Sin et al. (2008) recommend the use of a genogram, and that siblings' needs should be taken into account when seeing people with first-episode psychosis.

It would also be helpful if assessments could be undertaken with the family members, particularly with the sibling of the attempter. However, the author recognises that this is a desirable proposal and could be problematic. For example, the suicide attempter may live far away from the other family members.

Since the accounts reveal an impact on the mental health of some siblings, Counselling Psychologists should be aware of any possible signs of depression and anxiety. Furthermore, although PTSD is not an outcome from this study, one should be aware of any trauma symptomology, particularly if the sibling has witnessed the attempt or found the attempter in the immediate aftermath. Screening for PTSD and trauma-focused therapy should not be provided until a least a month after the attempt, although support can be made offered sooner (National Institute for Clinical Excellence [NICE], 2005). A risk assessment should also be routinely undertaken with the sibling, with sensitivity to the fact that issues of shame may inhibit admission of depression or suicidal thoughts themselves.

The findings of this study suggest that the meaning siblings of attempters attach to receiving professional help and to psychotherapy influences their decision to seek out and accept these resources. The implication of this may be that service providers should explore any possible feelings of shame or misconceptions within siblings, in order to facilitate acceptance of their resources, if required. Alternatively, written information regarding the nature of the support available and what it entails could be made readily available to siblings. For example, if the attempter is staying in a hospital ward, this information could be accessible in that location. Similarly, written, factual information regarding mental illness and common responses to a suicide attempt could be provided to siblings and their families, since this is a strong finding from the accounts. This supports NICE guidelines (2009) which recommends that written information should be provided to families on how to support an adult family member experiencing depression.

Additionally, health care professionals should be mindful of a possible sense of shame and isolation within families of people who have attempted suicide. Therefore, there should be an avoidance of appearing judgmental or excluding families, particularly siblings from the attempter's treatment. For example, siblings should be accommodated in any clinical meetings involving the family if they wish to attend, with effort made to value their opinions. However, the issue of patient confidentiality is delicate and provides a challenge. At the very least, professionals should be mindful of the sense of exclusion that this can create for the families, and respond in a way that is as sensitive and informative as possible. Counselling Psychologists should

ensure that they provide a fair and non-blaming atmosphere during any family therapy sessions that are offered.

Although much of the data in the study is reflected from on average, five years ago, a perusal of the NICE guidelines shows little difference currently in the attention paid to families, particularly siblings of people who have attempted suicide. Although NICE (2004) suggests families of people who have self-harmed should be offered support if needed, the guidelines stop short of recommending specific therapeutic interventions. Indeed, the closest that the UK's foremost institution for good practice and emotional support gets to considering families' therapeutic needs, is in their recommendations for family therapy for families of people with schizophrenia (NICE, 2009).

The findings of this study strongly suggest a need for family therapy to be offered following a sibling's suicide attempt, although implementing this could be problematic. For example, feelings of shame may prevent the take-up of this service, as per this study. An American quantitative study found that hospitalised suicidal adolescents were more willing to undertake individual therapy than family therapy sessions (King, Hovey, Brand, Wilson & Ghaziuddin, 1997). However, since the study indicates that siblings would like more emotional support, family therapy should still be made available. Indeed, the author contends that if family therapy was mandatory, this would overcome the family's reluctance to seek out help, and more families would have access to the support they may need. Since 5,706 suicides were recorded in the UK in 2008 (Office for National Statistics, 2010), with attempted suicides estimated to be twenty times higher (WHO, 2010), it can be assumed that a large number of families are affected by this act. It is therefore proposed that many families, particularly siblings may need some form of professional support but are not receiving it. Furthermore, professional support should be not just supportive to the family, but also helping to change unhelpful dynamics.

Additionally, since there appears to be an unmet need for guidance and information on how to respond to a suicide attempt and mental illness, this resource could be re-framed as a psychoeducational service, which may facilitate its acceptance. It should also be borne in mind that some siblings may initially prefer individual therapy to explore and express strong feelings, followed by family therapy if required.

If family therapy is offered, it could be tailored in a number of ways. For example, it could be used to improve communication and expression of feelings between family members, thus reducing secrecy and isolation within the family. However, there should be an awareness of the implicit rules by which families operate, which may impede change. The challenge for Counselling Psychologists is in overcoming these barriers and opening up the issues which families tend to suppress. The author suggests that Counselling Psychologists should be bold in raising these issues, to avoid being drawn into a possible 'conspiracy of silence' that may operate within the families. Similarly, Humphrey and Zimpfer (1996) discuss how this family silence should be broken with the aid of family therapy following suicide. At the same time, Counselling Psychologists should be mindful of the debate regarding the role of expressed emotion in families and mental illness (e.g. Hooley, 2007). Therefore, caution should be taken when facilitating the expression of emotions within families through systemic therapy.

Familial role conflicts could also be identified and explored, with a view to reducing the sibling's frequent parentified or peacemaker role in the family. Therefore, secondary gains of the suicide attempt or of the attempter's ongoing problems for all family members should be openly discussed in a non-blaming manner, to help address any unhelpful status quo being maintained. Similarly, psychoeducation could be provided about the complexity of suicidal behaviour, possibly reducing any 'magical thinking' that discussing the attempt will prompt a re-attempt. Furthermore, reassurance or education in how to respond to the attempter and addressing any overly-cautious behaviour could possibly reduce unhelpful family interactions. Above all, empathy and support should be offered to all family members during family therapy, since the findings suggest that they experience feelings of isolation and confusion.

However, in seeing a sibling of an attempter individually, Counselling Psychologists should consider the extent to which they can effect change in an unhealthy family system. At the very least, encouraging the client to reflect on familial communication difficulties, with the possibility that they could attempt to open up a dialogue within the family may be helpful.

A strong implication for Counselling Psychologists is that in seeing a client individually whose sibling has attempted suicide, it may also be necessary to help them to identify and work through unresolved feelings of grief. Therefore, an adequate training and understanding of complicated grief is required to support people in this situation. Furthermore, within family therapy, there should be an awareness that siblings may be at different points of the grieving process to other family members. In this situation, the Counselling Psychologist should open up a discussion about this, normalising feelings and facilitating an understanding between family members of the others' experiences.

Tangney and Dearing (2002) discuss the importance of therapists addressing shame within the client, and understanding the difference between that emotion and guilt. The author endorses this, and suggests that Counselling Psychologists should also be aware that shame may inhibit the client's expression of feelings, and that they may also be ashamed of their shame. Therefore, the client's feelings should be validated and normalised, within an empathic environment in which 'forbidden' feelings such as anger can be facilitated.

Similarly, Wagner et al. (2000) propose that therapists should educate parents of suicide attempters about the variety of feelings, with an awareness of ambivalent emotions, which again is echoed by the present study's findings. Since sibling relationships are characterised by ambivalence, and even more so after a suicide attempt, Counselling Psychologists should normalise these conflicting emotions and help the client to accept these, also advocated by Wertheimer (2001) following completed suicide.

The study reveals that a large factor inhibiting the grieving process for siblings is a lack of explanation for the attempt, and being unable to make sense of it. Therefore, an important goal for Counselling Psychologists is to help the client to come to terms with possibly never having the answers for which they are searching, and to find some path to acceptance, despite this. Similarly, Walsh (2007) asserts that there is often no absolute resolution to traumatic loss. Therefore, since the experiences described by the siblings in this study are analogous to traumatic loss, Counselling Psychologists

should help clients to come to terms with the fact that these feelings may never be fully resolved.

Of equal importance in the conclusions of this research is that Counselling Psychologists should also retain a focus on the resilience in siblings, and the protective factors that may alleviate the impact of a suicide attempt, such as having access to supportive friends, and continuing with daily activities. These findings support a recent general change of focus in psychology towards the resilience of clients, rather than purely their difficulties. Indeed, the author suggests that the competency model as advocated by Marsh and Lefley (1996), in relation to mental illness in families, could be a useful adjunct for Counselling Psychologists to support siblings of people who have attempted suicide.

Most importantly however, is that the client's experience of their sibling's suicide attempt is unique and personal to them. Therefore, Counselling Psychologists should ensure that they value and respect the client's story, and do not seek to generalise or make assumptions that their experience is the same as those of other siblings.

Strengths, limitations and suggestions for future research

Since the literature demonstrates a lack of attention paid to the sibling's experience, the research could be viewed as 'giving voice' to a neglected population, enabling participants to express their feelings, sometimes for the first time. All participants appeared to be trying to make sense of the attempt through the interview, and described it as cathartic and thought-provoking, demonstrating the value in focusing on the subjective experience through IPA. Furthermore, the semi-structured interviews advocated by IPA allowed for spontaneity and freedom in the accounts. Since Smith and Osborn (2003) assert that IPA is suited to areas that are novel and complex, it is argued that the research encompassed these qualities, and therefore illustrates the appropriateness of IPA. Furthermore, an advantage of employing IPA is that the interpretative element enabled a deeper analysis, for example, allowing the hidden emotion of shame to emerge in the findings. It appears that the aim of the study, which was to explore the thoughts, feelings and experience of someone whose

sibling has attempted suicide has been met. It is argued therefore that these findings demonstrate that IPA was the most effective methodology in capturing this experience, providing rich and in-depth accounts that would not have been yielded by quantitative methodologies. Furthermore, it is argued that IPA has captured the nuances that may have been overlooked by methodologies such as Grounded Theory.

Although the author maintains that IPA was appropriate for attempting to gain insight into the participant's subjective experience, Discourse Analysis could provide interesting findings at the societal level, and elucidate how language is used in the construction of their world. However, in view of the sensitivity of the topic and the lack of research in this area, the author contends that initially future research should continue to focus on the individual's lifeworld through the use of IPA, until there is further insight of the individual's experience. Other methodologies could then also be employed to broaden the focus. For example, Grounded Theory could be used to generate a theory of the experience of people whose sibling has attempted suicide, and to help our understanding of the social processes involved. This theory could then have a wider impact on decisions for service provision. Nevertheless, one should not lose sight of the fact that a sibling attempting suicide is an event that is unique to the individual, and caution should be taken in constructing models and generalising this experience.

It is hoped that by providing novel, qualitative research in this area, it may stimulate further studies, leading to better service provision for siblings in the future. Furthermore, the findings suggest significant implications for Counselling Psychologists and other professionals.

However, there are some limitations to the study. Firstly, the sample was small and homogenous and cannot be generalised to a larger population. However, due to the dearth of research in this area, it is hoped that this study draws attention to some siblings' experiences and stimulates further research, perhaps expanding to larger, more diverse populations in the future. It could be argued that the sample is self-selecting, and therefore only siblings who had a 'story to tell' volunteered to participate.

It is also acknowledged that the participants' accounts are retrospective, and therefore their recall is susceptible to possible inaccuracies. Since the suicide attempts were some time ago, there is a possibility that the availability of professional resources may have since changed. However, the most recent NICE Guidelines do not provide specific recommendations for siblings or families of people who have attempted suicide, and the author's clinical experience suggests that this professional support is still currently lacking.

At the time of the interviews, the ethical concerns for the participants were prioritised. Based on the rationale previously described, it was decided that a minimum two year period since the attempt was necessary for participation. Future research could examine participants' experiences closer to the time of the attempt, which may help to eliminate any distortions in recall, and possibly capture a more intense emotional experience. If this entails problematic ethical issues, one idea could be to ask participants to record experiences through diaries over time. Several participants commented that they could have sought out information on the internet to inform themselves, but it was not so widely available at the time of the attempt. It would be interesting to observe whether the current increased availability of internet information satisfies some of the unmet needs of families who have experienced more recent suicide attempts.

It is also acknowledged that the experiences in this study are highly emotive, and as such, language is a blunt tool with which to access the participants' lifeworlds. Willig (2008) argues that language may be inadequate in capturing the complexity of the participant's experience, and that its constructive quality impedes the representation of the experience. She also queries the suitability of accounts, questioning how effective participants can be in conveying the full richness of their experience, to achieve the phenomenological aspect of IPA (Willig, 2008). On this point, the author concurs with Willig's assertion of the possible exclusion of participants who have difficulty verbalising their experiences. Despite the fact that participants in this study were articulate and well-educated, it is acknowledged that the intensely emotive nature of the experience could have been difficult to convey in words. However, once again, reference is made to the recognition that through IPA one can only learn

something of the participant's lifeworld, and that direct access to that experience is impossible (Eatough & Smith, 2006). Furthermore, it is argued that the issue of language would apply to many methodologies, and is not just exclusive to IPA. Nevertheless, Willig's point is a continuing challenge for phenomenological researchers.

A further criticism of IPA is that it is concerned with the participant's cognitions rather than the 'lived experience' which should be characteristic of phenomenological research (Willig, 2008). In response, Smith et al. (2009) argue that IPA views cognitions, not as separate processes as suggested in cognitive psychology, but rather that they are complex, involved in meaning-making, and are part of 'being-in-the-world'. Furthermore, cognitions enhance our understanding of how one makes sense of their world (Eatough and Smith, 2008).

Based on the epistemological position of the study, one should bear in mind that the familial themes in the research originate from the participants' *perceptions* of the family dynamics. Additionally, it should be remembered that IPA involves the *researcher's* interpretation of the analysis, and that there is a possibility of any number of interpretations of the accounts.

Due to the restrictive recruitment criteria, there were several participants whose siblings had attempted suicide more than once, or had subsequently been diagnosed with mental illness. Therefore, it was difficult to isolate changes purely to the attempt. However, this has been acknowledged and illustrates the complexity of the phenomenon being studied.

Since there are few qualitative studies of the impact of attempted suicide on siblings, there is much scope for this study to be replicated and extended. Since the participants were mainly white, British and well-educated, it would be useful to extend the research cross-culturally and to different educational levels and religious beliefs. Future research could be undertaken with more male participants to explore possible gender differences. Furthermore, other age groups for both participants and the attempters could also be studied, to investigate any possible influences from other

stages of the family life cycle. Longitudinal studies could also enhance the richness of the data. Since most of the participants were older than their siblings who had attempted suicide, it would be interesting to include a greater variety of birth orders, for example to see whether this influences the experience of parentified family roles. Expanding contexts, such as studying those who are living with their sibling at the time of the attempt, or those who witness or find their sibling after the attempt, (accounting for ethical issues) would also be interesting. This study was concerned with understanding the sibling's perspective, rather than a focus on family systems theory. However, examining the impact through a family systems approach would be another fertile avenue for research.

Willig (2008) discusses the importance of personal and epistemological reflexivity in qualitative research, and the author has endeavoured to include these reflections throughout the report. The following extract taken from the author's reflective diary presents some of her final thoughts:

In considering how I may have shaped the research, the title of the study implicates the participants' experiences of their family, as do some of the interview questions. A completely unstructured interview, with the question "what was your experience of your sibling attempting suicide?" may have yielded different findings, although I suspect that themes relating to family dynamics would still have emerged.

Furthermore, Willig (2008) discusses the constructive element of rhetoric, and how specific questions will define the answers given. For example, I introduced a temporal element to the findings by asking participants about their relationships both at the time of the attempt and now. I therefore acknowledge that my questions have helped to guide the findings that have emerged. However, the participants were also given the opportunity to introduce any other elements of their experience that they so wished, and encouraged to expand on any points that arose. Therefore, the findings were not wholly guided by the interview questions.

I also acknowledge that although I tried to bracket some of my assumptions, that it is impossible for the researcher not to bring some of the self to the research, and that this would have influenced the themes that emerged. Therefore, I recognise that other

interpretations of the accounts are possible and valid, which could be challenged by researchers from a different epistemological position. For example, a researcher who is concerned with trying to obtain an objective reality may choose to approach the study by interviewing multiple family members, in an attempt to get to the 'truth' of the impact of a suicide attempt.

Reflections on the experience of conducting research: its challenges, opportunities and tensions within the Counselling Psychologist practitioner role

Undertaking research has been a challenging role, which at times has felt in conflict with my role as a clinician as a Counselling Psychologist, but at other times a valuable experience. During the research process, I found that skills required as a clinician, such as being empathic, building a rapport, and retaining a curiosity about the client were also applicable when interviewing participants. Therefore, I felt that my clinical experience facilitated the interview process. However, it was challenging to stay in the 'interviewer' mode and to not enter into the 'therapist' role during the interviews, especially as the subject matter was so emotive.

It was also difficult 'leaving' the participants with their feelings after the interview, and being unable to offer a subsequent therapeutic session to help process these emotions, which would be part of my role as a clinician. However, in accordance with BPS Professional Practice Guidelines (Division of Counselling Psychology, 2008), support and aftercare were offered in the form of a debriefing, the provision of a comprehensive resource list, and follow-up communication via e-mail. This dilemma also extends to the question of how to disseminate the findings to the participants, since my interpretation could differ to their understandings. Again, consideration has been paid to the BPS Code of Ethics and Conduct (BPS, 2009) of the responsibility of taking care in conveying research outcomes to participants. The shared objective between researcher and practitioner of avoiding causing harm to clients is helpful in guiding my response to this difficulty. My interpretation of this objective is to emphasise that the findings are <u>my interpretation</u> of their accounts, and that it is not a definitive 'truth'.

Since my research participants were unconnected to my clinical practice, I did not engage in a dual relationship with them. Although seeking a non-clinical sample undoubtedly complicated my recruitment process, I believe that engaging in these dual roles with a participant could present a challenge to a Counselling Psychologist. For example, there is a risk that a client may feel pressured into participating in the research, or that a clinician's knowledge of the client/participant's history could influence their research interview. Therefore, it is imperative that these issues are carefully considered and discussed with colleagues before embarking upon this type of relationship.

Undertaking other parts of the research procedure also proved testing for me. I felt uncomfortable breaking up the participants' texts during the analytic process, and I was concerned that it was taking away from their unique experience, which is my main focus as a practitioner. However, as in my clinical work, I had to trust the research process and found that their narratives came together again during the write-up. Furthermore, both clinician and researcher help the client or participant to 'tell their story', and to give voice to their experience. In this respect, the research experience felt compatible with my clinical work, as both entail a certain amount of catharsis for the client or participant.

A further tension that I experienced as a researcher was extrapolating commonalities, and being selective with themes across the accounts. My experience as a clinician led me to be reluctant to generalise, and I was concerned about being reductionist and moving away from the participant's unique experience. However, I felt that IPA was a good 'fit' with my clinical way of working, in that it values both the subjective experience of the participant, but also the nuances involved.

Working clinically in a psychodynamic way could also prove challenging, since one would have to be take care not to impose a psychodynamic framework onto the analysis within IPA, although both situations involve a level of interpretation. Nevertheless, I can imagine that undertaking a different methodology and working from a different epistemological position could feel more difficult. Indeed, Corrie (2010) discusses the conflict between the philosophical basis of Counselling Psychology, citing guidelines from the Division of Counselling Psychology (2010),

which places more value on the subjective experience of a client than concepts such as diagnosis and treatment. I feel uncomfortable that my clinical work is guided by an evidence base which is founded on a positivist paradigm, using mainly quantitative studies which assumes 'one size fits all', and doesn't account for individual and idiosyncratic differences and growth. Again, I would concur with Corrie (2010), who asserts that there is a possible disparity between what happens 'in the lab' and what happens in 'the real world'.

In a broader sense, I agree with Corrie (2010) that there are concerns that research is often politically and financially motivated, with a vested interest in generating studies that confirm the efficacy of CBT, which is known to be more cost-effective than other therapies. But what constitutes scientific evidence? Milne, Britton and Wilkinson (1990) call for the implementation of a broader classification of research, whilst Corrie and Callahan (2000) suggest that phenomenological research must be included, as well as quantitative studies. Indeed Corrie and Callahan (2000) suggest that although the scientist-practitioner model is useful for building theories, that there should be a new kind of unification between research and practice, and I concur with their assertion. However, I appreciate the value of conducting quantitative research in helping to test and generate theories, which can help inform sound clinical practice. Nonetheless, this issue will be a challenge for me in the future that I will need to navigate.

Working in a methodical and systemic way as a researcher also at times felt contrary to the intuition often used as a clinician. For example, being systematic in undertaking the analysis and in evaluating the literature was a challenge, when I frequently had to resist relying just on what 'fitted'. However, these two roles of Counselling Psychologist were not as incompatible as they first seemed. As a clinician, I am required to work in an evidence-based way and establish my work on a sound rationale, which my main working approach of CBT accomplishes. Furthermore, CBT in itself is a fairly structured and methodical form of therapy. The role of a Counselling Psychologist involves an ability to evaluate the efficacy of the treatment that I'm providing, therefore being able to conduct and understand research in a systematic way, and to contribute to the field is an important part of being a clinician. Indeed, Corrie (2010) discusses the importance of grounding our

clinical practice in a sound knowledge base (through the use of research), so that we can offer our clients the most effective and up-to-date therapies. However, a Counselling Psychologist who ordinarily uses a more intuitive therapeutic approach, (e.g. person-centred therapy) in their clinical work, could find the systematic demands of the research process challenging.

The benefits of conducting the research however outweigh the challenges that it has presented. My research can inform my clinical practice, and although I cannot generalise the participants' experiences, it has raised my awareness of certain issues and increased my sensitivity to siblings and families of people who have attempted suicide. I have furthered my theoretical understandings of family systems, and issues such as shame and grief, which can help to inform my clinical practice, and the research has motivated me to raise awareness of the subject matter in the public domain. Undertaking the research has provided me with the opportunity to add knowledge to the field, and to inform other Counselling Psychologists. The hope is that this may inspire further studies, which could lead to an improvement in services provided to siblings and their families. Finally, the research process has required me to be disciplined, systematic and committed to giving voice to the participants, all of which are qualities that can only enhance my work as a clinician.

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APPENDIX A – INTERVIEW SCHEDULE

A) <u>Do you have a view on suicide, and if so, what view?</u>

B) <u>Details of the suicide attempt</u>

1) I understand that this may be painful but can you give me some brief details of when your sibling attempted suicide?
2) Without too much detail, can you briefly describe what happened?

C) <u>The impact of the suicide attempt on the participant</u>

1) How did you feel at the time when your sibling attempted suicide?
2) What did you think about the suicide attempt at that time?
3) Did the suicide attempt affect your mental well-being, and if so, in what way?
4) Did the suicide attempt affect your physical health, and if so, in what way?

D) <u>The impact of the suicide attempt on relationships</u>

1) Did the suicide attempt affect your relationship with your sibling, and if so, in what way?

   prompt: thoughts/feelings expressed to sibling? did you talk about the suicide attempt with him/her? Did your behaviour change towards him/her?

2) Did the suicide attempt affect your relationships with other family members, and if so, in what way?

   prompt: were thoughts/feelings expressed? did roles and responsibilities change? Was there increased conflict or support?

3) Did the suicide attempt affect your relationships with other people outside of the family, and if so, in what way?

   prompt: did you disclose the suicide attempt? what reactions did you get? how did you feel? was your social life restricted?

E) <u>The current situation</u>

1) Have your thoughts and feelings about the suicide attempt changed since it happened? If so, in what way?
2) How would you describe your relationship with your sibling now?
3) How would you describe your relationship with your family now?
4) Looking back, would you liked to have received more professional support, or details of self-help groups? If so, what type?

F) <u>Thoughts and feelings about participation in the study</u>

1) How do you feel about taking part in this study?

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

First of all, I would like to obtain some general demographic information about you, for research purposes. These details will be kept strictly anonymous. However, you do not have to answer a question if you do not want to.

Thank you for your help.

- Which gender are you?
- How old are you?
- Are you currently working? If so, what is your occupation? If no, then what was your previous occupation?
- What is your highest educational qualification?
- What is your current legal marital status?
- Do you have any children? If yes, then how many?
- In which area of the U.K. do you live?
- How would you describe your ethnic origin?
- How long ago did your sibling's suicide attempt happen? What ages were you and your sibling?
- What were your living circumstances when your sibling attempted suicide? For example, were you living in the same home?
- Has your sibling been diagnosed with a mental illness? If so, which?
- Has anyone else attempted suicide in your family? If so, was this before or after your sibling's attempt?

APPENDIX C – RECRUITMENT FLYER

Have you got a brother or sister who has attempted, but not completed suicide in the past?

If so, I would really like to hear about your experience, as part of my doctoral research at City University, London.

Your participation will involve an interview lasting 1-1½ hours, during which you will be asked some open-ended questions and given the opportunity to talk about your experience.

If you agree to participate, your confidentiality and anonymity will be assured, and you will have the right to withdraw your consent to participate at any point.

Due to the nature of the research, participants must:

- Be at least 18 years old
- Have no current depression, suicidal tendencies or be receiving trauma counselling
- Have not witnessed the suicide attempt

If you fulfil these criteria and you would like to share your experience, I would welcome hearing from you.

Please contact me as follows:

Louise Ball, Counselling Psychologist in-training
Tel:
Email:

Supervised by Dee Danchev,

Email:

APPENDIX D

Information Sheet

Thank you for agreeing to take part in my study. This form provides details of the purpose of the research, what your participation will entail, and the ethical guidelines in place.

The purpose of the study is to explore the experiences of people whose sibling has attempted, but not completed suicide. I hope that this research will help to increase our understanding of what this experience is like, from the non-suicidal sibling's perspective.

Your participation will involve an interview of between 1-1½ hours, during which you will be asked some open-ended questions and given the opportunity to talk about your experience. The interview will take place either in your home or in a private, neutral, mutually convenient setting. There is a condition that the sibling who has attempted suicide must not be present during the interview, to minimise any potential discomfort to either yourself or to him/her. The interview will be arranged at a mutually convenient time during the daytime on a weekday. There will be a debriefing after the interview, when you will have the opportunity to discuss how you found it. A comprehensive list of resources, including local groups will be provided, should you feel the need for further support after the study. Contact details of myself and my research supervisor will also be provided, should you have any questions or concerns.

Your written consent to participate in this study and for it to be recorded will be requested. Information on confidentiality and anonymity will be provided. You will have the right to withdraw your consent at any point during the research, without penalty.

If you would like a copy of the final report, this can be provided.

If you have any queries at any point, please do not hesitate to contact me as follows:

Email:
Tel:

Thank you very much for agreeing to take part in my research. Your participation is very important and valued.

Louise Ball,

Supervised by Dee Danchev,

APPENDIX E – ETHICS RELEASE FORM, CITY UNIVERSITY

~~Appendix H~~

Ethics Release Form for Psychology Research Projects

All students planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ☐ M.Phil ☐ M.Sc ☐ Ph.D ☐ D.Psych ☑ n/a ☐

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

ATTEMPTED SUICIDE IN THE FAMILY: THE SIBLING'S EXPERIENCE

2. Name of student researcher (please include contact address and telephone number)

LOUISE BALL, 128 HIGH ST, SANDHURST, BERKS, GU47 8HA TEL: 07879 698456

3. Name of research supervisor

DEE DANCHEV

4. Is a research proposal appended to this ethics release form? **(Yes)** No

5. Does the research involve the use of human subjects/participants? **(Yes)** No

If yes, a. Approximately how many are planned to be involved? 6

b. How will you recruit them? ADVERTISING IN LOCAL SUPPORT GROUPS, COUNSELLING AGENCIES (NON NHS), POSS ADVERTISING IN LOCAL PAPERS, BACP.

c. What are your recruitment criteria? AGED 18+, NO CURRENT/HISTORY OF SUICIDAL BEHAVIOUR, NOT IN TRAUMA THERAPY, NOT WITNESSED ATTEMPT, ATTEMPT MIN 2 YRS AGO, SPEAKS ENGLISH FLUENTLY, MENTALLY COMPETENT.
(*Please append your recruitment material/advertisement/flyer*) FLYER DOESN'T SPECIFY ALL THIS, WILL TELL POSS. PARTICIPANTS VERBALLY

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent?

Yes **(No)**

e. If yes, will signed parental/carer consent be obtained? Yes N/A No

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

THE PARTICIPANT WILL BE REQUIRED TO ANSWER QUESTIONS & TALK ABOUT HIS/HER EXPERIENCE IN AN INTERVIEW WHICH WILL LAST BETWEEN 1 HR ~~45 MINS~~ – 1½ HOURS.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes (No)

If yes, a. Please detail the possible harm? --

b. How can this be justified? --

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

(Yes) No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?

Yes (No)

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

(Yes) No

(Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)? CONSENT FORMS

TAPE-RECORDINGS, DEMOGRAPHIC PROFILES, TRANSCRIPTIONS (TYPED ON PC & PRINTED OUT)

12. What provision will there be for the safe-keeping of these records? THEY WILL BE KEPT (CODED) ANONYMOUS & STORED IN A LOCKED FILING CABINET IN A SECURE PLACE. KEY ~~FOR~~ WITH ID & CODE NUMBER WILL BE KEPT IN SEPARATE, SECURE PLACE (LOCKED CABINET)

13. What will happen to the records at the end of the project? THEY WILL BE DESTROYED, FINAL WRITE-UP WILL USE PSEUDONYMS, IDENTIFYING DETAILS CHANGED

14. How will you protect the anonymity of the subjects/participants? PSEUDONYMS WILL BE GIVEN, ANY IDENTIFYING DETAILS WILL BE CHANGED, DATA WILL BE CODED,

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

DEBRIEFING AFTER INTERVIEWS. WILL BE GIVEN COMPREHENSIVE RESOURCE LIST OF LOCAL & NATIONAL SUPPORT GROUPS, COUNSELLING AGENCIES, DETAILS ON LITERATURE HOW TO LOCATE A COUNSELLOR (NHS & PAID, LONG TERM & SHORT TERM), CONTACT DETAILS OF MYSELF & RESEARCH SUPERVISOR

(Please append any de-brief information sheets or resource lists detailing possible support options)

DEBRIEF SHEET INCLUDED, RESOURCE LIST WILL BE EXTENDED EXTENSIVELY ONCE I KNOW CATCHMENT AREA OF PARTICIPANTS

WILL SPECIFY PARTICIPANTS MUST NOT HAVE CURRENT/PAST SUICIDAL BEHAVIOUR, NOT WITNESSED ATTEMPT, NOT IN TRAUMA COUNSELLING. CRITERIA WILL BE STIPULATED WHEN POSS PARTICIPANTS CONTACT ME OR IF I HOLD A RECRUITMENT PRESENTATION

If you have circled an item in bold print, please provide further explanation here:

INVOLVES HUMAN PARTICIPANTS BUT ALL ETHICAL ISSUES HAVE BEEN CONSIDERED - INFORMED CONSENT, OPTION TO WITHDRAW AT ANY POINT, CONFIDENTIALITY, ANONYMITY, DEBRIEFING, RESOURCE LIST, CONTACT DETAILS ALL WILL BE PROVIDED - INTERVIEWS WILL BE HELD AT PARTICIPANTS HOME OR NEUTRAL PRIVATE SETTING - ESSENTIAL SIBLING WHO ATTEMPTED SUICIDE IS NOT PRESENT, TO AVOID POSS. HARM. INTERVIEWS WILL BE IN DAYTIME ON WEEKDAY SO THAT RESOURCES CAN BE CONTACTED AFTERWARDS IF NEEDED.

Signature of student researcher -- Date 1st November 2006

Section B: To be completed by the research supervisor

Please mark the appropriate box below:

Ethical approval granted ☑

Refer to the Department of Psychology Research Committee ☐

Refer to the University Senate Research Committee ☐

Signature -- Date 20 November 2006

Section C: To be completed by the 2nd Department of Psychology staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above ☒

Signature -- Date 23 Nov 06

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APPENDIX F

CONSENT FORM

I consent to participate in the research project entitled 'Attempted suicide in the family: The sibling's experience', conducted by Louise Ball, a trainee counselling psychologist in the Department of Psychology, the City University, London, and supervised by a member of staff of that Department (Dee Danchev, City University, Northampton Square, London, EC1V OHB). The research will be conducted according to the Code of Conduct and Ethical Principles of the British Psychological Society.

The purpose of the study is to explore the experiences of people whose sibling has attempted but not completed suicide.
I understand that the only requirement will be for me to participate in an interview which will take approximately 1-1½ hours.

I understand that the results of this research will be coded in such a manner that my identity will not be attached to the information I contribute. The key listing my identity and code number will be kept securely and separate from the research data in a locked file and will be destroyed when the research is completed. In addition, I understand that the purpose of the research is to examine groups of people and not one particular individual.

This research project is expected to provide further information on the experience of attempted suicide of a sibling which will increase our understanding of the psychology of family trauma.

I understand that the results of this research may be published in psychological journals or otherwise reported to scientific bodies, but that I will not be identified in any such publication or report.

I understand that my participation is voluntary, that there is no penalty for refusal to participate and that I am free to withdraw my consent and discontinue participation at any time.

I understand that this project is not expected to involve any risks of harm any greater than those involved in daily life, and that all possible safeguards will be taken to minimise any possible risks.

If I have any questions about any procedure in this project, I understand that I may contact the researcher at , tel: ,

Signed (Participant).. ....

Name (block letters)..

Date.. ....

APPENDIX G

CONFIDENTIALITY AGREEMENT ON THE USE OF AUDIO TAPES

This agreement is written to clarify the confidentiality conditions of the use of audio tapes by Louise Ball for the purposes of psychological research.

The participant gives Louise Ball permission to tape the research interview on condition that

- the permission may be withdrawn at any time
- the tapes are used solely for analysis by Louise Ball
- the tapes will not be heard by any person other than Louise Ball
- the tapes will be stored under secure conditions and destroyed at the appropriate conclusion of their use.

This agreement is subject to the Code of Conduct and Ethical Principles of the British Psychological Society and the law of the land.

I have read and understood the above conditions and agree to their implementation.

Signed (Research participant)..Date....................

Name (block capitals)..

Signed (Psychologist)...Date..................

APPENDIX H

DEBRIEFING

You have now finished your participation in this research project.

Thank you so much for your help.

As explained previously, the aim of this study to is to explore the experiences of people whose sibling has attempted but not completed suicide. I am interested to know what it is like when a sibling has attempted suicide, and if there has been any impact on participants.

How do you feel now that you have taken part in this research?

Do you have any questions?

Would you like the results of the research? If so, we can make arrangements for that now.

If you have any difficult feelings of sadness or depression, I have telephone numbers here of counselling services that will help you, and I will be glad to give you this information.

APPENDIX I – EXAMPLE OF RESOURCE LIST
(current at time of interviews)

National

Aware Defeat Depression

Support, information or a listening ear for all those affected by depressive illnesses, including families/carers.

Tel: 08451 20 29 61
Opening hours for helpline: Monday – Friday, 10am – 4pm. Based in Northern Ireland but calls from the U.K. charged at local rate.
Email: help@aware-ni.org
Website: www.aware-ni.org
Online discussion forum also available.

British Association for Counselling and Psychotherapy (B.A.C.P.)

Representative body for counsellors and psychotherapists in the U.K. Online register to search for an accredited/registered counsellor/psychotherapist in your local area.

Tel: 0870 44 35 252 (Monday - Friday, 8.45am- 5pm).
Email: bacp@bacp.co.uk
Website: www.bacp.co.uk
Address: BACP House, 15 St John's Business Park, Lutterworth, Leicestershire, LE17 4HB.

British Psychological Society (B.P.S.)

Representative body for psychologists in the U.K. Online register to search for chartered psychologist in your local area.

Tel: 0116 254 9568
Email: enquiry@bps.org.uk
Website: www.bps.org.uk
Address: St Andrews House, 48 Princes Road East, Leicester, LE1 7DR.

Careline

Confidential crisis telephone counselling on any issue.

Tel: 0845 122 8622
Opening hours for helpline: Monday - Friday 10am - 1pm and 7 - 10pm.
Website: www.carelineuk.org
Online counselling service also available.

Depression Alliance

U.K. 'umbrella' charity, providing information and support to anyone affected by depression, through local support groups network, publications, pen-friend scheme, research etc.

Tel: 020 7633 0557 or 0845 123 2320 (not a counselling helpline, calls charged at local rate).
Opening hours Monday - Friday, 10 am – 5 pm.
Email: information@depressionalliance.org
Website: www.depressionalliance.org
Address: 212 Spitfire Studios, 63-71 Collier Street, London, N1 9BE.

HOPELineUK

Part of PAPYRUS (prevention of young suicide), this is a helpline to give support, practical advice and information to anyone who is concerned that a young person they know may be suicidal.

Tel: 0870 170 4000 or 01978 367333
Opening hours for helpline: Monday - Friday, 7pm - 10pm, and at weekends, 2pm - 5pm. They also operate a call-back service.
Email: admin@papyrus-uk.org
Website: www.papyrus-uk.org
Address: Lodge House Thompson Park, Ormerod Road, Burnley BB11 2RU.

Rethink

U.K. 'umbrella' organisation for people affected by severe mental illness, including families/carers, through support groups, advocacy, campaigning etc.

Tel: 0845 456 0455 (also for details of local carer support groups).
Opening hours Monday – Friday, 9am – 5.30pm, excluding bank holidays.
Email: info@rethink.org
Website: www.rethink.org
Online discussion forum also available.
Address: Rethink Head Office, 5th Floor, Royal London House, 22-25 Finsbury Square, London, EC2A 1DX.

Samaritans

Offers 24 hour, 7 days a week confidential telephone support for people in distress.

Tel: 08457 90 90 90
Opening hours for helpline: 24 hrs, 7 days a week. Free call rate.
Email: jo@samaritans.org and someone will reply to you within 24 hours.
Website: www.samaritans.org
Address: The Upper Mill, Kingston Road, Ewell, Surrey, KT17 2AF or write anonymously to: Chris, PO Box 9090, Sterling, FK8 2SA.

Saneline

An out-of-hours telephone helpline providing information and support for anyone affected by mental health problems, including families, carers and health care professionals and service users themselves.

Tel: 0845 767 8000 (local call rate).
Opening hours 1pm - 11pm every day of the year.
Website: www.sane.org.uk

U.K. Council for Psychotherapy (U.K.C.P.)

Organisation aiming to promote the highest standards within the profession of psychotherapy in the U.K. Online (voluntary) register to search for psychotherapists in your local area.

Tel: 020 7014 9955
Email: info@psychotherapy.org.uk
Website: www.psychotherapy.org.uk
Address: 2nd Floor, Edward House, 2 Wakley Street, London, EC1V 7LT.

Through this website, you can also locate a local family therapist registered with U.K.C.P. Select the link 'Find a therapist', input your postcode, and select 'Institute Of Family Therapy' in 'organisation' drop-down menu.

LOCAL

G.P.

You can ask your G.P. for referral to a counsellor or for urgent psychiatric attention. Many G.P. surgeries have counselling services attached. Depending on your location, services may be within the N.H.S., voluntary or private.

Carers' Network Westminster

Carers network offers advice, information and support for carers of those with mental illness.
Tel: 020 8960 3033
Email: info@carers-network.co.uk
Address: Office 8 Beethoven Centre, Third Avenue, London, W10 4JL.

Central London Samaritans

Tel: 020 7734 2800 (local rate charge within Greater London) or 08457 90 90 90.
Opening hours for helpline: any hour of the day or night, 365 days a year.
Opening hours for drop in: 9am – 9pm, 365 days a year, no appointment necessary.
Email: jo@samaritans.org
Website: www.cls.org.uk
Address: 46 Marshall Street, Soho, London,W1F 9BF.

Counselling & Psychotherapy Associates (C.A.P.)

Counselling and psychotherapy service. CAP therapists also practise in Harley Street, Clapham, Brixton, Tufnell Park, Soho, East Finchley and Kingston. Fees are £95 plus VAT per session, reduced fees of £60 plus VAT may be available.

Tel: 020 7637 7763
Opening hours: Monday – Friday, day and evening appointments available. Saturday appointments also available at Central London premises. Reduced fee appointments offered on Thursdays and Fridays.
Website: www.counselling.org
Address: 4 Wimpole St, Marylebone, London, W1G 9SH.

Phoenix Counselling Service

A BACP accredited counselling service in Essex and London. Self-referral is possible and a variety of counselling approaches are offered. Assessments often offered within a week, fee of £35-50, ongoing counselling sessions £30-50.

Tel:
Opening hours Monday – Friday, 9am – 7pm, Saturday mornings.
Email:
Website:
Address:

WPF Counselling & Psychotherapy

Counselling and psychotherapy service, with short-term and long-term counselling available. Self-referral, initial assessment waiting list approx 3-4 weeks. Sliding scale of fees, with a £15.00 minimum fee.

Tel:
Opening hours Monday – Friday, 8am – 6pm.
Email: ı
Website:
Address:

Literature

Baker, B. (2003) *When someone you love has depression*, Sheldon (available from Mind bookshop – www.mind.org.uk).

Howe, G. (1997) *Serious mental illness – a family affair*, London: Sheldon Press.

Karp, D. A. (2001) *The burden of sympathy: how families cope with mental illness*, Oxford University Press, (available from Mind bookshop – www.mind.org.uk).

Kuipers, E. and Bebbington, P. (1997) *Living with mental illness, a book for relatives and friends* (second edition), London: Souvenir Press.

Researcher and supervisor's contact details

Louise Ball, Counselling Psychologist in-training, researcher.
Tel:
Email:
Address:

Dee Danchev, Chartered Counselling Psychologist, research supervisor.
Email:
Address:

APPENDIX J – FOLLOW-UP EMAIL TO PARTICIPANT

Thank you

From: **Research Siblings**
Sent:
To:

Hi

Thank you very much for giving up your time to be interviewed yesterday, it was really nice to meet you.

I know that you were talking about something very personal yesterday, and I hope it didn't leave you with too many upsetting feelings. Please let me know if it did, and if you're feeling at all distressed. I should also say that you can still withdraw your consent to participate at any point, and the data will be destroyed.

As discussed, I am very happy to send you a final copy of my findings and conclusions. Please let me know if you change your email address/contact details in the intervening time.

Good luck for the future. Again, thank you very much for letting me interview you . I really appreciate it.

Best wishes,
Louise

APPENDIX K - DEMOGRAPHIC DETAILS & RELEVANT CIRCUMSTANCES OF PARTICIPANTS

	Number of participants
Gender of participant	
Male	2
Female	6
Age range of participant at time of interview	
20 - 29	5
30 - 39	3
Geographical location of participant	
West Midlands	1
South West	1
London	1
South East	5
Ethnicity of participant	
White British	7
Other?	1
Educational level of participant	
Diploma	1
BSc/BA	4
Post-graduate	3
Age range of participant at time of suicide attempt	
10 – 19	2
20 - 29	5
30 - 39	1
Age range of attempter at time of suicide attempt	
10 – 19	6
20 - 29	1
30 - 39	1
Birth order	
Participant older than sibling	7
Sibling older than participant	1
Gender of attempter	

	Number of participants
Male	5
Female	3
Number of years since attempter's suicide attempt	
2 - 4 years	4
5 – 7 years	2
8 – 10 years	2
Participant's living circumstances at time of suicide attempt	
Living away from family home	7
Living with sibling away from family home	1
Principle method of suicide attempt	
Overdose	6
Cut wrists/self	1
Hanging	1
Subsequent diagnosis of mental illness of attempter	
Borderline Personality Disorder	1
Schizophrenia	1
Depression	2
None/undecided/unknown	4

Table 1. Demographic details of participants

APPENDIX L – SUMMARY OF STEPS INVOLVED IN THE ANALYTIC PROCESS

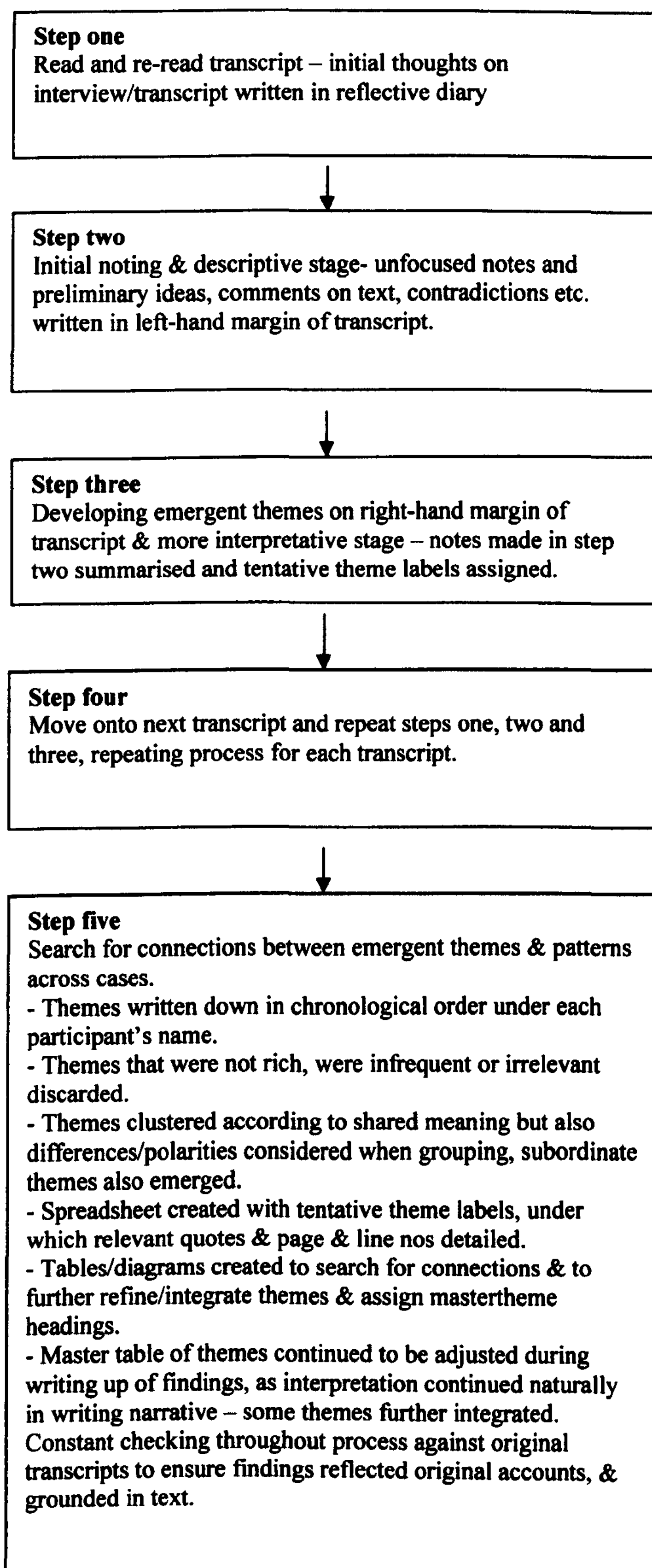


Figure 1. Summary of steps involved in the analytic process

TEP TWO

STEP THREE

1 **Researcher:** And so what…so what was it like being in between…you said your mum and dad sort of grew apart? (*Fiona coughs*)

2 (sorry) That's ok...um...that...that your mum and dad grew apart…(yeah) your dad withdrew into himself more...and your mum

3 couldn't really understand why?

4 **Fiona:** Yeah...that's right.

5 **Researcher:** What...I suppose I'm wondering what it was like for you... it sounds like you…?

6 **Fiona:** Um...I suppose...I didn't really um…talk to them very much about how I was feeling (right) because it seemed much more

7 important to look after them (*emphasis*) (right) um...I stayed down for quite some time so...for them to (*inaudible word on the*

8 *recording*) for a...section of time (right) (*Fiona sighs*) um...how did I feel? Um...I felt like...I…I suppose at that time I felt that my

9 family was falling apart (mmm) um...(*pause 4 secs*) I did actually speak to one person and that was a…a friend of mine from school

10 whose sister had done basically the same thing...(mmm) um...sorry I got a...(*Fiona points to throat indicating a cough*)

11 **Researcher:** That's alright...(*Fiona coughs*) that's ok...take your time.

12 **Fiona:** Um...but apart from that I didn't actually speak to anybody about how I felt (right) at all um...I just...(*pause 3 secs*) kept it

13 all inside I suppose.

14 **Researcher:** Right...(yes) and try to cope and look after…

15 **Fiona:** Everybody else…yeah.

16 **Researcher:** And so was the suicide attempt talked about in the family?

17 **Fiona:** Um (*pause 2 secs*) not really, no…(mmm) I suppose...well it was there because everyone was very upset (mmm) and

18 emotional but no we didn't (mmm) talk about it really, no.

19 **Researcher:** And so the way that...that you know your thoughts and feelings…you didn't talk about those (no) to anyone…and I

20 suppose I'm just wondering in the family um...did...did any of your family members talk about how they thought and felt about the

21 attempt?

Left-margin notes (handwritten, partly cut off at the edge):

- …mum + dad parents grew apart due to diff coping styles
- …n't tell family feelings …re important to look after …ent – parent role?
- …t family was falling apart …disintegration of family
- …ke to person whose sister …d same thing – feared …k of understanding?
- 2022 …idn't speak to anyone else …pt it all inside
- …ppress feelings to look after family – burden?
- …mily was upset + emotional …+ didn't talk about it

Right-margin notes (handwritten):

- Suppression of feelings/needs
- Roles
- Family fragmenting
- Seeking support from empathic others
- Suppression of feelings
- Communication – suppression of feelings

KEY TO TRANSCRIPT

(COMMA)	—	NATURAL PAUSE IN SPEECH
…	—	BREAK IN SPEECH
(pause 2 secs) – italics	—	LONGER PAUSE IN SPEECH OF APPROX 2 SECONDS
(emphasis)	—	PARTICIPANT'S STRESS ON PRECEDING WORD
(sighs)	—	NON-VERBAL LANGUAGE – IE, SIGHS WHEN TALKING
(mmm)	—	CONFIRMATORY UTTERANCE
(inaudible word on recording)	—	UNABLE TO HEAR WHAT PARTICIPANT IS SAYING ON AUDIO-RECORDING

1 **Fiona:** Not to...not to... to me um...(mmm) again my father had a counsellor that he goes to see...(mmm) and I know that he had

2 stopped seeing that counsellor for several years prior to this (right) but he…he still sees that counsellor now...(right) yeah.

3 **Researcher:** So did he start going back to the counsellor afterwards (yes) then? (yes) Right, so he needed to get some emotional

4 support (yeah) from someone?

5 **Fiona:** Yeah,…uh uh.

6 **Researcher:** And how and how did your mum deal with it?

7 **Fiona:** She didn't deal with it very well because she wanted to be able to help him (right) but she couldn't... she couldn't understand

8 what he was going through (right) um...he's quite a...um...(*Fiona coughs*) spontaneous person in the way he reacts to things

9 um...how can...he…he has extremes of (right) um...emotions, (yeah) whereas she's much more sort of level-headed (right) and

10 neutral, (right) he will get incredibly angry or (yeah) he'll be incredibly sad (mmm) so he...she can't really understand that at all,

11 (mmm) so he (inaudible *word on the recording*) and that really upsets her because she couldn't (mmm) do the…she's very much a

12 motherly mum (right) and she couldn't do the role that she wanted to do, which was you know to look after (yeah) everybody

13 involved…cos she didn't understand what was going on (no) so…

14 **Researcher:** So that...so your dad...you said your dad would sort of have extremes of emotion and (yeah) was very emotional

15 (yeah) from the sounds of it? Um...and I'm just wondering, how did your mum um...sort of deal with that and deal with the

16 aftermath?

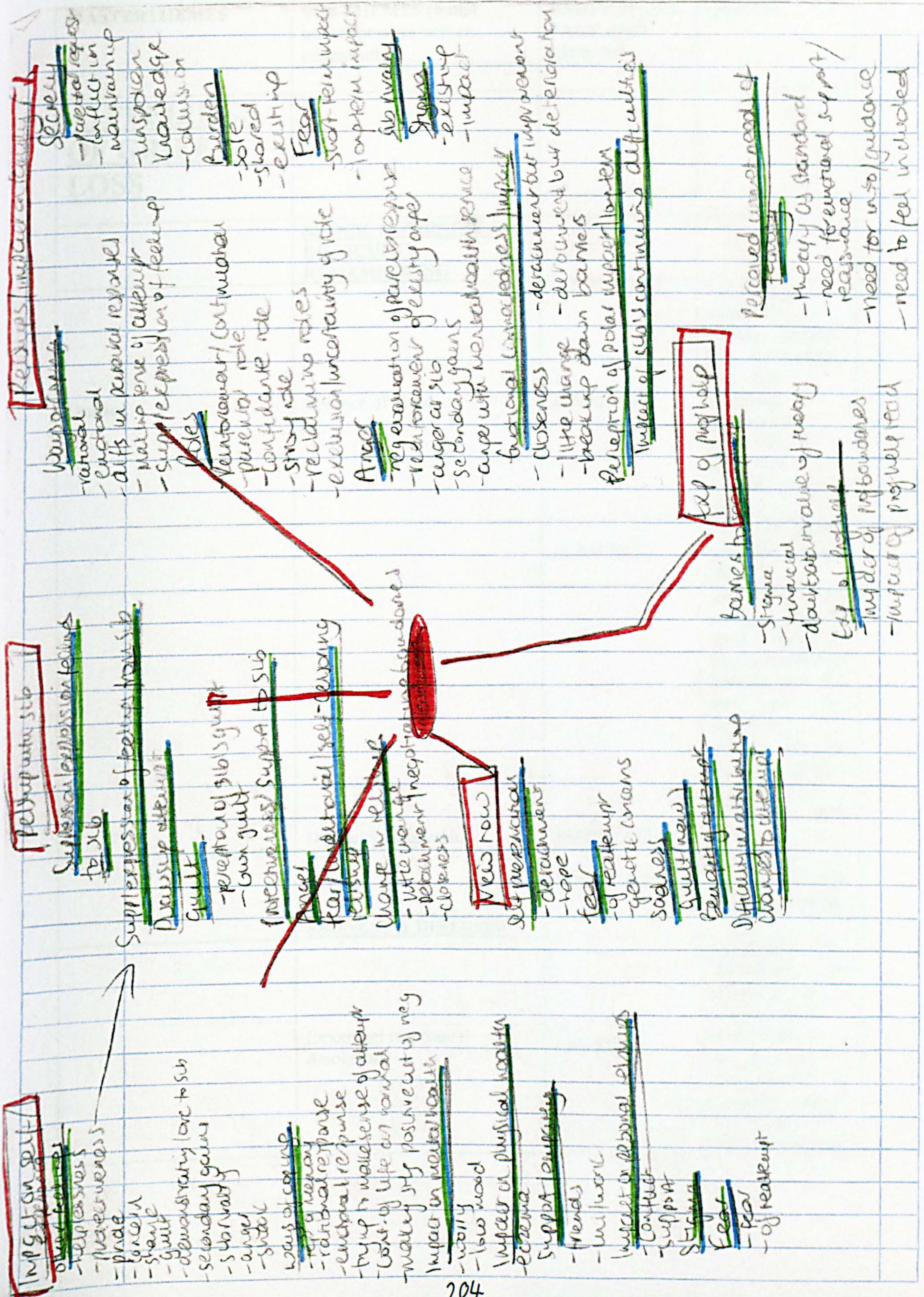
17 **Fiona:** I think...when I when I say he's got extremes of emotion, he's got um...particularly in terms of, like I said with anger and

18 (mmm) and happiness, he's…he's very uh...you know…he makes quite a division between the two but he…he...I've never seen my

19 father cry apart from then...(right) and I think for him to cry that much that frequently just for no apparent reason…you know, he'd

20 be eating a piece of toast and he'd start to cry (right) again….(right) um...for my mother who's used to seeing (mmm) a very strong

APPENDIX N – EMERGENT THEMES DURING EARLIER STAGES OF ANALYSIS



APPENDIX O – SAMPLE QUOTE ILLUSTRATING EACH THEME WITHIN TWO MASTERTHEMES

MASTERTHEMES	SUB THEMES (initial transcript notes written underneath)	PARTICIPANT, PAGE AND LINE NO	QUOTES
A) FEELINGS OF GRIEF & LOSS			
	SHOCK, NUMBNESS & DIFFICULTY REMEMBERING		
Outlier	Absence of shock	JAMES 4(20)	Not terribly surprised frankly…(mmm) um…my brother had…had emotional problems for years prior to that…so it certainly wasn't a surprise
		LUCY 5(15)	I was just sort of you know…shell-shocked…
	Difficulty recollecting	JAMES 5(21)	but it's very strange that I don't remember what I was feeling (mmm) and that sort of was significant…(mmm) um…but it's very much a blur…(right) very…very much a blur.
	Numb?	SOPHIE 3(2)	I remember feeling…somewhat numbed again.
	SADNESS & DISTRESS		
	Emotional response - desolation?	LEE 5(19)	Desolation…it's my brother…I've grown up with him you know and (mmm) to see…to know that…that he could have been hurting so much and so desperately

			unhappy with his life…(um) that he would want to kill himself…(mmm) that tore me apart
Outlier	Relief/pleased it wasn't me? Pleased to be strong one?	SARAH 3(9)	a bit glad it wasn't me that had done it… (*Sarah laughs slightly*) (mmm) um (*pause 2 secs*) kind of (*pause 3 secs*) I suppose there's that competition thing…I mean this is an odd…I'm just thinking on reflection now…but there was a little part of me that kind of…thought "well I've managed not to do that up until now" (*Sarah laughs*)
	GUILT & SHAME		
		LUCY 10(12)	I remember then thinking… just some stupid things thinking…"perhaps something I'd said had caused it or something?"...(mmm) um…(*Lucy gets a tissue out of a box*) (mmm) so I do remember, mum and dad of course and **** was there as well um…all immediately (*Lucy whispers tearfully*) "oh don't be ridiculous"…
	Perception of family as dysfunctional? Shame at family?	LUCY 2(16)	and shame…(*emphasis*) I can remember talking to somebody and…yeah…talking about sort of shame
	- attempt as code for family	SARAH 13(7)	I think with a

	dysfunctionality? Kudos?		group of friends that maybe they kind of saw me more as having come from a troubled family (*pause 1 sec*) but I didn't really mind that um (*pause 2 secs*) all these things I'm talking about that I'm not proud of (*Sarah laughs slightly*) but there's kind of a weird sort of kudos about it…(uh huh) it would have been different if she'd been successful (*pause 1 sec*) but that it was almost like (*pause 2 secs*) I don't know what it did for her but if you say your sister's had a suicide attempt to a friend then that then becomes shorthand for all the other things you might imagine that it was like in my family (*pause 2 secs*) whereas if she'd…if she'd succeeded then it would have been absolutely awful
	ANGER & RESENTMENT		
	Resentment	JAMES 5(12)	so I'm not sure I'd call it anger although probably I've certainly been angry with him about his mental (mmm) illness many times…(mmm) um…resentment is probably a little more (mmm) accurate.
	Anger	LEE 22(6)	that's kind of where the anger comes from…(yeah)

			because I am angry about it…(yeah) I think…I think…I don't think it's wrong, I don't think feeling that way is wrong…(mmm) I think it…(mmm) I think it'd be…I think it'd be worse if I denied myself (yeah) the right to feel angry about (yeah) some of the things he's done (yeah) because…because (yeah) they're not right
	displaced anger	JANE 19(14)	I remember the anger being directed at my mother… (yeah) now whether that was displaced anger or…I don't know… (mmm) (*Jane smiles*) I remember being angry (yeah) that… again (*emphasis*) … thinking this is so much harder because you're our mother (mmm) so even this (*emphasis*) (yeah) is gonna be harder
	HELPLESSNESS		
		JANE 4(15)	and also it reminded me of a time when he was a baby...and he was crying and screaming... trying to get through this gate to me... and I was trying to get to him... and I couldn't reach him... (oh) and it really... really brought that back
	WORRY		
		JANE 19(8)	I don't remember

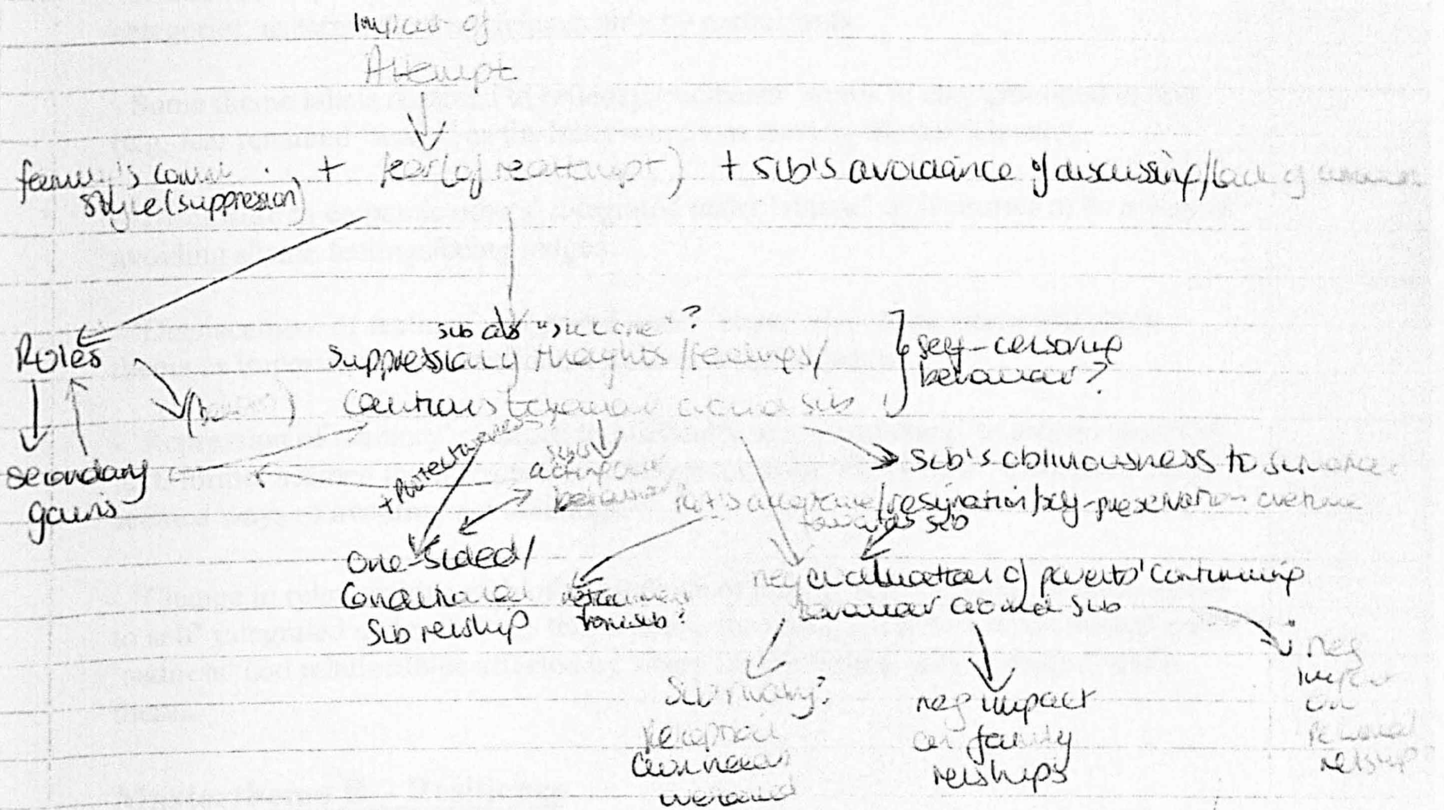
			feeling sad at the time, (mmm) it's more…you know… distraught and (mmm) fearful and… (mmm) angry
	Fear of re-attempt	FIONA 16(4)	I always worry that she'll do it again um (*Fiona sighs*) (*pause 7 secs*) I am always aware of what she's doing…
B) RESILIENCE			
	TRYING TO MAKE SENSE OF THE ATTEMPT		
	Trying to making sense of attempt	LUCY 4(15)	when I look back at sort of…notes and things that I made at the time…I think "gosh, (*Lucy laughs*) I was in quite a black period" um…(*Lucy sighs*) trying to make some kind of sense (*emphasis*) I think of…of it…and also how I could deal with it in a way that (*pause 2 secs*) um…made it more bearable really…sort of make some kind of sense of it and move forward (mmm) with it
	CONTINUING LIFE AS NORMAL		
	although things seemed trivial compared to attempt? took week off work	LUCY 17(7)	things sort of… seemed a bit trivial and a bit mundane (mmm) when you're sort of…I was facing that (mmm) um…I don't know that it (pause 6 secs) I think I made a quite

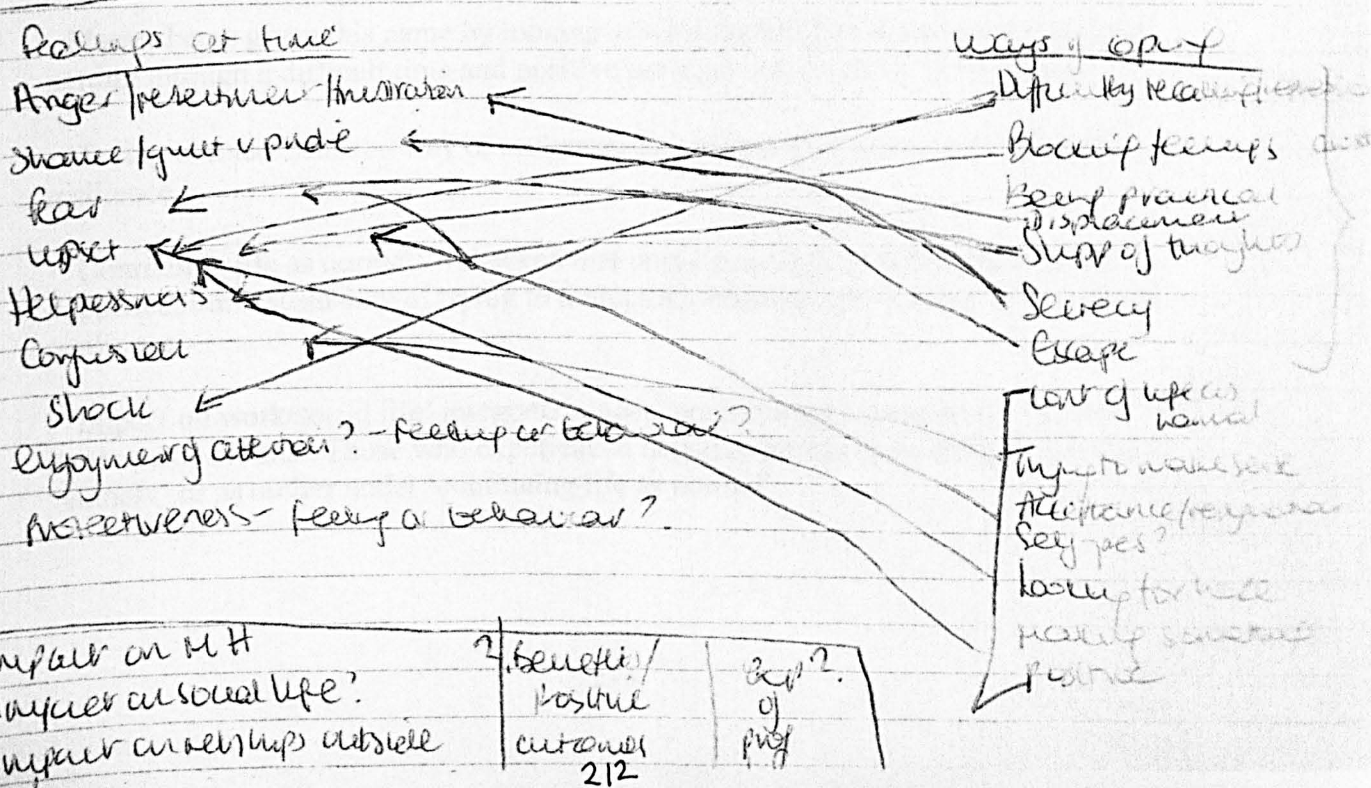
			conscious effort to kind of keep (mmm) doing things (mmm) you know…and keep…(mmm) keep (mmm) a certain amount of routine
outlier	Strong impact on daily life at time	LEE 8(17)	I lost about six months of my life…I…I was in my second year of university…I stopped attending a whole bunch of lectures…
	LOOKING FOR HOPE & CHANGE		
	Importance of hope? Focusing on positives or you would drive yourself crazy/Units of family for support/avoidance of discussing sibling's difficulties with negative family mbrs	ELLA 23(13)	my grandmother's eighty-two and she (mmm) gets very upset (right) about my brother so…(right) and she can be quite um…pessimistic (right) which is just not pleasant (right) to be around and she can't help it, she'll just say it in such a manner, (yeah) in…in that way (yeah) and I'm just…"oh you know, you've gotta hope for the best and I'm sure things will change" (yeah) which is the only way to…I (*emphasis*) think you can be…
	Focusing on positives/looking for signs of change	SOPHIE 18(8)	So it's more now I think my feelings have moved towards, just looking for signs of change.
	ACCEPTANCE		
	Acceptance of brother's choices/helplessness/absolving responsibility?	LEE 26(12)	I'd say I reconciled myself to the fact a fairly long time ago that…there may well come a time

			when he kills himself and there's not really (mmm) gonna be much I can do about (mmm) that…(mmm) and it's…it's not a nice thing to think (mmm) but it's self-preservation (mmm) you know?
	PERSONAL CHANGES		
	Forced to confront/understand subject of suicide?	ELLA 17(19)	I've definitely become more understanding of suicide (mmm) and just more respectful of it (mmm) as a as a subject…and I do feel more inclined, like to want to help people that do…have experienced it

Table 4. Sample quote illustrating each theme within two masterthemes

APPENDIX P – LOOKING FOR CONNECTIONS BETWEEN THEMES





APPENDIX Q - SAMPLE OF THOUGHT PROCESSES IN INTEGRATION OF THEMES

Mastertheme A – Feelings of grief and loss

- Mastertheme given this name as feelings collectively resemble grief/loss reaction.

- Integration of 'pride' under 'shame & guilt' as polarity - outlier.

- Looked at definitions of 'guilt' & 'shame' to ensure quotes ascribed to correct categories, as terms used interchangeably by participants.

- Some theme labels renamed to reflect participants' words & stay grounded in text (e.g. fear renamed 'worry' as the latter word was used by the participants).

- 'Disclosure to empathic others' integrated under 'shame' as it seemed to be a way of avoiding shame feelings/being judged.

- 'Displacement of feelings' integrated under 'anger' etc, rather than stand alone theme as important but not sufficient to have separate theme.

- 'Repression of memory' changed to 'difficulty in remembering' to ground words in text, former seemed too interpretative. Integrated with 'shock' and 'numbness' as all seemed ways of avoiding pain/feelings.

- 'Change in relationships with others outside of family' and ''Change in relationship to self' integrated under feelings that relate to the change, e.g. low mood moved under 'sadness' and relationships affected by worry for the sibling moved under 'worry' theme.

Mastertheme B – Resilience

- Mastertheme given this name by looking at what themes had in common = ways of getting through a difficult time and positive personal outcomes for participants.

- 'Trying to make sense' – way of understanding to move on seems to be form of resilience.

- 'Continuing life as normal' – checked that participants not denying that attempt happened, but instead way of trying to maintain job/studies etc – seems to be form of resilience.

- 'Impact on work/social life' integrated under 'continuing life as normal' as most participants did this. Those who experienced negative impact were integrated under 'sadness' or as outlier under 'continuing life as normal'.

Mastertheme C – Family communication, roles and changes

- Decided to move family responses under one mastertheme (except experience of prof help) to distinguish participant's experience from their experience within the family- referred back to research question and aims, didn't want study to be wholly focused on family, and wanted to distinguish sibling's experience as much as possible.

- 'Protectiveness' moved from Mastertheme A, together with 'sibling rivalry', 'own needs overlooked', 'resentment' and 'distancing' – all intergrated under 'ambivalent sibling relationship' as all are conflicting feelings and ambivalence typically characterises general sibling relationships.

- 'Strong one' and 'burden' integrated under 'parental role' as all related to responsible role in family.

- 'Parental role', 'confidant role' etc integrated under 'redefining roles' as they were mainly new roles.

- Renamed 'continuing roles' & 'redefining roles' as 'continuing v redefining roles' as polarities.

- 'Secondary gains' moved under Mastertheme C as normally related to family dynamics, renamed 'Pay-offs' to reflect participant's words.

- 'Family request for secrecy', 'unspoken knowledge', 'conflict maintaining secrecy' – all moved to 'collusion and conflict' under 'Secrecy' theme as all related to each other.

- 'Suppression of feelings', 'sibling's reluctance to explain', 'differences in parental responses' – all integrated under 'Secrecy' as all involve withholding information. 'Caution around sibling' also integrated with 'Secrecy' as involves similar behaviour of inhibition of feelings/behaviour.

- 'Emotional connectedness', 'increased closeness', 'breaking down barriers', 'detachment but improvement' – all integrated under 'positive changes'. 'Difficulty attributing changes' moved under 'positive changes' as difficulty was related to this.

Mastertheme D – Experience of professional help

- 'Need to feel included' integrated under 'feeling excluded and judged' as discussed by participants as experience rather than need.

- 'Impact of professional boundaries' integrated under 'disclosure to empathic others' in Mastertheme A (further integrated under 'guilt and shame'), and 'feeling excluded and judged'.

APPENDIX R – FINAL MASTERTABLE OF THEMES & REFERENCE POINTS ACROSS CASES

(Includes outliers)	James	Jane	Sarah	Lee	Fiona	Lucy	Sophie	Ella
Feelings of grief & loss								
Shock, numbness & difficulty remembering	4.20, 5.21, 6.5	4.4		11.14	3.4, 3.8	2.9, 4.1, 5.15, 5.20, 5.6, 5.13, 10.15,	3.2, 13.3	4.11, 4.13, 3.20,
Sadness & distress		4.7, 18.22, 19.8, 20.8	2.11, 3.9, 7.11	5.19, 6.10, 7.2, 7.14, 8.13, 18.14 23.1	3.15, 3.8	2.14, 3.15, 4.14, 5.3	15.19	4.11
Guilt & shame	16.18, 27.18,	12.6, 14.7, 14.10, 14.15, 15.20, 16.9	7.4, 13.7, 14.3, 16.20, 17.17	5.4, 5.9, 8.3, 18.19	8.9	2.16, 3.4, 10.8, 10.12, 16.5	3.6, 4.15, 3.14, 9.15	15.1
Anger & resentment	5.12, 15.13, 20.17	4.2, 4.11, 5.6, 13.16, 19.14	5.2, 5.6	21.7, 22.6, 22.11		3.1, 9.9, 13.2, 16.5, 16.11	3.16, 3.4, 4.1, 4.9, 24.12, 29.6, 29.14	
Helplessness		4.11, 4.15		8.4, 11.6	12.11	2.18	12.14, 20.11, 29.14	
Worry	6.19, 7.9, 7.15, 8.12, 20.17, 20.21, 22.3, 32.11,	5.20, 21.12, 21.18	3.7, 3.15, 4.16, 5.19, 20.5		16.4	3.19, 4.6, 6.8	5.3, 7.14, 8.7, 12.12, 16.20, 18.13, 19.2, 30.3	15.20, 17.2, 17.9, 20.21
Resilience								
Trying to make sense of the attempt	4.5	3.14	2.20, 3.8, 3.15, 4.2, 9.13, 25.1	12.11, 24.16	3.13, 4.9, 4.13, 6.4, 6.18, 24.14, 26.10	4.15	4.11, 8.16	3.20, 4.19, 5.3, 10.3
Continuing life as normal	28.4,		16.9, 16.14	8.17, 20.2	5.6, 15.18	5.15, 17.7	5.6, 5.12, 8.12	6.8, 16.1, 24.8

Looking for hope & change				26.19		11.1	18.8, 20.12	23.13, 26.18, 26.16
Acceptance	20.13		3.16	26.12, 28.2, 30.7, 35.18		4.18, 18.5	18.3	
Personal changes			13.17, 15.6, 15.11			19.7	30.18	17.19, 18.6
Family roles, communication & changes								
Secrecy & caution - collusion & conflict in maintaining secrecy - sibling's reluctance to explain + outlier - suppressing v expressing feelings - caution around the sibling	3.8, 17.5, 17.8, 18.1, 18.12, 8.11, 21.21 9.6, 10.5, 9.14, 11.14, 24.22, 22.11, 24.16, 11.1	6.3, 9.19, 14.17, 15.9, 15.2, 16.14, 14.17, 7.7, 7.20, 9.5, 12.1 8.3, 22.3	5.4, 21.18, 22.15, 4.2, 9.13, 4.3, 2.19, 6.7, 6.11 8.1, 9.7, 8.17, 8.4, 12.2, 13.1, 19.1	11.4 12.11, 18.4, 22.16	13.9, 14.1, 13.16, 14.1, 6.14, 25.8, 27.8, 6.18, 3.14, 8.6, 12.1, 8.16, 12.14, 8.16, 13.7 26.2, 20.16, 21.18, 25.6, 17.20, 18.10, 19.10, 21.6	8.10, 15.3 21.3	6.11, 7.5, 10.14, 13.1, 12.4, 10.11, 11.10, 11.16, 20.9, 20.19	12.2, 11.9, 11.12, 5.8, 5.21, 13.20, 8.21, 9.5
Roles - continuation v redefining roles - reclaiming roles over time	12.5, 12.10, 12.15, 14.19	10.13, 13.19,	21.18, 22.15,	27.15	7.7, 7.11, 7.14, 10.17, 10.21, 12.18, 3.15, 22.4, 22.12, 10.19	11.11, 12.3, 15.4	14.10, 9.16, 7.3, 13.12, 15.11, 21.7, 21.13, 21.18	11.17
Pay-offs	11.1, 15.13	20.19, 10.19	3.13, 4.10, 11.6, 14.18, 17.3, 23.1, 5.2	22.13	22.19, 16.5	21.3, 21.9, 21.12, 21.17		
Changes in the family - Negative - self & sibling - Imbalance and ambivalence - self & family - criticism of parents'	21.3, 22.3, 8.11, 8.14, 13.12, 13.6, 5.12,	16.6, 7.3, 7.12, 10.9	7.4, 17.9, 9.9	23.7, 22.6, 22.11, 10.18, 28.1, 14.20, 15.10,	20.16, 5.17, 19.17, 6.6, 4.13, 4.20, 21.18,	20.10, 15.15, 12.19, 6.19, 7.18, 6.16, 7.2,	9.7, 9.16, 11.16, 29.2, 12.11, 4.6, 20.6,	19.15, 20.1, 12.6, 18.11, 10.12, 21.14, 22.2, 20.17,

behaviour - Positive - Improvement in relationships & redefining boundaries - Uncertainty about reasons for change	15.13, 22.20, 25.15, 31.9, 9.15, 8.14, 9.2, 11.15, 11.14, 23.2, 13.1, 14.1, 15.11, 22.7, 24.1, 23.9, 6.13			28.15, 17.16, 14.19, 15.2, 29.4, 13.15, 15.13, 17.17, 18.9,	25.5, 23.6, 22.19, 23.11, 16.8, 17.5, 23.14,	7.8, 20.10, 20.1, 21.3, 12.16, 13.10, 19.1, 9.16, 9.19, 19.7	5.17, 14.3	
Experience of professional help								
Barriers to seeking help - stigma and shame (+ outlier) - doubts about the value of therapy	27.11, 27.18	8.10, 14.7, 23.14	24.10	29.15, 30.1	25.15, 27.10,		31.21	24.9
Feeling judged & excluded			26.3			22.11, 22.19	22.20, 22.12. 22.15, 23.14, 25.10, 25.17, 26.1, 26.5,	
Unmet needs of the family - Emotional support & therapy - Information & guidance	28.20, 30.1, 30.5, 28.2, 28.12, 29.13		25.8, 25.7		25.15, 27.16, 24.14, 24.4	22.8, 23.13, 23.3	23.16, 24.1, 24.17	

Table 2. Final mastertable of themes and reference points

APPENDIX S – TABLE FOR LUCY REFLECTING MASTERTABLE THEMES

Mastertheme	**Themes**	**Ref (page no. line no)**	**Sample quote (taken from highlighted ref in previous box)**	**Initial notes on transcript**
Feelings of grief & loss	Shock, numbness, difficulty remembering	2.9, 4.1, **5.15**, 5.20, 5.6, 5.13, 10.15	I was just sort of you know…shell-shocked…	Shock
	Sadness & distress	2.14, 3.15, 4.14, **5.3**	I think yeah…I was…pretty low yeah, yeah	Low mood
	Guilt and shame	**2.16**, 3.4, 10.8, 10.12, 16.5	and shame…(*emphasis*) I can remember talking to somebody and…yeah…talking about sort of shame	Perception of family as dysfunctional? Shame at family?
	Anger & resentment	**3.1**, 9.9, 13.2, 16.5, 16.11	Oh…and anger…(mmm) I was furious (emphasis) at my parents, absolutely livid (emphasis) with my parents, I can remember…yeah, mad at my parents.	Anger with parents in immediate aftermath - awareness poss displaced?
	Helplessness	**2.18**	It was evident that he was going into a real despair um…and I had long conversations with him and things like that and um…I think it was that sense of (*pause 2 secs*) God, we couldn't actually help him or (mmm) you know…we didn't stop it	Helplessness
	Worry	**3.19**, 4.6, 6.8	I suppose kind of thinking "God what's gonna happen?" um…um…I remember thinking as well (pause 2 secs) you know…"I've got to face the reality of this…that there's a very strong	Fear (of reattempt)

			likelihood that ****'s gonna try again and be successful" um (pause 2 secs) so I suppose there's a lot of thinking about that	
Resilience	Trying to make sense of the attempt	4.15	when I look back at sort of...notes and things that I made at the time...I think "gosh, (*Lucy laughs*) I was in quite a black period" um...(*Lucy sighs*) trying to make some kind of sense (*emphasis*) I think of...of it...and also how I could deal with it in a way that (*pause 2 secs*) um...made it more bearable really...sort of make some kind of sense of it and move forward (mmm) with it	Trying to make sense of attempt
	Continuing life as normal	5.15, 17.7	things sort of... seemed a bit trivial and a bit mundane (mmm) when you're sort of...I was facing that (mmm) um...I don't know that it (pause 6 secs) I think I made a quite conscious effort to kind of keep (mmm) doing things (mmm) you know...and keep...(mmm) keep (mmm) a certain amount of routine	Effort to keep routine, Triviality of life in comparison to attempt
	Looking for hope & change	11.1	I think that was...there was a discussion about...(mmm) maybe we can get through this...(mmm) um...oh yeah, and talking about how sometimes perhaps it needs to get to absolute rock bottom before (mmm) anyone can (mmm,	Discussion of attempt – looking for hope Reassurance

			mmm) really pick up again	
	Acceptance	**4.18**, 18.5	I I eventually sort of came to the conclusion, "ok, I don't like ****'s choices always but I will respect them"...(mmm) and kind of put that distance almost (mmm) between us in (mmm) that sense...	Eventual acceptance of sibling's choices/detachment
	Personal changes	**19.7**	Um...perhaps it was a catalyst maybe? (mmm) Um (*pause 5 secs*) I'm not sure it wouldn't have happened anyway, (mmm) I think (*Lucy coughs*) other events (*pause 2 secs*) but I think it's certainly...I think ****'s illness has been a bit of a wake-up call for me right? Not only for suicide...but suicide...suicide attempt but (mmm) prior to that I think it's...kind of been a wake-up call so like...(*Lucy laughs*) "ok, what are you doing with yourself Lucy? How you going to...?" It's sort of...(yeah, yeah) made me think about other things that I just wouldn't have done previously...(yeah) so...	Attempt as catalyst Existing mental illness as stimulus for change
Family communication, roles and changes	**Secrecy & caution**			
	Collusion & conflict in maintaining secrecy			
	Sibling's reluctance to explain	**8.10**	I think I've...I'm sure I've said on occasions (*Lucy*	Difficulty recollecting discussion Difficulty in

			laughs) "I'm glad it didn't work" you know? (mmm) Um…yeah and I do recall him sort of saying that he can't actually recall a lot about what happened that whole period, (mmm) he just hasn't got much memory of it…(mmm) um…so I guess we must have had some kind of discussion but…(mmm) yeah.	communicating
	Suppressed versus expressed feelings	**15.3**	I think they asked me, or my aunt used to ask me and she said "I don't like to ask your mother because she just bursts into tears and I don't want to upset her" sort of thing…(*Lucy smiles*)	Suppression of aunt's feelings – leads to role of mediator/ divided loyalties
	Caution around sibling	**21.3**	but he hasn't…sort of taken the viewpoint that it would be okay to say "no" to **** (right) um (*pause 2 secs*) I've occasionally suggested it but it's like "oh well, that's the least I can do for my son"…(mmm) so now I don't (*Lucy laughs*) (*inaudible word on recording*) "ok, that's your problem"…(yeah, yeah) (*Lucy laughs*) "if you want to do that, that's fine. If you don't want to…"…	Perception of parents' passivity towards sibling
	<u>Roles</u>			
	Continuing versus redefining	11.11, **12.3**, 15.4	I think the diplomat is what (*Lucy laughs*) I have become in the family (right) a lot of the time (right, yeah) um…because there's animosity then between mum and dad about this and	Role of diplomat – divided loyalties?

			(*pause 2 secs*) (*Lucy sighs*) yeah…I've definitely (mmm) taken on the…(mmm) the um (*pause 2 secs*) you know…kind of…you know diplomat and (mmm) um…be terribly (*Lucy whispers*) sensitive about this and…	
	Reclaiming roles			
	Pay-offs	21.3, **21.9**, 21.12, 21.17	I think there's (*pause 2 secs*) quite a play-off for them to keep worrying about him…I think it's a nice focus for their marriage um…they've always got to have something to worry about so that's quite good…I think "yeah, you don't want to see your son get better cos…" (Lucy laughs) "you're gonna have to look at yourselves a bit more and…" I…I don't know if I'm seeing that accurately or not (mmm) but um… yeah…that's sort (mmm) of the pay-off I think is (mmm) to keep their attention focused on him…they don't have to look too close to home…	Perception attempts/parents anxiety about sibling displaced from focus on marriage
	<u>Changes in the family</u>			
	Negative			
	Self and sibling			
	Imbalance & ambivalence	20.10, **15.15**, 12.19, 6.19, 7.18, 6.16, 7.2, 7.8,	I suppose it's all wrapped up with feelings of guilt and what have you because (*pause 2 secs*) a bit of sibling rivalry probably, cos	Jealousy at attention given to sibling

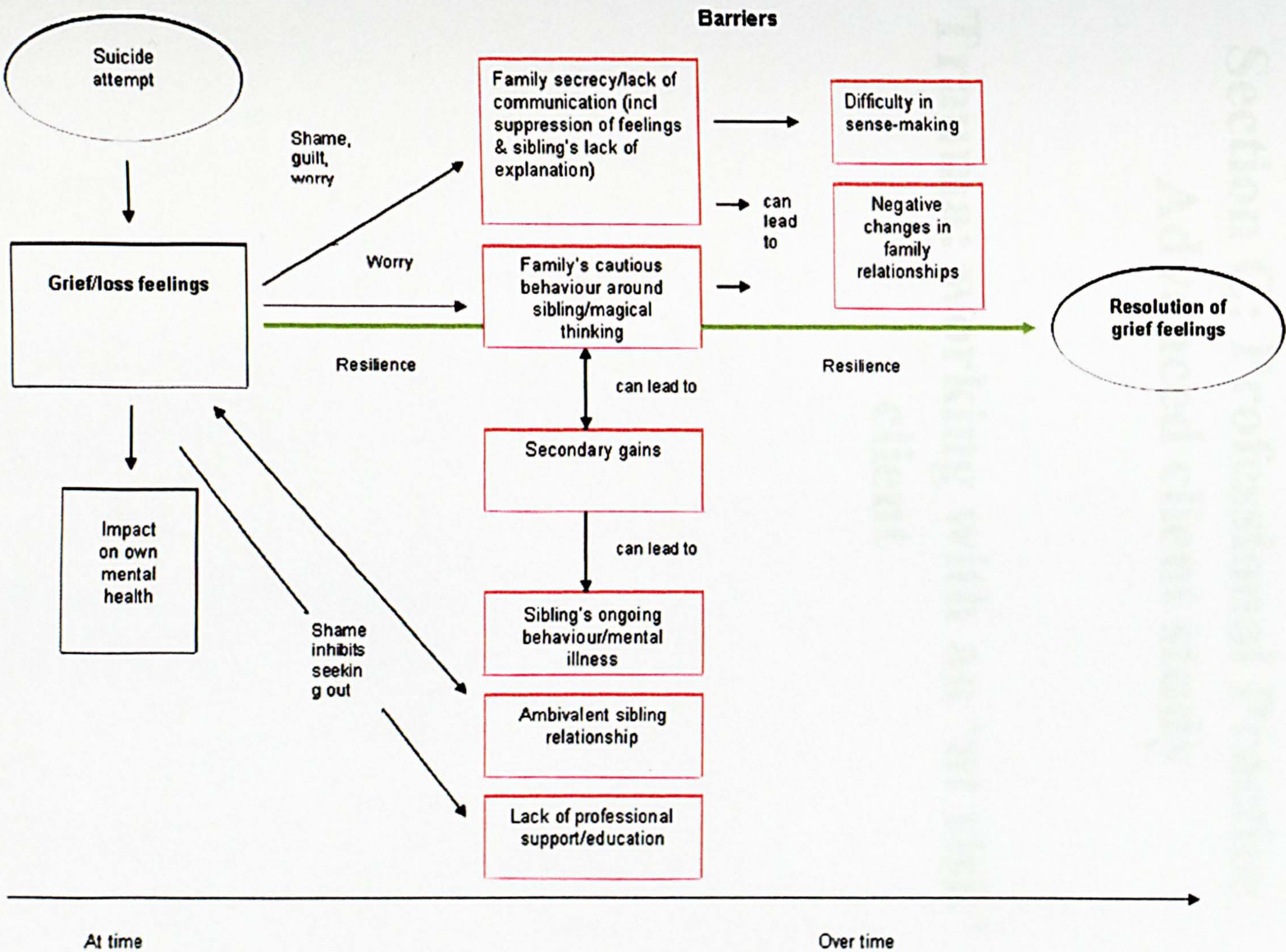
			then **** is becoming the focus of attention for my cousins' attention and "isn't **** wonderful?"...and then sort of (mmm) think (Lucy adopts a child-like voice) "oh, hang on, I'd like some attention or something" probably...(Lucy laughs)	
	Self and family			
	Criticism of parents' behaviour around sibling	**20.10**, 20.1, 21.3,	well I think that was a sort of "got to look after ****, got to take care of him", (yeah) and I was saying (*Lucy laughs*) "you're not doing him any favours by that sort of attitude you know?"	Perception of parents' behaviour as unhelpful
	Positive			
	Improvement in relationships & redefining boundaries	12.16, 13.10, 19.1, 9.16, **19.19**	now he's got his own flat and he's much more sort of...he's much more in control of the meetings (mmm) um...he'll invite my parents sometimes, they'll invite him sometimes and sometimes he'll say no and...(mmm) there's a much more sort of... independent (right) relationship there	Perception of sibling's increased independence from parents – clearer boundaries
	Uncertainty about reasons for change	**19.7**	Um...perhaps it was a catalyst maybe? (mmm) Um (pause 5 secs) I'm not sure it wouldn't have happened anyway, (mmm) I think (Lucy coughs) other events (pause 2 secs) but I think it's certainly...I think ****'s illness has been a bit of a wake-up call for me right? Not only for suicide...but	Difficulty attributing changes solely to attempt

			suicide…suicide attempt but (mmm) prior to that I think it's…kind of been a wake-up call so like…(Lucy laughs) "ok, what are you doing with yourself Lucy? How you going to…?" It's sort of…(yeah, yeah) made me think about other things that I just wouldn't have done previously…(yeah) so…	
Experience of professional help	**Barriers to seeking help**			
	Stigma and shame			
	Doubts about the value of therapy			
	Feeling judged and excluded	22.11, **22.19**	I understand that people are doing their job (mmm) there and I'm very glad they do it for **** um…but it doesn't feel very warm (mmm) and opening (mmm) for the family, (mmm) no.	Lack of warmth.feeling excluded Need for warmth/approachability from professionals
	Unmet needs of the family			
	Emotional support and psychotherapy	**22.8**, 23.13, 23.3	I am very pro-family therapy, (mmm) very (*emphasis*) pro and…it's not there (mmm) um…I think it'd be wonderful…(*Lucy sighs*) I don't think it's ever going to happen (*Lucy laughs*) in the mental health service, but I think it would be wonderful for families to be invited (yeah) um…they don't have to take it up, that's fair enough (mmm, mmm) um…but	Need for family therapy as standard

			when one of their relatives is in psychiatric, (mmm) to offer therapy for the whole family would be (yeah) fantastic	
	Information and guidance			

Table 3. Table for Lucy reflecting mastertable themes

APPENDIX T - SCHEMATIC REPRESENTATION OF KEY FINDINGS FROM THE ANALYSIS (Figure 2)



Section C: Professional Practice
Advanced client study

Trauma: working with an 'at risk' client

Part A) Introduction and the start of therapy

Introduction

This client study is based on a woman referred to an NHS trauma service. She has been chosen for this piece of work for various reasons. Firstly, she demonstrates the complexity of working with post-traumatic stress disorder (PTSD), particularly involving domestic violence. Furthermore, this work illustrates the importance of flexibility and adapting therapy according to the client's immediate needs. This study also demonstrates the challenge of working with risk, which is common to Counselling Psychologists, and the importance of working ethically. Finally, this woman is illustrative of the resilience often found in clients, and shows that therapeutic progress can be made, despite difficulties that arise over the course of therapy.

Part A explains the start of therapy, including the problem formulation and the aims of therapy. Part B discusses the content and process of the therapy over time, including difficulties encountered and the use of supervision. Part C details an evaluation of the model and my therapeutic work and interventions.

Theoretical framework

Curwen, Palmer and Ruddell (2000) describe how cognitive therapy was started by Beck in 1963, who was interested in depression. The basis of cognitive behavioural therapy, (CBT) is that distorted thinking patterns can negatively affect feelings and behaviour, leading to emotional problems. CBT aims to identify and modify negative thinking patterns and core beliefs, resulting in more positive feelings and functional behaviour. It is normally goal-orientated, is offered for a fixed number of sessions and involves the client completing tasks in between sessions.

The National Institute for Clinical Excellence (NICE, 2005), and Leahy and Holland (2000) recommend trauma-focused CBT to be used for people with PTSD. Therefore, CBT is used in the service to modify the thinking processes and behaviour that

underlie and maintain PTSD, and with other common co-morbid disorders, e.g. depression (Leahy & Holland, 2000). In line with Janoff-Bulman (1992), the client's existing schemas may need restructuring to assimilate negative beliefs formed from the trauma. Afterwards, narrative exposure therapy (NET), or eye movement desensitization and reprocessing (EMDR) may be implemented, to habituate the client to the feared memory, with the more functional beliefs integrated into the 'new' trauma memory (Foa, Steketee & Rothbaum, 1989).

Context and referral

The NHS service sees adults aged eighteen years upwards with PTSD, who are referred from their GP or psychiatrist. They complete various measures, e.g. the Impact of Event Scale-Revised (IES–R) (Weiss & Marmar, 1997), attending two assessment sessions, to gauge suitability for the service. Counselling is based on CBT, with NET or EMDR, if appropriate. Weekly individual supervision is provided by the service.

Nicola[1] had been referred by her GP to our service, to receive counselling for PTSD and depression. One of the constraints of the placement is that it shares the building with other services and it can sometimes be noisy. A common 'startle' response in people with PTSD is described in the Diagnostic and Statistical Manual of Mental Disorders *(DSM-IV)* (American Psychiatric Association [APA], 1994), therefore I arranged for a quieter room for our sessions.

Summary of biographical details of the client

Nicola was a white, slim 22 year-old woman, who was frequently casually dressed. At the beginning of therapy, her head was often bowed, with little eye-contact, and she spoke in a quiet, flat voice tone. Over the course of our sessions, she became more

[1] **For anonymity purposes, the name has been changed.**

animated and confident, taking more care of her personal appearance and maintaining eye contact.

Nicola had previously worked as a shop assistant, but she had been unemployed for three years. She lived with her younger sister and parents, and had a boyfriend. She described being bullied at school for four years, and for a long time she felt unable to disclose this to her family. When she did tell them, she believed that it was not taken very seriously, and that she often felt 'overlooked' at home. She tended to keep her thoughts and feelings to herself, and for three years she had been self-harming by cutting her arms, to cope with distressing feelings.

Initial assessment and the client's presenting problem

My initial impressions of Nicola were that she seemed shy and nervous, but likeable. She described how she had been experiencing ruminations, high anxiety, low mood and recent flashbacks, following her ex-boyfriend's attempt to drown her in the bath during an abusive four year relationship. He had subsequently been jailed, released, and again imprisoned for contacting Nicola. He was currently imprisoned for criminal activities unconnected to Nicola, and his imminent release date was currently unknown. Nicola was frequently anxious, and she was having difficulty sleeping and going out alone. She would then feel angry and low, sometimes self-harming to deal with these feelings. She wanted help to decrease her anxiety, to reduce her self-harming behaviour and to lift her low mood.

My supervisor had undertaken an initial assessment with Nicola, and I had sat and observed the second assessment with her. It appeared that Nicola fulfilled the criteria for PTSD (*DSM-IV*, APA, 1994); she had experienced a life-threatening situation, with feelings of helplessness; she had symptoms of emotional 'numbing'; she was re-experiencing the trauma through flashbacks; she was constantly avoiding trauma-related stimuli, and she had recurrent arousal. Furthermore, her symptoms had lasted over a month and were significantly impairing her life (see appendix A for full PTSD criteria).

Negotiating a contract

I explained to Nicola that she was suitable for CBT with our service, and that we would be working collaboratively. I explained the boundaries of confidentiality regarding risk to self and others, and the use of supervision. She signed an agreement form, permitting me to tape future sessions.

We negotiated twelve weekly appointments, which would finish on time even if she arrived late. This is the initial number offered by the service, but we agreed to review this in the twelfth session, with the option to extend these further if needed.

Problem formulation and therapeutic aims

Life stressors

Lack of communication in the family during childhood, with a perception that her needs were overlooked by her family.

1996 – 2000 – She was bullied at school.

2000 – 2004 – She moved out of home and experienced an abusive relationship.

2004 – She was a victim of an attempted drowning in the bath during the abusive relationship.

2004 –She lost her job due to non-attendance.

2005 – Her grandmother died.

2006 – Her ex-boyfriend broke his bail conditions and approached her, after his first release from prison.

Cognitive behavioural profile

Cognitive factors

Nicola showed the following thinking errors, as described by Curwen et al. (2000): dichotomous (either being "weak"or "strong"); personalisation ("It's my fault I was attacked"); and overgeneralisation ("All strangers will hurt me"). These are the most common thinking distortions in people with PTSD (Leahy & Holland, 2000). She also showed underlying beliefs of "I'm unworthy" and "My needs don't matter", linked to low self-esteem. Nicola also had underlying assumptions such as "If I trust people, I will be hurt", particularly related to young men with whom she was unfamiliar.

Behavioural factors

Nicola seemed hypervigilant, avoiding trauma-related situations, (such as having a bath), and going out alone. She expressed anger through outbursts and self-harming behaviour, such as cutting herself.

Emotional factors

Nicola had recent intrusive memories of the attempted drowning, anxiety at trauma cues, feelings of detachment from people and low mood. She also felt angry and ashamed, and she lacked assertiveness skills.

Depression

Nicola presented with depression, and scored in the severe range in the Beck Depression Inventory (*BDI-II*) (Beck, Steer & Brown, 1996). She was encouraged to see her GP to review her anti-depressant medication. She also scored significantly on the *I.E.S–R* (1997).

Physical factors

Nicola was experiencing anxious feelings, such as tense muscles and a racing heart. She lacked concentration and she had sleep disturbance.

Social factors

Nicola had the support from family and friends, but she believed that they sometimes lacked understanding. She described her boyfriend as "supportive" but sometimes felt detached from him. She had withdrawn socially as she was fearful of going out alone, of being in crowded places, and of being around unfamiliar, young males.

Problem formulation

Nicola appeared to have chronic PTSD and severe depression. Her PTSD symptoms seemed to have been precipitated by a particularly violent assault during an abusive relationship, in which she was almost drowned. Lack of communication in her family and a perception that that she was overlooked during her childhood, appeared to inhibit her expression of needs and feelings. This experience, combined with being bullied at school, appeared to have resulted in core beliefs such as "I'm worthless" and "I'm vulnerable". Being involved in an abusive relationship seemed to have strengthened her negative schemas of powerlessness and unworthiness. The traumatic memory of the serious assault evoked great anxiety, resulting in hypervigilance and the avoidance of trauma-related cues. This maintained her anxiety, reinforcing her assumption "People can't be trusted", which perpetuated her social withdrawal. Safety behaviours such as always being accompanied when going out strengthened her assumption "I need someone with me to be safe", alongside feelings of helplessness and low mood. Ruminations of the abusive relationship maintained deeply angry feelings, and difficulty in managing these feelings resulted in self-harm as a strategy of dealing with them. This then led to low mood and feelings of shame, further reinforcing her core beliefs concerning worthlessness. Other factors maintaining her PTSD and depressive symptoms were being unemployed leading to increased time to ruminate, uncertainty regarding her ex-boyfriend's release date from prison and his previous unpredictable behaviour, low self-esteem, lack of assertiveness, and negative thinking errors. Protective factors were a now supportive family and current

boyfriend, support from the police, and the imprisonment of her ex-boyfriend, with him not making contact with her for some time (see appendix B for cognitive conceptualisation diagram).

Therapeutic aims

- Reduce self-harming behaviour by teaching alternative coping strategies.
- Reduce low mood.
- Reduce anxiety in going out alone and engaging in activities being avoided, (e.g. taking a bath instead of a shower).
- Reduce intrusive memories and ruminations of trauma, through cognitive restructuring of dysfunctional thoughts and meaning attached to the trauma.
- Relapse prevention through psychoeducation and relapse plan.

Nicola's long-term goals were to re-start working, and to be driving again. We contracted for an initial 12 sessions, which was extended to 24 sessions, with the agreement of my supervisor.

Part B) The development of the therapy, difficulties encountered and the use of supervision.

First phase of therapy

Nicola appeared to have a largely shame-based reaction to her trauma, i.e. her experiences were mainly ruminatory and accompanied by feelings of helplessness and guilt. Herman (1992) suggests that people who have these feelings and who have experienced prolonged abuse (e.g. domestic violence), may have a more complex form of PTSD. Adshead (2000) discusses the importance of safety and the therapeutic relationship with these clients, since they often have little ability to self-soothe. I initially concentrated on demonstrating core counselling skills of acceptance and empathy, creating a safe space for Nicola to open up, building "a sound therapeutic

alliance", as required in CBT (Beck, 1995). This was particularly important given Nicola's underlying assumptions concerning trust in people and feelings of shame.

Nicola was socialised to CBT as advocated by Beck (1995), and given psychoeducation on PTSD and depression, and told the nature of the therapeutic work. Normalising symptoms is an important part of therapy for PTSD (Leahy & Holland, 2000), and Nicola was reassured to learn that she wasn't 'going mad'.

During supervision and as recommended by Beck (1995), we decided Nicola's safety was of primary importance due to her current level of risk to self, (from cutting) and from others, (her ex-boyfriend). Linehan (1993) advises focusing on emotional regulation and distress tolerance to reduce impulsive behaviour, (i.e. self-harming). Furthermore, Leahy and Holland (2000) recommend that trauma exposure work cannot begin until the client is stable. As a consequence of risk issues, many sessions began with clarification of the legal circumstances of Nicola's ex-boyfriend, the advice from police regarding exposure work and any safety measures in place, alongside assessment of her self-harming behaviour.

Supervision was an important support for my anxiety at this time since I had not worked with a client in this situation before, and it was important that I could contain Nicola's anxiety. I was also experiencing a sense of responsibility for Nicola's safety should her ex-boyfriend be released from prison and approach her, and these transferential issues needed to be addressed. I also learned through supervision about therapeutic practicalities, such as assessing risk and thoroughly documenting the outcomes from this in the clinical notes.

Although we had started exploring some of her angry thoughts during our sessions to challenge her personalisation thinking, Nicola felt that learning to express her anger less self-destructively was very important. My initial thoughts, in line with traditional clinical practice were to encourage her to express her anger cathartically, e.g.s. by punching a pillow or writing a diary. However, supervision was valuable in directing me to more recent contradictory research, (e.g. Bushman, 2002), which suggests engaging in anger can actually worsen it, in view of Nicola's ruminations. With this in mind, Nicola and I experimented with self-soothing and distraction strategies

recommended by Linehan (1993), of which she found listening to classical music and diaphragmatic breathing the most effective. We also devised a written crisis management plan, as suggested by Rudd, Joiner and Rajab (2001), including asking her mother to lock away sharp objects to minimise her risk of self-harming, and telephoning her boyfriend or a good friend for support.

Another major difficulty for Nicola was coping with anxiety and recent flashbacks. Supervision was helpful alerting me to anxiety management and grounding techniques that gave Nicola a sense of control and instant relief from the distress (Leahy & Holland, 2000). We experimented with these in our sessions, and Nicola found that positive visualisation of a happy holiday and grounding herself, by focusing on her external surroundings were particularly effective in reducing the intensity of her flashbacks. I also learned from supervision that symptoms may worsen in the time surrounding trauma anniversaries (Morgan, Hill, Fox, Kingham & Southwick, 1999). In discussing this with Nicola, we discovered that the anniversary of the attempted drowning coincided with the temporary occurrence of her flashbacks, and I therefore realised the importance of keeping in mind the anniversaries of traumatic events when working with clients. It was enlightening for me to see how simply providing psychoeducation about trauma anniversaries and flashbacks immediately reassured Nicola, and combined with distraction and grounding techniques, her flashbacks abated.

During this time we also focused on Nicola's low mood, when she kept a thought diary to start challenging unhelpful thinking that was maintaining it. I also encouraged her to do some form of physical exercise, since she had previously found this enjoyable. Since she felt unable to leave the house much at this stage, we decided on an activity she could do at home, such as using an exercise or dance DVD. Nicola described finding this helpful as she felt better after doing some physical exercise, and it helped to reduce the rumination time that was maintaining her anxiety and low mood.

Second phase of therapy

About a third of our way through the sessions, Nicola felt able to start facing her anxiety about going out to places alone, originating from a sense of vulnerability and a fear that she would be attacked. Therefore, I provided psychoeducation about the nature of anxiety and how it is maintained by avoidance and safety behaviours, such as always being accompanied by someone. In accordance with Leahy and Holland (2000), we then compiled a list of situations she feared, assigning fear ratings and arranging them into a hierarchy. The hierarchy was fairly comprehensive, and ranged from situations such as standing alone outside the front door for five minutes to her most feared situation, taking a bath when she was alone in the house, with the bathroom door unlocked.

Wells (1997) suggests that exposure should be undertaken without relaxation to demonstrate that anxiety is tolerable. However, my supervisor and I agreed that due to Nicola's distress levels, that relaxation should be paired with exposure. This is supported by Leahy and Holland (2000) who report there are no studies showing superiority of one approach over another. Consequently, Nicola felt more able to attempt these tasks and more readily agreed to the exposure work. The police also supported the exposure work since Nicola was 'safe', i.e. her ex-boyfriend was still in prison and there was no current suggestion that he would contact or threaten her upon his release. However, we were mindful of precautions to take upon his release if he approached her, such as relaxation not being appropriate if she was in immediate danger.

I found this part of the therapeutic process challenging, since CBT normally involves helping the client to challenge unhelpful thoughts, but in Nicola's situation there was some basis to her anxiety. It was a delicate balance encouraging her to reduce her anxiety and to go out alone, but at the same time not wanting to compromise her safety.

Time was spent challenging Nicola's absolute beliefs maintaining her symptoms, such as "Strangers can't be trusted" by considering evidence for and against the belief, and

evaluating the trustworthiness of various people on a continuum (Leahy & Holland, 2000). Initially, Nicola found the cognitive work in between sessions difficult, struggling to challenge her negative thoughts maintaining her anxiety. Therefore, we agreed to change to a more behavioural homework, and she found this more effective in decreasing her anxiety, and in increasing her confidence. For example, trusting people in little ways was a behavioural experiment that she undertook to test out her negative predictions (Leahy & Holland, 2000). Furthermore, each time that she completed in-vivo exposure of a feared situation, she was disconfirming her certain assumption that "I will be hurt if I go out alone". We started by practising imaginal exposure during the sessions with tasks at the lower end of her fear hierarchy, using relaxation exercises and challenging any negative cognitions that arose. We then set in-vivo exposure as work for her to do in between sessions, and during this time I learned the importance of being flexible and collaborative, and to follow the client's needs. For example, Nicola preferred some tasks to be broken down into smaller goals, such as initially walking halfway to the local shops by herself, and gradually increasing the amounts of time she spent at the shops by herself. In this way, the tasks felt more achievable and it also reduced her thoughts of 'failure'. At the same time, Nicola attempted other tasks more readily. Occasionally, she would achieve a task we had set her to do between sessions, but she would also complete another one that was higher on the fear hierarchy, that we had not set. In reflecting on this in supervision, I realised that perhaps at times I was underestimating Nicola's ability to manage her anxiety and that I was taking too much responsibility for her behaviour. Therefore, my caution could have been perceived by Nicola as reinforcing the powerlessness that she had experienced in her life. I realised that it was Nicola, ***not me*** that was the expert in judging her capabilities, and that *I* needed to have trust, and for me that was in the therapeutic process.

The difficulty in our work during this time was waiting for the release date from prison for her ex-boyfriend, and the uncertainty of whether or not he would approach her again. Unfortunately, at the time of his imminent release, Nicola disclosed to me that she had taken an overdose of anti-depressants three days previously. She had discovered that he was due for release the following day, and her catastrophic thinking that he would kill her was so great that she impulsively decided to kill herself before he could do it. It seemed that her sense of hopelessness overwhelmed her so

much that she panicked, preventing her from following our crisis plan. Although I felt upset at this, I was encouraged that Nicola had disclosed this to me, as I felt that it demonstrated the trust in our relationship. Her intent and feelings of regret and shame were discussed, along with reasons for living. As recommended by Rudd et al. (2001), she rated her hopelessness on a continuum at the beginning and end of the session. It emerged that Nicola did not want to die, but at the time of the overdose she believed that it was her only way of escaping an unbearable situation, resonating with literature by Williams (2001). In common with other suicide attempts, it seemed that there was some ambivalence to Nicola's actions (Williams, 2001). On the one hand, she had written a suicide note to her family implying serious intent to take her own life, yet she had taken the overdose in the family home, where she knew they would be returning shortly.

We then challenged Nicola's belief that her ex-boyfriend was absolutely certain to harm her. For example, he had not approached her the last time he was released from prison, and he would be immediately sent back to prison should he approach her. Williams (2001) discusses that any circumstance that fuels feelings of helplessness can increase a suicide risk. Therefore, we also focused on what she *could* do should her worst fears be realised, such as the safety measures she had in place, how she could defend herself and the possibility of a witness protection scheme. This appeared to give her some sense of empowerment and helped to disprove her absolute belief "I am helpless", commonly found in traumatised people (Herman, 1992). Periodic ratings of Nicola's emotional upset were gained throughout the session, demonstrating that her distress would decrease, and to encourage self-monitoring of her emotions and decrease impulsive actions after the session. We reviewed our crisis plan, such as asking her mother to keep hold of the medications in the house, and she agreed to give a copy to her family immediately after the session, since she did not want help from our crisis team. The attempt had opened up a dialogue between Nicola and her family, and she felt more supported as a result of this. By the end of our session, she rated her suicidal thoughts as very low. However, we agreed on a telephone consultation before our next session. Furthermore, she would see her GP, since she had refused to seek medical help following the attempt. We also agreed that I would also write to him to advise him of the situation.

Immediate supervision afterwards was helpful, both practically and emotionally. I felt guilty that I had not spotted the 'warning signs', commonly felt among therapists in similar situations (Fox & Cooper, 1998). My supervisor was reassuring and containing, emphasising that I had done everything possible, and that Nicola had not displayed any signs of suicidality in previous sessions. We discussed my empathy, and I realised that I also felt anxious and experienced a sense of hopelessness at the situation with her ex-boyfriend, but I had to take care to instil hope in Nicola. I learned that crisis intervention had to take precedence during this time (Beck, 1995), and not to introduce exposure or behavioural work whilst she was vulnerable (Leahy & Holland, 2000). Having to respond to Nicola's immediate needs, and to postpone a prescribed 'treatment plan' was challenging for me at this time. I realised that I like to feel 'in control' of the therapeutic process, and I learned that it is important that the therapist is adaptable to the client's current circumstances and not motivated by their own need to 'achieve results'.

Consequently, the next few sessions were spent assessing Nicola's level of risk and reviewing anxiety management techniques, and she described no further suicidal thoughts or behaviour. Accordingly, we agreed to extend therapy by another twelve sessions. Fortunately, Nicola's ex-boyfriend made no contact, and this provided behavioural disconfirmation of her belief that he was certain to kill her, decreasing her anxiety and providing evidence towards her new belief of "I'm safe enough".

Once Nicola felt more stable, we explored her beliefs around the trauma of almost being drowned, such as her personalisation thinking of "I should have fought back". As suggested by Leahy and Holland (2000), we explored the choices and knowledge available to her at the time. For example, fighting back in this situation may have endangered her life even more, and eventually we modified the belief to "I did what I could in a life-threatening situation". Previously, she seemed to believe that there was some unknowable solution available to her at the time of the trauma, without negative repercussions, common in traumatised people (Scott & Stradling, 2006). We also discussed how she had stayed in the relationship to protect the lives of herself and her family, due to her ex-boyfriend's threats against them, with reflection on the courage it took for her to eventually leave him. Nicola found this enlightening, and realised that she did what she could at the time, and that she needed to be kinder to herself.

Nicola's core belief of "I'm unworthy" had been further reinforced by the apparent leniency of the court's sentencing of her ex-boyfriend, which she attributed to her unworthiness as a person. Unsurprisingly, this made her feel low and angry. Using Socratic questioning and writing down evidence for and against this belief (Beck, 1995) helped her to see the sentence was unrelated to her worth as a person. Later on, she was able to apply this learning when her "unworthy" belief arose in other situations, such as when her current boyfriend ended their relationship. My empathy with Nicola meant that I also felt powerless and angry with the justice system. In exploring these feelings in supervision, I learned the importance of validating Nicola's angry feelings, but to also discourage rumination, as discussed previously. I found that I had to also apply this to myself.

Third phase of therapy

I noticed a shift in Nicola's thinking after the suicide attempt, also reflected in her appearance and demeanour, such as maintaining eye-contact, walking with her head held up and wearing make-up again. We spent time challenging her trauma-related beliefs such as "What happened was my fault", common among traumatised victims (Herman, 1992). Nicola liked the visual aspect of the responsibility pie (Leahy & Holland, 2000), and rating her belief in that thought periodically helped her to see the progress she was making in decreasing her personalisation thinking (Curwen et al., 2000). Encouragingly, she was no longer self-harming, as her angry feelings externalised towards her ex-boyfriend, which we discussed in the sessions.

Although Nicola's nightmares had significantly reduced, supervision taught me the importance of helping the client to explore and 'rescript' them, giving a sense of control (Davis & Wright, 2006). Therefore, we challenged schemas of helplessness and vulnerability that occurred in her symbolic dreams, and Nicola found this empowering. Eventually, she was rarely having nightmares, and if she did, she was able to soothe herself back to sleep.

Alongside the agreement of the police, Nicola was happy to resume her behavioural work, managing to complete all the items on her fear hierarchy, with significantly less anxiety. As advocated by Beck (1995), she was by now setting her own in-vivo work to do between the sessions. I learned in supervision that due to Nicola's vulnerability and her thoughts being of a more ruminatory and shame-based nature rather than re-experiencing, that NET was not appropriate in addressing her fear of taking a bath. Indeed, Adshead (2000) discusses how this could increase distress in someone who struggles to tolerate difficult feelings. Therefore, Nicola and I challenged her cognitive distortions around this 'hotspot', which she was finding easier to do. In between sessions she completed in-vivo exposure of taking a bath, breaking it down into manageable steps, as suggested by Beck (1995). For example, she started by sitting in the bath without water, gradually increasing the time she spent in the bath, and eliminating the safety behaviour of only taking one when a family member was in the house. Initially, when she occasionally found herself re-experiencing the trauma, she would run the cold water tap over her feet to 'ground' herself. Eventually, she was able to take a bath alone, with the door unlocked, and with significantly less anxiety than at the start of therapy. Throughout the sessions I positively reinforced Nicola's progress (Curwen et al., 2000), and I was happy to see her growing in confidence.

There seemed to be a great change in Nicola over the therapeutic process, in that her beliefs of worthlessness and fear of her ex-boyfriend seemed to be replaced by one of determination to move on with her life. In addressing relapse prevention, Nicola and I spent time reviewing her coping strategies and examining how she would manage future distress, adding to her written crisis plan. For example, we discussed how she would cope with a possible revival of her PTSD symptoms on the next anniversary of the trauma, and how she would manage a scenario of encountering her ex-boyfriend. She had taken the decision to provide evidence in court against him in a case of his assault on someone else. Although anxious, she was keen to undertake this, saying that she felt stronger and she was even prepared to appear in court without a witness screen. This showed a change in Nicola's self-esteem and her personalisation thinking; in the past she believed that she deserved the abuse, and now she recognised that her ex-boyfriend was responsible for his actions. My supervisor's experience in domestic violence court cases was particularly useful in advising me how to help Nicola plan how she would do this, e.g.s. finding out beforehand the court processes,

preparing her statement, and reviewing the anxiety management techniques that she would use, if needed. Imagining what thoughts and feelings might come up at difficult times such as this, and how she would manage them formed part of the relapse prevention plan that we produced. I was surprised to learn in supervision that some victims of domestic violence return to the perpetrator to 're-work' the trauma. Therefore, although it seemed highly unlikely with Nicola, I was aware of this possibility.

Nicola and I agreed that all the goals of therapy had been met, as her low mood, anxiety in going out alone and self-harming behaviour had reduced. Furthermore, ruminating and re-experiencing the trauma had also decreased. She was now working part-time and about to change to a full-time position, and she was driving again. The assessment measures showed that she now fell into the non-clinical range for depression and PTSD, supported by Nicola's anecdotal comments. As recommended by Beck (1995), we spaced out the last sessions, and in discussing ending, she said she now felt ready to cope by herself. I reflected in supervision that I felt almost like a mother, letting a child 'fly from the nest'. She did not want a referral on for further support, although she was given a resource list. Although I was aware that some progress was due to Nicola's ex-boyfriend no longer contacting her, I greatly admired her courage and motivation to work therapeutically. I truly felt we had shared her difficult journey together.

Part C) Evaluation of my therapeutic work, interventions and the model used.

I think Nicola and I had "a sound therapeutic alliance" (Beck, 1995), working collaboratively in our sessions and negotiating homework. I believe that we had built trust into our relationship, shown for example by her disclosure of shame at her suicide attempt, and her regular attendance of the sessions.

Although it was my supervisor's decision for me to use CBT for the reasons mentioned previously, and from her own research, I believe it was the appropriate

model for this work. This is because Nicola was overwhelmed by her feelings, and modifying her beliefs and behaviour was needed through CBT to decrease her PTSD and depressive symptoms. Although self-soothing techniques originate from dialectical behaviour therapy and it was my supervisor who encouraged me to use them, I believe that these and the grounding techniques were particularly helpful to Nicola, giving her a sense of control over her feelings. This was important due to their overwhelming nature, and Nicola's schema of powerlessness. The in-vivo exposure work was also very effective in undermining Nicola's negative beliefs, and breaking tasks down into manageable steps was imperative for Nicola to feel able to undertake them. It seemed that a client with schemas of powerlessness benefited from initial behavioural work which provided tangible 'evidence' of her sense of efficacy, which then facilitated cognitive restructuring. Furthermore, being collaborative in setting the exposure tasks and working at the client's pace also seemed to add to Nicola's sense of empowerment and to the trust in our relationship.

The theme of empowerment also appeared to be very important and beneficial to Nicola through interventions such as 're-scripting' her upsetting dreams, and imagining how she could effectively manage a future court case involving her ex-boyfriend. Furthermore, focusing on what she *could* do in a difficult situation, and instilling hope was an important part of therapy following her suicide attempt, to decrease her feelings of helplessness and hopelessness.

In relation to the suicide attempt, I have realised in hindsight that in anticipating the imminent release of her ex-boyfriend, it would have been useful to have explored earlier on Nicola's beliefs of hopelessness and helplessness surrounding this. At the same time, her impulsivity may still have prompted her actions, and she had shown no signs of suicidality prior to the suicide attempt. Nevertheless, I could have been more mindful of these feelings and attempted to draw them out, rather than waiting for Nicola to raise them. Her suicide attempt was also a learning experience for me in how to thoroughly assess a client's risk to self, recognising the importance of instilling hope in a client, and in not taking too much responsibility for a client's actions.

Although we staggered the last few sessions, it would have been preferable to have started this earlier on, and had longer gaps in between, reinforcing Nicola's sense of competency and dealing with any possible dependency issues (Beck, 1995). Furthermore, although our large number of sessions was partly due to the complexity of the problems, I have since reflected that we could have finished slightly sooner, and I wonder if my own feelings about endings had influenced this. I need to be aware of this in the future, and to be careful not to encourage dependency in a client, stemming from my own needs.

Nicola rarely missed a session, and always completed her homework. Given her history, I have since wondered if she was trying to 'please me', and it is something I could have addressed with her. It would be interesting to think how I would have felt had she not been so motivated. Furthermore, I am aware that her ex-boyfriend's decision not to approach her was also a factor in our therapeutic progress, and I understand that the course of therapy may have been very different if he had made contact with her.

Above all, my biggest learning has been the importance of therapeutic collaboration, of adapting therapy according to the client's immediate needs, and of recognising the resilience in clients. I am slowly becoming more comfortable with 'not knowing' what a client will bring to a session, and letting the sessions be more client-led, rather than following a 'textbook'. I hope that my experience of working with a client in a complex situation will give me confidence in my therapeutic work in the future.

Post-research reflections on the application of the findings to the therapeutic work

I saw Nicola before the emergence of the findings from my research in this portfolio. However, I would like to briefly reflect on how some of my findings (see appendix S) could have been applied to my therapeutic work with her, if I been aware of this knowledge at the time of our therapeutic work.

Since the findings reveal a lack of communication and possible shame within the suicide attempter, I could have looked for and explored these feelings in Nicola following her suicide attempt. Although she said that the attempt had opened up a dialogue with her family, I am unsure of their perspective and particularly the impact on her sibling. Although trying to avoid intensifying possible feelings of shame, I could have encouraged Nicola to reflect on the impact of her actions and how these could have caused possible changes in family dynamics. Issues of family communication could have been discussed in our sessions. Encouraging Nicola to discuss her feelings and motivation for the attempt with her family could have quelled any persistent fears they had of a re-attempt. An assessment could have been undertaken (by someone else) with her family, particularly her sibling, following the attempt, to ascertain whether or not they required support or family therapy. However, this could have been problematic due to Nicola's refusal in receiving medical help.
Although I eventually recognised the resilience within Nicola, the findings could have alerted me sooner to the importance of realising and fostering this quality.

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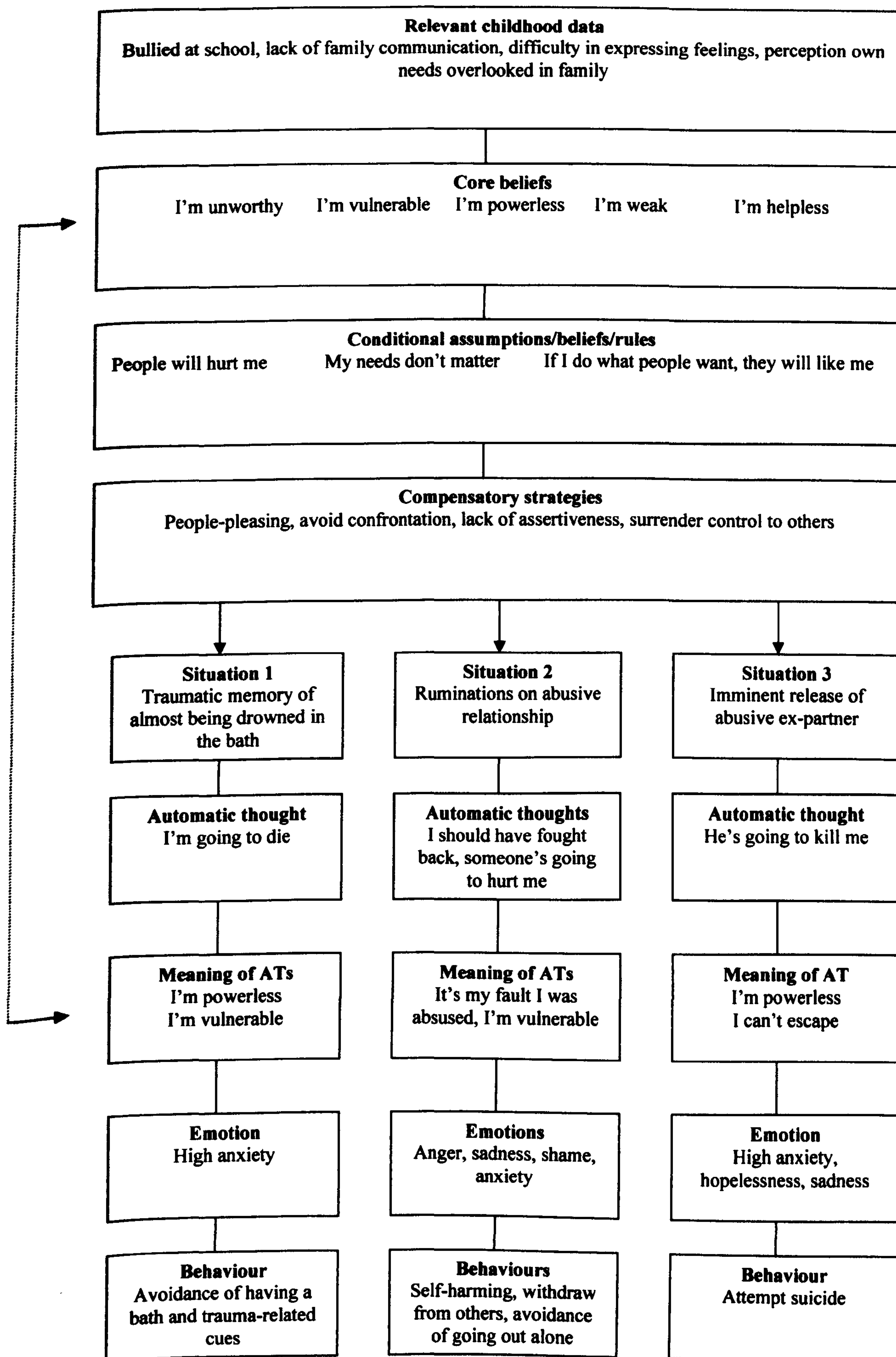
Appendix A - Diagnostic criteria for Post-traumatic stress disorder (*DSM-IV*, American Psychiatric Association, 1994)

A. The person has been exposed to a traumatic event in which both of the following were present:
(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
(2) the person's response involved intense fear, helplessness, or horror.
Note: In children, this may be expressed instead by disorganized or agitated behavior
B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
(1) recurrent and intrusive distressing recollections of the event,
including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
(2) recurrent distressing dreams of the event.
Note: In children, there may be frightening dreams without recognizable content.
(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response
E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

APPENDIX B – DIAGRAM OF COGNITIVE CONCEPTUALISATION FOR NICOLA (Figure 1)



Section D: Critical literature review

Adolescent suicide: a review of possible risk factors, and their implications for Counselling Psychology

Introduction

There are several reasons why this review focuses on suicide in adolescents. There has been a worrying global increase in suicide in young people, and it is the second cause of death in people aged 10-24 years old in some countries (World Health Organization [WHO], 2009). Furthermore, Arnett (1999) argues that there is a greater probability of stress during adolescence than at other times through the life-cycle, and additionally there appears to be a lack of mental health service provision for this population (Smith & Leon, 2001). Youth suicide has an impact on family, friends and professionals, therefore addressing this issue is important for society as a whole.

The issue of suicide is very relevant to Counselling Psychology. Clients may seek therapy at a time of distress and vulnerability, therefore the prospect of suicide is a plausible possibility. A study of counsellors by Rogers, Gueulette, Abbey-Hines, Carney and Werth (2001) revealed that 71 per cent of the participants experienced at least one attempted suicide by a client, whilst 28 per cent had at least one client die by suicide. Moreover, a Counselling Psychologist has responsibility to assess a client for risk of harm to self and others. Increasing our knowledge of what may lead to youth suicide can facilitate Counselling Psychologists to be aware of the 'warning signs' and to help support these clients, whilst encouraging us to explore more useful intervention strategies.

For the purpose of this review, the terms 'adolescence' and 'youth' are used interchangeably. The age-group used in most of the studies ranges from 13 years to 19 years old, however statistics classify those to an upper age limit of 24 years. There is a vast amount of literature detailing multiple and complex risk factors that may be associated with adolescent suicidal behaviour. Due to the scope of this review, the discussion is not exhaustive, and instead focuses on just *some* of the psychiatric, psychological and familial risk factors related to adolescent suicidality. Furthermore, this appraisal is limited to research that is empirical and has been published in the last 12 years (1997-2009).

There is considerable debate in the literature regarding the definitions of 'self-harm', 'deliberate self-harm' and 'attempted suicide', due to the frequent difficulty in ascertaining the true intention of the action. Favazza (1998) uses the term 'self-mutilation', distinguishing this behaviour as a form of self-help to obtain relief from distressing feelings, as opposed to the intention of suicide to end all feelings. Indeed, Favazza (1998) asserts that self-harm can be viewed "as a morbid form of self-help that is antithetical to suicide" (Conclusion, para.1). He therefore views self-harm as a way of continuing life, in contrast to suicide as a way of ending life. Accordingly, this review is based on literature which relates to suicidal behaviour as a perceived intention to die, as opposed to self-harming as a coping behaviour.

Initially, there is a brief overview of the epidemiology of adolescent suicidal behaviour, followed by a review of the findings regarding psychiatric disorders. Some personal and psychological risk factors are then discussed, since these are all aspects of suicidal adolescents that a Counselling Psychologist may encounter in a therapy session. Finally, as our personality and behaviour are hugely shaped by our family environment (Parke & Buriel, 1998), and Counselling Psychologists often work systemically, there is a review of the familial circumstances that may be linked to adolescent suicidal behaviour. At the end of each section is an explanation of the implications for Counselling Psychology. Finally, there is a general critique of the literature, with a summary and conclusions of the evaluation.

Epidemiology of adolescent suicidal behaviour

Although there has been a recent increase in youth suicide rates worldwide, in the U.K. in recent years there has been a slight decrease (WHO, 2009). In 2002, the number of suicidal deaths in the 15-24 age-group was 5.3 per 100,000 (WHO, 2005), and in 2007 it was 4.6 per 100,000 (WHO, 2009).

However, it is important to note that the number of suicides is frequently underestimated, depending on the country that is supplying the statistics. The main reason is the way in which suicide is determined, but stigma, social and political issues may also play a part. Therefore, some suicides may be reported as accidental or

unknown cause (Andriessen, 2006). Furthermore, suicide attempts are not included in these statistics, with an estimate that the figure would be twenty times higher if they were available (WHO, 2009). With this in mind, suicidality in adolescents is an important issue to be considered.

Suicide appears to be more common in older adolescents, shown by the number of suicides in the U.K. and Northern Ireland in 2007: 14 in the 5-14 age group, and 379 in the 15-24 age group (WHO, 2009). Brent, Baugher, Bridge, Chen and Chiappetta (1999) suggest that this difference may be due to the increased pervasiveness of psychopathology in older teenagers.

In the U.K. and Northern Ireland in 2007, there were 309 male suicides, and 70 female suicides in the 15-24 age group (WHO, 2009). This gender difference in adults is representative of most countries for whom the WHO has data, with a noticeable exception being rural China (WHO, 2009). However, the opposite is true for *attempted* suicide, with the number of female adolescents being much larger than male youths (Fergusson, Woodward & Horwood, 2000).

Risk factors and psychiatric disorders

There is substantial literature suggesting that many psychiatric disorders are hugely influential in adolescent suicidal behaviour. Regarding depressive orders, many studies demonstrate a strong and direct relationship between depression and teenage suicide (e.g. Kim & Kim, 2007). Thompson, Mazza, Herting, Randell and Eggert (2005) found direct independent effects of depression on male American students at high risk of prematurely leaving high school. This supports findings by Roberts and Chen (1995) and Walter et al. (1995). However, the self-report study by Thompson et al. (2005) involved a selected male student population that cannot be generalised to females and other populations (e.g. non 'drop-outs'), and further longitudinal research is needed to confirm cause and effect relationships. Moreover, as the researchers suggest, this study was based around a hypothesised theoretical model and this could have 'guided' their findings. Thompson et al. (2005) state that other mental health problems such as anxiety are co-morbid with depression.

One of the strongest associations with adolescent suicidal behaviour according to the literature is that of mood disorders (e.g. Fleischmann, Bertolote, Belfer & Beautrais, 2005). In a multi-ethnic study of youth populations in the U.S.A. and Puerto Rico, Gould et al. (1998) found a much increased likelihood of completed and attempted suicides in both genders, when experiencing a mood disorder. In a case-control study of a New Zealand sample of adolescents, 70.5 per cent had an affective disorder at the time of attempt (Beautrais, Joyce & Mulder, 1998). However, Brent et al. (1999) discovered in a psychological autopsy that mood disorders were more common in female suicide victims.

Another area that has been studied is that of anxiety disorders, with various studies showing a significant correlation between anxiety disorders and youth suicidal behaviour (Beautrais et al., 1998). However, when the effects of mood disorder have been statistically controlled, there is no significant association between anxiety and suicide risk (Shaffer et al. 1996). Furthermore, Thompson et al. (2005) found that anxiety was only indirectly linked to suicidal behaviour through its effect on hopelessness and depression. This suggests that anxiety disorders only increases suicidal risk when co-morbid with other mental disorders. In contrast, surveys in a community study of American students revealed that after controlling for depression and substance abuse disorders, that there was an increased risk of suicidal behaviour in students experiencing panic attacks (Pilowsky, Wu & Anthony, 1999).

In a study of American high school students, Mazza (2000) supported his hypothesis that there was an association between post-traumatic stress disorder (PTSD) and suicidal behaviour, even after controlling for depression and gender. However, other confounding variables were not controlled for, and this was a very small-scale study so the results cannot be generalised beyond this population. A larger study by Wunderlich, Bronisch and Wittchen (1998) found that there was only a significant correlation when other co-morbid disorders were involved. No psychological autopsy studies have so far shown previous symptoms of PTSD, therefore further research is clearly needed in this area.

Although there has not been an abundance of research, there may be a significant relationship between abnormal eating habits and suicidal ideation (Beautrais, Joyce & Mulder, 1996; Borowsky, Resnick, Ireland & Blum, 1999). It would seem intuitive that other confounding variables would be involved, and this is demonstrated in a study by McGee and Williams (2000), showing an effect of an added influence of self-esteem. A meta-analysis of data across four countries by Pompili, Mancinelli, Girardi, Ruberto and Tatarelli (2004) showed a higher rate of suicide in adolescents with anorexia nervosa, when compared with the general population. However, there are a number of limitations with this study. One is that only information from research in medical journals was used, perhaps excluding data in other reports, and that the countries included were only those in the Western world. Further research is needed with male adolescents to clarify their association with risk of suicide, since most studies are based on female adolescents with eating disorders.

In contrast to the moderate studies of eating disorders, the topic of substance abuse and youth suicidal behaviour is extensive, with findings consistently pointing to a significant relationship (e.g. Molina & Duarte, 2006). However, Shaffer et al. (1996) found that this only holds true when co-morbid with a mood disorder, and the high risk pertains particularly to older, male adolescents. However, Brent et al. (1999) found that substance abuse was a high risk factor for both male and female suicides. Supporting the theme of multiple risk factors, Fortune, Seymour and Lambie (2005) conducted a retrospective audit at a New Zealand child and adolescent mental health service. They discovered an association in older adolescents between substance abuse and suicidal behaviour, when combined with factors such as sexual abuse and maternal substance abuse. However, problems with this research include variations in data reporting, and the small sample number impedes the generalisation of the findings.

In a U.K. psychological autopsy study of male youths aged 15-24 years, Houston, Hawton and Shepperd (2001) discovered that the majority of young men had alcohol or drug problems, but rarely had substance abuse disorders. However, it should be noted that psychological autopsy studies are susceptible to recall bias, thus skewing the findings, and that this research also includes men beyond adolescence.

A two year longitudinal study of Norwegian high school students showed that over 25 per cent of suicide attempters had been drinking alcohol (Wichstrom, 2000). There may be several reasons for this association, such as using alcohol to muster the courage to attempt suicide. Alcohol may have generated conflict with friends or family, which Beautrais, Joyce and Mulder (1997) state is a high risk factor. However, it should be noted that 75 per cent of the sample were not intoxicated, therefore results seem to have been presented in a way so as to support the researcher's hypothesis. Clearly, more research is needed to clarify the role played by intoxication. As discussed by the author, the community and emergency ward samples cannot be generalised to patient populations, and it should be remembered that only a minority of suicide attempters are seen by mental health professionals.

Another highly researched theme is that of having multiple psychiatric disorders, again consistently showing a strong correlation with suicidal behaviour (Beautrais et al., 1996; Houston et al., 2001). Shaffer et al. (1996) found in a New York psychological autopsy study that the majority of completed youth suicides had co-morbid psychiatric disorders. This appears to be the same for attempted suicide amongst young people. This supports findings by Gould et al. (1998), who discovered 47.6 per cent. of suicide attempters in his study had more than one disorder. Co-morbidity of mood, substance abuse and conduct disorders appear to have the highest correlation with risk to suicide (Brent et al., 1999; Shaffer et al., 1996).

However, although the majority of adolescent suicide victims have had at least one psychiatric disorder, Brent et al. (1999) found in their study that those under 16 years old were less likely to have a psychiatric disorder, (60 per cent compared to 89.5 per cent of adolescents aged 17 years or more). This is supported by Groholt, Ekeberg, Wichstrom and Haldorsen (1998) and Shaffer et al. (1996).

- Implications for Counselling Psychology

It is clear from the literature that there is a strong correlation between young suicidal behaviour and psychiatric disorders, particularly those of mood, conduct and substance misuse disorders. Older adolescents especially may have more than one disorder (Brent et al., 1999).

It is highly likely that Counselling Psychologists will encounter a young client with a psychiatric disorder, therefore they should be aware of the studies showing associations between disorders and suicidal behaviour. Knowledge of these disorders and characteristics is essential. They should also be familiar for any signs of suicidal ideation, however covert they may be.

Counselling Psychologists should build a supportive, trusting therapeutic relationship with the client, allowing him or her to be as open as possible, whilst sensitively gathering as much information as possible. By asking the client appropriate questions, these risk factors should be elicited. Diagnostic tools such as the Beck Depression Inventory (*BDI-II*) (Beck, Steer & Brown, 1996) may need to be administered, and Counselling Psychologists should be looking for signs of depression, alcohol misuse, and other mood disorders. The use of cognitive behavioural therapy (CBT) may be appropriate to treat eating disorders, depression, anxiety or panic disorder, or substance misuse (Curwen, Palmer & Ruddell, 2000).

Knowing the limitations of one's abilities is important and working in a multi-disciplinary way is essential, since the client may also need support from other specialist services. For example, a psychiatrist may be needed to 'diagnose' and provide medication. Care and sensitivity needs to be taken with 'diagnosis', remembering that the client's individual experience is of the highest importance, rather than 'labeling' him or her.

If a client is showing signs of a disorder, this should not be regarded in isolation, keeping in mind the possibility of co-morbidity and other risk factors. Counselling Psychologists need to undertake a thorough risk assessment of the young person, to assess risk of harm to self and others. Above all, it should be kept in mind that although correlations between mental disorders and risk of suicide have been found, this does not mean that the client is automatically a suicidal risk. The professional needs to concentrate on what the client is bringing to the therapy session and not make assumptions if there is nothing to substantiate it. However, if a young client is presenting with suicidal signs, this must be addressed seriously, sensitively and openly, and specialist services may need to be informed.

Risk factors and other personal characteristics, experiences & psychological factors

Literature shows that one of the strongest risk factors of completed suicide is that of an adolescent who has made a prior suicide attempt. There is a 30-fold increase in probability that male youths who have attempted suicide will eventually complete suicide, with female adolescents having a three times increased risk (Shaffer et al., 1996). This is supported by Hulten et al. (2001) in a longitudinal study of seven European countries. A past suicide attempt was significantly associated with suicide for both genders and young and older adolescents, even after controlling for psychopathology (Brent et al., 1999). Despite this high prevalence, Groholt, Ekeberg, Wichstrom and Haldorsen (1997) worryingly found that most of the completed suicide victims in their study had given signs of their suicidal intentions, but only one third had received treatment. Supporting this, Beautrais (2001) discovered that 23 per cent of adolescent suicide victims in a New Zealand study had threatened suicide within the year before their deaths. This clearly is an area that needs to be urgently addressed by mental health services.

With regards to personality traits, adolescents who behave aggressively when frustrated are at significant risk of serious suicide attempt, but only if they also display traits such as hopelessness and neuroticism (Beautrais, Joyce & Mulder, 1999). An eight year longitudinal study of Finnish school students by Sourander, Helstelä, Haavisto and Bergroth (2001) discovered that many adolescents experiencing suicidal ideation at aged 16 years had shown a high degree of behavioural problems at aged eight years. Just 20 per cent of those admitting suicidal thoughts had received mental health treatment. This study highlights the importance of providing interventions at an early age, and again points to the gap in service provision for this age group.

Another personal trait, that of self-esteem and its correlation with suicidal behaviour, appears to have mixed findings. Although there seems to be a consensus that it is linked to adolescent suicidal behaviour, there is some debate as to whether this only happens when combined with other traits or disorders. For example, Groholt, Ekeberg, Wichstrom and Haldorsen (2000) have shown self-esteem may have a

significant, independent effect, whilst others have found self-esteem is only influential when combined with depression (Beautrais et al., 1999; Fergusson, Beautrais & Horwood, 2003). In a more recent cross-sectional study of Norwegian young people, Groholt et al. (2005) found that suicidal adolescents demonstrated lower self-esteem than non-suicidal youth, but it was associated with depression and loneliness. The sample used was representative and the measuring instrument valid, however cause and effects need to be explored in longitudinal studies.

There is general agreement that the characteristic of hopelessness is strongly linked to suicidal behaviour but again, only when combined with depression (Goldston et al., 2001, as cited in Bridge, Goldstein & Brent, 2006.; Rutter & Behrendt, 2004). In a more recent study of American potential high-school dropouts, Thompson et al. (2005) found an association between anxiety, hopelessness and suicidal behaviour for both genders. However, they advocate using several indicators of hopelessness in future research, to increase generalisation of results, and limitations of this study were as mentioned previously.

In recent years, the issue of same-sex orientation and its association with youth suicidal behaviour has been explored, yielding inconsistent findings. Russell and Joyner (2001) examined data from the National Longitudinal Study of Adolescent Health. In this, a representative sample of nearly 12,000 American high school students answered questions, of which some were regarding sexual orientation and suicidal behaviour. They discovered that same-sex orientation is a significant risk factor for suicidal behaviour. However, this risk is reduced when controlling for other factors such as depression, alcohol abuse and victimisation. Although this study was representative, meaning the findings could be generalised to that population, it should be remembered this was a study undertaken in the U.S.A. and cannot be applied to other countries. Furthermore, adolescents not attending high-school were not included and only one measure of sexual orientation was used. This study supports findings by Garofalo, Wolf, Wissow, Woods and Goodman (1999), who discovered that sexual orientation has a significant relationship with male suicide attempts, but is mediated by drug use and victimisation factors in female adolescents. A longitudinal study of New Zealand adolescents also discovered a significant association between suicidal behaviour and same-sex orientation (Fergusson, Horwood & Beautrais, 1999).

Conversely, Savin-Williams and Ream (2003) found that same-sex orientation does not predict suicide attempts in a study of homosexual male youths in a Detroit gay support group. However, the researchers point out that their self-report method assumes participants are giving accurate reports and that the small male sample cannot be generalised to a larger population. One could also argue that being part of a support group may reduce any factors that could contribute to suicidal behaviour, e.g. depression.

One must also consider that adolescence is a time of forming an identity and that the issue of same-sex orientation may feel uncomfortable or confusing. It may feel shameful to be homosexual or bisexual (Allen & Oleson, 1999). Therefore, some findings may be inaccurate and same-sex orientation could be under-represented. Longitudinal studies may be helpful in addressing this, and larger samples and clear, unambiguous data need to be collected.

One of the most heavily researched areas is that of abuse, and there appears to be many findings strongly linking it to suicide, particularly sexual abuse. Johnson et al. (2002) conducted a community-based longitudinal study of New York families, which revealed a significant relationship between childhood abuse and suicide attempts later in adolescence. This association appears to be mediated by poor relationships with family and friends. This supports work by Brown, Cohen, Johnson and Smailes (1999) who discovered a significant link between physical abuse and suicidal behaviour, but state that other contributing factors are involved.

Other research shows a stronger correlation between sexual abuse and adolescent suicidal behaviours (Borowsky et al., 1999; Fergusson et al., 2000). Brown et al. (1999) undertook a longitudinal study of over 700 children in two New York counties, who had been studied until early adulthood. Different factors were addressed, such as family environment and psychiatric disorders, but sexual abuse was the most significant and independent factor. It emerged that adolescents who had suffered sexual abuse were eight times more likely to attempt suicide repeatedly, (odds ratio = 8.40, $p < .01$). Data was obtained through retrospective self-reports and official abuse reports. Due to the common difficulty in recollection of abuse, the longitudinal methodology of this study is appropriate. However, the researchers have admitted that

the more depressed participants were more likely to remember abuse, and that the study failed to explore the timing and severity of abuse. Since shame is often felt by youngsters who have suffered abuse (Deblinger & Runyon, 2005), one has to question whether sexual abuse is under-reported in the studies.

Gutierrez, Thakkar and Kuczen (2000) found in a study of female university psychology students in Midwest America, that enduring more than one kind of abuse is associated with higher levels of suicidal ideation. However, this was a retrospective study so that participants' responses to the questionnaires may be inaccurate due to the time elapsed since abuse. Furthermore, a small, specific population was drawn, meaning that generalisation is extremely limited and other effects, e.g. depression were not controlled for statistically.

In summary, the majority of this literature points to the effect of sexual abuse on suicidal behaviour being influenced by other factors. However, Borowsky et al. (1999) and Rey Gex, Narring, Ferron and Michaud (1998) have demonstrated a possible independent effect of sexual abuse on suicide attempts.

Due to a greater awareness of the impact of suicide, there is an increasing amount of research on the effect of suicidal behaviour on friends and peers. However, this seems to present inconsistent findings. For example, Rey Gex et al. (1998) found that there was no significant correlation between completed suicide of a friend and suicidal behaviour. Conversely, Ho, Leung, Hung, Lee and Tang (2000) conducted a cross-sectional study of Hong Kong high-school students, who were divided into three groups: peers of suicide completers; peers of suicide attempters; and a control group of adolescents not exposed to either suicidal behaviour. Using self-report instruments covering family circumstances, drug use, mental health etc., researchers found that 15-21 per cent of peers of both suicide attempters and completers engaged in suicidal behaviour. They were more likely to have psychiatric problems and to be suicidal than the control group, after controlling for age, sex and other factors. Using a control group of participants lends weight to the validity of this research. However, there is a problem with ascertaining whether or not the onset of psychiatric illness and suicidal behaviour was present before the peer suicidal behaviour. Further longitudinal studies are needed.

There is also growing literature exploring the relationship between suicide reporting in the media and suicidal behaviour and 'clusters' in adolescents. This is beyond the scope of this review, but could be a very important area to explore, given the prevalent media influence and widespread internet access in the U.K. today.
Similarly, the issue of religion and adolescent suicidal behaviours cannot be addressed in this appraisal. However, this is another fertile avenue for research, particularly as the U.K. is developing an ever-increasing multi-cultural identity.

- Implications for Counselling Psychology

The findings of Groholt et al. (1997) that only a third of suicide victims received treatment pior to their deaths despite giving warning signs, highlights a serious deficiency in service provision for adolescents. Although the study was undertaken in Norway, it also applies to the U.K. (Smith & Leon, 2001). Therefore, Counselling Psychologists should ensure that any client who has made a previous suicide attempt, or who threatens it, is taken seriously and followed up, since evidence shows that this is a significant indication of completed suicide. Furthermore, care should be taken to elicit any history of past suicidal behaviour when assessing adolescent clients.

Historically, there are few studies showing the best therapeutic approach to use with adolescents who have attempted suicide, for reasons such as lack of help-seeking and treatment compliance following suicide attempts. However, there are promising studies currently being undertaken into the efficacy of therapeutic interventions, such as one combining cognitive-behavioural therapy and dialectical behavioural therapy for suicide prevention (CBT-SP) (Stanley et al., 2009). Therefore, Counselling Psychologists should keep themselves informed of the latest research outcomes and recommendations.

It would seem intuitive that a Counselling Psychologist would use person-centred skills at least, and to encourage the client to identify and explore the pressures that led to the suicide attempt, or is leading him or her to feel suicidal at the current time. Additionally, Counselling Psychologists should seek support from other colleagues

skilled in working with suicidal clients (Culley & Bond, 2004) and from other professionals, if needed (e.g. psychiatrist). Risk assessments and appropriate interventions should be undertaken. Clearly, a greater awareness of vulnerable traits in adolescents that may predispose them to suicidal behaviour is needed by professionals and society as a whole.

Although instruments used to measure traits such as hopelessness etc. may be reliable, it should be remembered that these are standardised and there may still be some scope for error. Psychologists should also bear in mind that there may be mediating factors linked to suicidal potential. For example, an adolescent who is presenting with loneliness may also covertly have low self-esteem, which may relate to suicidal ideation. Since adolescence is a time of identity formation, it may be difficult for Counselling Psychologists to distinguish what may be representative of a psychiatric disorder, and what is attributable to personal traits in an adolescent. Counselling Psychologists should ascertain the psychological characteristics and experiences of their young clients, through building a supportive therapeutic relationship and gently eliciting a comprehensive picture.

For those working with children, it should be borne in mind that some research suggests that eight year-old children exhibiting behavioural problems may go on to have suicidal ideation (Sourander et al., 2001). Therefore, support and interventions should be given as early as possible. Counselling Psychologists should be aware that sexual orientation may be a sensitive and confusing issue for adolescents, therefore building trust and being non-judgemental is essential in supporting an adolescent with this issue. One should also be aware of the possible suicidal risk if a client is also showing signs of drug use or is being victimized.

The topic of sexual abuse again is extremely sensitive, and Counselling Psychologists should be empathic, patient and non-judgemental if a client discloses this information. One should be aware of the potential impact of this experience on a client, and if dealing with this issue is beyond the capability of the psychologist, referral to another specialist, e.g. trauma service is essential.

Counselling Psychologists should also look for other possible factors that may lead to suicidal risk, such as poor family relationships. If a young client has lost a friend to suicide, again this should serve as a warning sign and care should be taken, particularly if the adolescent is also showing signs of a psychiatric illness. The client may value time to explore their feelings about their loss, and creating safety and an atmosphere of openness is essential.

Familial risk factors

There are consistent findings of a strong association between family history of a suicide and suicidal behaviour in adolescents (Brent et al., 2002), even when controlling for parental psychiatric illness (Agerbo, Nordentoft & Mortensen, 2002). The issue of genetic versus environmental familial influences is the subject of some research in this area. Glowinski et al. (2001) conducted telephone interviews with a sample of female adolescent twins born in Missouri, U.S.A. The participants were asked a variety of questions, including a section relating to suicidal behaviour. The study showed a familial link in adolescent suicidal attempts and also suggested a possible genetic influence. However, this study was based on a very specific population, in a particular geographical area and only included females, therefore these findings cannot be generalised to male youth or nationwide. Furthermore, suicide-related data was based on the participants' recall and therefore may be inaccurate.

Another important familial aspect surrounds the quality of the parent-child relationship, the prevalence of family conflict, the level of communication and the parenting style that is adopted. There are consistent findings associating poor family relationships with adolescent suicides and attempts (Beautrais, Joyce & Mulder, 1996; Rey Gex et al., 1998). However, there are discrepancies as to whether poor parent-child communications are an independent factor in suicide risk. A 21 year longitudinal study of New Zealand babies suggested that although the adolescents who showed suicidal behaviour were likely to have had poor parent-child attachments, this element could be not separated from the youth's own mental health problems (Fergusson et al., 2000).

Again, the literature appears to associate family conflict with youth suicidal behaviour. Brent et al. (1999) conducted a psychological autopsy of 140 Pennsylvanian teenage suicide victims, and compared findings with a control group. However, the majority of the victims were white, male youths aged more than 16 years old, and they did not adequately represent females or different ethnicities. It was discovered that parent-child conflict was more frequently a trigger for suicide in younger adolescents, but romantic difficulties was more prevalent in older adolescents, (50.5 per cent versus 29.7 per cent). However, neither sources of conflict were significant risk factors when multivariate statistics were carried out. Contrastingly, Beautrais et al. (1997) discovered that relationship difficulties are a very significant risk factor in serious suicide attempts, even when controlling for social, family and personality history.

Johnson et al. (2002) undertook a community-based longitudinal study, interviewing 659 New York families. They discovered that maladaptive parenting, (e.g.s. harsh punishment, over-protectiveness, lack of support etc.) during childhood is indirectly linked to suicide attempts in early adulthood, if interpersonal difficulties are also experienced during middle adolescence. Although rigorous statistical analysis was performed and a relatively large number of participants were studied, it should be pointed out that the fathers were not interviewed and paternal data was only obtained through the maternal and children interviews. This raises the question of accuracy and bias in the data. Furthermore, the researchers gave no reason for the absence of paternal interviews, and the sample was taken from one geographical area, thus limiting findings.

Many studies appear to show a significant correlation between adolescents whose parents are separated or divorced, and suicidal behaviour. For example, in a 10 year retrospective study by Beautrais (2001), 67 per cent of New Zealand youths under 15 years old who had committed suicide had not been living in a family containing both biological parents. However, many findings show this association is reduced when parental psychopathology is considered (Gould, Fisher, Parides, Flory & Shaffer, 1996), or adolescent mental health problems are taken into account (Fergusson et al., 2000). Furthermore, as mentioned previously, the suicide rate for adolescents in the

UK has declined slightly in recent years, despite the increasing divorce rates, which challenges the findings of Beautrais (2001).

In some of the most up-to-date research, Ostry et al. (2006) have identified a lack of studies into the effects of parental working conditions on suicidal behaviour on their children. They performed a nested case control study of over 28,000 male sawmill employees in British Columbia and their children, of whom there was over 19,000. The physical and psychosocial work conditions of the fathers during the first 16 years of their children's lives were correlated with hospital reports of attempted and completed suicide among their offspring. The work conditions consisted of factors such as periods of unemployment, job demands, etc., evaluated by senior employees of each sawmill. Findings included the following: 252 children in the study attempted or completed suicide; three quarters of the suicide completers were male; after controlling for paternal mental health, male offspring who were less than 16 years old when their fathers were only employed for a short time were at increased risk of attempting suicide; daughters of fathers who experienced low job control when they were 16 years old or younger were significantly at increased risk of attempting suicide. These findings suggest that paternal adverse working conditions can significantly increase the risk factor of suicidal behaviour in their children, and that these effects may differ for genders. Whilst a large number of participants were used in this study and the effects of paternal mental history were controlled, there are a number of limitations. For example, there may have been a number of mediating factors that were not accounted for, e.g., paternal parenting skills. No information on maternal employment was included, data was only collected for suicide attempt admissions at limited locations and the specific occupation, geographical area and sample means generalisation of findings are restricted. Nevertheless, this is an area with scope for further research.

Research suggests multiple familial factors appear to influence susceptibility to adolescent suicide. Future research would benefit from looking at co-occurring simultaneous familial factors. Wagner (1997) has also criticised the research, stating that it does not demonstrate experience of familial risk factors that occur before suicidal behaviour. He advocates using more prospective studies, e.g. longitudinal research. This type of research is increasingly being undertaken.

- Implications for Counselling Psychology

Counselling Psychologists should be aware of the familial factors that may lead to an increased risk of suicidal behaviour in their adolescent clients. This may mean gently eliciting the information from the client to fully explore their familial circumstances, such as the quality of their relationship with their parents, family history etc. If a client has previously attempted suicide and is experiencing friction with their family, he or she may not have much support. Therefore, it is important that Counselling Psychologists and other mental health services fill this gap. Furthermore, if there is conflict with relatives, therapy and support may be necessary for the family too.

One should remember that the risk factors are complex, therefore a broad and comprehensive understanding of the client is required. Again, although there are many findings associating risk factors with youth suicide, it should be remembered that it is a complicated, multi-faceted issue and that causal effects have yet to be identified. Research findings should be kept in mind, but the therapeutic relationship with the client and valuing his or her own experience is still of the utmost importance.

General critique of the research

One problem with psychological autopsy studies, upon which much of this review is based, is that they are normally established from the perception of the significant others of the suicide victim. Therefore, accuracy and bias has to be questioned, alongside consideration of the stress involved in this process for them. However, Hawton, Houston, Malmbergand and Simkin (2003) followed up 68 informants who had participated in three recent studies, and discovered that only one felt worse and a third believed that it was beneficial. Of the 30 participants who received a bereavement pack, 90 per cent found it useful. This highlights the importance for Counselling Psychologists and researchers in providing post-suicide support to the families and friends of suicide victims.

Hawton and van Heeringen (2000) also criticise the psychological autopsy method for its inability to examine biological aspects, and its failure to uncover many of the psychological factors that contribute to suicidality. Many of the studies used self-report measures and interviews, however one has to consider whether or not participants responded in a way to 'please' the researchers, thus compromising the validity of findings. Furthermore, one could contend that the quantitative approach, with its focus on risk factors reduces a highly complex subject to a set of statistically measurable variables. It could also be argued that this type of research conveys a sense of inevitability about a 'high risk' adolescent, and does not account for their ability to overcome their vulnerability. Indeed, Shain (2007) cautions clinicians in their construal of risk factors due to their rate of occurrence, in contrast to the rarity of suicide. Nevertheless, a lack of risk factors does not guarantee an adolescent's safety (Shain, 2007).

It can be argued therefore, that there is a need for more qualitative studies to capture the uniqueness of a suicidal adolescent's experience. This type of research could access the nuances and complexities that motivate an adolescent to take their own life, informing research on completed suicide, and adding depth to the risk-factor studies that have been undertaken. Therefore, the author concurs with the assertion by Hawton (2000) that a suicide risk assessment should consider an individual's personal situation, and not be based purely on the outcome of scores on ratings scales. Interviewing adolescents who have failed in their suicide attempts would allow us to gain more detailed insights into suicidality, and facilitate longitudinal studies to be undertaken. However, consideration would need to be given to the classification of a 'serious suicide attempt' (Hawton & van Heeringen, 2000).

Additionally, much of the research on youth suicide risk factors has been undertaken in the Western world, particularly in the U.S.A., Australia and New Zealand. There is a need for more studies in the Far East and Africa, to gain a more global perspective. More research should be conducted in the U.K., since findings from other countries cannot be generalised to this country. Moreover, there is a need for more research involving different ethnicities, youth with disabilities, and young people who are often excluded from society. It must also be remembered that many suicide attempts go

unreported, and suicidal attempts can be difficult to ascertain. Therefore, there could be a whole population of adolescents whose suicidal behaviour has yet to be explored.

Finally, literature on youth suicide has been criticised for traditionally focusing heavily on risk factors, rather than on the positive factors that may *protect* young people from engaging in suicidal behaviours (Evans, Hawton & Rodham, 2004). However, research is increasingly examining these protective qualities, which are being incorporated into prevention and intervention programmes. Nevertheless, the research on risk factors for youth suicide has greatly enhanced our knowledge of what may contribute to an adolescent taking their own life, and has played an important role in the development of prevention strategies.

Summary and conclusions

This review has studied literature in the last 12 years that examines some of the psychiatric, personal and familial risk factors that may be associated with youth suicidal behaviour. It should be noted that there are many other areas of risk factors, such as biological and social aspects, and experiences of other negative life events that may also correlate with suicidal tendencies in adolescents. However, it is beyond the scope of this review to discuss them. Suicide is a highly complex subject, and it is likely that many different risk factors may be interrelated and involved.

As a Counselling Psychologist, it is vital to be aware of risk factors that may be connected to adolescent suicide, and to understand their complexity and interconnectedness. One should elicit a full and comprehensive picture of the client to identify any risk factors, to identify possible suicidality. However, it should also be remembered that each person's experience of suicide ideation is unique and cannot be reduced purely to a set of risk factors. Paulson and Everall (2003) interviewed previously suicidal adolescents to discover what aspects of therapy were helpful. They found that the therapeutic relationship, communication and creative expression were some of the most valued elements of the process. Therefore, although a thorough knowledge of what might contribute to adolescent suicide and the skills to apply any appropriate interventions are needed, the ability to demonstrate empathy, to be non-

judgemental and to build a supportive, therapeutic relationship are equally as important.

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