The Personal Impact of Uncompleted Suicide on Partners: Transformations for Better, for Worse

Francis Edward McGivern

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School of Nursing and Human Sciences

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Supervisors: Professor Pamela Gallagher, Dr. Gemma Kiernan

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctorate in Psychotherapy is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed:_____
Francis McGivern (Candidate)

ID No.:59105143

Date: September 15th 2014

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Abstract

Title: *The Personal Impact of Uncompleted Suicide on Partners: Transformations for Better, for Worse*

Author: *Francis Edward McGivern*

Research to date in the area of suicidology has paid very little attention to partners of those who attempt suicide. The few studies that *have* accessed partners have done so as part of a larger cohort of 'significant others' in order to either explore the role of care provision to those at risk of suicide or to advance assessment and intervention strategies for suicide attempters. There is an incomplete picture, therefore, of the personal impact of an uncompleted suicide specifically for partners. The study aimed to (1) explore the lived experience of living with a partner following an uncompleted suicide and (2) to examine the meaning that partners attributed to an uncompleted suicide and the significance of these meanings for their everyday lives. Five individuals exposed for the first time to an uncompleted suicide were interviewed using a semi-structured interview schedule. Interviews were transcribed and analysed using an interpretative phenomenological framework. The super-ordinate theme *"I'm not the same person I was": transformations for better, for worse*, reflected the transformative impact of a partner's suicide attempt for individuals with both negative and positive trajectories. The overarching theme of transformation evoked three sub-themes namely, *"It put nearly ten years on my life": suffering the trauma of the attempt*; *"It shifted the whole world on its axis": adjusting in the wake of the attempt*; and *"It never ever goes away": the legacy of the attempt*. This study contributes to the field of psychotherapy by recognising the transformative impact on partners as traumatic, and identifying potential psychotherapeutic pathways for both individual and/or couples therapy including reactivation of adverse childhood experience, ambiguous loss, boundary ambiguity, attachment injury, and posttraumatic growth. Implications for training and future research are also discussed as well as recommendations for practice and policy.

Chapter 1. Introduction: Genesis of the Research Question

1.1 Introduction

I have had a long-standing interest in the broad area of caring and more specifically the 'cost of caring' that we are inevitably met with to greater or lesser degrees. Spanning from my early adolescent experience working during the summer months as a care-attendant in a residential facility for elderly people to my first introduction to the work of Charles R. Figley on compassion fatigue during my master's degree at the University of Ulster, it has been a topic that has come up time and again. Indeed, this has certainly been the case in my psychotherapeutic work particularly in employee assistance provision and clients who have dependent others in their lives.

A number of years ago I began working with a lady who sought out psychotherapy support approximately six months after her husband had attempted suicide. She described an experience of almost immediately being dubbed chief caregiver to her husband following his attempt by both hospital staff and family members. Her own difficult journey on foot of his attempt and the strong ambivalent feelings she had toward him subsequently, however, were not socially recognised nor sanctioned for that matter. My encounter with this lady caused me to confront my own as well as societal/cultural/religious expectations around caring for others particularly for spouses and particularly if spouses are perceived as vulnerable and dependent. All of this roused my interest in looking beyond the role of caregiver and, indeed, cost of caring to explore the personal lived experience of this phenomenon for individuals who have encountered partner uncompleted suicide. This particular client, therefore, provided the impetus for this research prompting the research question "what is the personal impact of uncompleted suicide on partners?" I chose to employ the term 'uncompleted suicide' to be explicit about there being no fatality, although the term is at times used interchangeably with 'attempted suicide' throughout.

I reflected for some time on the use of language to describe the title of the research and that which would be used in the recruitment strategy. I thought it important to avoid restricting the research to married couples only as I believed that this phenomenon applied to any individual who recognised their relationship to be an established, meaningful one where a secure attachment bond had been accomplished. Consequently, I made a conscious decision to receive expressions of interest to participate in the research using the umbrella term 'partners' which included spouse, common-law spouse, and long-term partner. I also reflected upon the use of the term 'experience' of uncompleted suicide on partners and felt that this could inadvertently prompt participants to provide a description of their lived experience that emphasised the role of caregiver and in so doing provide an account that was more in keeping with societal expectations. I was mindful here of what are known as 'demand characteristics' (Lucas 2007) that is in this case, the possible over-reporting of subjective well-being in order to appear well-adjusted and embracing the caregiver role. Thus, I employed the term 'personal impact' in order to give permission to participants to share how the experience impacted them on a very personal level and beyond the confines of roles.

1.2 Research Question to Study Formation

Having firmed up a specific question I believed was original and important to explore, my initial investigations of the phenomenon involved making contact with long established researchers in suicidology in countries such as the USA (Lester), Norway (Hjelmeland; Leenaars) and Austria (Kapusta). All suggested that the research topic was either very rare or had never been researched before. This feedback ultimately prompted an in-depth review of the literature and an exploration of how best to set about answering the research question. I found that many studies had highlighted the burden of care that relatives experienced following a suicide attempt of a loved one (Sun, Long, Huang, and Huang 2008; Östman,

Wallsten, and Kjellin 2005) but relatively little research had been conducted on the 'inner world' and 'meaning making' of significant others (Magne-Ingvar and Öjehagen 1999) both in the initial stages after learning of the suicide attempt and in the time following on from this.

My intention, therefore, was to capture a rich, in-depth, detailed account of the lived experience for partners and that a qualitative approach, in particular a phenomenological approach would, therefore, meet this criterion. However, I aimed to move beyond a mere description of their experience toward gaining insight into how participants made *sense* of the phenomenon for their everyday lives. Thus, the emphasis on 'sense-making' pointed me naturally in the direction of Smith's (2009) interpretative phenomenological analysis (IPA) method. IPA favours taking an idiographic approach and also puts the researcher centre-stage in terms of attempting to make sense of the participant's sense-making of a significant experience. Another significant commitment of IPA is to develop an interpretative analysis of the participant's 'sense-making' more towards 'meaning-making' that is, "to think about 'what it means' for the participants to have made these claims,...in relation to a wider social, cultural, and perhaps even theoretical, context" (Larkin et al. 2006, p.104). What unites both researcher and participant is "that of being a human being" (Smith et al. 2009, p.3) where both are engaging similar mental processes to make sense of a phenomenon. My role as researcher, however, would be to employ a systematic approach to this sense-making similar to the guidelines for analysis as set out by Smith et al. (2009) in order to produce as coherent and rigorous an account as possible. This would also do justice to the generosity shown by participants to the research endeavour. Thus, the aims of this study were to explore the lived experience of living with a partner following an uncompleted suicide and to examine the meaning that partners attributed to an uncompleted suicide and the significance of these meanings for their everyday lives.

As part of my endeavour to ensure transparency I maintained a reflexive journal through the research journey. This afforded me an opportunity to bring any of my own biases, prejudices, and assumptions to the surface in order to minimise as much as possible any confounding of the research process. It also provided a forum in which to document rationale for key decisions made throughout the process. I have provided entries from the journal at the end of each chapter in order to highlight my personal journey as researcher through this process.

1.3 Thesis Layout

The thesis consists of six chapters in total.

Chapter 2 provides a review of literature relevant to the phenomenon in question. It looks at the significance of nomenclature in the area of suicidology, current rates of suicide and suicide trends. It then turns to reviewing literature on families and mental illness, the dual role of 'significant others' as informants and caregivers, and relates the phenomenon of partner impact from uncompleted suicide to theory including loss, trauma, resilience, and transformative learning. The chapter details the rationale for undertaking the present study and outlines the study's aims and objectives.

Chapter 3 reiterates the aims and objectives of the study. The design of the study is described along with IPA's theoretical roots: phenomenology, hermeneutics, and idiography. A critique of IPA is also provided. Researcher positioning and reflexivity are then discussed. Access to participants, the rationale for the data collection method and the method of analysis are also outlined. Finally, ethical considerations are set out along with an overview of how these were managed.

Chapter 4 provides a detailed account of the research findings. A master summary table outlines the overarching super-ordinate theme and three sub-ordinate themes with

accompanying clusters. The super-ordinate theme, *"I'm not the same person I was": transformations for better, for worse*, denotes the lived experience for participants as transformative in both positive and negative ways. The sub-ordinate themes chart their journey of transformation from initial aftermath of the attempt (*"It put nearly ten years on my life": suffering the trauma of the attempt*), through to adjusting in the wake of the attempt (*"It shifted the whole world on its axis": adjusting in the wake of the attempt*), to highlighting its legacy ("*It never ever goes away": the legacy of the attempt*). Numerous quotations are offered throughout the chapter that best highlight convergence and divergence amongst participants.

Chapter 5 discusses the findings in the context of the extant literature. Findings are explored in the context of trauma, loss, and resilience as set out in the literature review chapter as well as through the lens of more relevant literature and theory based on the particular themes extrapolated. The significance and value of this original piece of research and how it contributes to the field of psychotherapy is also discussed.

Chapter 6 looks at the implications for the findings of this research across a number of domains. It explores the major implications for the practice of psychotherapy including assessment and intervention. It explores potential influences on training practices, and puts forward suggestions for policy development in the light of current findings. The chapter closes with a review of the strengths and limitations of the research and suggestions for future research directions.

1.4 Reflexive Journal Entry

I was very mindful of the fact that my limited research experience to date stretched as far as quantitative methodologies only and so this research endeavour was very much a journey into the unknown for me. I was completely unfamiliar with IPA prior to exploring a suitable

methodology to answer the research question and naively interpreted Smith, Flower, and Larkin's systematic approach to interpreting raw data to mean that it would take the 'blood, sweat, and tears' purportedly involved in qualitative analysis out of the equation. The more I read about the approach the more I anticipated that Smith et al. were offering signposts only and that the process of developing an interview 'guide' rather than an interview schedule, the responsibility of facilitating the participant in keeping on task as much as possible relevant to the phenomenon in question, and the responsibility of carrying out the painstaking analysis were all on my shoulders, and my shoulders alone. I had faith in my experience and skill as a counselling psychologist which would inevitably stand to me during the entire research journey but nonetheless knew that I would need to take a leap of faith in order to reach my ultimate destination.

Chapter 2. A Review of the Known and Unknown

2.1 Introduction

> Suicide, an act in which one objectifies and destroys one's self and which challenges the fundamental meaning of life, is perhaps the most lonely and most impersonal act that can be performed by a human being.....There are few other acts that so profoundly affect others.
>
> (Talseth, Gilje, and Norberg 2001, p.249)

A limited number of studies in the past fifteen years or so have highlighted the value in accessing the 'significant others' (SOs; that is, parents, grown-up children, siblings, friends, as well as partners) of suicide attempters (Magne-Ingvar and Öjehagen 1999a; 1999b). However, despite this increased attention being paid to the relatives of those who have attempted (or, indeed, died by suicide), it has for the most part been to improve the outlook for those at risk rather than to gain insight into the relative's own personal experience.

This chapter will provide a synopsis of key challenges involved in creating a comprehensive nomenclature within suicidology; current and projected prevalence rates of suicide and attempted suicide both at a global and local level; and a review of some of the earliest research on suicidal behaviour that featured partners and more recent studies pertaining to the experience of partners among other SOs of suicide attempters in their primary role of caregiver. The experience of partners within the context of 'significant others' and uncompleted suicide will then be explored through the lens of loss, trauma, resilience, and transformative learning. The chapter concludes with an overview of implications for the present study.

2.2 Literature Review Strategy

Literature for the purposes of this review chapter was accessed in the main through online library database searches including PsycINFO and MEDLINE. Identification of nomenclature within suicidology and prevalence rates included various permutations of key search terms including "definition", "suicide", "attempted suicide", "suicide attempt", "parasuicide", "self harm", "self injurious behavio(u)r", "prevalence", "prevalence rates", "global statistics". For definitions and prevalence rates within the Irish context websites such as the National Office of Suicide Prevention as well as the Central Statistics Office were accessed. Empirical studies and theoretical literature related to attempted suicide and partners were identified using the Boolean/Phrase search mode. The results of searches using combinations such as "attempted suicide" AND spouse; "attempted suicide" AND family; "attempted suicide" AND partner; 'parasuicide AND family'; 'impact of attempted suicide on family'; 'incomplete AND suicide'; 'trauma AND suicide (attempt)'; 'grief AND suicide (attempt)' were reviewed for relevance to the current study.

2.3 Towards a Definition of Terms

Since ambiguity regarding the clear definition of various terms has historically plagued the suicidology literature (World Health Organisation 2004), it is paramount that a transparent delineation of terms is set out for the purposes of the present study.

Inconsistencies in operational definitions have created challenges in the comparison of results across various studies. In addition, the lack of an established and agreed means of assessing 'intent to die' or 'level of lethality' has inevitably led to inaccurate classification of suicidal and non-suicidal behaviours. The World Health Organisation (WHO) defines suicide as one of four possible types of death, applying the acronym NASH: natural,

accidental, suicidal, and homicidal (Leenaars et al. 1997). The late Edwin Shneidman known as the 'father of suicidology' defined suicide as:

> ...a conscious act of self-induced annihilation, best understood as a multidimentional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution. (Shneidman 1993, p.4)

However, this definition appears to solely apply to those individuals who have serious intent to die and desire to employ high-risk acts that have high lethal potentiality. It does not take account of those who may have been ambivalent about their self-annihilation or indeed ultimately did not wish to die. It is the case that the outcome of suicide attempts are ultimately difficult to completely control by the attempter and thus depend on a number of variables such as degree of intent to die, where the attempter is situated along the continuum of planning versus impulsivity, the level of lethality of the method of suicide, and whether or not assistance was pursued (Beautrais 2004).

Some investigators view all intentional self-injurious behaviours not resulting in death as 'suicide attempts' or 'parasuicide'. 'Parasuicide' was introduced by Kreitman et al. (1969) and was coined as a result of the difficulties arriving at a consensus on how to measure or infer "intent to die" during self-injurious acts. Some authors use the term to define behaviours that vary from suicidal gestures to serious attempts to kill oneself (Hider 1998). Both the behavioural act and the injurious outcome are considered intentional. Other authors view parasuicide as a subset of attempts defined as an unsuccessful suicide attempt usually of low lethality (Garrison 1991).

For the purposes of the WHO/Euro parasuicide epidemiological monitoring studies, parasuicide is defined as:

> An act with nonfatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences. (Platt et al. 1992)

Leenaars et al. (1997) view the term 'parasuicide' as problematic as it encompasses a plethora of self-harming behaviours including suicide attempts. A case in point is the individual who survives an attempt on his/her life with a shotgun is clustered in the 'parasuicide' group alongside the individual who has accidentally overdosed on his/her prescription medication. Similar challenges can exist with the term 'suicide attempt' if one considers how a teenager following ingestion of a small number of pills of low lethal potentiality following a relationship breakup can be labelled as having 'attempted suicide' similar to an individual who engages in a behaviour of obvious high lethal potentiality such as deliberately driving in front of an oncoming train.

According to the National Registry of Deliberate Self Harm Ireland (2010), the term 'parasuicide' has been replaced internationally by the term 'deliberate self harm' which encompasses varying degrees of suicidal intent and motivations such as a cry for help, loss of control, or self punishment. Since terms such as *'parasuicide', 'attempted suicide', 'suicide attempt', 'deliberate self harm', 'non-fatal deliberate self harm'* which refers to self-harming behaviour not intended to be fatal and any death occurring being accidental (Ogundipe 1999), *'(indirect) life threatening behaviour', and 'high risk taking behaviours'* have all variously added to challenges regarding accepted nomenclature within suicidology, Leenaars et al. (1997) have attempted to give some shape to the issues surrounding the ongoing difficulties with operational definitions:

1) *Defining Suicidal Acts*: Suicidal acts need to be clearly defined in terms of description of method and medical lethality. The WHO's formal listings of methods

such as hanging, firearm, jumping from a height, poisoning and so on should, therefore, be utilised to facilitate this process.

2) *Definition of Circumstances:* It is paramount to establish whether the individual was alone at the time of the attempt and if so to what extent were they likely to have remained alone until the method had taken effect.
3) *Definition of Medical Lethality:* This is a measure of the degree to which the method would likely cause death. Therefore, high lethality in the context of uncompleted suicide, is assumed to refer to failed suicide whereas acts of low lethality is assumed to imply social or personal meanings.
4) *Definition of Intent:* In contrast to lethality, intent is defined as having "suicide or deliberate self-killing as one's purpose" (p.143). Gathering evidence of *actual* intent to die as opposed to an attempter having knowledge that death was imminent is pivotal here.

Jacobs et al. (2003) as part of the American Psychiatric Association (APA) produced best practice guidelines for the assessment and subsequent treatment of suicidal individuals in which a definition of 'suicide attempt' was utilised:

> Self-injurious behaviour with a non-fatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die. (O'Carroll et al. 1996, p.237)

For the purposes of the present study the above definition will be applied to the term 'uncompleted suicide' as it provides the most transparent and comprehensive description of the suicidal act and adheres to much of what Leenaars et al. (1997) purport should be contained within a nomenclature such as definition of suicidal acts, medical lethality, and intent. Although the term 'uncompleted suicide' is applied most frequently throughout this

study, the terms ‘suicide attempt’, ‘attempted suicide’, and ‘suicide attempter’ are used interchangeably with it.

2.4 Completed/Uncompleted Suicide Prevalence

The ever growing rate of attempted suicide in the vast majority of countries has created a significant public health concern (Mehlum and Ramberg 2010). Difficulties regarding the reliability of suicide statistics, however, have been evident for over 200 years (Goldney 2010). Confounding variables include societal, State, or religious issues; sensitivity about recording cause of death as ‘suicide’; multiple descriptions of suicide amongst the various professions such as psychology, sociology, and anthropology; and conflicting definitions of suicide amongst the psychiatric, medical and legal professions.

Between 1950 and 1995 it is thought that the rates of completed suicide worldwide have increased by a margin of 60%, with approximately 815,000 lives lost to suicide in the year 2000 alone (Krug et al. 2002). The World Health Organisation, however, believe the figure to be closer to one million with more people dying by suicide than all wars put together, and in some countries more than the number dying from road traffic accidents (1999). Suicide is now ranked within the top three leading causes of death within the 15-44yrs age range, and the second leading cause of death within the 10-24yrs age range. Some populations are thought to be particularly at risk, such as men in Eastern Europe, and adolescents and women in Western Europe. The Health Evidence Network (HEN) synthesis report initiated and coordinated by the World Health Organisation estimated a global suicide mortality rate of one death every 40 seconds (Guo and Harstall 2004). The WHO (2014) predicts that by the year 2020 approximately 1.53 million individuals worldwide will die by suicide. This equates to an increase of one death per 20 seconds on average.

Globally, statistics suggest that males tend to be more prone to suicide completion whereas women tend to engage more deliberate self harm (DSH) and suicide attempts. Unemployment, retirement, being single, and sickness absence have been identified as factors contributing to suicidal behaviour (Hawton 2000). The National Task Force on Suicide in Canada found that risk factors vary with age, gender, and ethnic group and, indeed, that these factors are subject to change over time (1994).

In 1941 the estimated global 'attempted suicide' to 'completed suicide' ratio was thought to be in the region of 6:1 (Stengel 1956). It is perhaps alarming to note then, that attempted suicide is currently up to 20 or more times frequent than completed suicide, and by 2020 it is anticipated that one attempted suicide will occur every 1-2 seconds somewhere in the world (Bertolote and Fleischman 2002).

2.4.1. Completed Suicide: The Irish Context

Relative to Ireland's population, the suicide rate here until 2009 has been at its lowest since suicide was decriminalised in 1993. In fact, Ireland has the sixth lowest rate of suicide in the European Union. It has, however, recorded the fourth highest rate of suicide amongst younger men in the EU, with Lithuania, Finland, and Estonia ranked within the top three. The 2007 report 'Mental Health in Ireland: Awareness and Attitudes' produced by the Health Service Executive (HSE) asserted that suicide ranked among the top three most pressing mental health issues for Irish adults along with alcohol and depression (Datta and Frewen 2010). According to the Central Statistics Office (CSO 2013) there were 507 suicides registered in 2012 or 11 per 100,000 of the population. There were 525 suicides registered in 2011, which amounts to a decrease of 3.5%. There was also a decrease (of 6%) in male suicides from 2011 but males still accounted for 81% of all suicide deaths in 2012. Lucey and Hough (2011), in a commentary of increased suicide rates among the older population, have highlighted a change in suicide trends since 2005 in Ireland. A number of

coroners have spoken out about the recent change in the age profile of those taking their own lives, now pointing more in the direction of those over 50 years of age, thus challenging the commonly held perception that suicide is occurring mainly amongst younger citizens. Overall, these figures reflect the serious public health concern that faces Ireland. They also underscore the challenges faced in obtaining an accurate picture of suicide rates, as determining a death to be accidental or by suicide is not always straightforward or, indeed, possible. One of the founders of the Irish Association of Suicidology (IAS) in 1996, Dan Neville TD highlights this dilemma:

> There is always a question in relation to undetermined deaths and suicide. It has always been accepted that the official suicide statistical rate does not fully reflect the true level of suicide (Datta and Frewen 2010).

In response to this the National Suicide Research Foundation (NSRF) commenced research in 2013 into the accuracy of suicide recording systems of suicide as well as criteria for assessing probable suicides (Arensman et al. 2013).

2.4.2. Uncompleted Suicide: The Irish Context

The difficulty in clearly defining a suicidal act as well as identifying degree of intent and lethality has already been highlighted (Leenaars et al. 1997). In Ireland, the National Registry of Deliberate Self Harm (NRDSH) was founded by the National Suicide Research Foundation (NSRF) to record incidences of deliberate self harm. One of the Registry's aims is to contribute to policy development in the domain of suicidal behaviour. The latest available statistics are for the year 2012 (Griffin et al. 2013) during which 12,010 presentations to Accident & Emergency Units around the country due to deliberate self harm (DSH), were recorded by the Registry involving 9,483 individuals, some with multiple presentations. This figure equated to 211 individuals per 100,000 population.

On examination of the figures by gender, the Registry recorded a national male rate of DSH at 195 per 100,000 population, which equated to a 5% reduction in comparison to the rate recorded in 2011. The national female rate was recorded at 228 per 100,000 which was 1% higher than in 2011. Consistent with international statistics, the female rate was found to be higher than the male rate. Contrary to hanging being one of the most common methods resulting in *completed* suicide, overdosing was found to be the most common method of deliberate self harm in 2012, accounting for 69% of incidences registered that year (75% women, 62% men). Self-cutting was found to be the second most common form of self harming accounting for nearly one quarter of presentations (23%) and employed more often by men (26%) than by women (21%). Attempted hanging accounted for 7% of deliberate self harm presentations in 2012 and at a figure of 776 cases (10% men, 3% women), this is the highest incidence of DSH involving hanging ever recorded by the Registry and 75% higher than the rate recorded in 2007 (n=444). 38% of cases presenting at Emergency Departments displayed evidence of alcohol consumption (42% men, 36% women), highlighting the phenomenon of 'alcohol induced myopia', that is the constricting of cognition and perception (Sue et al. 1997). A substantial proportion of these alcohol-related presentations tend to arrive around midnight, on Sundays and Mondays, and on public holidays (Griffin et al. 2013).

2.5 Attempted Suicide in the Context of 'Significant Others'

By 2020, if the estimated 1.53 million people die by suicide and if, indeed, 20 times more people attempt suicide as per the estimates, then over 30 million individuals worldwide will have attempted to take their own lives. Applying this locally, since 507 individuals died by suicide in 2012 (CSO 2013), then approximately 10,000 individuals will have attempted suicide in Ireland in that year. This figure is likely a conservative one as accurate estimates are hampered by those individuals who do not attend A&E following an attempt and by

those who discharge themselves from A&E before level of intent regarding self-harm can be determined. It is conservatively estimated that up to *6* individuals are directly *affected* by a suicide (Beautrais 2004). In Ireland, however, a national service for the suicide bereaved founded in 2002 'Console', estimate that a minimum of *12* people are *affected* by suicide (Tierney 2011). If both of these estimates are applied to the population of suicide attempters then there may be a population of between approximately 60,000 and 120,000 individuals *affected* by a suicide attempt in Ireland each year.

2.6 Attempted Suicide and Significant Others: Informant/Caregiver vs. Being Met as a Person

The literature search associated specifically with families and uncompleted suicide revealed early research based in the USA, with more recent studies active particularly in Taiwan and the Scandinavian countries of Norway and Sweden. These recent studies identified their participants primarily as informants and/or caregivers. The earlier 1960s studies, however, identified the partner as neither, but actually as a *contributor* to continued suicidal behaviour within the dyadic relationship.

Harris (1966) as a prelude to her own study, cited an American unpublished 1964 doctoral dissertation by Hattem who administered a battery of tests to twenty individuals who accessed support during suicidal crisis from the Suicide Prevention Center in Los Angeles between 1962 and 1963. Findings suggested that the 'significant other' or marriage partner was highly influential in precipitating suicidal behaviours of suicidal ideating individuals; 'significant others' were narcissistic and engaged unresponsiveness within the dyad as a defence mechanism; and participants displayed behaviourally opposite personalities to their partners. Harris (1966) embarked on a follow-up study to ascertain the impact of maintaining or ending the relationship on further suicidal behaviours. Fifteen of the original twenty individuals took part in a structured interview. Of the eight individuals who remained

with their partner, four continued to exhibit suicidal behaviour. The other seven individuals who separated from their partner exhibited no further suicidal behaviour. The findings of this study were interpreted as confirmation that if a dependent, masochistic partner engaging suicidal behaviour were to separate from their narcissistic/detached partner then their 'last resort appeal' suicidal behaviour would discontinue. Both studies support the proposition that the 'significant other' plays a pivotal role in the suicidal behaviour of their partner. However, both studies seem to imply a cause-effect relationship between the behaviour of the 'significant other' and the partner's suicidal behaviour. Furthermore, both studies gathered information from the perspective of the partner displaying suicidal behaviour and not from the 'significant other'. Hattem's study also found that suicidal individuals had a highly critical outlook on life and, therefore, this may have influenced the extent to which they negatively described their partner. Both studies ultimately concluded that suicidal behaviour was due to a lack of character 'fit' with a partner, thereby creating the foundations for a culture of blame toward the suicide attempter's partner.

A later Swedish study (Wolk-Wasserman 1986) found that of the 70 'significant others' of 37 suicide attempt patients admitted to hospital, the vast majority of significant others grasped they were suicidal but responded with almost total silence. More recent research (Deisenhammer et al. 2007) suggests that individuals discharged from psychiatric hospital are of greater risk of suicide just after discharge with 47.7% dying by suicide within one month of discharge (n=665). Furthermore, the type of care family members provide to suicidal relatives has been found to either reduce or actually increase further suicide attempts (Sun, Long, and Tsao 2007). Thus, taking these studies into consideration along with Hattem's and Wolk-Wasserman's early research, it stands to reason that both hospital and mental health professionals' priority is to look to immediate family members (including partners) to ensure the survival of those who have previously attempted suicide. The personal impact on the partner is thereby lost in the midst of this life or death crisis.

A number of studies have focused primarily on improving the provision of care for suicide attempters. A phenomenological hermeneutic study based in Norway was conducted by Talseth, Gilje, and Norberg (2001) in which they interviewed fifteen relatives chosen by patients who had been hospitalised as a result of having either attempted suicide or assessed to be at high risk. The study aimed to highlight the lived experience of 'being met' by staff during the care of their relative at risk of suicide. 'Being met' is a well known phrase within Norwegian culture which means "being aware of the needs of the other" (Talseth et al. 2001, p.253). The patients comprised spouse, parent, adult child, or in-law. The study highlighted the importance of (1) relatives being acknowledged as human beings; (2) participating in an 'I-Thou' relationship with staff; (3) trusting staff, treatment, and provision of care; (4) feeling trusted by staff; and (5) being consoled. All of these variables were seen as a pathway to hope for relatives. The study concluded that greater emphasis on working closely with relatives maximised the likelihood of recovery for the patient.

Further research focusing on care provision for attempters and based in Sweden sought primarily to establish the efficacy of broadening the psychiatric assessment protocol following an attempted suicide to include information from significant others (Magne-Ingvar and Öjehagen 1999a). However, the immediate well-being of the significant other was also recorded. A total of 81 individuals identified by the suicide attempter as a 'significant other' (SO) were contacted shortly after they were admitted to hospital. All SOs were interviewed mostly via telephone over a 16-month period between 1993 and 1994 using a semi-structured methodology. Of the 81 SOs, less than 30% were current partners of the patient. The remaining SOs comprised former partners (n=7), parents (n=30), grown-up children (n=12), siblings (n=2), and friends (n=6). 57% of the SOs who had provided support to the patient prior to and following the attempt whether emotional or practical, reported this to be a significant burden to them. This was particularly apparent to them if the patient was living with a psychiatric disorder other than adjustment disorders. 75% percent of SOs reported

feelings of worry, upset, and shock on becoming cognisant of the suicide attempt. 16% of SOs on exploration of their own health reported feeling physically unwell and approximately 25% communicated sleep, mood, and/or appetite difficulties. 41% percent reported other personal problems on top of the current burden of care. Significantly, over half of the SOs (53%) reported an interest in engaging in counselling *conjointly* with the patient, with 37% desiring individual counselling only. This may indicate the tendency for significant others to place an emphasis on the welfare of the patient over and above their own welfare. The results of the study also indicated that despite SOs having relatively good supports in place for themselves, it was established that additional professional support was desirable in order to better cope with the experience.

A one-year follow up study (Magne-Ingvar and Öjehagen 1999b) was conducted in order to glean further valuable information about the welfare of both the suicide attempter and the SOs. The interview conducted by telephone, comprised 68 questions focussing primarily on incidence of further suicidal communication; the occurrence of additional suicide attempts; the interventions received by the patient and the SO's evaluation of these. As in the original investigation, the wellbeing of the SO was explored albeit to a limited degree. The well-being of SOs was measured by means of questions related to particular somatic and psychological symptoms. 77% of respondents reported having worried that the patient would engage in further deliberate self harm following the initial suicide attempt. On exploration of symptomatology, approximately 60% of SOs reported at least one of the following symptoms: worry, tiredness, headache, irritability, downheartedness, epigastric pain, disrupted sleep, tension, hopelessness, and anxiety. What is of note is that partners reported: (1) less social supports than the other SOs; (2) outstanding questions regarding the suicide attempt, more so than other SOs; (3) less satisfactory well-being in comparison to that of parents or other SOs (65%); and (4) a greater need than other groups to engage individual professional support.

The findings from the follow-up study indicate the depth of impact that a suicide attempt can have on SOs, and on partners in particular (Magne-Ingvar and Öjehagen 1999b). In order to investigate the views of SOs at the time of the acute psychiatric consultation of suicide attempters, the sample within this study was formed solely on the basis of the recommendations of the patients. Thus, less than one third of respondents were *current* partners. The remaining respondents whilst being SOs, may not have been as intimately involved with the patient on a daily basis at the time of the attempted suicide nor continued to live with the patient following discharge. Both studies were conducted for the most part via telephone rather than face-to-face and required the SO to respond to a substantial number of questions thereby focusing on breadth rather than depth, and minimising opportunities for the SOs to share aspects of their lived experience of particular significance to them. These studies reflect the need to gain a more in-depth appreciation of the lived experience of a suicide attempter's partner in the wake of the attempt, in order to better understand the *personal* impact and its meaning for their everyday lives.

Östman and Kjellin (2002) explored the experience of stigma for relatives (spouses, parents, children, siblings, and a further sub-group identified as non-relatives) of individuals with mental illness, interviewed 162 relatives of individuals in acute psychiatric wards using a semi-structured questionnaire. Again the questions were closed requiring a 'yes/no' response rather than focusing on the individual experience of each relative and included items such as: 'Has the person's mental illness impaired the relationship between you and that person?'; 'Has the person's mental illness led to any mental health problems of your own?' and 'Is the burden of the situation of being a relative so heavy that you have thought of suicide?' Spouses of individuals with mental illness, in comparison to the other subgroups of relatives, were found to show a high rate of relationship impairment; and a high rate of their own mental health problems with accompanying suicidal ideation. They also displayed a greater wish to have never met the patient. This study focussed on burden of care for relatives and

their subsequent need for support. It provides a valuable insight into levels of psychological distress experienced by relatives as well as the importance of feeling supported by mental health personnel, similar to the findings of Talseth et al. (2001).

A number of studies have also highlighted the burden of care associated with relatives at risk of suicide. Östman, Wallsten, and Kjellin (2005) conducted a longitudinal study in 1988, 1991, and 1997 in Sweden. They interviewed a total of 455 relatives of some 623 patients admitted during one of the three periods of investigation. The subgroups of relatives included *parents; spouses; adult children; siblings; and non-relatives*. Results highlighted that approximately one-third of the respondents had ongoing concerns about the patient making a suicide attempt and reported mental health difficulties for themselves. What is of particular note for the present study is that relatives *living with* the patient demonstrated increased burden than those not living with the patient. In addition, spouses displayed more burden than the other subgroups overall. Spouses more often felt unable to engage in social interaction with others and experienced feelings of isolation as a consequence. Spouses also tended to be significantly more involved in patient treatment and were obliged to give up work more often in order to prioritise care of their partner. This longitudinal investigation employed a semi-structured questionnaire comprising 95 questions regarding burden of care for relatives. It appears that at least a portion of the questionnaire required a 'yes/no' response from participants thereby minimising the potential to gain insight into the relatives' 'lived experience' of being close to an individual at risk. There was a clear emphasis here upon statistical analysis of the raw data rather than 'meaning making'. In fact, the authors suggest that further qualitative methodologies be employed into the future in order to elucidate the *'context'* of relatives' participation in the care of a loved one. Furthermore, respondents reported fearing their relative making a first-time suicide attempt and so the lived experience of a relative post-suicide attempt was not captured.

A very limited amount of information is available about patient's home life after discharge from hospital (Sun, Long, Huang, and Huang 2008; Sun, Long, Huang, and Chiang 2009) and logically this extends to the experience for their family members including partners. Sun et al. (2008) using a grounded-theory approach (GT) explored both the family carers' and ex-patients' perceptions of their home life and the provision of care at home. They interviewed fifteen suicidal individuals (13 had attempted suicide, and 2 had suicidal ideation for over 2 weeks) and fifteen family members. The suicidal individuals had just been discharged from one of two Taiwanese hospitals. The fifteen 'carers' comprised of partners (n=6); parents (n=4); siblings (n=3); and children over 20yrs (n=2). The data generated 'A theory to guide families and carers of people who are at risk of suicide'. The interviews revealed that family members experienced worry and the burden of responsibility following patients' discharge as they feared s/he would attempt suicide when not under their supervision. The quality of the relationship was also found to impact the home environment with pre-existing closeness positively influencing communication, and poor relationships resulting in greater distancing between members. The main emotions that manifested for carers were dog-tiredness, anger, stress, fear, anguish, and numbness. The stigma associated with the suicide attempt was also felt by family members due to the particularly negative view Chinese culture takes on suicide. Family members consequently experienced shame, foolishness, and 'buhsiao' (implying that those who attempt suicide are not devoted to their parents). The amount of external supports such as family, friends, and professionals that carers had access to significantly influenced their experience of caring. For those that felt isolated their ability to provide care was hampered. Carers employed various coping mechanisms such as time with friends, exercising, relaxation, and ignoring. Other mechanisms were religion and 'letting nature take its course'.

Three further categories came to light relating to the aforementioned study (Sun et al. 2009). The first category *'guarding the person day and night'* entailed constant observation and

ensuring safety. The second category *'maintaining the activities of daily living'* entailed providing basic care; ensuring treatments; and arranging remedial activities. The third category *'creating a nurturing environment'* entailed conveying care and support; fostering tranquillity; and reawakening hope.

This study is significant in terms of highlighting the needs of individuals who have attempted suicide and are at risk of further attempts following discharge from hospital. Sun et al. (2009) assert that these needs can realistically only be met through the co-operation of family members:

> The findings highlight the need for family caregivers to be provided with evidence-based knowledge and skills to effectively and continually assess suicidal intent; protect ex-patients' safety; maintain activities of daily living to promote physical recovery; and create a nurturing environment to facilitate the ex-patients' mental health and healing and regain their desire to live. (Sun et al. 2009, p.551)

The implications of these findings for family caregivers are substantial in that there is an expectation that they engage multiple strategies to ensure the safety of suicidal relatives including assessment; protection; maintenance; promotion; creation; and facilitation. This study aims to explore the provision of care in the home but is premised upon both a will and an ability on the part of the relative to provide such care. Whilst the researchers acknowledge the expectation within Chinese culture for families to participate in the recovery of suicide attempters, there is an important opportunity missed to probe family members about their feelings both about their suicidal relative and their obligation to provide ongoing care to them. Furthermore, one criterion for selection to the sample was at least three days care experience which would provide only very limited, short-term insight into relatives experience.

Mehlum and Ramberg (2010) at the University of Oslo stress the need for more systematic assessment, management, and follow-up treatment for suicide attempters presenting in

hospitals. They acknowledge the adverse impact of a suicide attempt on 'next-of-kin' but highlight the requirement to apply a more assertive approach to treatment engagement by for example requesting participation from parents in the treatment of their adolescent children. This call for greater cohesion in assessment and intervention for attempters is typical across the extant literature, highlighting the potential benefits of utilising next-of-kin to improve treatment outcomes for attempters with any costs or benefits to relatives of little or no importance.

Further studies have continued to build upon the likes of the aforementioned GT study such as exploring the efficacy of a suicide education intervention for family caregivers (Sun et al. 2013) and optimal conditions for healing following a suicide attempt (Sun et al. 2014). Both of these studies whilst important in their own right, highlight SOs as caregivers with no attention paid to the personal impact of the attempt and how they make sense of it in their lives.

2.7 Situating 'Significant Others' and Uncompleted Suicide within a Theoretical Framework

2.7.1 Introduction

The available empirical evidence outlined above highlighting the role of a 'significant other' both as informant and as caregiver denotes the considerable weight that they carry in terms of society's response to this life crisis. The substantial cost to a SO's general well-being whilst caring for an actively suicidal relative has been noted but less attention has been paid to the meaning of the experience from the perspective of the SO in terms of personal impact and its associated trajectory. This provides the basis for exploring the phenomenon of uncompleted suicide from the personal perspective of a 'significant other' and in particular the partner, through a number of lenses namely, loss; trauma; resilience; and transformative learning.

2.7.2 Ambiguous Loss Theory and Uncompleted Suicide

The experience of grief and loss as a repercussion of a suicide attempt is one that needs to be validated for relatives and significant others (Popadiuk 2005). There are many ways to conceptualise grief but many theories of grief are now considerably outdated as they emphasised a linear model of grieving with an end goal of 'letting go' of the deceased. New models of grief view loss as a complex and individual process that is non-linear in nature. Stroebe and Schut (1999; 2001) describe a 'dual process' model of grief which moves between loss-oriented processes and restoration-oriented processes which facilitates construction of new meaning systems. Malkinson, Rubin, and Witztum (2006) describe a 'two-track' model particularly useful for traumatic loss. Their model views loss as a changing 'state' and proposes that the mourner is again moving between general functioning and nourishing an imaginal relationship with the deceased. Worden's (2009) task model of grief describes 'normal' or 'uncomplicated' grief as that which is commonplace following a loss. 'Abnormal' or 'complicated' grief on the other hand occurs when grieving 'goes wrong' in some way and can manifest as chronic, delayed, exaggerated, or masked reactions.

The suicide of a loved one according to Worden (2009) encompasses a special type of loss that can cause quite a distinct set of problems for the survivor at an emotional, physical, cognitive, and behavioural level. It is not uncommon for 'survivors' of suicide to experience shame, guilt, anger, fear, denial, and other distorted thinking. There are also occasions where a loss lacks both clarity and acknowledgement but can nonetheless instil deep feelings of devastation, sorrow, and confusion. Such 'ambiguous losses' occur as a result of *external* circumstances rather than any particular process an individual is failing to engage internally.

Many authors (Worden 2009; Attig 2004; Doka 2002) describe the experience of 'disenfranchised grief' in the context of completed suicide that is, a loss that is viewed as being socially unspeakable. With 'completed suicide' there is clarity in the permanency of

the death. However, with regard to the 'uncompleted suicide' of a loved one, death has not occurred but the grief of a 'significant other' is disenfranchised *and* the nature of the loss ambiguous.

> Unlike death, an ambiguous loss may never allow people to achieve the detachment that is necessary for normal closure. Just as ambiguity complicates loss, it complicates the mourning process. People can't start grieving because the situation is indeterminate. It feels like a loss but it is not really one. (Boss 1999, p. 10)

Ambiguous loss can be conceptualised as a relational disorder that is unclear and traumatic. It is externally caused rather than through individual pathology, and is incredibly difficult to process (Boss 2010). With ambiguous loss the individual is still here, but not *fully* here, therefore, there is neither an official notice of the loss nor a ritual to mark it. Ordinarily, communities support families in resolving loss through mourning, funeral, and other rituals but for losses that are not obvious no validation from the community is usually forthcoming. Two main types of ambiguous loss have been conceptualised (Boss 2010). (1) *Physical absence with psychological presence*: a significant other is missing physically but kept psychologically present. This can manifest as a result of a loved one being lost, kidnapped, or more familiarly through adoption, separation/divorce, or immigration. (2) *Physical presence with psychological absence*: a significant other is present physically but for whatever reason missing psychologically. This can be manifested through illnesses such as Alzheimer's disease and other dementias (Boss 2010), as well as the result of acquired brain injury (Landau and Hissett 2008), heart attack, stroke, coma, depression, autism (O'Brien 2007), addiction, obsessive-compulsive behaviours, or fixation with work (Boss 2010). A psychotherapist whose partner experienced an acquired brain injury highlights the intensity of her ambiguity, an experience which may resonate for partners of uncompleted suicide:

> How is it possible to lose half a person? Half is dead, half remains alive...the uncanny story violates the observer's trust in reality. Life may then deceive by promising substance and delivering ghosts. The doppelganger sits at the dinner table. (Feilgeson 1993, p. 335)

Boss (1999) first identified the phenomenon of ambiguous loss in 1974 through research with the families of pilots missing in action (MIA) in Vietnam and Cambodia. Interviews with forty-seven families throughout California, Hawaii, and Europe found that increased conflict and general dysfunction existed in those families where the wife of the MIA pilot invested in keeping him 'psychologically' present despite his 'physical' absence. Thus, wives who consistently communicated to children in a way that implied the imminent return of their father, "wait until your father gets home!" displayed more psychological and emotional disturbance, as did their children. A later study by Boss, Pearce-McCall, and Greenberg (1987) surveyed 140 parents whose adolescent children had recently left home and found that there was a positive correlation between the parents perception of their absent adolescent as being still 'present' and level of parental distress. More specifically, greater parental anxiety, depression, sleep disruption, negativity, and illness particularly among fathers was associated with having recurrent thoughts about their welfare, difficulty accepting that their children had grown up, and yearning for their return home. Later research developed the study of 'psychological' absence of a family member. The families of seventy individuals with Alzheimer's were assessed for depressive symptomatology and again three years later. Boss (1999) found that the best predictor of depression was not the severity of the patient's illness but rather the caregiver's perception of whether the patient was 'present' or 'absent' within the family.

Literature to date, however, does not seem to have recognised the phenomenon that is the psychological absence arising from the 'uncompleted suicide' of a loved one and its possible resulting ambiguous loss for partners. Partners of individuals who have attempted suicide

may have to cope with both the intentional nature of the attempter's behaviour i.e., knowing their partner intended to die through their own volition, but *also* the ambiguity surrounding their continued presence/absence.

2.7.3 Trauma Theory, Resilience, and Uncompleted Suicide

Since ambiguous loss entails a loved one being either psychologically present but *physically* absent or physically present but *psychologically* absent, the individual can be deemed 'here' but 'not here' to some degree. Partners or other family members can experience their grief as 'frozen' in time and as a consequence forces life to be put on hold (Boss 2010). The potentially debilitating, intrusive, pervasive nature of ambiguous loss establishes it as a trauma:

> ...ambiguous loss is traumatic because it is painful, immobilizing, and incomprehensible so that coping is blocked. It is akin to the trauma that causes posttraumatic stress disorder (PTSD) in that it is a painful experience far beyond normal human expectations. But unlike PTSD, it remains in the present; that is, the traumatizing experience (the ambiguity) often continues for years, a lifetime, or even across generations...(Boss 2010, p. 139)

In exploring the relationship between trauma and the complicated grief of ambiguous loss, Boss (2010) describes the traumatic impact Alzheimer's disease can have on a partner. The diagnosis of the disease can be experienced as just the first of a litany of losses or multiple traumas. Partners can experience not only the loss of their partner's memory but the loss of mobility, the loss of their partner being able to swallow, the loss of continence, the loss of being able to holiday together, and the loss of their partner being able to recognise them. Each deficit can cause a partner to become frozen in their trauma.

Applying the potential of multiple traumatic experiences to the context of suicide, McKenna (2010) describes a case study of an adolescent suicide attempt and the subsequent impact on both parents and siblings. Neuropsychological assessment later revealed that he had an

acquired brain injury as a result of the attempt, manifesting in personality and memory changes. Thus, part of him was present and part of him was missing, in this context physical presence but psychological absence. Both his parents and siblings showed symptoms of post-traumatic stress encompassing flashbacks of the incident, sleep disturbance, hyper-vigilance, anxiety, and fear. The ICD-10 classification of mental and behavioural disorders (WHO 2004) views post-traumatic stress disorder as one that develops as a reaction to "a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone" (p. 147).

The WHO (2004) has also proposed that not everyone who is exposed to an extremely stressful incident will automatically experience trauma or even a transient acute stress reaction, due in the main to individual differences regarding vulnerability and coping ability. In other words, a certain factor or factors can be in evidence within certain people to produce psychological hardiness or 'resilience' in the face of adversity.

> Stress resilience reflects an individual's capacity for successful adaptation in the face of acute stress, trauma, or chronic forms of adversity. Resilience is an active process - not just the absence of pathology - that can be promoted by enhancing potentially protective factors.
>
> (Feder et al. 2010, p. 47)

Previous research in the area of traumatic stress has suggested that such incidents would cause chronic emotional dysfunction within an individual. More recent research, however, has shown that in the region of 50% of those exposed to various potentially traumatic events such as bereavement, illness, and even terrorism have demonstrated resilience (Bonanno & Mancini 2008). Zautra et al. (2010) in attempting to operationalise resilience offer two variables for consideration. The first is 'recovery', the degree to which an individual is able to recuperate socially, physically, and psychologically in the aftermath of stressful experiences. Second is 'sustainability', the ability to move forward during adverse periods

whilst maintaining one's physical and psychological health. Feder et al. (2010) have identified a number of psychosocial determinants of resilience including active coping such as planning and problem solving; facing fear in order to appraise and respond to threats rather than engage escape and avoidance behaviours; positive emotions and optimism; purpose in life, moral compass, and spirituality; social support; and ability to cognitively restructure difficult experiences.

A review of the extant literature reveals no prior exploration of the relationship between uncompleted suicide and trauma or resilience, in the context of 'significant others' such as partners. Rather it has focussed on areas such as trauma following the *completed* suicide of a family member (Lukas and Seiden 2007; Lindqvist et al. 2008); prevalence of attempted suicide amongst vulnerable populations such as adult survivors of childhood trauma (Roy and Janal 2005); attempted suicide in the *aftermath* of developing post-traumatic stress disorder (Wilcox et al. 2009; Panagioti et al. 2009); vicarious trauma of professionals working with clients engaging fatal and non-fatal suicidal behaviour (Ting et al. 2008); the relationship between 'flashbacks' to trauma and 'flashforwards' to suicide (Holmes and Butler 2009). Since exposure to an uncompleted suicide is situated well beyond the normal range of human experience, is within the realm of life versus death, and may constitute the trauma of ambiguous loss, it was deemed that exploration of trauma theory and resilience would be of value to the present study.

2.7.4 Transformative Learning Theory and Uncompleted Suicide: The Process of Meaning Making

Tranformative learning first conceptualised by Mezirow (1990) has its origins in pedagogy and adult learning. In this context it is thought that transformation can occur in response to a 'disorienting dilemma' that is, a challenge to one's world view or frame of reference. Beyond adult education, however, transformative learning has been shown to be applicable

to disorienting dilemmas triggered by a 'life crisis' such as illness, unemployment, and bereavement. The resulting disorienting dilemma triggers critical reflection which "enables us to correct distortions in our beliefs" (Mezirow 1990, p.1). Critical reflection ultimately facilitates meaning making out of a "chaotic situation that was not understandable from within existing meaning frameworks" (Mälkki 2012, p.207). The challenge for an individual in chaos is to transform their meaning perspective in the midst of essentially being in a 'vacuum of meanings' where "one is neither able to imagine one's life ahead as based on one's previous experiences nor able to have coherent anticipations of the future" (Mälkki 2012, p.209). Mezirow's theory has been criticized for relying too heavily upon rationality and cognitive processes. More recent empirical investigations applying the paradigm of transformative learning, therefore, have explored the emotional dimension of transformation as well as the social construction of meaning perspectives (Taylor 2007). These include life crises such as elder bereavement (Moon 2011), involuntary childlessness (Mälkki 2012), and suicide bereavement (Sands and Tennant 2010).

Sands and Tennant's study (2010) aimed to understand the various aspects associated with the 'healing and meaning making' processes of those bereaved by suicide. A group case study method of data collection was employed capturing several forms of data during suicide bereavement group workshops (16 male and female participants). Three core themes were identified that facilitated meaning making and were conceptualised through a relational lens. The first theme 'intentionality' represents the bereaved individual's emotional attempt to understand why their deceased relative chose to take their own life, involving a process of 'trying on the shoes' of the deceased. The second theme 'walking in the shoes' represents an effort to reconstruct the death scene, the deceased's life prior to the suicide and the meaning the suicide has for the bereaved in the context of the relationship. The final theme 'taking off the shoes' represent the bereaved individual's ability to move beyond their relative's

decision to die, thereby creating new meaning and integrating the death. Sands and Tennant (2010) conclude that the process of meaning making experienced by those bereaved by suicide reflected the phases of transformative learning namely:

> A disorienting dilemma; a self examination; with feelings of fear, anger, guilt, or shame; a sharing of experiences with others; the exploration of new roles; and a reintegration of a new perspective in one's life (p.114)

The significance of the emotional dimension within transformative learning has been highlighted by Sands and Tennant which concurs with Mälkki's (2012) research on involuntary childlessness. In fact Mälkki proposes that emotion is a fundamental aspect of disorienting dilemmas. In essence, the more open one is to working through emotions both positive and negative, the more open to reflection and thereby transformation one becomes. In addition, the significance of the social dimension within transformative learning has been noted by both researchers. Mälkki (2012) describes a 'second-wave' trigger for reflection in which social engagement during a disorienting dilemma can create further disorienting dilemmas as a result of new disagreements with significant others that come to the surface.

Sands and Tennant's study highlights the applicability of Mezirow's transformative learning theory to those bereaved through suicide and the role of meaning making in the context of relationship with the self, the deceased, and with significant others. Taking the position that the study is one within a "highly emotionally charged context" (Sands and Tennant 2010, p.100) the researchers view the transformative learning experience involving an ontological process in which individuals experience profound change in 'being'. In the context of the present study, Sun et al. (2009) have identified an uncompleted suicide as a 'life crisis' for family members. Therefore, partners may experience a 'disorienting dilemma' in response to this highly emotional event, with possible 'second-wave' dilemmas experienced on foot of

social interaction. This may have important implications for supporting this vulnerable group psychotherapeutically in their meaning-making process and ultimately in 'being'.

2.8 Implications for the Present Study

Many of the studies identified in this review highlighted 'significant others' as either potentially exacerbating the situation of the suicidally inclined individual (Harris 1966; Sun et al. 2007) or being fundamental to their recovery and welfare. Some of the studies or reviews in this vein have utilised the knowledge of SOs to improve assessment and care provision for attempters (Magne-Ingvar and Öjehagen 1999a; Rajalin et al. 2001; Talseth et al. 2001; Mehlum and Ramberg 2010), with scant recording of symptomatology rather than in-depth investigation of the personal impact for SOs. The remaining studies have emphasised the role of SOs as caregiver and so have explored burden of care rather than their personal lived experience (Östman et al. 2005; Sun et al. 2007; Sun et al. 2008; Sun et al. 2009). Some of these studies, although qualitative in nature, were not conducive to gaining in-depth data about the lived experience of the SO. Furthermore, none of these studies distinguished partners from 'significant others' (i.e. parent, adult child, sibling, in-law, other relative, other non-relative) as a subgroup of particular interest given how heavily they usually feature in the suicide attempter's life.

Whilst Sun et al. (2009) may be correct in identifying family members as main caregivers, I believe that there is a gross assumption made that partners are physically and emotionally able or, indeed, motivated to take on such considerable responsibility as that outlined earlier. Therefore, there is a significant gap in the extant literature regarding psychotherapy's insight into the personal impact of an individual's uncompleted suicide on relatives, particularly on partners.

Gustafsson (1999) provides some evidence to suggest that SOs coping with a loved one who is actively suicidal are actually at greater risk of suicide themselves, yet it is SOs particularly partners, who are identified as the main caregiver. The present study intends to elucidate the 'context' of a partner's experience following an uncompleted suicide. This will be more from the perspective of their own *personal* 'lived experience' rather than solely from the position of caregiver.

It appears that whilst a need for a paradigm shift to include attempted suicide was recognised during the 1950s (Stengel 1956), it does not appear that research interest has expanded to incorporate 'survivors' of those who have *attempted* suicide and lived, in the same way as it has embraced and championed 'survivors' of *completed* suicide. Psychotherapists have to date been guided by the extant literature on uncompleted suicide and SOs which for the most part has conceptualised the SO as informant and/or caregiver. The present study aims to explore the personal impact upon partners in particular, thereby adding further dimensions to inform the field of psychotherapy. The 'motorway metaphor' articulated by McKenna (2010) describes the desire for the suicide attempter to move quickly into the 'fast lane' of recovery, not wishing to look back. Family members remain in the 'slow lane' fearful of moving too quickly forward while simultaneously reluctant to let go of the past. The present study aims to capture the personal journey of a partner by exploring their lived experience following uncompleted suicide, and examining the meaning they attribute to an uncompleted suicide and the significance of these meanings for their everyday lives.

2.9 Reflexive Journal Entry

I have struggled to find any existing literature in this area through search engines and rather than view this as adding to the rationale for pursuing this research, I am questioning my review skills. It turned out that there is truth in both arguments – there is very little literature out there on the impact/adjustment for partners beyond the role of carer, and it

took me quite some time to fall upon the term 'significant other(s)' which acted as a gateway into exploring the literature in this area.

One of the earliest drafts of the literature review inadvertently placed a huge emphasis on those who attempt suicide and very little about significant others. This was quite an eye opener when pointed out to me by my supervisors. However, with further thought I viewed it as a reflection of the reality in which we live where most attention if most all is understandably (and necessarily) paid to the suicidal individual to the detriment of those around him/her. All the more reason, therefore, I thought, to ensure my gaze is at all times firmly affixed on the experience of partners from here on out.

Chapter 3. Methodology and Method

3.1 Introduction

This chapter provides an overview of the research methodology employed beginning with a statement of the research aims and objectives, followed by an exploration of the research design; the philosophical underpinnings of IPA; researcher positioning and reflexivity; and a critique of IPA. A description of the IPA research method is then provided, detailing access to participants, the selection process, and participant profile; method of data collection; analysis; ethical considerations; and an evaluation of IPA.

3.2 Research Aims & Objectives

Suicide incurs a significant social and psychological burden on individuals and society as a whole. Much of the literature on suicidology, the study of suicide, suicide prevention, and suicidal behaviour has highlighted those who attempt suicide, with very little focus on the impact on partners. The main aims of the study, therefore, were:

1. To explore the lived experience of living with a partner following uncompleted suicide; and
2. To examine the meaning that partners attributed to an uncompleted suicide and the significance of these meanings for their everyday lives.

The objectives of the study were to elucidate the meaning that individuals ascribed to their reaction to the critical incident; and to explore the meaning that individuals ascribed to the aftermath of the attempt over time.

3.3 Design

The present study employed a qualitative methodology as it was deemed the most appropriate method of gaining greater *insight* into the phenomenon of individuals who have experienced the uncompleted suicide of a partner. In particular, the emphasis for this study was to gain insight into the *meaning* they attribute to living with a partner who had attempted suicide.

> One of the primary reasons for adopting [Qualitative Methodologies] is a recognition that our knowledge and experience of the world cannot consist of an objective appraisal of some external reality, but is profoundly shaped by our subjective and cultural perspective, and by our conversations and activities (Yardley, 1997a). Thus, "truth", "knowledge" and "reality" are actively created by the communal construction and negotiation of meaning, both in our daily life and our academic endeavours. (Yardley 2000, p. 217)

IPA was considered an appropriate approach due to it privileging and capturing lived experience and meaning as well as being recognised as particularly suited to exploring a distinctive and multifaceted phenomenon. Phenomenological research is concerned with the opinions, experience, feelings, and meaning-making of individuals, is open and responsive to its subject and "…tends to focus on exploring, in as much detail as possible, smaller numbers of instances or examples which are seen as being interesting or illuminating, and aims to achieve "depth" rather than "breadth" " (Blaxter, Hughes and Tight 1996, p. 60).

IPA has been described as being a particularly good fit for exploring a unique phenomenon of a complex nature (Smith & Osborn 2008). Therefore, since there is a limited body of research into the impact on partners following an uncompleted suicide, the present study employed this qualitative approach using a semi-structured interview to explore the respondents' phenomenological view in the context of relating to a partner in the aftermath of his/her suicide attempt. Previous research has engaged structured interviews with a large number of individuals that can more likely be subjected to generalisations. The nature of the present study's particular design denotes that it does not endeavour to make such

generalisations but rather to illuminate the experiences of a small number of individuals so as to inform psychotherapeutic practice. Figure 3.1 sets out the research process employed by the current study.

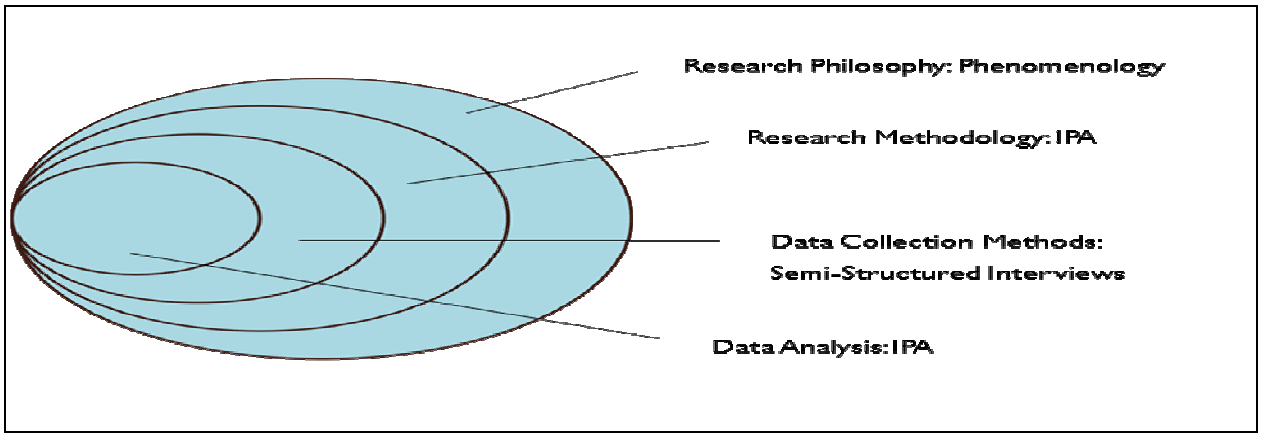

Figure 3.1 Research Process 'Onion' – Adapted from Saunders et al. (2009)

3.4 Philosophical Underpinnings

Interpretative Phenomenological Analysis was deemed an appropriate fit for the aims of the research as it endeavours to go beyond a mere descriptive account of the phenomenon by not only recording the subjective lived experience as constructed by each individual, but by acknowledging the significant role of the *researcher* in facilitating a *co-constructed* account of the phenomenon.

3.4.1 The Theoretical Roots of IPA: Phenomenology, Hermeneutics, and Idiography

Interpretative Phenomenological Analysis (IPA) is a relatively recent development within the phenomenological tradition with its roots within both phenomenology and symbolic

interactionism (Smith 1996) which suggests that not only is the meaning(s) a person assigns to an event significant but can only be achieved through a process of interpretation (Biggerstaff and Thompson 2008). It endeavours to not only capture a detailed account of lived experience, but also the *meaning* of the experience, as well as the process through which the individual *makes sense* of the experience. Larkin et al. (2006) describe the essence of IPA as having two commitments which are complementary to one another namely, the phenomenological aspect of 'giving voice' to and understanding the lived experience of individuals, and the interpretative aspect of 'making sense' of the individuals concerns in a given context. Thus, IPA offers an interaction between 'emic' and 'etic' positions.

3.4.1.1 IPA in the context of Phenomenology

IPA is interested in exploring the lived experience of individuals and, therefore, is heavily influenced by phenomenology. According to Finlay and Ballinger (2006) phenomenology can be conceptualized as both a philosophy and an approach to research. IPA is an inductive approach and as such aims to gain insight into an individual's lived experience and sense-making of a phenomenon, rather than trying to find causal explanations (Smith and Osborn 2008).

Smith, Flowers, and Larkin (2009) describe phenomenology as essentially interested in recording what the experience of being human is like and in particular:

> .....one key value of phenomenological philosophy is that it provides us with a rich source of ideas about how to examine and comprehend lived experience. (Smith et al. 2009, p. 11)

Some of the most influential phenomenological philosophers including Husserl, Heidegger, Merleau-Ponty, and Sartre all shared fundamental ideas about phenomenology but

conceptualised it in varying ways. This reflects the study of phenomenology as a singular but simultaneously pluralist undertaking (Smith et al. 2009). Both Husserl, the founder of phenomenology, and Heidegger rejected the notion that the individual can be separated from the world in which it occupies, that is, a dualistic separation of 'subject' and 'object'. Rather, they viewed the person as always a 'person-in-context' who is continually involved with and relating to the world in which they live. In fact Heidegger referred to the person as *Dasein* literally translated as 'being-there' or 'there-being', and highlighting the fact that the human-*being* is inextricably located and immersed in some way within their environment. Consequently, the person comprises a fundamental part of the meaningful world and the meaningful world comprises a fundamental part of the person (Larkin et al. 2006).

> It must be stated that the entity as an entity is 'in itself' and independent of any apprehension of it; yet, the being of the entity is found only in encounter and can be explained, made understandable, only from the phenomenal exhibition and interpretation of the structure of encounter. (Heidegger 1985, p. 217, cited in Larkin et al. 2006, p. 107)

Indeed, Husserl would argue against a reality that exists which is separate from human beings insofar as it is only through our *consciously* encountering the world that we can develop knowledge of this reality. This conceptualisation of reality as something which is constructed serves to highlight the derivation of 'reality' from a verb meaning 'to think'. Thus, within this context 'reality' can be considered as something consciously constructed as opposed to something that exists in the absence of thought (Larkin et al. 2006). Heidegger, on the other hand would not place as much emphasis on the moment-to-moment conscious construction of reality. Rather, he suggested that conscious thought is for the most part, transient in nature and is engaged only when one encounters a problem of some kind. Otherwise we are consistently in relationship with the world around us and as such a 'person-in-context'.

> ...it is not actually possible - even if it might be desirable – to remove ourselves, our thoughts and our meaning systems from the world, in order to find out how things 'really are' in some definitive sense (Larkin et al. 2006, p. 106)

In reflecting upon the essence of phenomenology Heidegger draws upon an etymological definition of the word which is derived from the Greek words *phenomenon* and *logos* (Smith et al. 2009). *Phenomenon* can be described as 'show' or 'appear' (Smith et al. 2009), and the revelation of something 'as it is in itself' (Larkin et al. 2006). From the standpoint of 'appear' or the 'appearance' of our being, Heidegger implies that *phenomenon* has a twofold perspective in that it represents moving from a state of being hidden to a state of appearing or showing itself to us. This reflects Heidegger's conceptualisation of phenomenology as that which endeavours to gain insight into that which is brought to light. Phenomenology strives to not only lay witness to the thing which has remained hidden as it emerges, but to also more closely *examine* what comes to light as this has an important relationship to what has lain hidden or in latent form heretofore.

Logos, the second word from which phenomenology is derived is thought to mean variously 'judgement' or 'discourse' implying that it is concerned with reasoning something out through an individual's discourse and as such is analytical in nature (Smith et al. 2009). Of significance here then is that "...the phenomenon appears, but the phenomenologist can facilitate this, and then make sense of that appearing" (Smith et al. 2009, p. 24). It is from this perspective that Heidegger champions the view that phenomenology is ultimately hermeneutic as a discipline.

3.4.1.2 IPA in the context of Hermeneutics

Hermeneutics is the theory of interpretation and it is Heidegger's belief in the interpretative aspect of phenomenology that contrasted from Husserl's conceptualisation of

phenomenology as a simply descriptive methodology without presupposition on the part of the phenomenologist. Heidegger described the concept of 'fore-conception' on the part of the phenomenologist that is, those presuppositions, biases, and prejudgements that they bring to the study of a phenomenon. This fore-structure could be said to potentially hinder interpretation of a phenomenon or 'new object'. However, it is in acknowledging the existence of this fore-structure that guides the phenomenologist to prioritise interpretation of the 'new object'. In this sense, understanding can work counter-intuitively, by getting a deeper understanding of the phenomenon in question, one may develop a deeper understanding of one's preconceptions (Smith et al. 2009).

Interpretative phenomenological analysis has been described as a 'variant of phenomenology' in that it aims to explore the *meaning* of individual's experiences and perceptions of those experiences (Finlay & Ballinger 2006). In this sense it purports to go *beyond* a reductionist 'Husserlian' descriptive approach employing standard thematic analysis.

It is with this spirit in mind that IPA was chosen as the most appropriate approach to use in the exploration of the lived experience of those living with a partner in the aftermath of suicide attempt. The approach not only allows the researcher gain an 'insider's perspective' of the particular experience of significance to the person (Larkin et al. 2006) but to also conduct a thorough analysis of each case and to identify patterns across these cases (Smith 2011). An objective of the present study was to identify convergence as well as divergence in these patterns that would ultimately inform psychotherapeutic practice.

> In choosing IPA for a research project, we commit ourselves to exploring, describing, interpreting, and situating the means by which our participants make sense of their experiences. (Larkin et al. 2006, p.110)

Smith first used the term 'insider perspective' in his position paper on IPA (1996), a term originated by Conrad (1987) in his writings about the experience of living with illness. However, since then the use of the term may have had an adverse impact on some IPA researchers insofar as they judge that a simplified, descriptive account of an individual's experience can be deemed a phenomenological interpretative analysis. Rather, the goal of a *quality* IPA study is to engage both a 'first order' and 'second order' analysis. Many IPA studies heretofore have misinterpreted the stance that IPA takes providing only a 'first order' analysis in which participant experience is summarised but not developed at a deeper hermeneutical level (Larkin et al. 2006). Smith et al. (2009) advocate a dual process within IPA in which 'first order' analysis involves the participant's meaning-making of experience, whilst 'second order' analysis involves the researcher's sense-making of the participant's experience "...through the researcher's own, experientially-informed lens" (p. 36). This dual process is what Smith (2011) has described as a *double hermeneutic* in which the researcher is attempting to interpret the participant's own interpretation of an experience. Another manifestation of a double hermeneutic within IPA is the 'hermeneutics of empathy' in which the researcher is wishing to construct an account of experience as authentically as possible, as if they were in the participant's shoes; and a 'hermeneutics of suspicion' in which the researcher is attempting to embed the participant's account in some theoretical framework (Ricoeur 1970).

> Thus the IPA researcher is in part, wanting to adopt an 'insider perspective'...see what it is like from the participant's view...On the other hand, the IPA researcher is also wanting to stand alongside the participant, to take a look at them from a different angle, ask questions and puzzle over the things they are saying. (Smith et al. 2009, p. 36)

From an IPA perspective, Smith et al. (2009) are advocating adopting a hermeneutics of empathy and a hermeneutics of questioning. The hermeneutics of empathy represents the 'insider perspective' as a means of getting as close to the participant's experience as

possible. The hermeneutics of 'questioning' in contrast, represents more closely employing the interpretative work of the researcher and in doing so relying less on the participant's account. One of the most significant aspects of IPA is its interpretative slant which Larkin et al. (2006) have argued is appropriate if the research expressly aims to illuminate the meaning of a specific experience.

3.4.1.3 IPA in the context of Idiography

Illuminating the *specific* or idiographic, is the third important foundation upon which IPA is built along with phenomenology and hermeneutics. Quantitative approaches to research are mostly concerned with 'nomothethics' which looks at making generalisations about large populations of people. IPA, however, adopts an idiographic approach as it is concerned with looking at *specific* individuals who are experiencing a *specific* event at a *specific* time. Thus, IPA can be understood to encompass analysis of specific detail in an in-depth manner, as well as capturing how specific phenomena are understood by specific people in a specific context (Smith et al. 2009).

Interpretative Phenomenological Analysis was deemed to be the most appropriate design for the present study as it facilitates an in-depth analysis of a specific individual's lived experience whilst simultaneously acknowledging the significant and substantial role the researcher has to play in articulating and developing the meaning of this experience.

> That is, the research process itself must be seen as socially constructing a world or worlds, with the researchers included in, rather than outside, the body of their own research. (Steier 1991, pp. 1-2)

The aim was to not only 'give voice' to the participant's experience in the aftermath of a partner's suicide attempt but to illuminate the 'meaning' of this specific experience for the specific individual. Phenomenology, interpretation, and idiography all play a significant role in elucidating 'how it is' and 'what it means' to live with a partner following their

uncompleted suicide. Larkin et al. (2006) suggest that IPA as a qualitative approach might in fact be better described as a 'stance' to analysis rather than as a distinct methodology. This assertion reflects IPA's flexibility as it is open to engaging with many forms of knowledge.

> This epistemological openness is quite unique among qualitative approaches in psychology. Because of this, IPA researchers can make cautious inferences about discursive, affective and cognitive phenomena. (Larkin et al. 2006, p.114)

IPA goes beyond the confines of the participant's own conceptualisations generating new interpretations that can ultimately inform psychotherapeutic practice. According to Caldwell (2008), whilst it is not the motivation of IPA to *create* theory with a capital 'T' *per se*, analyses can certainly make significant contributions nonetheless. Furthermore, Reid et al. (2005) assert that "IPA is particularly suited to researching in 'unexplored territory', where a theoretical pretext may be lacking", and in doing so "…provide meaningful and unexpected analysis of psychosocial issues" (p.23). The lived experience of individuals whose partners have made a first-time suicide attempt is a quintessential example of such 'unexplored territory' and, therefore, IPA was employed to facilitate navigation of this new territory.

3.4.2 Researcher Positioning and Reflexivity

Of paramount importance in any research endeavour and arguably more so within qualitative research, is an appreciation of how the researcher conceptualises how knowledge is manifest within a person as well as articulating his/her own worldview. Since we are inextricably linked to the world in which we live I believe that as 'persons in context' knowledge is achieved through an interpretative process. Thus, the *knower* comes to knowledge by *interpreting* an experience and thereby, finding meaning and making sense of it in a manner that is unique to them. By the same token the researcher is also a 'person in context' experiencing the world through a process of interpretation. According to

Biggerstaff and Thompson (2008) this fits with the philosophy of IPA as "it assumes an epistemological stance whereby, through careful and explicit interpretative methodology, it becomes possible to access an individual's cognitive inner world" (2008, pp.4-5).

Conceptualising the person as eternally a 'person in context' holds resonance for me not solely because it reflects the person's continual involvement with and relating to their world, but because this inevitably occurs at certain points in time and is further influenced by social and cultural factors. Todorova (2011) highlights IPA's coherent approach to research with its interpretative epistemology sitting comfortably within IPA's phenomenological, hermeneutic, and idiographic roots. However, she also champions the view that greater contextualisation should be applied to IPA analysis taking into consideration socio-cultural meanings particularly if one was to identify "limiting or stigmatising social meanings" (2011, p.36). Todorova (2011) maintains that applying a constructionist epistemology would not diminish IPA's coherence as an approach. Whilst the priority throughout this research was to access the personal sense-making of the participants, I thought it prudent to be mindful of the epistemological flexibility of IPA mentioned earlier.

By engaging with Heidegger's 'fore-conceptions' such as where the researcher stands in relation to some fundamental concepts such as the nature/nurture argument, learning, personality and individual differences, social interaction, and indeed his/her 'attitude' to the research topic, the impact of presuppositions and biases within the research can be minimised. I was acutely aware that I was approaching this research with a background in psychology and quantitative research, and with that an assumption that *quality* research comprised large sample sizes, hypotheses testing, and the derivation of a 'singular truth' that could be generalised to the masses. However, this positioning has all very much been at odds with what I have actually encountered in psychotherapeutic work where I have been met

with as many unique stories as I have clients. I have found that these stories are unique not by virtue of their content but by the *meaning* an individual places upon this content. Herein lies my interest in meaning and meaning-making and what ultimately bound the research topic and IPA together.

Acknowledging from the outset my background in quantitative research and its associated quest to 'test' a specific hypothesis or even glean a specific outcome is an early instance in which reflexivity was exercised throughout this research process. Shaw (2010) describes reflexivity as a necessary "turning of [the researcher's] gaze to the self" (p.234), since both the researcher and researched are experiencing beings which will inevitably impact how and what data will be gathered and analysed. IPA is mindful of how vital it is to bring the researcher's presuppositions to consciousness and how they can both work in favour of and against the interpretation of a participant's lived experience.

> Through making ourselves aware of our own feelings about and expectations of the research, we can begin to fully appreciate the nature of our investigation, its relationship to us personally and professionally, and our relationship as a researcher and experiencer in the world to those with whom we wish to gather experiential data. (Shaw 2010, p.235)

Reflexivity was practiced through supervision, dialoguing with work and academic colleagues, and journal writing. This 'challenge-to-competency' (Shaw 2010) was at times an uncomfortable and uneasy experience but to move beyond mere reflection toward reflexive research meant "confronting [my] prejudices..., interrogating them, moving beyond them, and subsequently incorporating them into my understanding of [the participant's] lived experience" (Shaw 2010, p.240). In essence, I conceptualised this practice as an intentional *dis*-orienting exercise in order to (hermeneutically) reflect upon my own possible biases and ultimately *re*-orienting myself within the research in a more aware or 'authentic' fashion. Since reflexivity reflects an interpretivist ontology (Shaw 2010) similar to my own

ontological perspective I positioned myself as a 'reflexive co-constructor' of the study phenomenon. I chose to situate my reflexive journal entries in distinct sections at the end of each chapter within this thesis rather than incorporate reflexive notes throughout the text. Indeed, this decision in itself brought to my awareness my tendency to want to compartmentalise things and, therefore, to monitor this through the research process.

3.5 Critiquing IPA

Giorgi (2010) asserts that there are fundamental considerations within IPA that have been overlooked and consequently IPA violates many of the "principles of good science" (p.3). He argues that Smith fails to offer any theoretical *justification* of how the IPA method is employed, instead simply providing a description of the method. Thus, by only providing what he calls a 'content definition' of phenomenology he holds that IPA has tenuous connections to philosophical phenomenology. Smith (2010), however, refutes these claims stating that IPA's theoretical foundations are firmly located within phenomenology, hermeneutics, and idiography and in fact heavily influenced by the writings of the major phenomenological philosophers (Husserl, Heidegger, Merleau-Ponty, Satre, Schleiermacher, Gadamer).

Giorgi's (2010) second charge against IPA is that since it's method promotes flexibility and taking a non-prescriptive stance it is, therefore, not scientifically sound. Smith (2010) contends that the IPA method should be viewed as suggestions rather than prescription. Indeed, Smith asserts that IPA is scientific but wishes to avoid 'methodolatory', that is, the glorification of method. Following a prescriptive method Smith claims, does not guarantee the production of quality or sound research.

> Doing good IPA requires the development of some complex skills – interviewing, analysis, interpretation, writing, and researchers at different stages will have different degrees of fluency and adeptness at these skills. It is the degree of

> proficiency in these skills which will influence the quality of the research carried out more than the conscientious following of procedures. (Smith 2010, p.188)

Smith (2010) further defends against Giorgi's (2010) attack that IPA is unscientific due to limitations around replicability and checking. Smith argues that replicability is an inappropriate criterion for evaluating IPA research as it is applicable more to quantitative research. In fact, it would stand to reason that since qualitative research is "a complex, interactive, dynamic process" (Smith 2010, p.189) the replication of a study applying an IPA methodology regardless of its data collection method would be impossible. Smith (2010) differentiates replicability from checking and agrees that the reader should, indeed, be able to check how the findings of a study were arrived at. He advocates a number of means of doing so including: 1) a supervisor overseeing the analytic process carried out by the researcher; 2) creating an audit trail in which the journey from transcripts to initial noting to emergent themes to the final write up is clearly mapped out; and 3) evidence of extracts that clearly support emergent themes and demonstrate both convergence and divergence across cases.

The following sections within this chapter chart the research method employed for the present study taking into account access to participants, the selection process, and participant profile; method of data collection; analysis; ethical considerations; and an evaluation of IPA.

3.6 Participants

3.6.1 Access to Participants

The intent of the present study was to access a purposive sample of individuals who have experienced the unique phenomenon of uncompleted suicide by their partner. Due to the very sensitive nature of the research topic lengthy consideration was given to the means by which participants could be accessed. Cooper (1999) in her discussion of ethical issues in a

psychological autopsy study of suicide found that the twelve independent ethics committees associated with the study all requested that General Practitioners be ultimately responsible for identifying potential 'informants'. Since GPs were thought to stereotypically have a relatively long established and trusting relationship with their patients they would, therefore, be best placed to screen for suitability to participate in such a sensitive study. Whilst the present study aimed to gain access to partners of those who had experienced *un*-completed rather than completed suicide, it was also deemed that recruitment via GPs and at their discretion was the most appropriate and sensitive means of accessing this unique sample, rather than approach establishments such as accident & emergency departments or psychiatric facilities.

Participants were recruited from General Practitioner (GP) practices in the North East region of Ireland. The GP practices were chosen under the following criteria: I had an established professional relationship with the majority of the GPs involved (I have practiced as a counselling psychologist within a multi-disciplinary team in one of the participating GP practices); the GP had an already established interest in research and psychotherapy; and all GP practices were geographically convenient to conduct interviews. Cumulatively, the GP practices catered for a wide cross-section of the community serving a population of at least 15,000 patients both private and medical card holders, thereby ensuring access to a large population.

A letter of invitation to become involved with the study (Appendix A) detailing the rationale for the research, ethical considerations, and a sampling strategy was circulated to six GP practices, comprising ten GPs in total. This was followed up with a telephone call and meetings were arranged with the GPs to discuss the research in more detail, to address any concerns regarding issues such as confidentiality, and to agree a protocol for the recruitment

of participants. GPs that consented to involvement in the study were requested to provide consent in writing.

Whilst GP practices were viewed as the most sensitive means of recruiting participants I was mindful that challenges might nonetheless exist in recruiting due to the sensitive nature of the research. Therefore, alternative sources for recruitment were identified as an adjunct to recruitment via GPs. The CEO of 'Suicide or Survive' (SoS) was contacted vis-a-vis gaining access to research participants. SoS is an Irish charity focusing on supporting those recovering from uncompleted suicide and breaking down the stigma of mental health issues. After furnishing SoS with a written research proposal detailing a recruitment strategy, similar to that above, approval was sanctioned to commence recruitment. In addition, the Clinical Director of AWARE was also contacted with a view to receiving support in publicizing the research. The Clinical Director offered to speak to a number of other organisations on my behalf that she thought appropriate to accessing a sample relevant to the present study.

3.6.2 Participant Selection

Participants were recruited from the GP practices by identical means. Recruitment was conducted by two means, an agreed GP protocol, and an advertising campaign. Firstly, if a GP identified a patient as being relevant to the study the protocol entailed informing them about the study and inviting them to consider taking part; they then gained consent from the patient to pass on the patient's contact details to me; and finally issued them with a flyer with written details of the research. The GP subsequently passed on the patient's contact details to me and I made telephone or email contact with the patient to discuss the research further and assess their suitability for the study vis-a-vis the inclusion/exclusion criteria. If

the patient consented to participate and was deemed suitable, a location and time convenient for the patient was arranged.

The second means of recruitment comprised highlighting the study on a notice board located in the reception area of each GP practice as well as circulation of flyers in the waiting areas. The recruitment advertisement and flyer were identical and provided a short synopsis including rationale for the study, method of data gathering, and inclusion/exclusion criteria (Appendix B). It was intended that patients attending the GP practices would either express an interest in participation themselves or inform other potential participants outside the GP practice. Interested participants were requested to make contact with the researcher via telephone or email to receive more information about the study and discuss requirements such as their participation in an interview.

Participants were recruited from SoS via circulation of an email by the charity containing the flyer advertising the research.

Following contact from interested participants via telephone or email, I assessed their suitability for participation vis-à-vis the inclusion and exclusion criteria. The following inclusion and exclusion criteria were established in order to recruit as homogenous a sample as possible:

Inclusion Criteria:

1. At least 18 years of age
2. Living together in a relationship experienced by the participant to be an established, meaningful, and significant one (to ensure the likelihood of participants having some kind of attachment to their partner at the time of the suicide attempt; a specific

length of time for an established relationship was not specified in order to reflect the unique nature of every intimate relationship).

3. Partner/spouse made a first time non-fatal suicide attempt (It was thought that if a partner/spouse has made a first-time attempt, this would manifest itself within the relationship in a very different/unique way than if s/he had made previous attempts during or prior to the current relationship. The present study wished to record the lived experience of the individual whose partner had made a first-time attempt).
4. The attempt was made *at least* 6 months ago (to minimise distress to the respondent as a result of participating in the study; to record the impact upon the partner as well as their view of the relationship over time). This time frame was also in line with Cooper's (1999) psychological autopsy study which had a mean time interval between the suicide and the informant interview of 7 months.

Exclusion Criteria:

1. Individuals whose partners have made multiple attempts (more than one) to take his/her life (The current study wished to record the lived experience of individuals where attempted suicide was featuring for the first time for both parties so as to minimise bias from previous similar experiences).
2. Individuals who have experienced suicide attempts by significant others or by partners in previous relationships (The current study wished to record the lived experience of individuals where attempted suicide was featuring for the first time for both parties so as to minimise bias from previous similar experiences).

3.6.3 Participant Profile

Smith et al. (2009) recommend a sample size of between three and six participants. They postulate that this sample size should allow for meaningful analysis to take place that adequately highlight both convergence and divergence across cases and without the researcher being potentially overwhelmed by a larger sample. Smith et al. (2009) note that emphasis should be on quality rather than quantity and that a larger sample size is more likely negatively correlated with meeting IPA's commitment to the idiographic approach. This point is further expounded by Hefferon and Gil-Rodriguez (2011) who conduct and

supervise IPA research as well as facilitate IPA research groups. They champion the generation of small numbers of participants, questions, and themes in IPA. Therefore, five individuals who expressed an interest in the study and who met the inclusion/exclusion criteria participated in a one-to-one interview. Three were recruited from GP practices, one from SoS, and one participant was recruited via word-of-mouth. Prior to commencing each interview some demographic information was gathered in order to locate the participants' stories within a context. These demographic details included:

1. Sex/age of participant;
2. Sex/age of partner;
3. Current status of relationship;
4. Number of children at the time of the attempt;
5. Length of relationship prior to suicide attempt;
6. Length of time since attempt.

Since participants were more likely to be identifiable to others through a combination of their individual profile and their story I concluded that in order to preserve anonymity as much as possible, providing a more generalised descriptive summary would be most appropriate:

- Sex of participants: Four participants were women and one participant was a man.
- Age of participants: Ages ranged from 44 to 66 years with a mean age of 51.8 years. It was gleaned from these statistics that three participants were in their mid to late thirties at the time of their partner's suicide attempt and two participants were in their mid to late forties.
- Sex of partners: Four partners were men and one partner was a woman.
- Age of partners: Ages of partners ranged from 44 to 67 years with a mean age of 53.4 years.

- Current status of relationship: Four participants were still married and living together and one was divorced.
- Number of children at the time of the suicide attempt: Two couples had two children and two couples had one child. A further couple had no children at the time of the attempt but went on to have two children after the suicide attempt.
- Length of relationship prior to suicide attempt: It is particularly noteworthy that a significant time in the relationship had elapsed before the suicide attempt. This ranged from 12 years to 28 years with a mean of 21.2 years.
- Length of time since attempt: This ranged from just over 2 years to 20 years with a mean of 10.5 years.

3.7 Data Collection

> The overriding task of any data collection method within an IPA study is to elicit a first-person account of a specific phenomenon that provides detailed stories, thoughts, and feelings as rich data. IPA researchers wish to analyse in detail how participants perceive and make sense of things which are happening to them. It therefore requires a flexible data collection instrument. (Smith and Osborn 2008, p.57)

Once an individual satisfied the inclusion/exclusion criteria, the rationale for the study, the interview procedure, and ethical considerations were discussed in greater detail. Each participant was informed that on meeting with the researcher s/he would be furnished with a 'Plain Language Statement' (Appendix C) explaining the procedure and an 'Informed Consent Form' (Appendix D) which s/he would be required to sign prior to commencement.

Once verbal consent was given, a date, time, and venue agreeable to the participant was arranged. Four interviews were conducted at the request of each participant at my counselling room in the medical centre and one was conducted in the participant's own

home also at their request. Each participant was reminded of the rationale of the study, the procedure was explained again and each participant was given the 'Plain Language Statement' to read and the 'Informed Consent' form to sign prior to commencing the interview. The interview was audio-recorded and subsequently transcribed. Both the audiotape and transcripts were securely stored and destroyed on completion of the research.

3.7.1 Semi-Structured Interview

There are various methods of data collection within IPA studies including accessing participant diaries, participant observation, and focus groups. However, the semi-structured 'in-depth interview' is seen as the exemplary method and was employed in the present study particularly due to its focus on facilitating each participant "to speak freely and reflectively, and to develop their ideas and express their concerns at some length" (Smith et al. 2009, p. 56). This method of 'rich data' collection has been most popular for IPA studies as one-to-one interviews are viewed as easily managed and reflect the 'co-construction' ethos of IPA research, that is, between the researcher and participant. Furthermore, due to the sensitive nature of the research I believed one-to-one interviews to be the most appropriate means of recording as much rich data as possible.

3.7.2 Interview Schedule

In keeping with IPA principles an interview schedule was devised (Appendix E) in order that the interview be *guided* rather than dictated by it. In contrasting semi-structured interviews to structured interviews, Smith and Osborn (2008) view the ordering of questions as having less significance than in structured interviews; see the interviewer as having the freedom to probe areas of interest to the research that organically arise; champion the course of the interview being dictated by issues that are of importance to the participant; and view the semi-structured interview as being active in establishing rapport with the participant;

Of central importance for the present study was to approach the research question from a 'sideways' perspective (Smith et al. 2009). Rather than ask a *direct* question relevant to the research topic, the aim of the interview was to facilitate discussion around the topic which would in turn later facilitate answering the research question by way of the analysis. Thus, the interview schedule was designed to give me a broad guide to facilitate exploration of the phenomenon but simultaneously acknowledging the potential for participants to inform me about what the research is *actually* about (Steier 1991).

> The investigator has an idea of an area of interest and some questions to pursue. At the same time, there is a wish to try and enter, as far as possible, the psychological and social world of the respondent. Therefore, the respondent shares more closely in the direction the interview takes, and the respondent can introduce an issue the investigator had not thought of. In this relationship, the respondents can be perceived as the experiential expert on the subject and should therefore be allowed maximum opportunity to tell their story.
>
> (Smith and Osborn 2008, p.58/59)

By constructing an interview schedule in advance around the lived experience of living with a partner in the aftermath of their suicide attempt, I was able to more fully engage in the interview *process* with the participant. As recommended by Smith and Osborn (2008) I anticipated loosely the direction the interviews might take and prepared questions under the following headings: (1) recounting the experience; (2) the impact of the experience; and (3) the aftermath of the experience. The opening question in the interview was designed to encourage the participant to recount the experience at length in order to desensitise them to the interview experience. Verbal input from me was purposely kept to a minimum in order to provide a space for the participant to speak freely and at length. The sequencing of questions tended to move from a broader narrative focus to a more evaluative one as I encouraged each participant to reflect upon the meaning of the experience for them. Prompt questions were employed at times to encourage the participant to expand upon responses and to illicit the *meaning* of their particular responses (Smith et al. 2009) including for example:

'What was that like for you?', 'Tell me more about that', 'How did you feel about that?', 'What do you recall about your response at the time?', 'How did you make sense of that in your life?'

An informal piloting of early drafts of the interview schedule was conducted with both non-psychotherapists and psychotherapists with research backgrounds. The aim was to highlight any outstanding issues and thereby inform research interviews going forward. Issues regarding the length of the schedule prompted a revision of the number of questions downwards to three main questions. This process also highlighted the importance of issues regarding body language, linguistics, intonation, and interview 'rhythm' (Smith et al. 2009). The wording of the questions was simplified in order to minimise likelihood of confusion for participants. No formal pilot interview was done to reflect the semi-structured nature of the interview and the fact that the schedule functioned as a *guide* only (Smith et al. 2009).

3.8 The Process of Interviewing

Having successfully secured the first participant I can recall the almost immediate self-induced pressure to get the interview 'right' as there were no second chances. Intrusive thoughts abounded leading up to the interview about inadvertently asking an insensitive probing question; causing harm to the participant; the interview being unsuccessfully audio-recorded; and of course neither myself nor the participant adequately connecting in order to produce anything in the way of an meaningful interview. All of these concerns thankfully abated within minutes of meeting participant one ('Alice') as she communicated in such a way that suggested she was comfortable in my company and eager to share her story.

Within the first 2-3 minutes of the interview Alice had described feeling lonely, guilty, angry, and feeling like she no longer knew her husband following his suicide attempt. I also noticed early interpretations of the experience on her part when she viewed his actions as

evidence that all their years together meant nothing to him. All interviews were very much a co-constructed interpretative account of participants' experience. For example, when Alice was describing her changed outlook on life and her realisation about people not adequately making time for one another, I suspected that she was reflecting upon a new found respect for the power of communication. When I checked this out with her she communicated that it was more accurately a new found respect for life which I subsequently probed. Getting that 'insider's perspective' and understanding as closely as possible Alice's changed outlook on life was, therefore, a joint effort.

Another participant described in shocking detail standing by her husband's hospital bed feeling utterly confused about what took priority in this extra-ordinary situation. On the one hand I could see the 'hermeneutics of empathy' in evidence here were I facilitated the participant in reconstructing the experience, as well as the 'hermeneutic of suspicion' or questioning in which I communicated that it appeared that it was important for her at that point by his bed to understand why he had done what he did. In other words, she was experiencing a desperate attempt to free herself from ambiguity in order to regain some semblance of control and reassurance that she was not responsible. This suspicion turned out to be correct which then opened up the conversation to her sense of feeling like the 'prime suspect'. This same participant spent the entire interview at her request lying on my couch in my counselling room due to her chronic back pain (and fibromyalgia). She also spent the vast majority of the interview, the longest of the five, with her eyes closed. She said herself that this enabled her to recount the experience as accurately as possible. She tended to digress regularly throughout the interview as if she was attempting to give me the fullest account possible from every corner of her mind. This experience was at once exhilarating in terms of hanging on every word, and challenging in terms of having to gently return her to task.

I experienced all five participants as incredibly willing to share their stories so much so that my concern about talking too much during interviews did not have an opportunity to materialize. The experience had undertones of a story that had waited patiently to be both told and witnessed. I was incredibly humbled by each and every participant and their generosity in allowing me free rein during the interview to understand their lived experience from my point of view.

3.9 Analysis

> When people are engaged with 'an experience' of something major in their lives, they begin to reflect on the significance of what is happening and IPA research aims to engage with those reflections.(Smith, et al. 2009, p.3)

Various literature on IPA has not been 'prescriptive' in advocating a single method for analysis of raw data. Rather, IPA espouses an analytic *focus* that is, making sense of a participant's sense making of their own experience. IPA recognises that all human beings are essentially 'sense-making' beings and consequently the experiences people share are simply endeavours by those people to make sense of them. In employing the IPA analytic method I endeavoured to make sense of the participant's sense making, thus creating a double hermeneutic (Smith et al. 2009). Furthermore, the analysis entailed employing the 'hermeneutic circle' which involved moving between the part and the whole.

Interview one was transcribed and analysed prior to proceeding with analysis of interview two and so on in order that the uniqueness of each account be honoured as much as possible. The stepped approach to analysis as recommended by Smith et al. (2009) entailed six steps: 1) reading and re-reading; 2) initial noting; 3) developing emergent themes; 4) searching for connections across emergent themes; 5) moving to the next case; and 6) looking for patterns

across cases. This approach, however, is offered as a *guide* to analysis and Smith et al. (2009) stress that the analytic method should be approached in an innovative and flexible way, one that aids the researcher in the pursuit of making sense of the participant's experience.

> Although the primary concern of IPA is the lived experience of the participant and the meaning which the participant makes of that lived experience, the end result is always an account of how the analyst thinks the participant is thinking. (Smith et al. 2009, p.80)

Step1: Reading and re-reading

Analysis commenced with in-depth engagement with each transcribed interview. The audio-recording of each interview was listened to whilst reading the transcript for the first time in order for me to capture the emotion and nuances through the interview. Some of my own thoughts, ideas, and observations were noted on paper in order to temporarily 'bracket' them off and return to them at a later stage. Repeated reading facilitated gaining an in-depth familiarity with the particular interview as well as identifying where participants moved back and forth between the generic and the specific.

Step2: Initial noting

Initial noting merged with step 1 in that I made numerous notes on the left hand margin throughout the transcript whilst reading. This stage again involved spending substantial time exploring the content and language of the transcript. Text that I deemed pertinent in some way was underlined with key words and short notes written in the margin detailing its significance. Exploratory commenting comprised descriptive comments such as key events and details that struck me as significant in some way, and experiences that appeared pertinent to the participant; linguistic comments such as the participant's use of adjectives, laughter, pauses, repetition, imagery and metaphor; and conceptual comments which

manifested as questions for me to reflect upon in response to particular words or phrases within the text, as well as tentative initial interpretations. It was also at this stage that I was mindful of Smith's (2010) concept of the 'gem' that is, "the relatively rare utterance that is especially resonant...[has] a significance completely disproportionate to its size...and offers potent analytic leverage to a study" (p.6).

Step3: Developing emergent themes

Development of emergent themes involved a detailed analysis of the exploratory commenting made in steps 1 and 2 in order to reduce the level of detail gathered from the transcript and initial noting. I approached this by creating a handwritten list of the annotations from the transcript in chronological order. Each annotation was numbered and the pages were subsequently laid out so that I could get a 'bird's eye' view of them as a single unit. There were on average between sixty and eighty annotations recorded per case. Analysis then entailed looking for connections amongst these exploratory notes. Some annotations that were located in close proximity to each other stood out as being naturally related to each other and formed a theme whilst other entries were significant in their own right and acted as a kind of magnet, drawing annotations towards it from other parts of the transcript. This approach entailed a movement away from solely exploring the raw data produced by the participant to include more input from me in that my own reflections, thoughts, feelings, and indeed, experiences all played a part in the generation of themes.

Step4: Searching for connections across emergent themes

This step required a further analysis of the themes generated with a view to 'mapping' out how I saw these emergent themes fitting together. I created a hand-written list of the themes generated from step 3 and employed a number of methods as suggested by Smith et al. (2009) in order to organise them in a manner that made sense to me. The methods employed

involved ‘abstraction’ (identifying patterns *between* themes in order to identify a ‘super-ordinate’ theme for a cluster of themes); ‘subsumption’ (reconceptualising an emergent theme as a super-ordinate theme in order to bring other themes together); ‘polarization’ (looking at difference or opposition between emergent themes); ‘contextualisation’ (looking at connections between themes and at what points in the transcript they are located); and ‘numeration’ (recording frequency of theme occurrence). This process also resulted in discarding themes that were found not to strongly represent a participant’s experience. A table was subsequently created detailing super-ordinate themes and emergent themes for the participant. An ‘Excel’ table was also created on computer with each column detailing transcript extracts for an emergent theme.

Step5: Moving to the next case

Having followed steps one through to four for the first case, the analysis required that the same procedure be applied to the next case and so on. It was important to treat each case in a stand-alone fashion whilst acknowledging that my ‘fore-structures’ may have altered having been exposed to earlier cases. Nonetheless, it was imperative as far as possible to minimise any influence from the case before.

Step6: Looking for patterns across cases

Having followed steps one to five for each individual case, the analysis required an exploration of patterns across all cases in order to illuminate shared higher order qualities. I laid out all tables created for each individual participant and looked across them reconfiguring themes so as to reflect the corpus as a whole. Some themes moved to a higher order status as they more accurately represented the corpus as a whole while others lost their higher order status during this creative process. Step 6 culminated in the formation of a master table of themes for the group with one over-arching super-ordinate theme, emergent

themes, and clusters. At this stage the concept of the 'hermeneutic circle' came to the fore. The early steps in IPA required that I move from the 'part to the whole', with the latter stages requiring an exploration in the opposite direction: from the 'whole to the parts'. Appendix H provides excerpts from transcripts of two participants with analysis, appendix I displays individual tables of themes for these participants, and appendix J details the formation of the Master Table of themes.

3.10 Ethical Considerations

Ethics approval for the current study was sought and gained from the Research Ethics Committee at Dublin City University prior to commencement (Appendix F). Letters of consent were also sought from all participating GP practices. These have not been included as an appendix as this would serve to make anonymity less likely to be maintained by publicising details of GPs and exact practice locations.

Every effort was made from the research proposal stage through to seeking ethical approval, to adhere as much as possible to key ethical principles which served to guide the research process including autonomy, non-malfeasance, beneficence, integrity, and justice. However, I was very much aware that it would be unlikely to foresee *every* ethical issue prior to commencement of the research and so I remained mindful of the 'ethics as process' model (Ramcharan and Cutcliffe 2001) in order to highlight it as a dynamic and evolving process rather than a pre-determined exercise. For example, just prior to submitting a final draft of the ethics form challenging discussions with both colleagues and supervisors caused me to reconsider and subsequently withdraw an exclusion criterion which stated that individuals known professionally to me either currently or historically would not be eligible to participate in the research. The motivation here was to adhere to the ethical principle of non-malfeasance. However, this exclusion criterion also challenged the principle of autonomy in that it did not respect an individual's autonomy in choosing to *participate*. The principle of

justice also came to the fore here in that I determined the potential benefits to be greater than any risk to participants. The 'ethics as process' model also champions the creation of an 'audit trail' in order that readers are able to follow as clearly as possible rationale behind decisions made and conclusions drawn throughout the research process. Some of the most significant ethical concerns regarding the present study are set out below.

3.10.1 Informed Consent and Respect for Autonomy

I ensured that participants were free to make a choice about participation in the current study. Informed consent was required from all participants. Participants were informed prior to commencement of the interview of the exact nature of the interview. Each participant was issued with a written account of the rationale/procedure for the study and asked to provide written consent for participation.

Respect for autonomy was maintained by informing participants that they could choose to pause the interview or, indeed, withdraw from the research at *any* time. Each participant had the opportunity to receive debriefing following the interview with the researcher about their experience of the interview itself and any outstanding issues.

3.10.2 Anonymity and Confidentiality

Participants were informed that all information provided to the researcher would be audio-taped, transcribed and coded to maintain anonymity, that no identifying information would be contained in these transcripts and that all data would be computer password protected. Each participant provided demographic information prior to the recorded interview which was given a code and kept in a secure location and separate to transcripts so as to minimise participants being identifiable to others. In the final write-up a general statement about demographic information gleaned from participants would be provided rather than individual accounts in order to minimise participants being recognised through their stories.

No other individual apart from the researcher had access to either demographic information, audio-recorded interviews, or interview transcripts. It was also agreed that all audio-recordings and individual demographic material would be destroyed on publication of the thesis.

Each participant was assured that no identifying material would appear in the final write-up of the thesis. Although these considerable measures were taken to maximise anonymity, participants were informed that there could always be a possibility that they might be identified through their stories. The participants were also informed of the limits of confidentiality namely, if the researcher had reason to believe that either the participant or some other individual was in some way at risk of harm.

3.10.3 Non-Malfeasance

Due care was exercised to avoid inflicting harm on participants at any stage through the research process. Prior to commencing recruitment I requested that all GPs inform potential participants that participation was entirely voluntary and that the GP would not be informed whether or not s/he had consented to be interviewed. This was to avoid participants feeling in any way coerced or obliged to take part in order to remain in their GP's favour.

In Cooper's (1999) psychological autopsy study of suicide researchers received informant feedback about the importance of personalising any written communication to potential participants in order to respect the sensitivity of the topic. This was duly noted for the present study and I ensured that flyers and advertisements were personalised where appropriate, referring to the individual who had attempted suicide as 'your partner'.

As the research required participants to explore the sensitive issue of their partner's uncompleted suicide, it was anticipated that the interview process might prove to be at times

emotive and uncomfortable for them. Participants were, therefore, informed prior to commencement of the interview of the exact nature of the interview and that they could choose to pause the interview or, indeed, withdraw from the research at *any* time without explanation. Each participant had the opportunity to receive debriefing following the interview with the researcher about their experience of the interview itself and any outstanding issues. Participants were offered therapeutic support if the need arose, from an accredited psychotherapist who had agreed to provide this service free of charge to participants. Had a participant requested further counselling support following debriefing, the contact details of the psychotherapist were provided by me in order that s/he could consult with the psychotherapist regarding scheduling of appointments and venue.

In the event of me being approached by individuals interested in participating in the study but who were known to me in a professional capacity that is, either current or previous psychotherapy clients, I managed this dilemma by making explicit prior to the participant consenting to be interviewed, that whilst the interview might have a similar *appearance* to a therapy session, the interview itself would likely *not feel* similar to a therapy session. Furthermore, these participants also had an opportunity for debriefing with me following termination of the interview in order to address any challenges that arose as a result of participation and particularly with my dual role of researcher/therapist.

3.11 Evaluating IPA

3.11.1 Validity in IPA Research

According to Smith et al. (2009) a variety of guidelines for evaluating the validity of qualitative research have been published. Smith (2010), however, asserts that it is paramount that the criteria used are appropriate to its design. Some of the criteria he proposes include commitment, transparency, and plausibility. The researcher he maintains should occupy themselves with "how systematically and transparently this particular account has been

produced" (Smith et al. 2009, p.183), that is that the account is a *credible* one. An independent audit trail is, therefore, very appropriate for achieving this aim. For this IPA study the trail comprised of the research proposal, the ethics form, meeting the requirements of the DCU Ethics Committee, a record of how the final interview schedule was achieved, audio-recordings, written notes following each interview, transcripts, written observations and highlighting of keywords/phrases within the transcripts, tables of themes, draft chapters, and the final thesis itself. Supervision also ensured an invaluable addition to the "chain of evidence" (Smith et al. 2009, p.183) through my supervisor's checking of my analysis of the first interview transcript to ensure that there was validity between the raw data and my annotations, identification of 'gems' (Smith 2011), and theme formation.

3.11.2 Quality in IPA Research

IPA demonstrates a strong commitment to maintaining quality through the research process. Smith (2011) in his evaluation of the contribution IPA has made to research to date elucidated a number of important considerations when conducting any IPA study. These comprised ensuring the study have a clearly defined focus; provision of strong data; sufficient elaboration of each theme; an interpretative as well as descriptive analysis; attention to convergence and divergence among cases; and a clearly written and engaging analysis. Additionally, Smith et al. (2009) recommend Yardley's (2000) broad principles to facilitate assessment of the quality of any qualitative research effort. These include sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. A discussion of quality as applied to the current research is more fully explicated in Chapter 6.

3.12 Reflexive Journal Entry

I was mindful from the early stages of this research that its origins were embedded within my clinical work with a client that described her husband's suicide attempt as the 'ultimate betrayal'. By acknowledging my possible assumptions that all participants would have a similar conceptualisation I was more able to remain open to multiple perspectives and Steier's (1991) conceptualisation of the 'informant' telling the researcher what their research is about rather than the other way around!

In respect to sample size early into the research, I found the process of identifying when enough richness in the raw data had been gleaned to warrant a 'punctuation', that is, when was enough, enough? Aware that single case studies employing the IPA method were increasingly being accepted and since the data gleaned from interview one was so rich I found myself questioning if further recruitment was warranted at all. I came to the realisation, however, that since this research was tapping into unexplored territory I wanted the findings of the study to at the very least contribute to theory with a small 't' and that identifying patterns across cases would have a greater influence in this process.

Chapter 4. Findings: "I'm not the Same Person I was": Transformations for Better, for Worse

4.1 Introduction

This chapter intends to delineate the main findings from the five participants within this study which explored the impact of uncompleted suicide on partners. The main aims of the study were:

1. To explore the lived experience of living with a partner following uncompleted suicide; and
2. To examine the meaning that partners attributed to an uncompleted suicide and the significance of these meanings for their everyday lives.

The objectives of the study were to elucidate the meaning that individuals ascribed to their reaction to the uncompleted suicide; to explore the meaning that individuals ascribed to their general outlook on life following the attempt; and to describe the meaning that individuals ascribed to the relationship following the attempt.

The semi-structured interviews provided a valuable means for me to construct an in-depth interpretation of the phenomenon. Table 4.1 below represents a master summary providing a synopsis of the main themes extrapolated from all five participants and organised hierarchically. Participants described their experience using stark imagery like wanting to 'scream from the mountain tops', and metaphors such as their 'whole world shifting on its axis', a 'show stopper', and it being an event of 'monumental' proportions. They interpreted it as traumatic, an act of survival, and that their life as they knew had crashed. However, they also perceived the experience to have triggered increased personal strength and enhanced relationships. Collectively these experiences reflected the importance, scale, and far-reaching consequences of the event for them. Participants ultimately experienced the suicide attempt as transformational in various ways. Thus, the super-ordinate theme '"I'm

Not the Same Person I Was": Transformations for Better, for Worse' captured the paradox that was the lived experience of all participants following the uncompleted suicide of their partners. 'For better, for worse' is also a reference to the marriage vows traditionally undertaken by couples as a mark of their mutual commitment to the relationship.

Table 4.1 Master Table of Themes

Super-ordinate Theme	Sub-ordinate Themes	Clusters
"I'm Not the Same Person I Was":Transformations for Better, for Worse	"It Put Nearly Ten Years on My Life": Suffering the Trauma of the Attempt	**"It's a Shock that Comes in Waves"**
		The Walking Wounded
		A Desperate Search for Answers
	"It Shifted the Whole World on Its Axis": Adjusting in the Wake of the Attempt	**The Blame Game**
		Countering the "Torment": Strategies for Self Preservation
	"It Never Ever Goes Away": The Legacy of the Attempt	**What Lies Beneath**
		Transcending Death-Enhancing Life

Three key sub-ordinate themes were identified from the analysis of the data. The first theme described as "It put nearly ten years on my life": suffering the trauma of the attempt, aimed to articulate the sheer force of the impact the experience had for participants. They faced a complex struggle both at the time of their partner's suicide attempt and in the early aftermath to process the shock that they were exposed to and all that came with it including emotional upheaval and sensory overload; acknowledging the hurt in the midst of practical obligations;

and a barrage of unanswered questions. Theme two entitled “It shifted the whole world on its axis”: adjusting in the wake of the attempt, reflects the harrowing journey taken by participants as they came to terms with this permanently life changing event. An unavoidable part of this journey involved thrashing out whom or what was responsible for their partner trying to kill themselves. It was an uncomfortable but necessary process to go through in order to move forward. Participants began questioning their ability to withstand the torment that the situation had created for them. This torment caused them to develop various means of self preservation. For some it involved renegotiating boundaries, and for others it meant either supporting their spouses in their recovery or disengaging from them completely. The third theme described as “It never ever goes away”: the legacy of the attempt, denotes the extent to which the suicide attempt left a permanent imprint in almost every aspect of their lives. This imprint manifested psychologically, emotionally, and for some physically, bringing to the surface vulnerabilities that participants were unaware of. The event had the impact of reactivating childhood traumas for some participants and for others it exacerbated underlying physical conditions. Hyper-vigilance became another feature that lay just beneath the surface for participants, avoiding getting too comfortable with partners or children in case suicide were to revisit them. Some participants also experienced significant growth as a consequence of the experience. They described emerging from it with an enhanced outlook on life, enhanced personal strength, and enhanced relationships.

Where identifiable information such as names and locations are contained within extracts from participant transcripts, these are highlighted within square brackets, e.g. [husband’s name]. Irrelevant information within the extracts such as repetitive utterances or pauses (“Umm”, “emm”, “you know”) are at times deleted in order to provide a better flow for the

reader and is denoted with (...). The terms 'uncompleted suicide', 'suicide attempt', 'attempted suicide', and 'attempt' are used interchangeably.

4.2 "It Put Nearly Ten Years on My Life": Suffering the Trauma of the Attempt

This subordinate theme highlights the extent to which participants were impacted by the traumatic force of their partner's attempt. Their ability to recall the minute of the incident during the interview as well as the ease and speed with which they were able to tap back into the feelings they experienced during this time reflected the extent to which this had been permanently embedded within their psyche. Everything they knew or *thought* they knew about the world, about themselves and about their relationship was at once thrown into disarray which made for a tumultuous and inevitably life transforming event. Participants experienced a traumatic assault on their senses with all they were exposed to in one fell swoop. The experience brought them closer to death as a result of being faced with their partner's attempted suicide but also through their perception that the trauma substantially aged them in a way that brought them closer to their own death.

Set against the backdrop of the intense stress they initially experienced participants launched into action in a frantic attempt to save their partner's lives. Participants experienced their shock in waves, being 'hit' and forever scarred by the enormity of what had just happened over the weeks and months and when they least expected it. Despite having just been 'through the wars' participants still had to honour obligations to work and family as well as come to terms with strong ambivalence about what their partners had just done. They instantly felt overwhelmed by their need to put the pieces of the puzzle together and bombarded themselves with questions that needed answers as soon as humanly possible. Thus, this theme elucidates a cluster of three further themes namely, "It's a shock that comes in waves", "The walking wounded" and "A desperate search for answers".

4.2.1 "It's a Shock that Comes in Waves"

This theme serves to evoke the utter terror, uncertainty and raw pain that repeatedly crashed down on them both on discovering their partner's suicide attempt and in the events that ensued. They were forced to confront the near ending of a significant relationship through death that was both violent and self-inflicted. Four participants actually found their partner hanging or overdosed whilst one participant went through the arduous task of waiting for her husband to be found. Either way, none of the participants knew if their partner was dead or alive. This bore a substantial brunt on their emotional well-being. No participant had prior exposure to a suicide attempt of a significant other in their life which made this experience personally unchartered territory. In the days and months following the attempt participants continued to experience intrusive images, shock, and anxiety at a depth that was exceptionally unsettling for them, thereby challenging assumptions about the world they had come to take for granted.

Evan's (pseudonym) wife had a history of anxiety and depression and was involved in psychiatric care both as an in-patient and day-patient for a number of years at the time of her suicide attempt. Evan, similar to the other participants, experienced the time leading up to his partner's suicide attempt as unremarkable in that nothing in particular stood out for him looking back. In fact, on the night of her attempt, they had been entertaining friends which he assumed they both had enjoyed. Later that night, however, his enjoyment comes to an abrupt and violent halt when he comes from bed to find his wife overdosed in another part of their home. His conceptualisation of it as a 'show stopper' reflects the depth of his shock:

> It's huge...it's a show stopper in your world...I mean, you're faced with the finality of life or...you don't know whether...you're bringing somebody in [to hospital] that's about to die or are you bringing somebody in that can be brought back or...it's a complete and utter show stopper for you. (Evan p.1,l.35-38)

Finding his wife's body forces into sharp focus his belief that the world as he knows it has transformed forever and so he too is transformed. Evan finds it incredibly stressful and anxiety-provoking to not fully comprehend what he is faced with. Is he rescuing a spouse who is very close to death but still has a chance of life or is he essentially recovering a body? His train of thought is now bombarded with uncertainty about his wife's future, his future, and their future together. Evan's shock is like an agonising pain that comes and goes as he battles to transport his wife by car to A&E. He is exasperated at his obligation to provide mundane details to staff about her name, date of birth, and her condition, and then ultimately left alone with her in a cubicle which subsequently deteriorates into mayhem:

> She was all clammy an' all, but after about fifteen minutes...I noticed her colour had completely changed, she had completely stopped breathing, so I lay her back on the table and ran around getting people...so the emergency team came up and they jumped on her, and started trying to resuscitate her, eventually they had to put the panels on her chest...and bring her back and it was a result of leaving her with me and what happened was, she had actually choked on her own vomit as a result of the stuff they had given her which was quite incredible. (Evan p.2,l.58-66)

Evan bore witness to this incredible event knowing that only a short time ago he and his wife, now lying stripped and lifeless on a hospital trolley, had been entertaining friends in their garden. He described himself as ordinarily having a poor memory but due to the enormity of this, he is certain it will be etched in his memory forever and that it has transformed him:

> But I can recall the doctor straddling [wife's name], I can recall the doctor's face, I can recall the words she used, I can recall the people around, I can bring myself into that moment in a heartbeat...where there's a little bubble of light, I'm here, I know who's standing here, here and there, that's how vivid an impression that made on my life, on my memory, and again I have a bad memory, so... (Evan p.2-3,l.88-94)

'Alice' (pseudonym) and her husband lead busy lives, both working, his job requiring absences from home for a number of days at a time. They were in many respects like 'ships

passing in the night' communicating for the most part about practical issues with little time set aside for each other after the kids were taken care of. On finding his lifeless body Alice's entire world comes crashing down in an instant around her and she is shocked into paralysis:

> And I went down to the shed and I opened the door and there he was with the rope around one of the joists and around his neck. So, I froze, I stood there, I froze. And I looked and I says 'are you joking me?' and I'll never forget the look in his eyes. They were...dead, his eyes were dead in his head. He just didn't care. (Alice p.12,l.436-441)

Her level of utter shock, disbelief and fear causes her to struggle to process what her senses are telling her, so much so that she initially thinks it can only be some kind of malicious joke. She recalls being haunted by the memory of his eyes, believing they communicated that he had given up not only on life, but on her and their relationship also.

Alice continues to be hit intermittently with shock in the hours following the attempt as she fights for his survival. Her world as she knows it has become unrecognisable to her. She finds herself in an extraordinary position of driving her husband to a psychiatric hospital but feels as if the man in the seat next to her has been taken over by a sinister force. Where she is overcome with emotion and taking every ounce of him in, he appears numb to emotion and numb to her. Alice feels completely out of the loop in that whatever is going on for her seems irrelevant to him:

> He never spoke, never opened his mouth, he had a cigarette that was it. Even the colour of his face was just like grey...it's as if, as if somebody had drained all the blood out of him. There was no emotion...his eyes were something that you would see as if he were possessed. They were just focussed on, in front of him, never looked sideways nothing just straight in front of him, never looked at me. (Alice p.12, l.456-462)

Alice's account of the events that followed can be described as a 'blow-by-blow' account in the literal sense. She is struck dumb when informed by hospital staff that there is nothing

they can do for her husband and so the onus she feels, is on her to manage this situation. At this moment she feels very much alone with this heavy burden and so needs to keep her shock in check in order to manage the situation. She compares it to other critical incidents that she believes she would have at least *some* idea about how to proceed but coping with an actively suicidal spouse is something she is utterly ill-equipped for in every sense:

> I felt as if I was on my own. This was...this never happened me before, like God if somebody was after having a child you'd know what to do, if somebody was after having an accident you'd know what to do. But this was completely...beyond. I couldn't believe what they were asking me to do. I really and truly, even to this day, I can't believe what they asked me to do and expected me to do. (Alice p.13, l.472-477)

'Margaret' (pseudonym) described a marriage that had a long history of being challenging particularly as problematic drinking was a feature of her husband's lifestyle as well as depression. On the afternoon of his suicide attempt he locked Margaret out of their home whilst she was out and took an overdose of antidepressant medication. Although he appeared to have simply fallen asleep and to any other individual this was a relatively benign scene, Margaret could nonetheless intuitively perceive the extra-ordinary in it. She knew that this was a crisis unfolding before her and that her life would never be the same again.

She describes, like some other participants, that sense of being less in touch with reality, like playing some kind of 'role' in order to manage the shock. The experience for her is like being set to automatic pilot or controlled by another in some way:

> It's not logic, you just work on impulse...some other part takes over and you do things...as if you're governed by somebody else maybe...you do whatever you think and I knew I couldn't open the door, so I just had to get somebody else to open the door, so then we called the ambulance, I think at that stage, and he was brought to hospital. (Margaret p.2, l. 32-36)

Margaret is in effect, engaging parts of herself both cognitively and behaviourally that she didn't recognise but simultaneously attempting to counteract the intensity of feeling so

overwhelmed and out of control. She perceives that she is *not* engaging logic but what transpires is that she is incredibly focused and logical.

Margaret alluded to a sense of being emotionally in 'freeze' mode, prioritising 'doing' over 'feeling', with the possibility of an anger response coming at a later date. She recounts the experience moving back and forth between past and present tenses demonstrating how it is never fully in the past for her:

> At the time, you wouldn't be feeling, you would just be doing. Like you don't feel, I don't...you're not angry or anything, you just feel you must do whatever... At the time, it was...a bit numb...it's like...you just wait. I think you're in the lap of the Gods or sort of depending on others. (Margaret p.2, l. 53-54; p.3, l. 80-81)

'Tanya's' (pseudonym) husband failed to come home the night of his suicide attempt. He is a man you could ordinarily set your watch by and so she instinctively knows that something is not right. Her shock is akin to living through something that is in the realm of the 'real' whilst simultaneously experiencing it as 'surreal' and catastrophic in its impact. It is going against the normal order of things in her life and she grapples with the notion of people not being where they are *supposed* to be. Her husband is missing and her family and friends have stepped outside of their own lives to support her through this terrifying experience:

> This is Tuesday morning, everyone's supposed to be at work...the world is supposed to be normal, I wasn't supposed to have woken up to this, this morning…(Tanya p.11, l.254-255)

Tanya's world continues to disintegrate around her when her husband is finally located and it is confirmed that he has overdosed. It is only in A&E that her emotions finally catch up with her and she oscillates between shock and exhaustion. She appears to be struggling to

figure out a procedure where there is none – should she prioritise understanding how all of this came about or be resigned to comforting her dying husband:

> You're going through these surges of adrenaline, like nearly to palpitations and sweat level to just "Oh please let me just lie down on the floor and sleep" through "Would you for God's sake quickly tell me what happened before you die in case you're dying because I still don't know if you're dying", to "Oh dear God, if you're dying well then let's just hold hands for your last few hours and I'm not going to disturb your last", you know "if you've done what you've done"... (Tanya p.21, l.529-534)

Many participants described the experience as all the more stressful and lonely because ironically they didn't have their own partner to turn to for support. They had to manoeuvre their way through this life changing event on their own struggling to see an end in sight:

> I presume its up there with bereavement and divorce and moving house, it has to be up there as one of the most stressful situations, certainly it was *the* most stressful things that has ever happened to me because – and I mean I've been through situations, my mother had been ill and took a while to die and it was awful...but never been through anything like this and it went on and on and on because it was like...if the person you love has an accident there's rehabilitation and there's an end point, that could be all physically and emotionally draining but now you find out the person you love chose to die with their own hand and leave you and your [daughter] because of a perceived situation, a historical situation that could have been – something could have been done about, it's a shock that comes in waves. (Tanya p.35, l.918-927)

Like Alice has suggested earlier, Tanya feels that if he had had an accident of some kind there would be an established intervention – rehabilitation which would encompass a care plan and a prognosis. However, her husband's suicide attempt has left her completely at sea regarding what the future holds for her. Here Tanya is suggesting that she doesn't see an end point for her regarding her partner's suicide attempt. The 'shock that comes in waves' represents the recurrent impact this has for her. Tanya uses the term 'the person you love' twice which perhaps reinforces the depth of pain she is experiencing. She also alludes to him having chosen to 'leave' her and that she believes his actions were ultimately not warranted.

This provides some insight into her bubbling resentment toward him having played such a pivotal role in causing such a traumatic impact on her life.

'Carla's' (pseudonym) marriage had been slowly disintegrating over the past several years and she felt that the cracks were particularly apparent just prior to her husband's suicide attempt. Her husband's mental health had been deteriorating over the past year and a half. He attended a psychiatric hospital as an inpatient for a period of six weeks at the end of which he and Carla had agreed to enter into couple counselling. Two days after being discharged from hospital she is shocked to find her husband overdosed. In stark contrast to her expectations for engaging in couple therapy to reconnect with her husband, she is faced with the prospect of widowhood. Her experience is so traumatic that she has gaps in her memory to this day:

> It was our son's sixth birthday and my children were in the house...and the babysitter was in one room and the children were in another room and he was in the room in the middle when I found him. I have no idea how or what happened for my child's birthday. I know someone took over that day and attended...because I was obviously in the hospital and meeting with his family. In addition, when he woke up, I think he was actually given the last rites...
>
> (Carla p.2-3, l.81-88)

The juxtaposition of the ordinary with the *extra*-ordinary is something that Carla finds almost impossible to process. The innocence and stillness of sleeping children in one room and the stillness of their father overdosed in the adjoining room; the impending celebration of a child's birthday juxtaposed with his father receiving the last rites.

Carla acknowledges the epic proportions of this event, but is all too aware that facing the *extent* of her shock will send her 'over the edge' causing further casualties including both herself and her children:

> ...My life had just crashed in the sense of something monumental had just happened in my life. There was no sense of 'happy days, out of here, it's done'. There was nothing like that, because there was so much stuff around it and, obviously, his own family, the way they were around it and we had two children in the middle of it all. Where was I for them? I was capable of being there, I'd say...being there holding myself together was about as much as I could do. (Carla p.10, l.386-391)

Carla describes a process of 'holding' herself together which perhaps suggests that she imagined bracing herself against the next wave of shock so as to avoid falling to pieces altogether. She may also have experienced feelings of guilt related to her perception that she could have done more to protect her children at the time.

4.2.2 The Walking Wounded

This theme is representative of the double-edged process of continuing to meet life's practical obligations in the midst of dealing with the extreme emotional fallout for participants in the days, weeks, and months following their partner's suicide attempt. Whilst their partners had given up on life and attempted to escape it, they found no escape from their immediate responsibilities: employment; care of children; financial obligations; roles within their community; obligations to friends and wider family; and of course continuing to relate in *some* capacity to their spouse. What might have been viewed only yesterday as a mundane, routine task today became a debilitating chore as they were effectively a 'man' down due to their partner's incapacitation.

Whilst trying to keep their heads above water financially and in other ways, participants struggled to digest what their partners had done and to negotiate a new dynamic within their relationship beyond the suicide attempt. They had to come to terms with the fact that their partners had *chosen* not to share their pain with them during a critical time in their life. This caused them to re-evaluate how they conceptualised the relationship in a past, present, and future context. Participants struggled with a barrage of emotions about this that most kept

hidden for fear of being ridiculed socially, including loss, fear, rejection, anger, betrayal, regret, and responsibility. Although *their* world had crashed, the world kept turning regardless and so participants *had* to move forward whilst tending to these open wounds.

Alice felt the heavy burden of trying to keep everyone's head above water following her husband's suicide attempt. As her husband falls into a 'zombie'-like state, she effectively becomes a single mother fighting to pick up the pieces of their shattered family life:

> I had to worry about him, I had to worry about a mortgage to be paid. I had to worry about kids needing stuff for school. There was no income coming, well...my part time income had to be put on hold cos I couldn't go to work. There was nobody I could even go out there and say 'well can you help with the mortgage, can you help me with this?' Didn't want to know, didn't want to know. (Alice p.14, l.510-515)

Alice repeatedly mentions her worry here which serves to underpin both the pressure to maintain some semblance of normality for her children and the overwhelming fear of losing what she has in her life namely her husband, her home and the life they have built together. Although functioning in a 'zombie'-like state, Alice is unsure whether he still harbours the desire or has the capacity to attempt to take his life for a second time. She is constantly feeling on edge as a result and 'looking over her shoulder' so as to prevent a possible recurrence of this whilst on *her* 'watch':

> I had no trust...because if he could do it once and he was in such a dark place...if there's tablets left there, lexapro, like that's like handing a gun to a fella who's gonna go out on a shooting spree...so any sort of medication in the house had to be hidden. But that wasn't because of him, that was because of me. This was were the 'psycho' comes into it...I was frightened to even leave a cough bottle in the house. I was frightened to leave anything that, in case he wanted to make another attempt and succeed the next time...that he wasn't going to do it on my watch basically and I know that might sound selfish or whatever but I always had a fear of going out to work, the two kids away at school and I'd be at work and I'd come home and I'd find him (Alice p.6, l.206-217)

Alice describes herself here as a 'psycho' referring to the torment she experienced in her efforts to micro-manage every aspect of her husband's life so that history wouldn't repeat itself. Although he attempted to hang himself all Alice can see around her are potential further means of suicide whether it is antidepressants or cough mixture. She alludes to her fear of facilitating another suicide attempt but describes handing a 'gun' over to someone who shoots others rather than shooting themselves. This may provide an insight into Alice's belief that his suicide attempt or a possible further attempt would ultimately be inflicting harm on her and her children rather than solely on him.

She juggles her immediate concerns for her husband's safety with her profound sense of loss for the closeness and shared outlook on life she had perceived them to have. When she compares the countless occasions he communicated with her about issues that didn't really matter, against all the missed opportunities he could have taken to confide in her about issues that *actually* caused him concern, a sense of utter betrayal comes strongly to the fore for her:

> The hatred I had towards him was because...everything we both worked for and our dreams and everything...we could talk about everything and anything, and why all of a sudden was I blocked out and he couldn't talk to anybody. I hated, I felt as if that...he betrayed me...'oh it's okay to talk to me if...the tyre blew up in the lorry' or his clothes weren't washed properly, or dinner wasn't nice or...'but yet you couldn't talk to me when there was something that *really* mattered in your head'. And I felt that he didn't trust me to talk to me. (Alice p.16, l. 575-583)

Alice experiences a roller-coaster of emotions here as she perceives that his suicide attempt has nullified or at least threatened the very fabric of their relationship and all that they shared between them. In using the term "blocked" she evokes an image of perhaps a door being slammed in her face or barricading being erected by him to keep her on the outside. This provokes in her an issue about fundamentally trusting each other.

Tanya's level of devastation was palpable. She felt deeply wounded for having been kept completely in the dark regarding her husband's turmoil. Not only had he rejected her but Tanya felt he had rejected their daughter also. Tanya's maternal instincts came to the surface as she fought to protect her from the reality of the situation and its aftermath. Thus, her first and *only* priority became the welfare of her daughter:

> She was now living in a very confusing world where her father had been whisked away, gone to one hospital, gone to another hospital, came home – she had a father that had basically come to ignore her or had very little to do with her and me 24/7, to having both of us 24/7, so it was a very stressful few months within the house. You're conscious of your relationship, my relationship with her, watching out for her. (Tanya p.36, l.941-945)

Coupled with the pressures of responding on a practical level to their partner's suicide attempt as described above, participants simultaneously experienced a profound sense of loss. For some participants their loss related to facing up to the unhealthy dynamic that existed for much of their married life. For others the loss came with a realisation that their partner had turned away from them rather than toward them in their darkest hour. This challenged their assumptions about the state of their marriage and, indeed, about the identity of the person they fell in love with.

Tanya shares Alice's sentiment in that she views her husband's actions as the 'ultimate betrayal' of their relationship. 'Ultimate' in that she views there to be very little else that could surpass it in terms of breaking her trust, excluding her, deceiving her, and turning away from rather than toward her at a most critical time in their lives:

> I lived with a person that I thought I knew inside out, I thought we had great friendship, you're soulmates, we were good together and I found out then that the person I lived with and loved did not turn to me during his – what you would call the greatest crisis in his life and I remember trying to tell people at the time, to varying reactions, that I saw this as a complete and utter ultimate betrayal of our relationship which I put on a par with – I said to friends your husband, you know, runs off with another woman, runs off with another man, runs off, gambles the

> house from under you, various scenarios, or commits suicide, like, where would you put it? And different people, obviously in the heightened emotion of the situation, had different reactions but I would pretty much have put suicide – I would have put suicide up there quite highly. (Tanya p.31-32, l.816-824)

Evan's outlook on his wife's suicide attempt was quite different to other participants due to the fact that for years prior to this he had taken a very active role in helping her get the best help possible to improve her mental health. However, her attempt is completely unexpected and leaves him dazed and deeply saddened. Despite his sadness he needs to find a way of moving forward and does so by 'aggressively' advocating for her through the mental health system in order to find a 'solution':

> ...what becomes very clear is that if you don't have somebody batting for you, putting you centre of...if you can't do it yourself...of your own mental health, or your own health, whether it be mental or physical, in the system, you just become part of it, you won't be getting the actual treatment you need...so you do absolutely need somebody that's willing to look out for you, willing to shout for you, willing to talk for you...if you can't do it for yourself. (Evan p.4, l.156-162)

Evan uses the metaphor of 'batting for' his wife suggesting that regardless of what is going on for him on foot of her attempt, if he doesn't fight for her in some way he will be responsible for her becoming *part* of the system. Since his wife is currently not in a fit state to 'bat' for herself right now Evan feels the pressure to maintain his stamina with this lest things deteriorate further.

For Evan, his wife's suicide attempt reignites a sense of loss that he experienced a number of years earlier when she entered a psychiatric hospital for the first time. He knows intuitively that her suicide attempt represents another defining moment that will inevitably change how he sees her and the relationship forever:

> ...but I remember walking out of there and I remember saying to myself...'Okay, the person I loved and married has gone because the person that's going to come out of there, no matter what, or how you look at it, no matter how you dress it up, because of the very nature of what they're going through, is going to be adversely changed'.

> So you're sort of thinking to yourself...'Okay, so who's going to come in, will it be someone I like less, will it be someone I like more, will it be someone I can deal with more, will it be someone I can deal with less...it's all that coming. (Evan p.16, l.695-703)

Evan is perhaps suggesting here that her suicide attempt heralded a fundamental change in who she was. He describes his anticipation about who she will become. The person he fell in love with he believes is gone and the stranger in her place will look like his wife but possibly think, feel, and behave in ways that he will not be able to love.

4.2.3 A Desperate Search for Answers

All participants were exposed to an event of extraordinary proportions that was far removed from the 'everydayness' of their life. Without a tangible framework within which to process the experience participants engaged in a frantic and fraught attempt to develop a plan of action and to understand their partners' motivation to attempt suicide. Indeed, for some, the period of time in which their partners' whereabouts was unknown was fraught with just as many unanswered questions as they had when they located them and learned of their suicide attempt. Searching for answers to a throng of questions conceived by participants was a desperate act for them in that the sooner they gained insight the easier it would be to begin the task of putting their lives back together. It also answered the very human call to gain relief from ambiguity, regaining a sense of control for participants in an otherwise out-of-control experience.

Alice recalled her burning desire to know exactly why her husband tried to kill himself. Understanding the minute of what he was going through emotionally at the time of the attempt, she believes will aid in her *own* processing of the experience. Alice is exasperated, however, by the painfully slow way her husband is communicating *anything* to her:

> I was so fed up tryin' to…pull the words from his mouth for him to talk, for him to try and tell me was there a reason, if there was a reason, could he talk about it? For me to get me head around it, I wanted answers from him. (Alice p.15, l.561-564)

Being devoid of answers creates a significant blind spot for Alice which in turn creates both significant worry and anger for her husband. Not having the complete picture means that Alice is unsure if he will repeat the act:

> It was just the complete worry, the annoyance, the fear. Like the fear of not knowing I think makes you angry too. (Alice p.16, l.597-599)

Alice moves relentlessly back and forth along a continuum from an almost obsessive desire to gain *any* kind of information from him, to toying with her own ideas about what happened, to believing that answers she is looking for actually don't exist:

> So something went, something triggered, something happened and I don't think he can explain it because he doesn't know himself. And that's why I think people like myself and other people, 'til the day we die we're always gonna say 'but why?' And I don't think there is any answers for it. (Alice p.23, l.859-863)

Participants all had very individual styles of communication with their partners and consequently some looked directly to their partners for explanations whilst others looked outside of their relationship for answers.

Margaret recalled that virtually nothing was said between her and her husband about his suicide attempt as she believes that he would deny it was intentional. She doesn't force the issue as she is unsure she could face up to any explanation that might be forthcoming from him. She also creates distance between herself and the experience by depersonalising it, imagining how a person *in general* could make sense of it rather than for her in particular. Like Alice, Margaret moves backwards and forwards between there being no answers as to

why he attempted suicide and intuitively knowing that some kind of rationale for his attempt exists:

> There is no sense. There is no actual black and white...for anyone who does suicide, I don't think there's an explanation. There's certainly not an easy one. (Margaret p.5, l. 130-132)

In the absence of answers being volunteered by her husband Margaret instead turns to hospital staff to provide her with any semblance of understanding. The extent of her husband's alcoholism is highlighted and consequently becomes a kind of (pseudo-) explanation for his suicide attempt:

> He was in hospital and then he was in [name of psychiatric hospital] in [location] for a couple of weeks after that and he was being treated for alcohol addiction...and they told me at the time that he was never going to...stop...that he didn't have a pattern of stopping and that was their opinion and so I had to decide whether I could live with that or not and I decided to live with it rather than walk...that I could live with somebody who...as long as I knew that he probably wasn't going to stop drinking...you always hope somebody will change. (Margaret p.4, l. 109-115)

Margaret now has to face up to the news that her husband's alcoholism is unlikely to be a temporary phenomenon in her life and consequently has to let go of the hope she has held on to that he would eventually stop. She is now faced with another critical question to answer about how prepared she is to battle on in the relationship or say goodbye to it.

Evan's wife had been involved with mental health services for a number of years prior to her suicide attempt after she began to experience anxiety and panic attacks. Her suicide attempt was unexpected but *un*-surprising for him in the sense that they were on a kind of merry-go-round within the system (HSE) and getting nowhere. As an advocate for her, he had been trying for years to get answers about how best to deal with her illness but felt ignored. Ironically, only after her attempt did he realise that the 'answer' did not reside in any

intervention that came before, as an in-patient; a day patient; or in the array of psychotropic medication that she had been prescribed:

> I think I felt empowered again in the sense that I was able to say...'okay'...you know, it's not just my perception. I've been thinking this for a long time now, but it's actual, now I don't have to, now it's actual that the system's not working, it doesn't work, so everything we've done up to this point, you can wrap it up and fuck it away. (Evan p.8, l. 324-328)

Evan's renewed energy, possibly channelled from a multitude of feelings including anger and resentment for having previously not been listened to, is now being directed towards finding the *right* answer in order that his wife begins to show signs of recovery. 'Wrapping it up and fucking it away' denotes Evan's frustration and anger towards the professionals who have let him down or perhaps more significantly anger toward himself for not acting sooner on his hunch that the system was not working for her.

Evan describes 'waking up' to the inefficacy of interventions to date. It is bittersweet in that he is finally able to let go of the expectations he had but this immediately creates an urgency to come up with an alternative answer to avoid the real consequence that she might attempt a second time and succeed:

> I know now absolutely what's been happening to date is not working, so now I have the freedom myself to let that go. The awakening in the sense of this...okay, there has to be something else, there has to be a different way, no concept or notion of what that was, where it was going to be, where I was going to find it or whatever...it was no more than that. It was just an awakening that...if we continue on the way we're going to go, we're going to end up quite possibly around a grave... (Evan p.12, l. 515-522)

Tanya was bombarded with a barrage of questions both internally and from friends and family who rallied together in a very active attempt to locate her husband during the hours he was missing. On becoming worried about her husband's well-being, she quickly finds

herself immersed in impossible questions about the appropriateness of her response and its implications:

> I didn't know at what stage to do what, I mean do you start contacting people and then it turned out he's fallen asleep somewhere, you know that, do you make a fool of yourself versus how quickly do you act? (Tanya p. 3, l.55-57)

Tanya is conscious of how people in her life will evaluate her. This is also borne out later when she reflects upon what assumptions others will make about what caused him to try to end his life. She was positive that one of two things had happened, either he'd had a 'breakdown' and was missing somewhere or that he'd killed himself. In her desperation Tanya attempts to imagine walking in his shoes during this crisis in order to establish his whereabouts but this exercise fails miserably:

> Where are you? If you had spent 28 years with somebody, married 24 at that stage, with him 28, so been with him more of my life than I wasn't with him...if two souls are entwined in such close – soulmates, should I not know in my guts or heart and soul whatever where he was? That's just the – thinking on that level. Should I not know? (Tanya p. 8, l.191-195)

With little in the way of answers forthcoming, Tanya becomes embroiled in self doubt, chastising herself for not having an intuitive knowledge about her partner's inner world, a man she has known for almost three decades. She feels the burden of expectation from herself and perceives it from others about coming up with answers and resolving this ordeal for everyone concerned.

Subsequent to locating her husband, Tanya's desperate search for answers intensifies. She shifts focus to confirming whether he has tried to kill himself and then to indentifying his motive(s). The strength of her desire to understand 'why?' almost surpasses her compassion towards him during the period when she is unsure if he is going to survive. Dissatisfied with

the mumbled utterances from him in his hospital bed Tanya's patience is tested as she battles conflicting feelings of pity, frustration, and resentment at drawing a blank from him:

> I then *do* start, I think, needing a bit more: "Why...What has happened? Why?"...So you start the why, when, what, where sort of – nothing makes sense...there's phrases, half-phrases, half-sentences...it's exhaustion on his part and inability to articulate and he's looking at me as if to say "I've already told you this" and I'm going "you haven't", a growing resentment that he knows why he did it, I think his sister knows why he did it, his brother obviously knows why he did it, I think I need to know why he did it. (Tanya p. 26, l.670-678)

4.3 "It Shifted the Whole World on Its Axis": Adjusting in the Wake of the Attempt

This theme reflects the difficult process of adjustment participants went through in order to withstand the 'seismic' shift that the whole experience entailed for them. This was a very active experience for participants, ebbing and flowing in their thinking and in their behaviour in order to make sense of how this could have happened and to work out how best to remain functioning. They were forced to wrestle some dark feelings about both themselves and their partner. An unavoidable part of this journey involved thrashing out whom or what was responsible for their partner trying to kill themselves. It was an uncomfortable but necessary process to go through in order to move forward. Participants were tormented by negative thoughts about not being strong enough to cope with the situation and about the status and quality of their relationship. In an attempt to withstand this torment, participants developed various means of self preservation. For some it involved renegotiating boundaries, for others it meant supporting their spouses in their recovery or disengaging from them completely. Thus, this theme elucidates a cluster of two further themes namely, "the blame game", and "countering the torment: strategies for self preservation". Both of these themes reflect the adjusting endured by participants in the wake of the attempt that transformed their view of themselves, their partner, and their outlook on life.

4.3.1 The Blame Game

The 'Blame Game' denotes participants' back and forth 'finger pointing' about *whom* or *what* 'drove' their partner to attempt to take their own life. This was a natural progression in their desperate search for answers. They experienced conflicting thoughts and feelings about how they found themselves in this circumstance, for some participants it was clearer cut than for others. The source of their conflict was internal, external, or a combination of the two. Internal in the sense that they perceived that they were in some way directly responsible for 'driving' their partner to suicide, more so by something they had *not* done for their partner, therefore, experiencing guilt by omission. External in the sense that participants blamed circumstances that were largely beyond their control. For some, however, they felt that responsibility ultimately lay with the individual who chose to attempt to take their own life. Playing the 'Blame Game' although unpleasant was a necessary evil in order to make any sense of the experience. Attempting to discover culpability at least helped in putting the pieces of the puzzle together and ultimately facilitate in the process of adjusting.

In the wake of her husband's attempt Alice is adamant that she has failed him as a wife and best friend. She is plagued with ruminations about what she *could* have done differently to have prevented this, particularly as she believed they were best friends:

> But it was coming on him and I think everything just came to a head then, and really and truly the way I felt was I felt guilty I didn't see it happening, I didn't see it coming, I didn't see the tell tale signs, I seen nothing, absolutely nothing, and so I was angry with myself then...because this was my best friend... (Alice p.3, l.88-92)

She considers there to be definite precursors to his attempt one of which is depression which she formulated to be an illness that *came upon* him like an outside force. She chastises herself for failing to see it coming and for failing to act upon it sooner.

Alice also holds society and its support systems accountable for his suicide attempt as they both have failed in her eyes to champion positive mental health particularly in men. Had society encouraged men to be more emotionally demonstrative rather than thrusting a 'big boys don't cry' attitude upon them, and had hospitals made a more concerted effort to highlight the 'warning' signs, she believes her husband would never have found himself in this situation:

> ...there's no signs out there, nobody gives information about this, nobody says if a man's depressed they shouldn't cry, they're tellin' ya not to cry. It's the way they grew up basically, that you know, you're a big hard man, you're a big tough nut, you'll be fine, and they're not, they're really not... (Alice p.3, l.100-104)

Tanya recounts a stark transition from hyperactivity in the search for her husband to waiting in 'Accident & Emergency'. Only when the dust begins to settle does she have the 'head space' to begin her ruminations about what motivated his behaviour. As with Alice, her automatic conclusion is that she is guilty of the crime of having somehow *driven* him to suicide and that others will uphold this verdict:

> Well...when a wife's murdered, the first suspect is the husband...when someone commits suicide and dies, "Well I don't think they were too happy anyway"...had [husband's name] succeeded I'm the first suspect, I'm the one that would have had to wear the t-shirt that said "Actually, it wasn't my fault", do you know what I mean? He said "This is nothing to do with you". Of course I'm the first suspect...I'm saying suspect – I would be the one that would...at someone else, who drives somebody to suicide? Their partner. (Tanya p.26-27, l.690-696)

Tanya is wary of how others will perceive her and likens herself to a prime suspect in a murder inquiry. She appears convinced that others will point the finger at her, consequently feeling obliged to try to 'clear' her name.

Participants were forced to grapple with the near death of their life partner, in a manner that went against the natural order of things. They assumed they would both pass away in their old age but instead were forced to look the finality of life square in the eye due to a decision

made explicitly by their partner. For some participants, knowing that this was the case was just too difficult to ignore, turning their gaze toward the person who authored this traumatic event.

The more information Tanya received about her husband's behaviour leading up to his attempt the more she felt that blame should lie with him. She learned that his decision was premeditated having planned his suicide months in advance of the act:

> You have been planning to do this and what? Sat opposite me eating dinner, like? You! And you can go on and extrapolate that on to all the normal mundane things which weave together a family life, a relationship, a – you don't think on the bigger level, I actually thought, I actually thought of the smaller, more mundane: you looked into my eyes at one stage, *knowing* you were going to kill yourself, so what – looking into my eyes not good enough to stop you? So, why wasn't I enough to stop you? Why was our daughter not enough to stop you? Why – so yeah, there is an actual part now of resentment, annoyance, there wasn't anger because you couldn't have but feel ultimately so sorry for this person, this man you loved lying in a hospital bed, you know what I mean? (Tanya p.28-29, l.744-752)

Tanya powerfully describes the raw hurt and pain she feels now knowing that he interacted with both her and their daughter on a daily basis, looking in to their eyes, chatting about the mundane, all the while having had a plan in place. She was perplexed that both she and her daughter did not seem worthy 'enough' for him to reconsider suicide. Tanya ultimately found his actions wanting and selfish in the extreme.

Margaret too feels the burden of responsibility for her husband imposed on her by in-laws *prior* to his suicide attempt which is likely to have added to her sense of responsibility and guilt after his attempt. This only serves to add to her confusion about the part she has played in all of this. In addition, despite the culture at the time of not promoting open communication, she firmly believes that her particularly poor communication skills promoted his suicidal behaviour:

> Could I have done more? Could I have...talking would have been one of them, not necessarily...it's one of the hardest, I think, to sort of sit down and have a ...I would still find it the hardest. I can talk all day but not, you know...it's...again, it's running away from the hard bits, not ignoring them. (Margaret p. 8-9, l. 248-251)

Following interactions with psychiatric personnel, however, Margaret simultaneously holds an opposing belief that she could *never* hold the power to either promote suicidal behaviour in another person or, indeed, keep them from harm's way:

> Yeah, well, if somebody decided to do whatever, drive dangerously, drink and drive, it was...I had no hand, act or part in it, you know what I mean. I didn't do it or could prevent it, that it was totally...like I could only do what I thought was right in my life, I couldn't live somebody else's life for them, right or wrong. (Margaret p.6-7, l. 184-187)

Margaret is perhaps alluding here to her husband's old habit of 'drink driving' and the sense of responsibility she felt over the years for having 'allowed' this reckless behaviour. She comes to the 'sobering' realisation that he has *always* been in charge of his *own* destiny whether drinking heavily, driving dangerously, or taking his own life.

For Carla, something clicks in her head the moment she finds her husband overdosed. Even more strongly than Tanya, Carla lays the finger of blame squarely on her husband's shoulders. She dissolves herself of responsibility for 'mothering' him any longer. This is a defining moment for her in the sense that although she has taken on responsibility for his welfare in the past, this is an act that had crossed the line for her:

> From when I found him, there was no doubt. I don't think I even attached to any negative feeling towards myself even having it...I don't think I said 'oh, that's an awful thing'...I don't think that came to me. I think it genuinely was so strong...the feeling was so strong that I was crystal clear. I said 'this relationship is over'. Not in an angry response to what he'd done, but in a ...as I said, crystal clear...this is done, this is done. (Carla p.3, l. 110-114)

As was the experience of some other participants, Carla feels the finger of blame coming in her direction from in-laws who believe that she could have been more sympathetic toward him:

> His parents and brothers and sisters who stepped in very quickly to have a meeting with me about what was going on and it was suggested that I hadn't shown enough TLC, you know, a bit more TLC would have made a big difference. That dimension was going on in the midst of it all. (Carla p.2, l. 67-70)

Here Carla explains the extent to which her experience was multifaceted. Her life as she knows it has just crashed; she desperately tries to process what has just happened; she must find a way to move forward; and then a further 'dimension' is added to her turmoil when family members accuse her of lacking in 'tender-loving-care'. Carla like most of the other participants found that the 'Blame Game' adversely transformed their assumptions about themselves, others, and the efficacy of the 'system'.

4.3.2 Countering the "Torment": Strategies for Self Preservation

Participants were exposed to an experience of extra-ordinary proportions, having no established language, behaviour, response or any other repertoire that could guide them through this. Their backs were against the wall and in stark contrast to their partners they were going to do whatever it took to ensure self preservation. They tapped into whatever resources that were available, including at times throwing caution to the wind and doing or saying things that may not have felt socially appropriate. All they could do was to rely on life experience and instinct as much as possible to preserve their emotional, psychological, and physical wellbeing. Participants were strongly motivated to find antidotes to this torment and talked about needing to 'trust their own counsel' and to 'take it on the chin' in an effort to avoid ironically ending up in a similar situation to their partner.

Alice has the sobering realisation shortly after his attempt that her husband is not going to receive the kinds of supports she imagined there to be to deal with this crisis. As his 'next of kin' she feels it falls to her to ensure he receives appropriate help. Neither immediate family nor in-laws have been told of his attempt. Her sons were not informed as she wants to protect them from the horror of what has happened and to protect their view of 'Dad' as their idol. As a result, Alice is left to carry the burden alone and talks a number of times about her desire to 'scream from the mountain tops' as a means of protecting her own sanity. She knows she needs to let go of this burden in order to preserve her own psychological and physical health:

> And I, I just said to him one day, I says look if that's what you want to do [kill himself] you go ahead and do it, I've done enough, I'm not stoppin' you, I can't stop you anymore, if that's the way you want to be you go ahead and do it. (Alice p.6, l.217-220)

Without knowing what help he needs coupled with feeling like every door is being slammed in her face Alice acknowledges that she has reached the 'end of her tether'. Alice's exasperation is evident as she abruptly tells him that it is not humanly possible for her to do any more. She hands the 'baton' to her husband to carry the responsibility for whether he lives or dies.

Alice is encouraged by her husband's response to her ultimatum. When she is made aware that he is engaging well in counselling this seems to make it easier for her to *re-engage* with him. Over time she is more able to cope with what she perceives as a painfully slow process of recovery for him:

> There was manys a night he cried in my arms and I just rubbed his hair or rubbed his shoulder, rubbed his back. He felt very insecure because he felt then that he was letting me down again. And, we had talks about it and I said 'look it, when things

> are right, we'll be fine, we are fine...'we have to get you better first...when we get you better first, then we can work on other things'. (Alice p.7, l.257-262)

Alice appears here to have found her hope for the future again. This enables her to carry hope for the both of them, offering reassurance about the strength of their relationship during the times when her husband is particularly low.

As her husband's well-being improves they begin a journey of rediscovery and re-acquainting themselves with one another. Alice highlighted the fact that for her, making the effort to become friends again overcame her wanting at times to 'shake' him. She mentioned frequently the extent to which the simple act of talking paid dividends for both of them and ultimately their relationship:

> So, we set boundaries for ourselves, we had a date night. We got to be friends again and that was the most important thing. And then on a Tuesday night was our date night. We got to know each other again...reminiscing on the past and when we were teenagers and anything to get his mind off that year and a half or so that he was in a very bad place. (Alice p.19, l.719-724)

The setting of boundaries encompassed a number of domains ranging from calling for her husband take a more active role in household chores and with the children, to being more authentic about how one another was feeling.

Evan gave a strong impression throughout the interview of a man relatively unperturbed by the trauma of his partner's suicide attempt with a strong focus on advocating for her and maintaining hope for her recovery. Nonetheless just beneath the surface the attempt was having a huge drain on the relationship. He often had to 'dig deep' emotionally in order to stay the course:

> One of the things that enabled me to stay was a little mantra I had with myself when things got really bad and that was...'get her better and then you can leave'. Now that's pretty powerful. (Evan p.13, l.561-564)

Evan was adamant that he had no intention of leaving her but took solace in knowing that the option existed. He describes it as a 'little' mantra but later acknowledges how far reaching the consequences would be if he followed through on it. His mantra reflected at the very least his duty of care he felt he had towards her and at most the love he still felt for her. Evan talked at length about his motivation to get his wife better and very little about his own coping. However, it appears he had a number of resources as he implies here that his mantra was *one* of the things that enabled him to stay.

Evan knew the only way his wife would ever turn a corner would be through her own motivation. He struggled, however, to see any evidence of this happening until she began dealing proactively with her anxiety. She joined a support group but for the first four weeks or so she sat in her car too terrified to go in and join the other members. Evan could see passed her non-attendance and saw instead evidence of progress and with that came hope:

> She'd come back...'How did you get on?' 'I didn't go in.' 'But you went', you know, but then to go the next week and do the same...but there's a fire in there somewhere, isn't there? So there was no absolute conversations, but there was bits that you could see that were starting to make sense which was great, because I knew there had to be a complete change and I didn't know where it was going to come from and I suppose I least thought it was going to come from [wife's name], but it did. (Evan p.20, l.878-885)

Evan talks here about the 'fire' for change he could sense in his wife. This was a resource for him, keeping him engaged in championing her recovery. He describes his belief that a sea change needed to occur, his pessimism about this happening, and his sense of reassurance when it did.

When the changes in his wife began to gather momentum this lightened the load considerably for Evan. The torment that had besieged him was countered with a sense of pride for his wife. He no longer viewed her as a helpless victim but as master of her own destiny:

> I see the suicide attempt as a metamorphosis, I absolutely see it as the caterpillar who thinks it's fucking dying and then turns into a butterfly. (Evan p.24, l.1059-1060)

Evan provides powerful imagery here in his metaphor of the butterfly of his wife having triumphed over adversity and having transcended her self-imposed near death experience to become something *more* than she was prior to the attempt.

What set Carla's experience apart from the other participants was her certainty that her life would deteriorate further were she to remain in the relationship. For her, her husband's attempt was the straw that broke the camel's back:

> I had this image of me...this very strong, visual image came to me of me in the corner fighting for my own life, that my survival depended on me leaving and that I chose to survive. That's where, I suppose, there was no turning back. I can't tell you that maybe we said we'd give it a go. I have no conscious memory of that. All I know is that, in that moment, I could see myself...I can still see myself having this...'I'll die if I stay in this relationship'. I didn't mean physically, I meant emotionally I would have died inside. I was going to die inside. (Carla p.5, l.175-181)

Carla emphasises here her belief that her *own* life is in danger on foot of this catastrophic event. She conceptualises a life of emotional turmoil as a kind of death in itself. Whilst her husband has conspired toward death, she chooses to move away from it. Protecting her emotional life ultimately entails creating as much physical distance from her husband as possible.

Carla had to carry the burden of sole parenthood, keeping the business going, and coming to terms with leaving the marriage both for herself and her children. Her husband was effectively absent from their lives for the best part of three months around the time of his suicide attempt. One way of countering the torment for her was to be as co-operative with him as possible as terms of the separation were agreed:

> We agreed on shared custody. I mean, we did all our legal work. Everything was done. There was no big fight, there was no throwing stones at each other, there was none of that. We did do it as...that dreadful word...'amicably' as possible. How could you be anything else when you're in the throes of something like that? We did do it with as much grace as we could in the circumstances, both of us, I'd say. (Carla p.7, l.273-277)

Carla describes the term 'amicably' as 'dreadful' perhaps implying that she was saddened by how cold and clinical the ending of their marriage was, devoid of the bond and emotion they once shared. Nonetheless, she couldn't imagine experiencing it in any other way given what she was going through at the time.

Carla sang the praises of her good friends who were obviously a tremendous support for her during her darkest moments when she felt devoid of energy and answers. Their positivity brought a welcome balance to her life at a time when she could have easily let the torment get the better of her:

> I had a number of friendships that were incredibly supportive and I think they would have been a huge assistance in helping my self esteem. I have a couple of relationships that would just have been so positive and yeah ... that would just have made such a difference to me … that would have been very supportive throughout the whole time. (Carla p.17, l.660-663)

Her self-worth got severely knocked in the wake of her husband's attempt on a number of fronts: she had been motivated to enter couple therapy with him just prior to his overdose;

she felt accused by in-laws of not being adequately supportive of him; and she felt guilty that she was breaking up her children's home. The quality of her friendships acted as a buffer between her and the torment that ensued, and in due course seeing her come out the other end of it still intact.

4.4 "It Never Ever Goes Away": The Legacy of the Attempt

Participants experienced the trauma of their partner's uncompleted suicide as a permanent imprint on their psyche. This imprint manifested psychologically, emotionally, and physically, bringing to the surface vulnerabilities such as physical illness, repressed traumatic memories from childhood, and transformation in how they now saw their relationship with their partner. Whilst all participants had a tumultuous time adjusting to the event, paradoxically all experienced increased personal strength and other forms of growth such as enhanced relationships and outlook on life. These experiences inevitably transformed how they saw themselves, their partner, their world, and indeed, their future. Thus, this theme elucidates a cluster of two further themes namely, "What lies beneath" and "Transcending death-enhancing life".

4.4.1 What Lies Beneath

This theme represents all the unseen or 'below surface' impact that transpired for participants subsequent to their partner's uncompleted suicide. The event had the impact of 'resurrecting' or reactivating childhood traumas and exacerbating underlying physical conditions. Hyper-vigilance became another feature that came to the surface for participants, avoiding getting too comfortable in case suicide were to revisit them with partners or children. This became a hidden but ever-present feature for some participants as their partner was a constant reminder of the suicide attempt but they were also easily triggered by for example conversations or media coverage of suicide or missing persons. The whole

experience also caused participants to adversely transform how they saw their relationship with their partner.

Alice provided a rich insight into how her exposure to the stress of her husband's suicide attempt brought a mass of 'unfinished business' to the surface surrounding her troubled childhood. She had felt supported over the years by her husband who was very familiar with her past:

> He's always been there for me like all through my childhood and that and he knows about the abuse I went through and that and...I'd be talking to him about it and talking to him about it and...hand on heart [laughter] I don't know how he listened. I really don't know, I don't know how he stayed as sane for as long as he did. But that's what I'm saying like we know each other so well. But emm...I think with him attempting this then it dug all this back up with me again. (Alice p.29, l.1105-1112)

Not only did his attempt strike a familiar chord with her on a number of fronts but it also meant that her greatest champion was no longer available to support her. Her early story which began with parental divorce and loss of her childhood home, echoes many of the themes that she experienced on foot of his attempt:

> So I haven't had much luck [laughter] with the HSE or doctors but...that's what I'm on about with mental illness. My mother probably had a breakdown as well but she got very violent with it, she got very abusive, she got very...an alcoholic like. And I'd have said to you before that I would've known about mental illness not from the husband but from somebody else. But...she's a totally different person. Like...she's just pure evil, really, really pure evil. (Alice p.29, l.1094-1101)

She describes a story of survival in which she needed to take extreme measures in order to keep things afloat similar to her response following his attempt. On reporting her own abuse she felt the 'system' was dismissive of her, similar to how she experienced it in the aftermath of her husband's attempt. Alice also confides here that she has had previous

exposure to mental illness through her mother but seems to view her husband as having been a victim of his 'breakdown' whereas she seems to attach some malevolence to her mother's breakdown. She described during the interview the loss of relationship with her father a significant male figure in her life, which has resonance with the possible near loss of her husband whom she had a bond with since childhood. All of this at once coming to the surface had a cost for Alice causing her to deteriorate both psychological and emotionally.

Whilst Evan feels in many ways thankful for the experience and is stronger spiritually as a result, Alice does not necessarily share this sentiment as she has had to adapt to a life in the shadow of her husband's suicide attempt:

> You're actually frightened to get comfortable again in case there's another big upheaval. That's basically what it is...I'm not saying you're living from day to day, that would be a lie. You're frightened to get too ecstatically happy, or plan too far ahead, or even to this day I would be the same...I just take every day now as it comes. (Alice p.24-25, l.915-921)

Alice provides a powerful summation here of how she relates to the world now in the wake of the attempt. Her daily life now is underscored by fear to varying degrees subject to her evaluation of how her husband is through his mood, tone of voice, facial expressions and so on. In essence Alice has maybe learned to live with the discomfort of knowing the 'rug could be pulled from under her' at any point.

Alice has created a new kind of template for relating to people she cares about particularly her children. This template comes from a place of real fear for her and carries with it the burden of recognising 'telltale signs', signs she believes she should have seen in her husband:

> Even with my two sons now...they would be my life...I can even see myself now *[laughter]* the ages they are, looking at them to see if there's any little telltale signs, if they're gettin' down in the dumps or if they're, anything like that or anything

> worrying them and they can talk to me about anything and they know that. (Alice p.9, l.316-321)

Tanya was hurt and angered by the apparent lack of consideration her husband showed for both her and their daughter in his decision to leave them behind particularly because of his knowledge of the early traumatic loss Tanya had experienced:

> And he chose to leave her and shocking as it is that he would choose to leave *me*, at least I was a grown adult and I had chosen to marry and be with him, she did not ask to be left without a father at ten years of age and I think I became very angry, more on her behalf possibly, maybe not, compounded by the fact that I lost my own father at 8 ½ by - and through an accident...and witnessed the Guards arriving at the door and he knew how - that's an awful thing to happen to an 8 ½ year old and I could picture a scenario that had he succeeded, had he succeeded the Guards would have arrived at my door... (Tanya p.32-33, l.843-850)

She was in two minds whether her anger was more on behalf of her daughter or for herself. However, since her daughter was very similar in age at the time of his suicide to the age she was when her father was killed it is likely that she began to have a new appreciation for the confusion, pain, and anguish that she experienced but couldn't understand as a child. Tanya imagines what could have happened had her husband been found dead and feels for her 8 ½ year old self.

Tanya's emotional fragility is paralleled with an ongoing physical condition that she is obliged to address despite the enormity of what has just occurred in her life. What should have been a fairly routine procedure and straightforward recovery turns into a more sinister and chronic condition:

> I'd had a medical procedure on my spine just the week before it which was bad timing on his part as well and it was another area of him not prioritising. As a result of running around hospitals and sitting on plastic chairs outside consultants' rooms or whatever, about weeks later I collapsed...and it had aggravated the procedure that

> I had had done on my back, over the months afterwards, it took - what should have been a pretty straightforward recovery, didn't recover, my health deteriorated...afterwards I knew I wasn't getting any better but I didn't know if this was lapsed into the upset and confusion, if it was depression, it did turn out to be established medically...I had an underlying condition which escalated and - into much more chronic condition during the months after the suicide through which…the medical personnel involved would no doubt that post-traumatic stress would be involved. (Tanya p.34-35, l.889-912)

Tanya's ongoing anger and resentment for her husband's actions are evident here. She views him as having been inconsiderate of what was going on for her just prior to his attempt. She questions why her recovery seemed so hampered to the point that she queries if she was suffering from depression. Tanya here is perhaps sharing that she *did* in fact experience something akin to depression in the months following his suicide attempt. What she is very certain of, however, is that she suffered symptoms of post traumatic stress as a *direct* effect of his suicide attempt. Confirmation by medical personnel of her post traumatic stress diagnosis seems to be important to her which may suggest that she felt it wouldn't be taken seriously otherwise.

Tanya provides a powerful image of the trajectory that both her and her husband took at the point of his suicide attempt. For her, his attempt marked him having reached rock bottom and so from then on the only way was up for him. However, she felt that her emotional and physical health took a nosedive from the moment she knew he was missing:

> The impact on him was that was his lowest point and he only got better after it because it all came out in the open, it was all established and he became stronger and better. The night of the suicide was only the start of my downward journey and back up - does that make sense? (Tanya p.38, l.978-981)

He was provided with everything he needed in her eyes to make a solid recovery including therapy and regular contact with his family of origin. Tanya, however, in the midst of her

turmoil felt pressure from in-laws to have him return as soon as possible to their marital home which was something she didn't want. She also felt the burden of responsibility on her shoulders from psychologists to prevent a second suicide attempt. All of this was happening whilst her physical health deteriorated.

Of all participants Tanya's description of how her life is now is the most saddening. The impact for her in terms of ongoing hurt and resentment is very tangible as she recounts a return to some form of normality:

> So as things quietened down and people stopped asking, slowed down in asking, as he re-established his life and goes back to work and goes to football matches and goes to all these places, people stop asking and we should have returned to what people call normality. But I didn't get over it. And I don't think I ever will actually get over it. (Tanya p.24, l.947-950)

What sets Tanya apart from the people in her life now is that whilst they appeared to be able to seamlessly slide back into the roles and day-to-day activities they pursued pre suicide attempt, her experience is completely at odds with this. It evokes how people describe life after burying a loved one, when people stop calling or asking how things are. Her resentment towards her husband is very evident as she describes his re-engagement with life, whereas she feels that his suicide attempt is responsible for her *dis*-engagement from life. Tanya feels a social pressure to put it behind her but she is not optimistic at all about being able to achieve this.

Something has changed in Tanya and by association something has changed in the relationship. She asserts that she will never again be in a position to 100% trust her husband. She eloquently describes how she experienced the relationship prior to the attempt and the devastating impact it has had on it since:

> Our relationship was never the same again. Never. And I really don't think it ever will be because I know *I'm* not the same person I was, definitely I'm not the same person I was. I would rely on him less emotionally, I don't think he's my first sounding board, and I mean emotionally...I think I'm actually probably stronger in some ways...where I lived in the situation, what I perceived to be a massively open loving relationship where he was both my best friend, the person I sounded, no - the person I turned to first about simple things like dinner... right through to the big things in life. He's not my first point now because I think I would think more for myself first, work it through myself first and also I think - I think I don't respect or value his opinion as much. (Tanya p.23, l.1035-1047)

Tanya emphasises here that things have changed permanently and adversely so. Her reflex to share all those parts of her life that reflect closeness in a relationship has diminished, from the everyday mundane to the most significant of life events. Ironically his suicide attempt has pushed her to trust her own judgement more but this is bittersweet as it has only come about through losing respect for her 'best friend'.

Tanya talks about the suicide attempt in the past tense but it is very evident that emotionally it is still very much *present* tense for her. As she sees it the attempt is 'dead and buried' for her husband, whereas she feels haunted by it, being bombarded regularly by reminders :

> It will never fully go away. He has the ability to bury it so deeply that he doesn't think of it whereas it pings in my head when I hear any missing person, suicide, anything like that, I feel for those people. I do think that the likes of suicide awareness week does wonderful, wonderful work in raising awareness but never, ever, ever have I found anything that's - I think it's wonderful what they've done and they're also trying to get rid of the word 'committed', committed suicide, like, and I know I used it there but there isn't - there was never one article during suicide awareness day or week that ever thinks of any other impact on anyone else. There isn't *[cries]*. (Tanya p.24, l.1064-1071)

Tanya seems to relive the experience of her husband's attempt and all that surrounded it when she is exposed to these reminders. At the heart of how Tanya experiences the world now is a sense of feeling like the forgotten one as everyone and everything seems to have

moved on except for her. In particular, she feels there is little if any focus given to 'significant others'.

As was the case for both Alice and Tanya, the suicide attempt had many ripple effects for Carla including distressing memories about growing up in an alcoholic household. She was intimately familiar with fear and tension in her father's presence and these very same feelings resurfaced living with her husband for that short period after his attempt:

> It certainly wasn't a pleasant atmosphere. It wasn't an aggressive atmosphere...but yet, there was tension ... that I had previously experienced in my own family home as a young person. I was very aware that this tension was there and concerned as to how that tension impacted on the children, because I had a sense of how it impacted on me. I mean, we lived in a house where my father was an alcoholic and there was huge tension around his presence when he was there or imminently going to be there or whatever, and I felt that same tension. So that was a very familiar feeling to me and was loaded with fear and what-not, whatever I would have experienced when I was younger. (Carla p.6, l.224-232)

Carla was also concerned about whether her children were living through what she did during this time, something that also came up for Tanya regarding her own daughter. Another significant aspect of Carla's experience in reaction to her husband's attempt was her sense of obligation to not only leave her husband but the entire community that was connected to this marriage including in-laws, mutual friends, and even her own home. All of this was going on just below the surface for her:

> I chose to leave all of that, so that was the marriage, the house, relationships and his family, apart from one whom I did stay connected to. So I chose that, as I saw it and I'm wondering now ... was that, in some sort of way, a punishment to myself ... oh, you're the one that left, so just suck it up, you've made this decision, you just have to take it on the chin. (Carla p.8, l.312-217)

Carla perhaps is suggesting here that she had to do what she thought was the honourable thing and fall on her own sword as 'punishment' for having instigated the demise of the marriage. There is likely some shame attached to her leaving at a time that outsiders looking in would construe as his greatest hour of need, and taking the children away from their father. All of this coupled with losing a large part of her support network, and her own home is likely to have deeply impacted Carla for some time.

The trauma of her husband's attempt forced Carla to confront many areas of her past that she either thought she had adequately buried or had already dealt with. One that was closest to her heart and so most fragile about related to the child she gave up for adoption when she was in her late teens:

> I then would have addressed the issue of giving my daughter up for adoption, because that was a box that was sitting up on the shelf with a bow on it and from an analytical perspective, I had sorted that one, but I hadn't connected with it on a feeling level at all until then. So the counselling for that...that took me to the next step which would have been taking that box down and walking that walk. (Carla p.16, l.605-610)

Carla speaks here about the part played by her husband's suicide attempt in forcing her to connect more with experiences in her life on an emotional rather than purely 'analytical' level. She uses the metaphor of a 'box' with a 'bow' on it to perhaps portray her tendency heretofore to compartmentalise her life. The suicide attempt completely disrupted this process creating all kinds of emotional distress for her that would later be worked through in counselling.

4.4.2 Transcending Death-Enhancing Life

Rather than the suicide attempt having the effect of defining their existence and dulling their sense of purpose in life, participants found that their experiences surpassed their

expectations regarding the legacy of the attempt. This was neither expected nor planned by participants. Participants described positive aspects of its legacy that was influential in them becoming better versions of themselves in a number of ways including experiencing life to a heightened degree and no longer fearing death, enhancing relationships with others, enhancing their own sense of inner strength, and feeling in greater touch with their spiritual selves.

Carla's view of what 'normal' is for her now is in stark contrast to her life prior to her husband's suicide attempt. The attempt was the final nail in the coffin for the relationship and heralded a difficult but ultimately satisfying journey of self discovery:

> I suppose, finding myself and my own voice... when you join all those things up together, there's no one particular thing, but really being free to be who I've become, or being free to start the journey of finding who I am, who I was and who I am now has been a long journey and a very interesting journey and a very empowering journey, and would have started with stopping the relationship. (Carla p.17, l.675-679)

Her conclusion here is that resources such as friendships, counselling, and her openness to facing any 'skeletons' from her past all contributed in their own way to her transcending the trauma of her husband's suicide attempt and enhancing the relationship with her 'true' self. Carla's new found sense of freedom to be herself and develop her own voice reflects the transformation she has undergone as a result of her experience.

This freedom also brought with it a re-channelling of her energy into being a mother, a role that she relished but at times felt she didn't live up to because of the demands of her marriage:

> I've always said I was a better mother as a result of it than had I stayed in the marriage. I think I would have ended up, well, I don't know, but I think I would have probably ended up either an alcoholic or depending on something to support me in the supporting of him and that the children would have gotten lost somewhere in the middle, that if I had to stay focussing on that relationship, he would have gotten so much that it would have been to the detriment of myself and my children and, in not being in the relationship…I can't say it's his fault…I think it's not being in the relationship I was free to be what I wanted which was a Mum, part of me wanted to be that. (Carla p.17-18, l.644-651)

Life for Carla now means a renewed self esteem and a greater confidence to be the mother she has always wanted to be. She recognises from how bad she was feeling following his attempt that where she is now both emotionally and psychologically is infinitely better than had she remained in the marriage. This of course can only have positive implications for her children and her relationship with them into the future.

It is evident that Carla has invested time and energy into reflecting upon this life transforming experience and its implications for how she wishes to relate to the world going forward:

> The importance of keeping a sense of self within a relationship, within any relationship, being watchful of where the relationship is, I mean, is there a very strong parental person/role within a relationship?...I've experienced people who...there's a strong Mammy thing of mammying people...to be careful of that, because then there's a lack of equality, you're not two adults in a relationship, you're a parent and a child relationship. I don't allow things any more to...if I've an issue with something, I look at it. If there's a feeling...I always look at it and say 'what's this about?' Feelings, sorry, I never mentioned feelings, did I? Nobody should ever ignore their feelings and we subdue them so much. (Carla p.19, l.731-739)

Carla's transformation has culminated in an enhanced sense of self, clearer boundaries between her and others, no longer ignoring issues but facing them head on, and giving herself permission to feel regardless of what comes to the surface.

In contrast to the other participants Margaret was markedly positive regarding the long-term ramifications of her husband's attempt. She would have preferred had they been a closer couple but was quite philosophical about accepting the things she could not change. Of note here is her awareness *post* suicide attempt of a deep well of untapped resources already within her which actually enhanced her life:

> Life after was better for me than it was before in a strange way. I was able to - I had the ability to make life better, you know, I realised that I could do it. (Margaret p.15, l.447-448)

Margaret's new found empowerment created a sea-change in terms of asserting her own needs and developing a life of her own independent of her husband, something that was long overdue:

> It's made me a much stronger thinking person…I would always sort of say...'Can I have the car to go wherever?'…whereas then I set about getting my own car and being independent and not having to go to ... that depressive level maybe, if one person is living in a depressing sort of state doesn't mean that the other person has to join them, and I felt I can rise above this … and…that took steps … tiny steps…not maybe always ideal, but it was my way of surviving. (Margaret p.11, l.314-328)

Margaret gained awareness that if someone in her life was 'in a hole' psychologically she was not obliged to stay in that depressive place with them and that by taking tentative steps she was able to transcend her husband's experience.

Margaret's experience forced her to face the possibility that she could be widowed at some point in the future and so in some ways this was affording her a rare opportunity to be exposed to the loss of her husband albeit from a safe vantage point:

> I think probably, so as if it ever happened again, I would be prepared, I would be more capable of dealing with it. I would…have myself set up to probably be able to

> live independently, that it wouldn't be such a big blow if he did commit suicide, I would be ready ... maybe. (Margaret p.12, l.342-345)

Margaret's growing empowerment is evident here in her ability to visualize being on her own. Set against the backdrop of living with the uncertainty of him repeating a suicide attempt, her greatest resource were he to die would be to have the fundamentals in place to live a healthy life in his absence. An important part of her journey has also entailed letting go of the illusion that she is personally responsible for whether he lives or dies:

> You then figure out that you can't run after somebody watching them and you have to be able to sort of block out that section, that if they go out the door, that it's their choice where they go or what they do, that you carry on with life. You have to develop your own life that doesn't involve living in that circle all the time. (Margaret p.5, l.147-150)

Margaret uses the image of a circle to perhaps represent the merry-go-round of care-taking that she has been on over the years regarding his fluctuating mental health and alcoholism. The circle may also represent her feeling trapped in a cycle that she had no sense of control over or escape from. Either way the circle/cycle has been broken and Margaret has become acquainted with a spiritual side to her that she was unfamiliar with:

> I've learned to trust in maybe a higher authority than me…accept that you don't control what's laid out for you in life and you just accept it, whatever it throws at you…I'm not hugely religious, but I would be - I suppose religion does play a part in it, yes. Faith is a good…I think people who don't have a focus point in their life, it must be very hard, whatever religion...(Margaret p.21, l.621-628)

There's a sense here of personal contentment for Margaret in her life now. Perhaps she is implying here that *she* is happy *in spite of* what might be going on for her husband at any given time. There's also a sense of a lady whose life experience particularly since the suicide

attempt, has created a more grounded mentality and with it more realistic expectations of life.

Whilst the bond in the relationship for Tanya, Carla, and Margaret has been irrevocably damaged to varying degrees, Evan's story feels worlds apart. He figures his wife's attempt has brought him closer to her in a way that is unrecognisable to anything that has come before in the relationship:

> I think...the whole relationship has evolved into something that never was in the beginning…The two people that got married were completely alien to me now, to the two people that are here now. Now that's probably the same in most marriages because of time and all the rest of it, but I think for all that's gone on and all that we've been through together ...(Evan p.20, l.906-912)

Evan describes both himself and his wife objectively as if he's outside looking in. He uses the term 'alien' which evokes unfamiliarity, the supernatural, and perhaps a spiritual dimension. He acknowledges change is par for the course in all relationships but suggests that both he in particular and his wife have transformed to an extent *far* beyond the normal range of experience.

There is a real sense of greater self respect for Evan since the suicide attempt and, indeed, a greater mutual respect as he admires all the 'wonderful things' she has gone on to do with her life. He talks about the attempt as having been a 're-birth' for his wife. In many ways, however, it has marked a re-birth for both of them individually and as a couple:

> Probably better than it's ever been. I think I certainly love the person I'm with now much more than I loved the person I married. I certainly love them differently…but certainly...it's definitely two people individually leading...or living a collective life, if that makes sense. There's no expectations of each other. (Evan p.24-25, l.1102-1106)

It strikes as quite a startling admission to love your spouse *much* more than when first married. However, this likely reflects the sheer level of impact and the vastness of the transformation for Evan that has ensued on foot of the suicide attempt.

Evan mentioned that in hindsight there was a need for somebody to have stirred the 'murky water' up in order for positive change to occur. His wife's attempt certainly achieved this to the extent that it stirred something up in their relationship dynamic also:

> It's funny because our individuality has acknowledged itself, it's very present in the sense that ... in a lovely way. So that's basically where we're at, at the minute, you know. It's all good, has all its problems, still has all its problems and all the rest of it, but it's all good. (Evan p.25, l.1114-1117)

There may be a suggestion here of a co-dependent relationship prior to the attempt which has since rectified itself. Whilst Evan has talked of the attempt bringing with it metamorphosis and re-birth, juxtaposed to this are all the 'normal' ups and downs of a happy and content marriage.

Evan too had a rather philosophical outlook on his experience of his wife's attempt. He described it as a 'massive journey' and akin to one train crash after another. He was positive overall, however, about how it has shaped him as a person:

> It's taken the edges off, and rounded me more…I think, to get them edges off…you know when you look at stones and you go...'that must have been in a river'...I think it takes nature to take them edges off. I don't think you can grind them off, or rub them down, I think they have to wear away, you know and the whole process has definitely done that for me. (Evan p.24, l.1090-1095)

Evan likens himself to a stone that has become a softer version of itself through time and experience. He suggests that aspects of his personality such as patience, empathy, and

tolerance have evolved in response to the extreme pressures he felt during the ebb and flow of the experience. He sees this as something that cannot be manufactured or rushed, but like the river, it follows its own course in its own time.

Witnessing his wife being very close to death and all that came after it has prompted reflection for Evan about his own mortality which has been a revelation for him:

> For me and my life, it has absolutely...here's one for you, I don't know if I ever feared death, but I certainly don't now. (Evan p.25, l.1124-1125)

Evan is uncertain here whether he was ever afraid of death but is now convinced that her suicide attempt extinguished any remnants of fear in him. Achieving greater ease with the circle of life and acceptance of death could only have had a spiritual dimension to it according to Evan:

> I'd be spiritual, but I wouldn't be religious. But that was definitely a spiritual journey without a shadow of a doubt for both of us and I think that if you're really lucky, you get to grasp that, you get to realise that…and I think we've been really lucky. On a selfish note, I wouldn't change a thing *[laughs]*. (Evan p.24, l.1138-1142)

Significantly Evan communicates that the journey is one that was made *together* with his wife thereby, enhancing their relationship in some way. He implies that not all couples who go through this may grasp this important spiritual dimension. In fact, it seems it has been so life changing for him that he is in many respects thankful for the experience.

4.5 Conclusion: Transformations for Better, for Worse

Findings suggest that the impact of a partner's suicide attempt is transformational for individuals with both negative and positive trajectories. Analysis has revealed that

transformation occurred for participants as a result of the trauma suffered by them during this life changing experience. Their shattered assumptions manifested in the midst of shock, feelings of hurt, betrayal, and desperation to comprehend what had happened, all the while continuing to meet life's obligations. Participants' transformative experience continued apace during the complex adjustment in the wake of the attempt, as they navigated their way through self blame and blame from others both perceived and explicit, and developed ways to counter their torment. The impact on partners has left a permanent transformative legacy that has forced them to both confront unresolved adverse childhood experiences and embrace new growth within themselves, for their relationships, and their outlook on life.

4.6 Reflexive Journal Entry

It is an incredibly daunting task to commence analysis of the first case. I am feeling the enormity of responsibility that inevitably comes with representing the lived experience of another individual. Although I am being guided by Smith's steps for analysis it is hard not to feel in some ways disloyal to the experience of the participant when the double hermeneutic comes into play. I am reassured on reminding myself that I view this as a co-constructed venture.

As I progressed with analysis on a case by case basis I noted the extent of my self-doubt regarding what I have 'missed' in the transcript rather than acknowledging any breakthroughs or identification of what I would deem to be a 'gem'. I also noticed how eager I was to create a 'finished' master table of themes well before I had even completed analysis of all five participants.

In my entire academic career I have never experienced such a constant 'live' working and reworking of a supposedly complete master table and the writing up of the findings. I see it as very much akin to something organic that has had a gestational period (longer than a

human pregnancy!) and has needed at times intensive care. The final master table, although appears simplistic to me on the surface, more than anything else represents at once the agony and triumph of this research journey.

Chapter 5. Discussion

5.1 Introduction

The aims of this study were to explore the lived experience of living with a partner following uncompleted suicide; and to examine the meaning that partners attributed to an uncompleted suicide and the significance of these meanings for their everyday lives.

The objectives were to explore the meaning ascribed to the experience of a partner's suicide attempt; relationship with partner post attempt; and outlook on life post attempt. The IPA method effectively facilitated the generation of valuable findings in the unchartered area of the impact of uncompleted suicide on partners.

The study revealed a transformative impact on participants on foot of their partner's uncompleted suicide. This transformation manifested in both positive and adverse ways. The experience had a traumatizing impact on them represented by the first subordinate theme "It put nearly ten years on my life": suffering the trauma of the attempt. They experienced recurrent shock associated with the event, "It's a shock that comes in waves", and feeling like "the walking wounded", experiencing raw pain and extreme adverse feelings toward their partner all the while honouring practical and financial obligations. Their strong desire to be relieved from ambiguity was denoted by their "desperate search for answers". A significant aspect of the second subtheme "It shifted the whole world on its axis": adjusting in the wake of the attempt, was their attempt to gain insight into whom or what was responsible for the suicide attempt and what if anything they could have done to prevent it. Participants consequently found themselves playing "the blame game". They also developed 'strategies for self preservation' as a means of 'countering the torment' both emotional and psychological. For some this encompassed renegotiation of boundaries and for others, a complete disengagement from their partner. The final subtheme "It never ever goes away":

the legacy of the attempt, represents "What lies beneath" that arose for participants in terms of the attempt altering their perception of the relationship and which they kept private. The attempt also brought to the surface adverse childhood memories for some and deterioration in physical health for others which have lingered to the present day. Participants also had the experience of 'transcending death-enhancing life' as a legacy, illustrated by growth across a number of domains including personal relationships and outlook on life.

This chapter aims to make sense of the research findings by contextualising them within extant literature both empirical and theoretical, and in so doing exploring how the findings build upon what we already know. The findings highlight the transformative experience for participants within the context of literature explored heretofore as well as signposting the way toward new literature. It was found that participants' experience was underpinned by multiple traumas which caused a permanent and profound transformation of their assumptive world. Literature will, therefore, be examined in more depth on trauma theory and the phenomenon of complex trauma. Findings also suggest that participants experienced a transformation of their 'psychological family'. Literature will be explored more closely on a significant aspect of ambiguous loss theory known as boundary ambiguity. Participants in this study all experienced a transformation in their perception of the quality of their attachment relationship pre- and post-suicide attempt and, therefore, it was deemed prudent to examine the literature on attachment theory and the implications of affectional bond violations. Finally, findings highlighted that the majority of participants were not only resilient in the wake of their partner's suicide attempt but experienced suffering-induced transformation in personal strength, spirituality, outlook on life, and relating to others. Literature on posttraumatic growth theory will be examined in light of this. The following sections provide an overview of the impact on 'significant others' based on the study findings and offers an in-depth treatment of the concept of 'transformation'.

5.2 Impact on 'Significant Others'

It was estimated in Chapter 2 that up to 6 'significant others' (Beautrais 2004) could be impacted by a suicide, whereas in Ireland the estimate was less conservative at a minimum of 12 individuals (Tierney 2011). It was assumed that a similar number of significant others would be affected by a serious suicide attempt. This, however, did *not* seem to be borne out in my exploration with the five participants. 'Significant others' (parents, grown-up children, siblings, close friends) were informed on a need-to-know basis only and with some of the participants no one other than the attempter and their partner were ever aware that the attempt had occurred. Whilst a completed suicide would have signified an actual physical death and some degree of public mourning and ritual that could not be avoided, the uncompleted suicide of a partner turned out to be an incredibly lonely journey for participants with their grief very much hidden and disenfranchised. For the in-laws of participants who were informed of their partner's suicide attempt, it seemed that their priority was to figure out 'what to do with him/her'. In other words, they were motivated to ensure the immediate physical safety of their brother, sister, son or daughter, preferably back under the care of his/her partner. From the perspective of the partners who participated in this study, however, the *long*- rather than short-term impact was experienced by them.

5.3 Understanding 'Transformation' within the context of the study

The main thrust of the findings saw participants experiencing *profound* change in various domains. For some the profound change manifested in how they saw themselves, for others how they saw the world and people within it, and for others still how they saw their partner and their relationship. Most participants, however, experienced profound change in all domains. As the average length of time since the suicide attempt at interview was 10.5 years all participants viewed these changes as not only permanent but ongoing.

'Change', however, does not adequately capture the depth or breadth of how participants experienced their partner's suicide attempt. One participant talked about her 'world shifting on its axis', another talked about 're-birth' and 'metamorphosis'. I postulate, therefore, that participants have experienced 'transformations' of various kinds on foot of their partner's attempts. The literature within psychotherapy tends to conceptualize transformation with either positive *or* negative connotations. For example, Bray (2013) offers a perspective from transpersonal psychology, the interface between human beings and spirituality, which describes transformation as an expansion of one's worldview, consciousness, and psyche. On the other hand, Neimeyer (2000) suggests that in loss, one can never fully resolve one's loss but are actually permanently transformed by it. The following authors, however, provide conceptualizations that offer scope for viewing transformation from both positive and negative perspectives. Tedeschi and Calhoun (2004) offer a more neutral definition of transformation in the context of trauma, describing it as "a qualitative change in functioning" (p.4). Within social research, 'transformation' is portrayed as:

> …the process of moving from one state (of being) to another: this may apply *inter alia* to abilities, awareness, knowledge, consciousness, environment, social status, fortune or wellbeing. (Harvey 2013, sec. 1, para. 1)

Taylor (2012) offers a view of transformation within humanistic psychology positing that it can manifest not only over a period of time but can also entail "a very abrupt shift to a completely different state of being", with experiences being "sometimes so powerful that they lead to permanent change of being, and even a permanent state of enlightenment". (Taylor 2012, p.32)

Harvey (2013) further explicates the meaning of transformation for the individual and the far reaching implications it inevitably has for their world view and within the context of relating to self and other:

> Transformation is about a fundamental change of form (and often functioning). It is much more than adjustment or repositioning; and implies more than reform, reawakening or reconsideration. It is closer to revolution in meaning and requires a fundamental re-evaluation and reconstruction. (Harvey 2013)

Daszko and Sheinberg (2005) also offer a view of transformation through an occupational psychology lens that is akin to the Greek term 'metanoia' meaning 'beyond the mind'. This suggests that transformation considers affective, somatic, spiritual, as well as cognitive experience:

> It's an idea of stretching or pushing beyond the boundaries with which we normally think and feel. It means a profound change in mind, a radical revision, a transformation of our whole mental process, a paradigm shift. (Daszko and Sheinberg 2005, p.4)

They too see transformation as qualitatively profound, creating shifts at a fundamental level, is unchartered territory and ultimately develops into something new that never was before. Like Harvey (2013) they operationalise it as a fluid process encompassing a multitude of actions rather than an immediate or abrupt shift:

> Transformation occurs through...continual questioning, challenging, exploration, discovery, evaluation, testing...beginning with the realization or revelation that the [person]'s current thinking is incomplete, limiting, flawed, or even worse – destructive. In transformation, there is no known destination, and the journey has never been travelled before. It is uncertain and unpredictable. It embraces new learning and taking actions based on the new discoveries. (Daszko and Sheinberg 2005, p.4)

According to Ebert (2010) what sets 'transformation' apart from simple 'change' is that transformation is neither linear nor foreseeable. In summary then, what participants experienced in the wake of their partner's suicide attempt was: **a fundamental shift or re-evaluation of being and functioning in response to revelations that permeated multiple modalities**, or a 'transformation'. Transformation generally has connotations of encompassing a positive trajectory. However, participants had experiences that suggested transformation existing on a continuum between 'adverse transformation' and 'positive transformation'. In addition, for the majority of participants paradoxically both adverse *and* positive transformation occurred, that is, it was a case of *both/and* rather than *either/or*.

5.4 Transformation of the 'Assumptive World'

'Adverse transformation' occurred for participants as a result of the trauma of their partner's suicide attempt. Rather than experiencing acute stress that was transient in nature, participants' experience comprised multiple traumas manifesting from the trauma of (1) exposure to the attempt; (2) the suicide attempt triggering previous childhood trauma (for some participants); (3) ambiguous loss within the partnership (section 5.5), and (4) attachment injury (section 5.6), all of which had far-reaching consequences.

Participants initial engagement with the suicide attempt, subsequent exposure to events in the hospital setting, their desperate search for answers, the shock that visited them in waves, and their overall sense of struggling to survive it, all contributed to participants' experience of it as *extra*-ordinary, far beyond the normal range of experience. Fosha's (2006) definition of the transformative potential of trauma captures perfectly, the impact of the event for participants:

> Trauma is the *definitum* of quantum transformation: in one fell swoop, everything changes. Nothing is ever the same again. (p.569)

The personal impact of participants in the present study was found to be very similar to the impact described by individuals in Sands and Tennant's (2010) study who were actually bereaved by suicide. As in the present study themes connected with 'staying alive'; 'culpability and motive'; "why" issues connected with responsibility, blame, guilt, confusion, and failure; and 'reorienting in a shattered world' manifested for those who were survivors of a relative's completed suicide. This has potentially significant implications in terms of assessment and psychotherapeutic intervention for the partners of uncompleted suicide which will be discussed in chapter six.

The trauma of a partner's suicide attempted is transformational in that it tears apart the individual's long held assumptions and core beliefs about how the world is *supposed* to work. Janoff-Bulman (1992) posits that people essentially maintain psychological and emotional balance by believing in certain illusions such as the world is a good and meaningful place. When they experience a trauma a dissonance is created between their 'assumptive world' and their reality:

> Life as it was and even as it has become is difficult to maintain on a day -to-day basis, and individuals are forced to reconcile themselves to the realities of shattered assumptive worlds. (Bray 2013, p.899)

An intricate part of this frightening experience for individuals is the subsequent challenge to 'transform' their now obsolete template of the world into a new template that takes account of "non-ordinary knowledge and experiences" (Bray 2013, p.899).

Fosha's (2006) understanding of trauma as transformation is further explicated by the APA's operationalization of trauma as *exposure* [direct or indirect] *to actual or threatened death...to a close family member or close friend...or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event* (APA 2013, para. 2).

This study is the first ever to recognise the impact of an uncompleted suicide as traumatic for partners. Until now, this very vulnerable group have been prioritised as caregivers with little or no priority given to their psychological or emotional welfare. It was deemed important, therefore, to highlight their lived experience within the conceptualisation of trauma as presented in the extant literature. Participants in this study were adversely transformed in being and functioning as a result of both witnessing their partner's suicide attempt in progress and later witnessing the at times, aggressive attempts to save their life. The genesis of transformation for participants occurred across four domains in which the trauma manifested: re-experiencing; avoidance; negative cognitions and mood; and arousal.

Re-experiencing for participants was described variously as the attempt 'pinging' spontaneously in their head on a frequent basis, and experiencing the distress from it 'never going away'. Some participants avoided talking with their partner or others about the experience but they were unable to avoid their partners who were constant reminders of the suicide attempt or places associated with the attempt for that matter as most took place within their own home. Some participants refused to have their partner return to the family home when they were discharged from hospital but eventually they returned. With regard to negative cognitions and mood participants talked about feeling helpless and a sense of hopelessness. They were acutely aware of feeling to blame or of blaming others and experienced a desire to withdraw from others. For some participants the experience was so traumatic that they cannot recall parts of it to this day. Arousal for participants manifested in anger toward their partner, and in sleeplessness and hyper-vigilance for fear of another

suicide attempt occurring 'on their watch'. This further added to the complexity of participant's unique trauma as there was an element of exposure to 'compassion fatigue' in the midst of living through the event, which is a form of stress as a result of being exposed to the emotional suffering of others (Figley 1995). Both 'fight' and 'flight' was a feature of participant's trauma. 'Flight' constituted avoidance behaviours and 'fight' constituted behaviours such as arguing with hospital staff; refusal to leave the counselling service until their partner was seen; challenging partners to take their own lives in moments of exasperation; and physically removing a partner from a psychiatric hospital when they perceived the care to be inadequate.

The domains described above converge very much with those articulated in the diagnostic literature for posttraumatic stress (WHO 1992; APA 2013). A significant divergence, however, is that for participants in this study, they experienced an extraordinary phenomenon in which both primary traumatic stress and compassion fatigue featured for them. Participants were not only traumatized by their partner's suicide attempt but continued to be exposed to their partner, the source of their trauma, when s/he returned home. Participants felt the strain of compassion and pity toward their partner but at the same time were motivated to be hyper-vigilant around them in order to minimize the likelihood of being exposed to further trauma should their partner attempt suicide for a second time. For some participants, therefore, disengaging from their partner (either fully or partially) may have constituted an avoidant defence mechanism so as to ensure their own psychological and emotional 'survival'. The phenomenon of concomitant primary trauma and compassion fatigue represents an original contribution to trauma theory insofar as a traumatized individual has a complex relationship to the source of their trauma, their partner in this case, in which they are at once compelled to ensure their welfare and repelled by them in order to minimise further trauma. In other circumstances where trauma features, avoidance

behaviours are an adaptive response to ensure survival. In this context, this intuitive response is neither personally nor socially sanctioned.

5.4.1. Transformative Activation of Memory and Physiology

In addition to participant's experience of their partner's suicide attempt as traumatic, a number of them felt that it triggered unresolved trauma from childhood which exacerbated their circumstances. Three of the five participants shared experiences of intrusive distressing memories regarding childhood physical, sexual, and emotional abuse; a parent's tragic and sudden death as a result of a road traffic accident; a father's alcoholism; and early traumatic loss as a result of giving a first-born child up for adoption. These memories inevitably negatively impacted participant's emotional and psychological equilibrium which in turn reduced their ability to withstand the trauma of their partner's uncompleted suicide. Cumulatively, trauma experienced as a result of the suicide attempt, compassion fatigue, and reactivation of childhood trauma, made participants particularly vulnerable to developing mental health difficulties. These all had a transformative effect on participants, permanently re-evaluating assumptions they had developed about self, other, and the world.

A number of meta-analytic studies reinforce this point of just how significant our early exposure to adversity is for coping with adversity in *later* years. Brewin, Andrews, and Valentine (2000) looked at risk factors for posttraumatic stress disorder in trauma-exposed adults and found that previous exposure to trauma; degree of childhood adversity; reported childhood abuse; and family psychiatric history were among the strongest predictors. Furthermore, greater severity of trauma, less access to social supports, and concurrent stressors increased the likelihood of developing PTSD. Likewise Ozer et al.'s (2008) meta-analysis of predictors of post traumatic stress disorder or of its symptoms in adults found that among the predictors established were prior trauma; prior psychological adjustment;

family history of mental health difficulties; social support post-trauma; and peri-trauma emotional responses.

Both of the aforementioned meta-analyses found that prior trauma, poor social supports, and adverse family history all contributed to poor coping with adversity in later life. All of these predictors were found to feature in the lived experience of some of the participants in the current study (i.e. childhood sexual abuse, living with the knowledge of the suicide attempt in isolation, and a family history of adversity such as parental separation and alcoholism). Another aspect of a participant's reactivation of childhood trauma is Freud's psychoanalytical construct of *Nachträglichkeit* otherwise known as deferred action, retroaction, or afterwardness. *Nachträglichkeit* is defined by Freud as "a memory which is repressed which has only become a trauma *after the event*" (cited in Laplanche 1976, p.41). A prime example in the context of the current study occurred for a participant when on thinking about the potential traumatic impact on her young daughter had her partner actually killed himself, she recalled her own experience at eight years of age of police coming to their home to inform the family that her father had been killed in a road traffic accident. This had the effect of transforming an otherwise relatively somber memory into a traumatic one. Thus, aspects of the present experience for some participants had the effect of assessing aspects of previous experience as traumatic, *after* the fact.

Adverse physiological transformation was another significant aspect for some of the participants in this study who noted general deterioration in their own physical health, feeling like the experience 'put ten years on their life' and that their partner's suicide attempt marked the beginning of their own downward journey physically as well as emotionally. A large scale meta-analysis of over 300 empirical studies (a total of 18,941 participants) conducted by Segerstrom and Miller (2004) highlights the possible somatic impact from psychological stress that was also noted in the current study. Their analysis looked at a

relationship between psychological stress and human immune functioning. The analysis found that chronic stressors (e.g. care-giving for spouse with dementia, becoming physically disabled) produced negative effects in nearly all aspects of the immune system. These effects were equal across all age groups and sex. In addition, physical vulnerability as a function of age or disease also raised the likelihood of immune change during stressful times. In other words, the older the individual and the less healthy s/he is the less able s/he is to physically withstand stress.

In the context of the present study, one middle-aged participant's physical deterioration is noteworthy in particular due to its close proximity to her partner's suicide attempt and medical opinion that its genesis was stress related and specific to the suicide attempt. What began as relatively low grade back pain prior to the attempt quickly developed into fibromyalgia, a chronic incurable syndrome that affects mostly women and manifests as burning pain in or around joints. It is viewed as idiopathic (without clear cause) but some studies purport that symptoms are caused by the body reacting to intense psychological stress (Irish Health 2014).

5.4.2. Summary

All participants in this study experienced their partner's uncompleted suicide as traumatic. In addition, a significant proportion of participants were confronted with reactivation of childhood trauma that they believe was triggered by their partner's suicide attempt. These experiences had the effect of transforming them in 'being' because at once nothing was ever the same again and their traumatic exposure became a lens through which they were experiencing the world. Transformation for participants also manifested in confronting this hitherto unresolved childhood trauma and working through it in various ways in an attempt to integrate it in some way. Some participants were more successful at this than others.

Some evidence was also gleaned from the current study that the significant psychological stress caused by the suicide attempt precipitated the adverse transformation of the body manifesting in chronic illness for a number of participants.

5.5 Transformation through Ambiguous Loss

Chapter 2 explored the application of ambiguous loss theory to the context of partners in the aftermath of an uncompleted suicide. Boss (2010) conceptualizes ambiguous loss as the most complicated type of loss because it is traumatic in nature; its cause is external and so out of the sufferer's control; and because there is no closure, which is generally the ultimate goal of grief therapy. In essence, there is *no* resolution of grief (Boss 1999). Participants in this study experienced ambiguous loss that was adversely transformative for them as the experience of their partner's uncompleted suicide profoundly impacted their view of their family unit and roles within it, their partner, their relationship, and their view of themselves within that relationship. Participant's perception of the suicide attempt as a 'show stopper' and 'monumental' reflects how influential the experience was for them and the degree to which it transformed their everyday lives. Participants were 'transformed' in *being* as a result of their ambiguous loss and *functioning* as a result of having to re-evaluate the 'psychological family' (see section 5.5.1 Boundary Ambiguity below).

There are two types of ambiguous loss outlined in this theory. The first type is *physical absence with psychological presence*, that is, a 'significant other' is missing physically but efforts are made to keep them present psychologically and *physical presence with psychological absence* applies in situations in which the loved one is present physically but missing psychologically in various ways. Either way, the trauma of ambiguous loss is felt:

> …when there is a sudden change from the ordinary dependable way things are in everyday life to the extraordinary and bizarre distortions that occur when a known person is profoundly altered. (Feilgeson 1993, p. 332).

Boss (2007) actively encourages the continued application of ambiguous loss theory to heretofore unstudied populations and/or situations. Her research to date has highlighted the prevalence of ambiguous loss both in common situations (e.g. adoption; divorce; children leaving home; obsession with work, internet, computer games) and catastrophic or unexpected situations such as missing persons, incarceration, dementias, addictions, chronic mental illness, depression, traumatic brain injury, coma (Boss 2002). At a conference on 'supporting individuals and families in transition' in 2011 Pauline Boss communicated that she could see great value in pursuing research into the relationship between the experience of uncompleted suicide for partners and ambiguous loss (Personal Communication, October 2011, Geneva).

Participants in the current study experienced loss that was devastating to them in the wake of their partner's suicide attempt. For some the loss came with a realisation that their partner had made preparations to die some time before the suicide attempt and all the while living a seemingly 'normal' life with them and their children. Participants now knew that their partners had turned *away* from them rather than toward them in their darkest hour. This challenged their assumptions about the quality of their relationship and about the identity of the person they fell in love with. This is reminiscent of Sands and Tennant's research (2010) on transformative learning in the context of suicide bereavement highlighted in chapter two, where relatives had to confront the fact that the deceased died by their own volition, thereby complicating the grieving process. For participants in the present study, it also caused them to experience the loss as 'uncanny': participants felt that since their partner originally *desired* to die, half of him/her was now dead and half of him/her alive. This is reminiscent of

Feilgeson's question *"How is it possible to lose half a person?"* (1993, p.335), and it was traumatic in that it caused participants to lose faith in their ability to predict reality (a shattering of their assumptive world).

The exposure to a loved one's uncompleted suicide left participants in the current study experiencing ambiguous loss of the kind that had the continued physical presence of their partner but his/her *psychological absence*. Participants described their partner as having emotionally and cognitively 'checked out' following their suicide attempt. Some described their partner as becoming a 'zombie' which was related to their sense of shame, their avoidance of providing an explanation for their suicide attempt, their consumption of heavy psychotropic medication or a combination of these. Some participants found that their partner was reluctant to engage with them after the attempt and there was a reluctance to answer questions about the 'whys?' of their suicide attempt with responses becoming more and more measured over time. Participants experienced a 'psychological' distancing instigated by their partners which resulted in a bizarre situation of recognising their partner physically but experiencing them as someone they knew less and less. This is reminiscent of the type of ambiguous loss experienced for individuals whose partners are physically present but become less recognisable to them as a result of dementia, addiction, depression, and chronic mental illness.

5.5.1. Boundary Ambiguity

When Pauline Boss (1999) first identified the phenomenon of ambiguous loss in 1974/1975 through research with the families of pilots missing in action (i.e. physical absence with psychological presence) she also identified that "neither physical presence nor physical absence tells the whole story of who is in and who is out of people's lives, because there is also a psychological family" (Boss 1999, p.13-14). The 'psychological family' refers to the

absence or presence of family members being a *psychological* as well as a physical concept. Boss (2006) highlights the significance of *perception* here in that how family members perceive ambiguous loss is connected to their perception of the degree of 'boundary ambiguity' within it.

With its origins in family stress theory, the concept of boundary ambiguity was first conceptualised in the 1970s and refers to "a state when family members are uncertain in their *perception* of who is in or out of the family or who is performing what *roles* and *tasks* within the family system" (Boss 1987, p. 709). From a family systems point of view then, a lack of certainty about the physical and psychological presence or absence of a family member can become a significant stressor. This stressor can have a considerable impact with higher levels of ambiguity creating greater levels of helplessness and dysfunction, in particular conflict and depression. Some normal life-span family boundary changes can occur such as the addition of a child or employment-related absences. Rapoport in her research on normative family stress and boundaries described these critical transition points as 'points-of-no-return' (1963). Carroll, Olson, and Buckmiller (2007) in their 30-year review of theory, research, and measurement of boundary ambiguity (BA) found that it has been comprehensively researched across 11 domains including: divorce; missing-in-action; stepfamilies; clergy families; illness and care-giving; and death. However, no prior research appears to have considered the boundary ambiguity for partners attached to the 'half-death' that occurs after an uncompleted suicide. The findings of the current study would suggest that the experience of their partner's attempt was transformational for participants in that it signposted a 'point-of-no-return' in how they perceived the organization of the family system.

According to Boss, Greenberg, and Pearce-McCall (1990) ordinarily there is either an overt or covert perception among family members of who is in or out of the family. Participants in the current study experienced a high degree of boundary ambiguity following their partner's suicide attempt due to their perception of their partner being no longer emotionally available to the system. Participants struggled with interpreting their new reality of the family and so this became a source of ambiguity. Some participants became ambiguous about where they located *themselves* within the context of the family system, experiencing a desire to withdraw or opt out of the system, which compounded an already complex situation. Ironically, for some participants this resulted in psychologically excluding the suicide attempter despite his/her physical presence. They described their 'reflex to share' with their partner having all but disappeared. Others talked about no longer consulting their partner or asking advice about important life matters that they would almost certainly have approached them about heretofore. This phenomenon has also been reported in families with a terminally ill or an alcoholic family member (Boss et al. 1990).

There are a number of theoretical propositions from the boundary ambiguity and theory development project developed by Boss in the period 1975-1988 (Boss et al. 1990) that may serve to shed more light on the possible implications of boundary ambiguity for participants in this study such as the greater the boundary ambiguity, the greater the stress with individual and family dysfunction; if a high level of boundary ambiguity remains for an extended period, the system can become stressed and ultimately dysfunctional; and the culture within which the family exists will influence the family's perception of an event. Individual differences occurred for participants in this study regarding the degree to which each was able to tolerate and assimilate information about the loss so as to begin a process of structural reorganisation (Boss 1980; Boss et al. 1990). For some participants whilst the journey was at times harrowing they managed to cognitively and interpersonally restructure

the "meaning of the event of the loss" (Boss et al. 1990, p.5) in order to regain clarity around the boundaries of the family system and return to a state of homeostasis:

> Stress continues in any family until membership can be clarified and the system reorganized regarding (a) who performs what roles and tasks, and (b) how family members perceive the absent member. (Boss 1980, p.21)

For some participants 'countering the torment' associated with boundary ambiguity involved keeping the lines of communication open with their spouse, identifying a cause for the attempt that they could live with, and attempting to extrapolate some meaning from the event. Another strategy was to ensure their spouse took a more active role within the family system for example, encouraging active participation with the children, carrying out apparently menial tasks like emptying the dishwasher or putting washing out, and ensuring s/he maintained personal responsibility for their own basic needs (food, personal hygiene) and for seeking out professional support in the community. None of these were achieved soon after the suicide attempt but over time as participants learned to adjust to the ambiguity associated with the loss and the boundaries within the system.

For other participants their ability to find a meaning for the psychological absence of their partner that they could live with was not as achievable. Some participants described the dynamic changing from living together to living side by side, or having lost respect for their partner and their ability to trust which they felt was fundamental to a functional relationship. Recall the participant who knew almost instantaneously following her husband's attempt that she could not resolve this in order to sustain the relationship, and another participant who repeated the mantra to himself 'get her better and then you can leave':

> Non-resolution of boundary ambiguity holds the family at a higher stress level by blocking the regenerative power to reorganize and develop new levels of organization. Boundaries of the system cannot be maintained, so the viability of the system is blurred. (Boss 1980, p.19)

These participants deeply questioned the viability of being able to maintain the system into the future. Of note here is that this seemed to occur where the suicide attempters displayed a very high degree of psychological absence. They were either unable or unmotivated to recognise and acknowledge the participant's experience which appeared to adversely influence participant's ability to resolve the boundary ambiguity. At the time of interview, some participants found it challenging to see their marriage intact into the future. From their point of view the attachment in the relationship had been irrevocably damaged.

The findings of the current study make a valuable contribution to a previously unstudied unique population within the context of ambiguous loss. This is the first known study of its kind to propose a link between ambiguous loss and the experience of individuals following a partner's suicide attempt.

5.6 Transformation through Attachment Injury

Attachment theory has become one of the most well known and influential theories spanning early childhood development to adult relationships. Bowlby (1988) highlighted our capacity to form powerful affectional bonds with significant people in our lives and the positive influences these bonds have on how we experience the world. A 'secure' attachment bond within a couple relationship emphasizes reciprocity in which both partners experience comfort, closeness, and security. It stands to reason, therefore, that a violation of this affectional bond can have far-reaching consequences for both the injured party and by extension the relationship itself. Johnson, Makinen, and Millikin (2001) first articulated

these "negative attachment-related events" (p.145) as 'attachment injuries' which are injuries that usually manifest in the form of betrayals and abandonment. An attachment injury, therefore, is perpetrated:

> …when one partner violates the expectation that the other will offer comfort and caring in times of danger or distress. This incident becomes a clinically recurring theme and creates an impasse that blocks relationship repair. (Johnson et al. 2001, p.145)

The construct of attachment injury first came to light during emotionally focused couples therapy (EFT). Therapists witnessed couples maintaining distress despite successfully negotiating an impasse in the relationship (Johnson 1996). This appeared to be connected with couples getting stuck in a 'blame/defend' cycle as a result of an unresolved specific incident in which one partner experienced betrayal by the other.

Feeney (2005) in her studies of hurt feelings in couple relationships explored the role of attachment and perception of personal injury. 'Personal injury' was defined as "damage to the victim's view of self as worthy of love and/or to core beliefs about the availability and trustworthiness of others" (p.256). This research postulated that 'hurt' is an emotional response to 'relationship transgressions' that induce a sense of personal injury and a low relational evaluation. Leary (2001) concurs with placing perception of relationship devaluation as a central feature of hurtful events and describes it as the perception that the 'offender' views the relationship as less significant or close than the other partner would prefer. Vangelisti (2001) has also highlighted the importance of a partner's *appraisal* of the event as intentionally hurtful or not. Various types of hurtful events have been suggested specifically in the context of romantic relationships (Feeney 2004): (1) active disassociation (rejection, abandonment, withdrawing feelings of love), (2) passive disassociation

(eliminating partner from activities or ignoring partner), (3) criticism (subtle or overt belittling), (4) sexual infidelity, and (5) deception (lying to, misleading, betraying confidence).

The suicide attempt of a spouse was appraised by participants variously as a form of disassociation (both active and passive) and as a form of deception. A number of participants in the current study articulated their perception of having been betrayed by their partner as a result of his/her suicide attempt. They described a total violation in trust and a sense of abandonment for both themselves and their children which for them exacerbated the injury. The experience was transformational for participants in that it profoundly altered how they saw their world, themselves, and their relationship. Participants were forced to confront the illusion of knowing their partners *inside out* and that they would consistently create a 'safe haven' for comfort and protection (Bowlby 1969).

Two factors seemed to mediate the extent of the injury for participants. First was the participant's perception of the degree to which their partner (the suicide attempter) acknowledged their hurt and made concerted efforts to reassure and repair the relationship. Second was the participant's willingness or ability to accept this reassurance from their partner:

> Much depends on how the injured partner interprets the event in question and how the other spouse responds to expressions of hurt by the injured party. When this spouse discounts, denies, or dismisses the injury, this prevents the processing of the event in the relationship and compounds the injury. (Johnson et al. 2001, p.149)

This is particularly relevant in the context of the current study where, in the eyes of some participants, the suicide attempter was very much absorbed in their own experience to the

extent that they did not recognise nor adequately respond to their partner's hurt. For some participants their attachment injury came to the fore very shortly after becoming cognisant of their partner's attempt - some of the suicide attempters asked after their mothers and other family-of-origin members immediately on regaining consciousness rather than desiring to see their own spouse. This left participants dazed, hurt, and confused about the 'security' of their bond with their partner and questioning the profound interdependence that is supposedly part and parcel of a healthy, loving relationship.

A transformational aspect of this experience may have occurred in the context of participants 'internal working models' of self (loveable vs. unlovable) and others (responsive/accessible vs. unresponsive/inaccessible) that significantly influence how they relate to other adults (Bowlby 1979). Their partner's suicide attempt may have challenged their internal working model of self as 'loveable'. The same might apply to their internal working model of 'other'. Some of the participants in the current study emphasized their perception of the suicide attempt as a betrayal and that their partner was abandoning both them and their children. Similar feelings have been found to surface as defining moments during times such as physical threat or uncertainty (e.g. illness), loss (e.g. miscarriage), or transitions (e.g. retirement). However, what seems to be paramount across all of these injuries is the impact it has on the attachment as evaluated by the 'injured' partner, rather than on specific content of each event. Some experienced the betrayal as a trauma. In fact Atkinson (1997) considers attachment theory itself as a 'theory of trauma' due to its potentially injurious impact on people given the right circumstances. 'Trauma' comes from the Latin word 'to wound' which resonates with the shattering of one's assumptive world outlined earlier and the theme of the 'shadow side' outlined in chapter four. Johnson et al. (2001) describe the onset of 'existential vulnerability' with the potential for symptoms reminiscent of PTSD:

> Memories and emotions connected to the event linger and manifest themselves in the form of dreams, flashbacks, and intrusive memories. Much energy may be spent in ruminating about every minute detail of the event and the reasons why it occurred. Offending partners may apologize for their transgressions, but injured partners cannot let the matter go. These events are pivotal moments in the ongoing definition of the relationship that constantly come up and color present realities. (p.150)

For some other participants in the current study, however, part of their trauma was related to their perception that *they* had inflicted an attachment injury on their *partner*. Participants in this light saw themselves as having perpetrated the 'crime' of 'not seeing it coming' and not being adequately attentive to their spouse who they knew at some level was stressed or busy or distracted in some way. The bottom line for these participants was that they felt they had not responded adequately to their partner's needs and consequently violated the sanctity of the secure emotional bond by failing to encourage 'proximity seeking' behaviour, failing to create a 'secure base', failing to create a 'safe haven', and failing to resist separation (Bowlby 1969). This manifested for these participants as self blame and ultimately had the effect of increasing their tendency to offer reassurance to both partners and significant others in their life. Some participants communicated a complex experience of attachment injury on both parties. Participants felt that their spouses had inflicted a deep wound on them but also felt that they were responsible for not responding to the needs of their spouse pre- and post suicide attempt.

Whilst some participants have continued to live with the deleterious effects of their partner's suicide attempt both for themselves and for their romantic relationship, others significantly have been able to experience what can only be described as 'positive transformation' across many domains of their life *in spite of* their traumatic stress.

5.7 Positive Transformation: Posttraumatic Growth

A number of authors have championed the notion of positive psychological transformation as a result of experiencing a very stressful or traumatic event. Tedeschi, Calhoun Morrell, and Johnson first introduced the term, 'transformation of trauma' in a paper presented in 1984 on grief and psychological development (Tedeschi and Calhoun 2004). Aldwin (1994) introduced the concept of 'transformational coping' in the context of development through stress. Grof (2000) noted that 'spiritual emergencies' usually as a result of traumatic experiences had the capacity to bring about 'spiritual emergence' that encompassed permanent positive changes for the individual. Joseph and Linley (2005) have developed 'organismic valuing theory' suggesting the individual has an innate drive to always move towards growth. Taylor (2012) has described 'suffering-induced transformational experiences' or SITEs in his research on positive psychological transformation after episodes of intense turmoil. Bray (2013) discusses the potential for transformation in the aftermath of bereavement. The research conducted by Calhoun and Tedeschi is the most comprehensive of its kind and will, therefore, be the focus for this section on positive transformation.

Whilst they would submit that the idea of positive change emanating from suffering has an ancient history, Calhoun and Tedeschi have arguably been the most influential in developing this construct empirically particularly from the 1990s when they first coined the term *posttraumatic growth* (1996):

> Posttraumatic growth describes the experience of individuals whose development, at least in some areas, has surpassed what was present before the struggle with crises occurred. The individual has not only survived, but has experienced changes that are viewed as important, and that go beyond what was the previous status quo. Posttraumatic growth is not simply a return to baseline-it is an experience of improvement that for some persons is deeply profound. (Tedeschi and Calhoun 2004, p.4)

Chapter two described the concept of resilience whereby individuals with particular personality traits or coping mechanisms have greater potential to sustain themselves through a life crisis and recover to pretrauma baseline levels of functioning (Zautra et al. 2010). Tedeschi and Calhoun (2004), however, stress that posttraumatic growth is much more than just resilience or similar concepts such as hardiness or optimism, creating a change in people that "goes beyond an ability to resist and not be damaged by highly stressful circumstances; it involves a movement beyond pretrauma levels of adaptation. Posttraumatic growth, then, has the quality of transformation..." (p.4). They make an important observation in that growth does not occur as a *direct* result of a trauma itself but instead is positively correlated with the extent to which a person is able to make sense of their new reality. There are a large number of life crises that have prompted posttraumatic growth for people including bereavement, arthritis, HIV infection, cancer, heart attack, coping with ill children, house fires, sexual assault, combat, refugees, and being taken hostage (Tedeschi and Calhoun 2004). The trauma of a partner's suicide attempt can now be added to this catalogue of events as for most of the participants in the current study their traumatic journey also entailed growth in fundamental ways. Tedeschi and Calhoun (2004) have developed five domains from their research in which people tend to experience growth following a trauma:

(1) Relating to Others (more meaningful and compassionate relationships);
(2) New Possibilities (grasping opportunities, different roles, new relationships);
(3) Personal Strength (feeling psychologically and emotionally stronger);
(4) Spiritual Change (greater spiritual connection; developing, renewed or increasing faith);
(5) Appreciation of Life (increased gratitude and enjoyment of simple aspects of life).

Participants in this study provided powerful descriptions of how they had experienced positive transformation and growth as a result of struggling through their partner's attempt. They described 'feeling blessed' and that they 'wouldn't change it [what happened to them] for the world'. Some also experienced a change in priorities for example investing more in

their relationship through more regular communication and nights away. Some described the aftermath of their partner's suicide attempt as a time for finding their own voice, for developing more freedom, autonomy, and independence. Others described becoming a better listener and more empathic, becoming a better person, feeling a greater bond with their partner, and not fearing death the way they had prior to their trauma. All of these elements were completely unanticipated by the participants in the time just following their partner's attempt and only came to the fore during their working through the 'loss' associated with the attempt and attempting to make sense of it in a way they could live with. Tedeschi and Calhoun (2004) note that individuals do not purposely set out to create positive transformation in any particular way but that it is experienced in the midst of them attempting to "adapt to highly negative sets of circumstances that can engender high levels of psychological distress" (p.2).

Participants in the current study reported greater ease in perceiving the feelings of others, they were more grateful for the simplest of things in life reporting that 'you'd think you have nothing but yet you've everything'. Participants described a greater sense of groundedness, being less hurried in their thoughts and actions. The current study captured the transformative experience of individuals whose partner's attempted suicide and, therefore, makes a valuable addition to the cohort who have reported positive transformation in the wake of trauma.

Calhoun and Tedeschi (1998) have likened the process of growth experienced by individuals following a trauma to the experience of an earthquake and its aftermath. They describe the trauma as a psychologically 'seismic' experience that shatters or demolishes previously held schemas about how the world is supposed to operate. Our 'assumptive world' (Janoff-

Bulman 1992) mentioned earlier, becomes either severely compromised or completely obliterated:

> The "seismic" set of circumstances severely challenges, contradicts, or may even nullify the way the individual understands why things happen, in terms of proximate causes and reasons, in terms of more abstract notions involving the general purpose and meaning of the person's existence. Such threats to the assumptive world are accompanied by significant levels of psychological distress. (Tedeschi and Calhoun 2004, p.4)

This metaphor resonates very much with the theme of 'the world shifting on its axis' in the current study in which participants had to find ways of adjusting to or 'countering the torment' that they were exposed to following the attempt. Countering the devastation caused by the 'seismic' event comes in the form of cognitively processing or *deliberate ruminating* over the event so as the individual can begin the process of 'rebuilding' in a way that will potentially protect the individual from similar shocks in the future. This was borne out by some participants in the current study who suggested that they felt better equipped to cope on their own into the future in the event of their partner dying either through suicide or of natural causes:

> Cognitive rebuilding that takes into account the changed reality of one's life after the trauma produces schemas that incorporate the trauma and possible events in the future, and that are more resistant to being shattered. These results are experienced as growth. (Tedeschi and Calhoun 2004, p.5)

Cognitive processing of the event is usually automatic in the early aftermath which entails negative intrusive thoughts and images. For growth to occur there needs to be a strong affective component to this cognitive reprocessing particularly if it involves the transformation of 'higher order' or fundamental goals, philosophies, or beliefs systems. The individual subsequently disengages from goals/schemas that have become redundant, over likely an extended period of time, thereby presenting opportunities for healthier more

deliberate rumination about the meaning and significance for individuals and their everyday lives. This fits with the experience of the participants in the current study who endured a 'desperate search for answers' particularly in the early stages. Their distress stayed with them for many months after the event which according to the posttraumatic growth model, needed to happen in conjunction with cognitive rebuilding so as to maximise the potential for a transformational growth experience to occur. In essence, what didn't kill them did, indeed, make them stronger but only with certain variables in play including cognitive and affective processing.

Tedeschi and Calhoun have highlighted the potential benefit in sharing the experience with others particularly with those who have been through something similar, in order to create new narratives. Some participants in this study did accept the support and alternative perspectives of close friends and seemed to reap rewards from this. Others, however, sought out support from no one else but reported substantial growth nonetheless. This adds an interesting contradiction to Tedeschi and Calhoun's model suggesting that individuals can indeed achieve transformational growth without processing the event socially. For one participant, however, she did not report growth to a transformational extent despite processing the experience socially. Both she and her medical team believe that her trauma had the effect of triggering a serious physical condition that was permanent. Thus, following the model it may be the case that if this participant did not experience *any* reduction in distress in the months following the trauma due to ill-health, she was less likely to experience transformational growth in the long-term.

For those who experienced growth there was a paradoxical component to it insofar as there was some degree of gain in their lives out of their traumatic loss. Posttraumatic growth is postulated to have some relationship to increased wisdom for individuals as they generate new narratives for life. Whilst it did not *nullify* the distress of the trauma for participants in

the current study, those that did experience posttraumatic growth reported an enhanced outlook on life and enhanced relationships but not necessarily with their partners.

5.8 Summary

All five participants in this study reported profound change in response to their partner's suicide attempt. The impact of the experience was that for most, it fundamentally changed or 'transformed' them for better and for worse. Transformation occurred in 'being' for better (e.g. more positive outlook on life; greater personal strength) and for worse (e.g. feeling less worthy, less loveable). Transformation occurred in functioning for better (e.g. taking on new roles) and for worse (e.g. decline in physical health). For some transformation happened quite abruptly, for others it was a process over time.

All participants described the experience in various ways as traumatic insofar as it instantaneously shifted their world on its axis, with nothing ever being the same again. They reported re-experiencing of the event, wanting to avoid their partner's presence, negative intrusive thoughts and images, negative mood, and hyper-vigilance.

Participants reported a type of 'uncanny' or ambiguous loss, in which their partner was half dead and half alive, and in this context physically present but psychologically absent. This compounded participant's trauma in that their 'assumptive world' continued to be shattered. Participants described boundary ambiguity in that they struggled to identify if their partner was in or out of the family. This was enormously stressful for participants and impacted their perception of who was performing what roles and tasks within the system.

For some participants their partner's suicide attempt was perceived as a personal injury that negatively reflected their attachment. They felt betrayed by their partner and that their trust

had been violated. Consequently this at times impacted participant's willingness to accept reassurance from their partner. The contrary was also experienced in that some participants also felt that they were guilty of perpetrating the attachment injury for not anticipating the attachment needs of their partner.

The majority of participants in this study also experienced positive transformation in the midst of the traumatic event. 'Suffering-induced transformational experiences' (SITEs) or posttraumatic growth permeated cognitive, behavioural, emotional, and spiritual domains. Spiritual transformation was explicitly reported by only a small number of participants but may have been implied by others in their transformation of relating to others; of new possibilities and roles; of increased psychological and emotional strength; and in their increased appreciation of and gratitude for life.

The present study is the first of its kind to capture the lived experience of individuals whose partners have attempted suicide and survived. It captured their experience not solely from the perspective of care-giver, giving participants a unique opportunity to describe the personal impact on them and their everyday lives. What permeated participant's experience across primary trauma, ambiguous loss, attachment injury, and posttraumatic growth were transformations both adverse and positive. Having a partner attempt suicide set in motion fundamental and profound change for all participants in varying ways and degrees. Some aspects of their transformation were relatively short-lived while others appeared to hold permanent status. The personal impact on participants was traumatic on multiple levels, including the trauma of ambiguous loss, and of attachment injury. The trauma also had the effect of sowing the seeds of positive growth. All of these elements in isolation or collectively demonstrate the experience as having elicited quantum transformation (Fosha 2006).

5.9 Reflexive Journal Entry

Making sense of the study findings in the context of the extant literature has been a truly interesting and satisfying experience. I was very aware of allowing myself be naturally steered by the findings toward the most appropriate extant literature rather than be dictated by the review conducted in chapter two. On discussion of findings with colleagues I was pointed toward literature within couples therapy. I was initially unsure whether this was appropriate as I felt I was moving away from the personal impact upon the partner. However, I quickly came to terms with the reality that the very nature of 'partner' is being one of a pair, a partnership, a couple, and so with participants expressing a sense of betrayal and a violation of trust as a 'person-in-context' that is within a relationship, this was a natural course to take.

Chapter 6: Implications of the Study

6.1 Introduction

This study has made an original contribution to the extant literature by highlighting the transformative personal impact on partners. Studies to date have viewed partners primarily as caregivers and/or informants, with a view to developing psychotherapy's understanding of risk assessment, prevention, and recovery for those at risk of suicide. This is the first study of its kind to take an in-depth idiographic approach to understanding the meaning of an uncompleted suicide from the perspective of a partner. "I'm not the same person I was" reflects the transformative personal impact of the experience for partners, their complex struggle with concomitant primary trauma and compassion fatigue, feeling like 'walking wounded', and desperately searching for answers. Adjusting to the trauma involved playing 'the blame game' and developing 'strategies for self preservation', transforming their perception of self, other, and the relationship. The experience left a legacy for partners that would "never ever go away", developing a 'routine of discomfort' as a response to adverse childhood memories, physical deterioration, and changing how partners related to the suicide attempter. However, the experience also left a legacy of increased personal strength, spirituality, improved relationships and outlook on life.

This chapter aims to draw attention to the lived experience of partners in the context of primary trauma and in so doing highlight recommendations for policy and procedure in supporting partners following an uncompleted suicide. Recommendations for psychotherapy practice and training will also be explored including the significance of therapeutic goals for treating ambiguous loss; the tripartite model of suicide grief as applied to uncompleted suicide; and betrayal as opportunity for transformation. The chapter will conclude with an evaluation of quality within the study, including limitations, theoretical transferability, and suggestions for further research in psychotherapy.

6.2 Reconfiguring 'Burden of Care' as Primary Trauma

The literature to date on the phenomenon of personal impact of uncompleted suicide on partners has approached it with the sole view of the partner in the role of 'caregiver' and has conceptualized their experience in the context of 'burden of care'. The lived experience of participants in the current study revealed that it went considerably beyond the impact of care-giving. Participants experienced something akin to compassion fatigue but the trauma of being exposed to 'the threatened death [at times violent] of a close family member' appears to have gone completely unnoticed by primary and secondary care services as documented in the available research literature, and by extension society as a whole. This is evidenced in the study of 'family care of Taiwanese patients who had attempted suicide' by Sun et al. (2008) which concluded that the priority of nursing staff was to educate family members on how to home care patients following their discharge from hospital as well as minimizing further attempts. Although they later recognize the experience as a "life crisis" (Sun et al. 2009, p.60) for family members, there is a presumption here that they are psychologically/emotionally prepared and/or motivated to care for their relative following the suicide attempt.

Participants were exposed to this event first hand consequently their traumatic stress was *primary* in nature, causing a *downward* trajectory for some in their psychological and emotional health. If health care professionals communicate with partners solely as 'caregivers' then partners may conclude that their trauma-related feelings are both inappropriate and unjustified.

6.3 Resilience in the midst of Ambiguous Loss and Boundary Ambiguity

It has been noted that an individual with a high degree of resiliency is more capable of navigating stress, and attaches less meaning to the trauma. Consequently s/he is less likely to

develop PTSD or PTG for that matter. Resilience, therefore, is an important construct in minimising the traumatic aftermath for individuals experiencing ambiguity associated with the uncompleted suicide of their partner.

Boss (2006; 2010) has proposed a number of guidelines for clinicians in supporting someone to develop their resiliency in the face of ambiguous loss. The findings of the current study highlighted the potential benefits of applying some of these guidelines in supporting individuals in the wake of their partner's uncompleted suicide. The findings of this study revealed that for some people gaining closure from their loss was almost impossible given that there was no clear ending. Adapting to this 'half-death' is not straightforward and so these guidelines should be viewed as non-linear and non-prescriptive. An extended treatment of resilience building with ambiguous loss is available in Appendix G. An overarching goal for the individual living with ambiguous loss is to find some kind of meaning in it. This can be explored in psychotherapy by naming the problem as ambiguous loss; encouraging dialectical or 'both/and' thinking; developing spirituality; forgiveness; practicing small good works; maintaining rituals and celebrations; creating positive attributions for the loss; and maintaining hope. Further interventions include 'tempering mastery' to address our innate need for certainty; 'normalising ambivalence'; and 'reconstructing identity'.

6.4 Tripartite Model of Suicide Grief as applied to Uncompleted Suicide

As highlighted in chapter five, the personal impact of participants in the present study was found to be very similar to the impact described by individuals in Sands and Tennant's (2010) study following their bereavement through suicide. Sands' (2009) 'tripartite' model of suicide grief that emerged from this study, or more likely an adapted version of it, therefore, may prove beneficial for psychotherapists and other professionals such as community mental health nurses in facilitating partners coming to terms with the uncompleted suicide. Like Boss (2006; 2010) has outlined in the treatment of ambiguous

loss, Sands (2009) has also highlighted the importance of the 'meaning making' journey that those bereaved by suicide take. The tripartite model is founded upon: 'intentionality' which encourages individuals to 'try on the shoes' of the deceased and make some kind of sense of the deceased's intention toward death; 'reconstruction' of the relationship which encourages 'walking in their shoes' with the aim of differentiating themselves from the *behaviour* associated with the attempted suicide (rather than from their partner as in the original model), and developing a new assumptive world; and 'repositioning' the relationship or 'taking off the shoes' denotes the re-engagement in relationship with the self, others but also an ongoing relationship with their partner (rather than with the deceased as in the original model). Sand's tripartite model may be a useful aid in individual psychotherapy for partners working through grief associated with an uncompleted suicide. However, it may also prove useful in a couple therapy context where the couple negotiate 'reconstruction' and 'repositioning' of the relationship. The following section offers a conceptualization of hurt and loss associated with uncompleted suicide as an opportunity to transform the relationship.

6.5 Attachment Injury as Opportunity for Transformation

The 'father of suicidology' Shneidman, contended that most suicidal acts are essentially dyadic events, i.e. there are ramifications not only for the suicide attempter but for the 'significant other' (Leenaars 2010). The finding in this study that participants perceived a sense of betrayal, abandonment, and violation of trust in response to their partner's uncompleted suicide pointed to the literature on attachment injury as a result of 'relationship transgressions'. This finding indicates that the potential consequences of a suicide attempt within the couple context are far-reaching and that interventions focusing on minimising risk regarding further suicide attempts and advising partners within the care-giving context tell only half the story. Participants believed that the suicide attempt reflected a low opinion of the relationship on the part of the suicide attempter, and consequently some either left the

relationship or thought about leaving. Warren et al. (2008) offer a three-stage psychotherapeutic model aimed at couples following an affair which may prove useful in exploring betrayal within the context of uncompleted suicide. The model is creative and metaphor-based, therefore chosen to potentially facilitate both parties visualising moving beyond the uncompleted suicide with the relationship intact. It is premised on a traditional Buddhist tale about how we can choose to manage a poisoned tree in one of three ways: cutting the tree down as it is viewed as both no longer useful or viable; building a wall around the tree in recognition of its history but simultaneously recognising it as a threat to ourselves and others; or taking a deeper perspective and seeing the potentially healing properties the poison has to offer when combined with other ingredients. It is suggested that infidelity can be reframed as an 'opportunity for transformation':

> Using a metaphor such as the poisoned tree can help couples distance themselves from the emotional chaos, even if only slightly, and find a new perspective as well as a path for potential healing. (Warren et al. 2008, p.351)

Stage one entitled 'do not cut down the tree', encourages a shifting of perspective for the betrayed partner from blame, a desire for retribution and/or separation, and any other behaviours that could be construed as reactivity. The couple instead is urged to slow the process down and view it as an opportunity for deeper insight and growth. The key question at this stage is "If the infidelity could speak, what would it say?" (p.353). Stage two, 'steps to protecting the tree from further harm', explores how each partner can protect the other partner and the relationship from encountering further harm. The couple is encouraged to construe the *poison* as problematic rather than the tree itself. The source of the poison, therefore, is explored such as unhealthy family of origin patterns of relating; a partner's view of self, other, and the world; and ways in which they cope with adversity. Considering the metaphor of the poisoned tree, these early patterns represent the soil in which the tree is

planted and so may require considerable attention in order to not only preserve the tree but enhance its wellbeing. Forgiveness (Dupree et al. 2007) is considered a significant aspect of this stage of the model where apologies from both parties can be forthcoming due to recognition of neglect of the relationship from both parties. The importance of the suicide attempter acknowledging the hurt of their partner and making concerted efforts to reassure and repair the relationship, as well as the participant's willingness to accept this reassurance was highlighted in chapter five. The function of forgiveness is ultimately to enhance healing within the relationship but it can also positively impact the well-being of the forgiver. The final stage, 'the tree that bears new fruit', highlights the implications of new personal insights and insights about one's partner for growth that transcends the poison of the infidelity. This entails taking risks through sharing of intense emotions and unmet needs in order to cultivate a 'relationship culture' that espouses shared values and goals for the future.

A key component of this three-stage model is the integration of a mindfulness philosophy throughout the process. Modelling non-judgemental awareness on the part of the therapist can facilitate the couple in moving beyond intense negative feelings and remaining open to the lived experience of their partner. Taking a mindfulness approach during the therapeutic process could potentially support the therapist/clinician in moving beyond issues of counter transference relating to family of origin or the therapist's own relationship history, as well as assumptions and prejudices about betrayal or attempted suicide.

6.6 Implications for Policy

The main findings of this study would suggest that current policy and procedure surrounding the management of care post suicide attempt need to take into account the welfare of the partner as well as that of the individual who has made the suicide attempt. Taking a Heideggerian perspective, an individual in an established meaningful relationship who

makes a suicide attempt is a 'person-in-context'. A significant part of their context is their partner who will likely be traumatised either on hearing about the attempt or as a result of being directly exposed to it. They may also initially experience ambiguous loss and attachment injury, thereby shattering their assumptive world and creating great uncertainty about their past, present, and future circumstances. Current policy, however, operates upon the assumption that partners are in an immediate position to undertake the substantial caregiver role that is required once a suicidal individual is discharged from medical or other in-patient care. It is recommended that policy and procedure take a systems approach to the management of suicide attempters in established relationships. Interventions such as psycho-education for partners aimed at normalising the personal impact for them, and a referral pathway for both individual and couples therapy, would increase the chances of recovery for both partner *and* the suicide attempter.

The National Institute for Health and Clinical Excellence (NICE 2012) in a systematic review of qualitative literature relating to carers experience of caring for people who self harm found that due to stigma associated with self harm relatives avoided seeking the support of others for fear of being negatively judged. Greater public awareness of the impact upon partners might encourage both primary and secondary care staff, and partners to engage social support in order to sustain them during this traumatic time. As per Tedeschi and Calhoun (2004), disclosure within a supportive group environment might also increase the possibility for posttraumatic growth.

In the UK, many NHS Trusts have a well established 'care programme approach' or CPA (Rethink Mental Illness 2014) designed specifically to co-ordinate secondary mental health services for individuals exhibiting mental health problems including suicide attempts. In Ireland, a National Clinical Programme for the assessment and management of patients presenting to emergency departments following self harm has yet to be implemented

nationally (MacHale 2013). Neither the CPA nor the National Clinical Programme acknowledge the psychological and emotional well-being for partners of attempters both in their own right and as a means of increasing the likelihood of recovery for suicide attempters. In fact the National Clinical Programme considers the carer or family member merely as a 'bridging strategy' to ensure the patient will attend his/her 'next care' appointment following discharge from hospital.

6.7 Implications for Primary Care and Psychotherapy Practice

Whilst the immediate welfare of the suicidal individual is and should be the priority of first responders such as doctors, nurses, and psychiatrists, the findings of this study indicate that it is paramount that the vulnerability of the partner be acknowledged by these professionals as well as those providing longer-term secondary care such as psychotherapists. They are likely to display very individual responses to the uncompleted suicide of their partner and, therefore, need to be met by staff with sensitivity and respect. The findings of this study provide the foundations for a model of psychotherapeutic intervention aimed at partners of individuals who have experienced uncompleted suicide. The model would serve as a means of highlighting the experience for partners as traumatic; normalise feelings associated with it including socially unsanctioned 'shadow side' feelings; recognise the phenomenon for partners as a loss that is ambiguous in nature; explore resilience building and finding meaning in the midst of ambiguous loss and boundary ambiguity; and aid partners in recognising betrayal as a potential opportunity for relationship transformation. In addition, whilst growth in the wake of trauma and loss are not inevitable, psychotherapists can support partners in 'normalising' the notion that growth can and does occur (Smith, Joseph, and Das Nair 2011).

A significant aspect of this model is psychoeducational in approach. Rather than immediately offering guidelines on providing care to the suicide attempter, partners first

need to be educated about the nature of trauma and the potential for a delayed reaction. Partners should be provided with an opportunity to express feelings such as shock, confusion, fear, guilt, and helplessness. Significantly, this study has found that partners should be invited to explore potential 'shadow side' feelings such as disappointment, anger, resentment, abandonment, betrayal, and violation of trust with a view to normalising them. In addition, psychotherapists can provide insight into the complex relationship between trauma and compassion fatigue that can likely manifest as part of partner's lived experience.

The partner's level of resilience that is, the degree to which they can sustain themselves through this life crisis and recover from it should also be assessed. It may prove disadvantageous to assume that a partner will be physically and psychologically capable of coping with the suicide attempter returning to the family home immediately following discharge from hospital. Discharging patients into the care of those who are neither capable nor motivated to offer care to their suicidal partner may actually exacerbate the situation for both parties concerned. Recall the recent finding that individuals are of greater risk of suicide after discharge from hospital particularly within the first month (Deisenhammer et al. 2007). It is paramount, therefore, that the partner's psychological and emotional wellbeing is given due consideration and that *both* partners receive ongoing aftercare following discharge. In the case where an individual receives in-patient care within a psychiatric facility, on-going assessment and intervention for both partners should be considered, to include individual and couple psychotherapeutic input.

A new variable known as 'event centrality' has been suggested as a significant predictor of both negative and positive trauma outcomes (Groleau et al. 2013). Event centrality can be described as "the extent an event has been incorporated into an individual's [sense of self and] identity" (Schuettler and Boals 2011, p.184). Consequently, if 'centrality' occurred to a high degree for participants following the uncompleted suicide of their partners then factors

such as coping (avoidant/problem-focused) and perspective-taking (negative/positive) may have influenced the direction the trauma took. Groleau et al. (2013) champion the view that psychotherapists should begin to pay attention to event centrality following a potentially traumatic experience.

6.8 Implications for Psychotherapy Training

Trainee psychotherapists need to be made aware about snap-shot assigning of the care-giver role to partners. Rather than being viewed in a one-dimensional way, partners need to be met by psychotherapists as multi-dimensional human beings whose assumptions about their world have just been shattered. Furthermore, by taking a systems approach and ensuring the welfare of partners, both partners are likely to fare better long-term. Psychotherapists need also to make themselves aware of trauma with a small 't' rather than overreliance on diagnostic criteria for PTSD or capital 'T'. Training on ambiguous loss and interventions for building resilience and finding meaning; attachment injury and injury as opportunity for transformation; and recognising and reinforcing signs of posttraumatic growth are all aspects of this phenomenon that could comprise continuous professional development for psychotherapists. In addition, emergency department personnel, particularly nurses, as well as mental health practitioners including psychologists, psychiatrists, and psychotherapists could benefit from reconfiguring the lived experience for partners as traumatic and offer triage and an appropriate referral pathway for *both* partners.

6.9 Assessing Quality within the Study

As outlined in chapter three, any qualitative research effort and particularly one employing IPA should aspire to maintain quality throughout from research question to dissemination of findings. A number of criteria as outlined by Smith (2011) associated with quality were met in this research effort including having a clearly defined focus throughout and a rich and

engaging analysis that attended to interpretation as well as convergence and divergence among cases. The strengths and weaknesses of the study are outlined below followed by a critical evaluation of IPA, and finally a formalized evaluation of its quality using Yardley's (2000) principles as recommended by Smith et al. (2009).

6.9.1 Strengths

One of the main strengths of this study was that it succeeded in achieving its aims which were to illuminate the personal impact on partners of an uncompleted suicide and the significance of the meanings they attributed to the experience for their everyday lives. It also met its objectives which were to elucidate the meaning ascribed to their reaction to the event; their general outlook on life; and their relationship. Another major strength is that this study is believed to be the first of its kind to focus on the impact of partners beyond the role of caregiver or informant that is usually bestowed upon them. It, therefore, provides a rare and valuable 'insider's perspective' into the personal journey for partners following the event. The study ultimately shines a light on the potentially transformative impact on partners, thereby opening up opportunities for further research in this neglected area.

6.9.2 Limitations

The process employed to recruit participants focused in the main on General Practitioner medical practices. Due to the substantial footfall within these practices it was thought that recruitment would prove not to be overly problematic. However, it transpired that very few voluntarily came forward expressing an interest in participation and GPs themselves had difficulty identifying partners of suicide attempters. On exploration with GPs it appeared that they found it easier to identify patients who were survivors of completed suicide. This may suggest that I underestimated the degree to which patients confide in a trusted GP about a life crisis should it be possible to keep it from becoming public knowledge such as a

relative's uncompleted suicide. Thirteen months elapsed between the first and final interview. Had I focused the recruitment strategy more within Emergency Departments and psychiatric hospitals, it may have resulted in a quicker response rate.

6.9.3 Critical Evaluation of IPA

As a first time qualitative researcher, IPA appeared to provide a buffer against many of the potential pitfalls associated with the complexities of engaging with and analysing the lived experience of others. Indeed, Larkin et al. (2006) assert that the "analytic processes described are largely unremarkable when compared with other qualitative approaches" (p. 104). Giorgi (2010) makes the case that IPA fails to delineate a prescriptive method of analysis, whereas Smith (2010) suggests that he wishes to avoid methodolatory and highlights the method as a stance to analysis by offering suggestions only. My own experience of employing IPA was mixed in that I applauded Smith championing flexibility and creativity among researchers at different stages of their research 'careers' but that this leaves the method wide open to the charge of always being a 'hybrid' of itself and that the existence of an audit trail does not necessarily guarantee it's quality. In fact, researchers could potentially manipulate the trail in order to give the *impression* of transparency and coherence. This potentially could be said of all qualitative approaches but with IPA being viewed as flexible and a 'stance' to analysis, possible more so with it.

I was a member of an online IPA forum throughout the entire research process which was invaluable in terms of support and reassurance. I did identify, however, that researchers using the method appeared to struggle with what I would view as questions fundamental to the process such as sample size and interview questions. There appeared to be an effort to 'quantify' what makes good quality IPA with many researchers advocating a minimum sample size in double figures. Researchers also appeared to be heavily influenced on this by supervisors who mistakenly viewed larger numbers as indicative of higher quality and

greater scope for generalisability, which IPA does not endeavour toward. Furthermore, I was aware that there were opposing opinions amongst researchers about applying the same interview schedule to subsequent participants. My own reflections on this resulted in acknowledging that the schedule was there as a guide only and that a theme that seemed relevant to one participant could be pursued with subsequent participants. For example, prior to commencing interviews one area I had earmarked as a potential line of questioning was on 'changed outlook on life'. When participant one brought this topic up of her own accord, I pursued this with other participants where appropriate which transpired to facilitate their exploration.

One of the key aspects of IPA is its commitment to interpretation yet much of the literature evaluating extant IPA research is critical of its application suggesting that many studies give the appearance of a second order interpretative account but in reality achieve a more first order descriptive account. Whilst I was very mindful of bringing my own interpretative voice into this study and believe that I have achieved this aim in the main, there is room for IPA to further integrate the concept of interpretation into the method rather than where I believe it remains currently located that is, within the methodological overview of IPA. Researchers may grasp an understanding of interpretation but may at times struggle in their endeavours to operationalise this within the analysis.

I thoroughly enjoyed exploring the IPA methodology and method through this research process and would not hesitate to recommend it to researchers unfamiliar with it as a means of developing our understanding of complex and unchartered phenomena. I would warn the researcher, however, against naive conceptualisation of IPA as a straight-forward and simplistic method due to the *appearance* of a prescribed stepped-approach to analysis. IPA compels the researcher to acknowledge one's own philosophical positioning and possibly

resolve this with that of IPA; confront one's 'fore-conceptions' and work these through; and ultimately become an integral part of the research process itself.

6.9.4 Yardley's Principles of Quality

6.9.4.1 Sensitivity to context

The choice of IPA as a methodology for the current research spoke to the issue of sensitivity to context as it is deemed a methodology particularly appropriate for exploring a unique phenomenon such as a partner's lived experience of uncompleted suicide. Furthermore, since the nature of the research was deemed to be of a sensitive nature, it was paramount from the outset, to remain engaged with key gate keepers such as GPs in order to access a purposive sample. Sensitivity was also applied throughout the interview process by prioritising the relationship with the interviewee, empathising with his/her story, and conceptualising him/her as the "experiential expert" (Smith et al. 2009, p.180), and later grounding the analysis firmly within the raw data gleaned from the interviews. Providing transcript extracts in order to champion the participant's voice throughout the analysis, grounding the findings within the existing literature, and offering interpretations as one of many possible alternative realities all further demonstrate sensitivity to context.

6.9.4.2 Commitment and Rigour

Yardley (2000) suggests that maintaining sensitivity to context is one way of maintaining commitment within a study. Commitment within this IPA study required investing considerable time and energy in the interview process, paying very close attention to the idiographic data offered by the participants, and producing an analysis in a systematic fashion.

Rigour within this study was ensured by giving careful consideration to the sampling procedure and accessing as homogenous a sample as possible. Due consideration was given

to the 'less is more approach' to data gathering and analysis recently highlighted by Hefferon and Gil-Rodriguez (2011) who champion generating small numbers of participants, questions, and themes in IPA. Rigour was also ensured through doing appropriate preparation prior to conducting interviews and ensuring a balance between maintaining rapport and keeping on task during interviews. Particularly relevant to an IPA methodology, the analysis aimed to demonstrate rigour by going beyond a mere description of the raw data towards interpreting the *meaning* of the raw data. Reflexivity was an essential part of maintaining rigour in this study as it ensured that any presuppositions or prejudices did not adversely impact the course of the research process. Reflexivity was practiced through supervision, dialoguing with work and academic colleagues, and journal writing.

6.9.4.3 Transparency and Coherence

Transparency within this study was maximised by articulating in as clear a manner as possible the sampling procedure, the rationale for the content of the interview schedule, how interviews were conducted, and how the IPA stepped analysis was carried out (Appendix H provides excerpts from transcripts of two participants with analysis; Appendix I displays individual tables of themes for these participants; and Appendix J details the formation of the Master Table of themes). A further contribution to transparency within this research was made by maintaining a reflexive journal throughout the research process which detailed the rationale for my pursuing this research topic; the influence of any biases and assumptions prior to and during the research process; and discussion of the challenges that were faced during the study.

Yardley (2000) describes coherence as "the "fit" between the research question and the philosophical perspective adopted, and the method of investigation and analysis undertaken" (p.222). Exploring the lived experience of partners in the aftermath of a suicide attempt is a phenomenon that has to date been largely ignored in the literature, and since IPA is noted as

being particularly suitable for such an endeavour (Reid et al. 2005) it was deemed a coherent methodological fit to 'answer' the research question. IPA allowed scope to apply inductive and iterative procedures that aided the researcher in developing an 'insiders' perspective and ultimately 'theoretical transferability' (Pringle et al. 2011). Coherence can also be conceptualised as the degree to which the completed thesis reads well in that it presents a coherent argument and that the themes make overall sense together.

6.9.4.4 Impact and Importance

Since the phenomenon of interest for the present study was an original one, the overarching goal of the research was to create a novel perspective that would not only challenge existing assumptions but set the foundations for readers to understand the meaning of uncompleted suicide for partners in new ways. This ultimately has implications for practice, policy, and training. Furthermore, the findings provide a platform for further research in this area.

To date, the findings have been disseminated to both academic and psychotherapy colleagues. I have contacted the Health Service Executive with a view to developing a psycho-educational leaflet for partners to support them in the aftermath of an uncompleted suicide. The National Office of Suicide Prevention will launch a 'One-Stop-Shop' website in September 2014 providing information for family and friends of those at risk. I have also been in touch with this office with a view to contributing to the website based on my research findings. Dissemination of findings via conferences and journals will also be pursued. I have also recently met with a Health Service Executive suicide prevention officer who has expressed interest in securing funding for the development of community support groups for both partners and significant others following uncompleted suicide.

6.10 Theoretical Transferability

Smith et al. (2009) emphasise the idiographic and the fact that accounts need to be viewed as local and always within a particular context. Smith et al. (2009) advocate thinking "in terms of theoretical transferability rather than empirical generalizability" (p.51). Examples of groups within a similar context to the phenomenon of partner impact following uncompleted suicide who may theoretically have also experienced both adverse and positive transformations are 'significant others' such as parents or siblings who may also experience trauma, ambiguous loss, attachment injury, and posttraumatic growth. Other groups are individuals whose partners experience adverse outcomes from choosing to engage in behaviours involving risk such as substance misuse; physical disability or acquired brain injury following dangerous sports; serious financial debt due to gambling; and relationship transgressions such as infidelity.

6.11 Implications for Future Research

This study is the first of its kind to place full emphasis on the personal lived experience of individuals following the uncompleted suicide of their partner. Future studies could conduct additional in-depth analyses of the personal impact on partners in order to further explicate this phenomenon.

Further research could explore the complex phenomenon of concomitant primary and secondary (compassion fatigue) traumatic stress that was found within the present study, and explore this manifestation among other SOs or groups within a similar context.

The average time since the uncompleted suicide in the present study was 10.5 years. Further research might take a temporal approach to the lived experience for partners ranging from short to long-term since the attempt in order to gain insight into any variance in coping, adjustment, and outlook over time.

The present study captured the experience of one man only. It may be illuminating to explore convergence and divergence between genders. Further studies in this area could also ascertain the attitudes of first responders or representatives of secondary mental health services to partners of those who attempt suicide in order to highlight their expectations of them.

In the context of relationship, future research could invite both partners to explore their lived experience pre- and post-suicide attempt in order to illuminate both risk and protective factors in the context of suicide.

Based on the findings of the current study, future research could administer psychometric tests on traumatic stress, ambiguous loss, boundary ambiguity, and posttraumatic growth in order to ascertain the extent of theoretical generalizability.

6.12 Conclusion

The main finding of this study suggests the impact of a partner's suicide attempt is transformational for individuals with both negative and positive trajectories. Adverse transformation occurred for participants as a result of the trauma suffered by them during this life changing experience. Transformations both positive and negative continued during the complex adjustment, as they navigated through the intricacies of blame and self preservation. The experience ultimately has left a legacy that has also been transformative in various ways, bringing to the surface what lay beneath and embracing new growth. Transformation was explored through the lens of trauma theory, ambiguous loss theory and boundary ambiguity, attachment theory, and posttraumatic growth.

I hope that these research findings and implications for practice, policy, training, and future directions have been 'transformative' for the reader in challenging their view of the personal

impact on partners as profound and far-reaching. One important outcome of this study, therefore, may be to champion a reframing of partners from solely care-givers to persons in their own right.

6.13 Reflexive Journal Entry

Looking back over the research experience affords me an opportunity to acknowledge the real extent to which 'construction' featured for me throughout the process. From becoming acquainted with the foundations of IPA: phenomenology, hermeneutics, and idiography; constructing inclusion/exclusion criteria that would provide as homogenous a group as possible in order to best 'answer' the research question; the trial and error of 'building' an interview guide that left substantial room for participants to 'reconstruct' their lived experience; and of course the unique and (in this case) one-off experience of both participant and myself co-constructing an understanding of their experience in order to grasp that potentially elusive 'insider perspective'. As a first-time qualitative researcher I was incredibly moved by the willingness of every participant to communicate their experience to me and as I read through each transcript I began to conceptualise what each had shared as a gift that I would pass on to others.

I had anticipated that I would struggle to refrain from engaging some form of therapeutic intervention during the interviews but was pleasantly surprised to find that all five participants were relatively well-resourced and had sought out various means of coping with or at least tolerating the experience of their partner's uncompleted suicide. Whilst most of the participants were upset at one point or another during the interview process, none were overtly distressed. This challenged my assumptions about qualitative research as a process of engaging with highly vulnerable populations that would likely need counselling input on foot of the research itself. It also challenged me to reconceptualise my ideas about what constitutes an ethical 'dilemma'. For example, before beginning the research I

assumed that the participation of current or previous clients would constitute a very obvious ethical dilemma and so would be part of the exclusion criteria but as a result of interactions with academic/psychotherapy colleagues I came to realise that this could more accurately be viewed as an ethical 'issue' that needed to be managed. This experience has impacted me both as researcher and practitioner insofar as I feel I am more inclined to explore options for making something work rather than be unnecessarily distracted by potential obstacles.

Reaching the end of this entire research process was at once joyful and burdensome. I felt the responsibility of producing a final chapter that did justice to the five participants in the study and the countless other partners who have not had their voices heard. Researching current policy and procedure was actually bittersweet as nowhere was the lived experience of the "carer" apparent, but reaffirming insofar as this study has been well overdue and incredibly worthwhile. It has also impacted my practice in subtle but important ways in that I pay closer attention than ever before to the language that clients choose in articulating their experience, metaphor in particular, and make more concerted efforts to facilitate sense-making processes and how s/he weaves or integrates a personally significant experience into the tapestry of their life.

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Appendix A: Invitation Letter to GPs

Dr. XXXXXXXXXX
XXXXXXX
XXXXXXX
Co. XXXX

Francis McGivern
5 Riverview Crescent
Bellingham Heights
Castlebellingham
Co. Louth

Date:_____

Re: Request for Approval of Research

Dear Dr. XXXXXXXX,

I hereby apply for approval to conduct research within your medical centre into the 'lived experience' of individuals whose partners have made an uncompleted suicide attempt. The aim of the research is ultimately to inform psychotherapeutic practice. The research comprises part of the Doctorate Programme in Psychotherapy at Dublin City University (DCU) and as such will be subject to ethical approval therein.

It is intended that participants will be recruited via advertising on the dedicated GP practice notice board as well as circulation of invitation leaflets within the waiting area. I would be grateful also if you could draw the attention of suitable patients to the research. Participants will be invited to take part in an audio-recorded semi-structured interview of approximately 60-90 minutes duration at the XXXXXXX Medical Centre or at a location that is convenient to them. Anonymity of participants will be maintained and all data will be held confidentially and used solely for the purposes of the current research. Participants can choose to withdraw from the research at *any* time and a counselling support protocol will be in place in the unlikely event of distress as a result of participation.

Should you have concerns or further queries regarding this research you may contact myself and/or participating DCU supervisors Dr. Pamela Gallagher (pamela.gallagher@dcu.ie) and Dr. Gemma Kiernan (gemma.kiernan@dcu.ie).

I would be obliged if you could respond in writing to this request at your earliest convenience.

Yours Sincerely,

_____
Francis McGivern
DCU DPSY Programme

Appendix B: Recruitment Advertisement

The Impact of Uncompleted Suicide on Partners:

An Exploratory Study

Has your Partner Attempted Suicide?

Would you be interested in sharing your experience with a researcher within a confidential one-on-one environment in order to help other people and professionals gain a deeper understanding of what it is like to live with a partner following their suicide attempt?

The research is being conducted by:

Francis McGivern, Counselling Psychologist

As part of a Dublin City University Doctoral Programme in Psychotherapy and as such will strictly adhere to their Code of Ethics.

At the time of the attempt if you were:

1. **Over 18yrs of age**
2. **Male *or* female**
3. **In a married or co-habiting relationship**

And :

5. **Your partner/spouse made a first time non-fatal suicide attempt**
6. **You had no previous exposure to suicide attempts**
7. **The attempt was made *at least* 6 months ago…**

You can contact Francis in order to receive further information about your participation. Interviews will be conducted in a confidential setting at your local GP practice or at a location that is comfortable and convenient for you. All information will remain confidential and at no point will participants be identifiable to others.

For further information contact:

Email: francisjmcgivern@yahoo.co.uk Tel. 087-9736417

Appendix C: Plain Language Statement

PLAIN LANGUAGE STATEMENT

Exploring the Impact of Uncompleted Suicide on Partners

School of Nursing and Human Sciences, Faculty of Science and Health, Dublin City University
Principal Investigator: Francis McGivern (francisjmcgivern@yahoo.co.uk) (Tel.087-9736417)
Co-Investigators: Dr. Pamela Gallagher (pamela.gallagher@dcu.ie)
Dr. Gemma Kiernan (gemma.kiernan@dcu.ie)

You are being invited to participate in an interview of approximately 60-90 minutes duration to discuss your experience of living with your partner in the aftermath of your partner's suicide attempt.

As the research requires participants to explore the issue of their partner's suicide attempt, the interview process may prove to be emotive at times and possibly serve to stimulate feelings related to the time of the attempt itself. You can choose to pause the interview or, indeed, terminate it at any time. There will also be counselling support available to you in the unlikely event of distress as a result of participation.

Participation is aimed at helping psychotherapists and other professionals gain a deeper understanding of what it means to live with a partner following their suicide attempt. This may ultimately benefit individuals who seek counselling and psychotherapy support following the suicide attempt of their partner. You will have the opportunity to give voice to your unique experience of living with a partner in the aftermath of his/her suicide attempt.

Inclusion Criteria for Participation:

1. Over 18yrs.
2. Living together in a relationship experienced by the participant to be an established, meaningful, and significant one.
3. Partner/spouse made a first time non-fatal suicide attempt.
4. The attempt was made at least 6 months ago.

Exclusion Criteria for Participation:

1. Individuals whose partners have made multiple attempts (more than one) to take his/her life.
2. Individuals who have experienced suicide attempts by significant others or by partners in previous relationships.

The research is confidential except in the event that the researcher has reason to believe that either you or another individual is at risk of harm in any way. The researcher is ethically required to breach confidentiality under these circumstances. In addition, confidentiality of information provided can only be protected within the limitations of the law - i.e., it is possible for data to be subject to subpoena, freedom of information claim or mandated reporting.

All information provided to the researcher will be transcribed and coded to maintain anonymity. No identifying information will be contained in these transcripts and all data will be computer password protected. Although these considerable measures are taken to maximise anonymity, you should be aware that there is always a possibility that participants might be identified in research through their stories.

All data pertaining to the research will be completely destroyed immediately after final write up of the research in 2014. Involvement in this research is entirely voluntary. You may withdraw from the Research Study at any point without explanation or negative consequences.

If participants have concerns about this study and wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9. Tel 01-7008000

Appendix D: Informed Consent Form

INFORMED CONSENT FORM

Exploring the Impact of Uncompleted Suicide on Partners

School of Nursing and Human Sciences, Faculty of Science and Health, Dublin City University
Principal Investigator: Francis McGivern
Dr. Pamela Gallagher
Dr. Gemma Kiernan

The aim of this study is to develop insight and understanding of what it is like to be a partner of an individual who makes a suicide attempt.

You are being invited to participate in an interview of approximately 60-90 minutes duration.

Please complete the following (Circle Yes or No for each question)

I have read the Plain Language Statement (or had it read to me) and I understand the information provided.	*Yes/No*
I have had an opportunity to ask questions and discuss this study.	*Yes/No*
I have received satisfactory answers to all my questions.	*Yes/No*
I am aware that my interview will be audio-taped.	*Yes/No*

I may withdraw from the Research Study at any point.

I have read and understood the information in this form. My questions and concerns have been answered by the researcher, and I have a copy of this consent form. Therefore, I consent to take part in this research project

Participants Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

Appendix E: Interview Schedule

Can you tell me a bit more about that?
How do you feel about that?
Tell me what you were thinking?
How?
Why?

Recounting the Experience:

Can you tell me about *your* experience of your partner's suicide attempt?

Possible Prompts:

What was that like for you?

Can you describe how you became aware of your partner's suicide attempt?

What do you recall about your response at the time?

Impact of Experience:

How has the experience impacted you personally?

Possible Prompts:

What meaning has the experience had for your outlook on life?

How do you feel the experience has impacted your relationship?

What concerns do you have for you and your relationship in the future?

What does the future hold for you and your relationship?

Coping:

How have you made sense of your partner's suicide attempt in your life?

Possible Prompts:

What helped/did not help you in the aftermath of your partner's suicide attempt?

Appendix F: DCU REC Letter of Approval

Dublin City University
Ollscoil Chathair Bhaile Átha Cliath

DCU

Dr. Pamela Gallagher
School of Nursing and Human Sciences
DCU

12th March 2012

REC Reference: DCUREC/2012/015

Proposal Title: Exploring the Impact of Uncompleted Suicide on Partners: An Interpretative Phenomenological Analysis

Applicants: Dr. Pamela Gallagher, Dr. Gemma Kiernan, Mr. Francis McGivern

Dear Pamela

Further to expedited review, the DCU Research Ethics Committee approves this research proposal. Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee. Should substantial modifications to the research protocol be required at a later stage, a further submission should be made to the REC.

Yours sincerely,

DCU
Office of the Vice-President for Research

Dónal O'Mathúna

Office of the Vice-President
for Research
Dublin City University,
Dublin 9, Ireland
T +353 1 700 8000
F +353 1 700 8002
E research@dcu.ie
www.dcu.ie

Dr. Donal O'Mathuna
Chairperson DCU Research Ethics Committee

Appendix G: Therapeutic Interventions for Resilience-Building in the midst of Ambiguous Loss and Boundary Ambiguity (Boss 2006)

Finding Meaning

In working phenomenologically with clients, psychotherapists can acknowledge the existence of multiple truths and recognise the client's subjective perception of an experience. This is particularly important for individuals whose partners have attempted suicide and feel socially under pressure to perceive the event in restrictive ways (e.g. "his suicide attempt will bring you closer together").

(1) A therapist first naming the problem as ambiguous loss can paradoxically enable clients to gain understanding of their experience and begin to move forward. A therapist witnessing their loss can help clients in their quest to find meaning where society does not witness the loss. Acknowledging that the only meaning for some may be that there is no meaning can be useful and can be construed as a meaning in and of itself. (2) Encouraging dialectical thinking is another important intervention that highlights both/and thinking or holding two opposing ideas simultaneously. The client acknowledges the parts of their partner that is still present and grieves for those parts that have been lost. In the context of the current study population, this can manifest as "He is both my husband and a stranger to me". (3) Developing their spiritual selves or embracing their faith can improve resiliency and facilitate clients to find meaning in the midst of their ambiguity. (4) Forgiveness has also been found to facilitate resilience. Forgiving a partner's decision to hide their intention to kill themselves, or forgiving in-laws for seemingly implying that one had not shown enough 'tender-loving-care' and so had a hand in driving him/her to suicide can help the search for meaning. (5) Small good works has also been found to mediate the impact of ambiguous loss and in finding meaning. Participants in the present study talked about providing a listening ear to others in a manner they had not done prior to their partner's suicide attempt or becoming an active member of a charitable mental health organisation. (6) Ensuring that rituals and celebrations continue in spite of the ambiguous loss can maintain resiliency and aid in finding meaning. They may not take the same form as they used to but

can provide a sense of continuity, e.g. a birthday celebration; a wedding anniversary. (7) Discovering positive attributions for the loss could significantly aid an individual's recovery. One participant for example described her husband's suicide attempt as a reaction to the strain he had been putting himself under in his heroic efforts to provide for his children. Another described his wife as having always been a fighter and that her attempt didn't make her any less of a fighter. Another participant struggled with her negative attribution of his suicide attempt which in her eyes was a complete overreaction to a minor dispute he had with a sibling. Reframing negative attributions and finding positive ones can significantly alter an individual's perception of the experience and aid in finding meaning in it. (8) Maintaining hope is paramount to finding meaning particularly with ambiguous loss where the future appears very muddied. It appears likely that individuals whose partners have attempted suicide will struggle to visualise their life returning to any kind of normality or their relationship rekindling the honesty and trust that existed before the attempt. Again this underscores the importance of dialectical thinking – individuals may simultaneously experience absence/presence and anger/pity. Likewise it may be therapeutic for individuals to simultaneously hold hopelessness/hope.

Further guidelines in the support of those experiencing ambiguous loss in the aftermath of a partner's suicide attempt include tempering mastery; normalising ambivalence; reconstructing identity; revising attachment; and discovering new hope.

Tempering Mastery

Our innate need for certainty can work against us particularly in the event of experiencing traumatic loss where ambiguity abounds. Thinking in both/and ways such as "I am both a wife and a parent to him" is challenging for clients as it calls for them to temper their need for a sense of mastery or certainty about situations. By letting go of what is uncontrollable externally, clients can turn their attention to mastering their internal self. Tempering mastery can be facilitated by helping clients to

acknowledge that the world is not always fair (reminiscent of Ellis' rational-emotive behaviour therapy); exploring a client's worldview and core beliefs regarding the origins of their need for mastery; externalising blame (i.e. identifying the *ambiguity* as the source of their lack of mastery); reducing self-blame (i.e. challenging clients to reframe their ideas about having a hand in their partner's suicide attempt, e.g. "All the signs were there, I should have seen it coming"); identifying past competencies (evidence of previous resilience); and championing experiences of success (i.e. behavioural activation in baby steps in order to increase a sense of competence and renewed trust in the world).

Normalising Ambivalence

In the case of a partner's uncompleted suicide, the other partner understandably can go through a rollercoaster of conflicting emotions. They may experience great joy and relief that their partner is still alive but simultaneously feel hurt and betrayed. The goal of psychotherapy here is to encourage clients to share feelings that they might assume are taboo in this context such as anger or shame. By normalising these difficult feelings, clients can learn to manage them rather than deny them and so increase their resilience.

Reconstructing Identity

Following a partner's uncompleted suicide, the other partner is forced to confront questions about who they are now. For example they may ask themselves "Who am I now that my wife has given up on our relationship?" Some may no longer feel like a spouse but rather a parent to their partner. Traditional gender roles may be thrown into chaos as a wife suddenly has to take on responsibility for paying bills, managing faulty electrics in the house, tending to the bins and so on much like the adjustments in roles and routines made following an actual spousal bereavement. Taking on these new roles may cause individuals to face up to their own prejudices and that of their community about what

tasks are appropriate for them to undertake. Some interventions that aids identity reconstruction include: reducing boundary ambiguity (i.e. who is in and out of the family); encouraging flexibility about gender roles; acknowledging ex-identities; adjusting tasks regarding rituals and celebrations (e.g. taking on the role of both mother and father to help a child celebrate his/her birthday during the psychological absence of the father following his suicide attempt); exploring the expansion of family rules regarding problem solving (e.g. a partner providing limited information to an insightful child about what has happened rather than the usual method of denying his/her awareness that something is not right).

Appendix H: Excerpts from transcripts of two participants with analysis

Step 2: **Initial Noting**	**Step 1: Reading and Re-reading** **Interview extract from participant Alice**	**Step 3:** **Developing Emergent Themes**
Making peace facilitated communication **Felt stronger as a person** **Worry/worry/worry** **Things/life needing to be put on hold** **Feeling the burden of responsibility** **Taking the bull by the horns**	R: So how did you make sense of all of this? P1: I think because I made peace with my husband, that we were able to talk about it. It made me...I won't say forgive the system, but it made me say 'well buggar you's I done it on me own'. And I think it made me feel a stronger person that well whatever they're...yez want to throw at me throw it at me. Emm...but I have to say my GP was brilliant, when he, when he found out he was brilliant now. And when he went to the counselling it was...it was, as I said it took a while. But for that first week there was...there was nobody absolutely nobody...nobody. I...he'd go to bed at about six in the evening after this happened. This is before counselling and emm...he'd wake up about two the next day. I couldn't go to work. Got my kids to school. I couldn't...I...there was no way I could go to work. Emm...I had to worry about him, I had to worry about a mortgage to be paid. I had to worry about kids needing stuff for school. There was no income coming well...my part time income had to be put on hold cos I couldn't go to work. There was nobody I could even go out there and say 'well can you help with a mortgage, can you help me with this?' Didn't want to know, didn't want to know. And I just said well 'bugger it, if no one else is gonna help us we'll do it ourselves'. Emm...I had to take on the role then ring the mortgage company, ask them to give me a bit of time, he wasn't well. They were fine, they were brilliant. Emm..I told the schools and I told them not to tell the two boys. They were brilliant as well. And...[sigh]...I just took the bull by the horns and I landed him up in the counselling place up in the hospital... R: Uh huh	**Reinvesting in relationship** **Enhanced strength of character** **The cost to self and others** **Picking up the pieces** **Survival mode** **Self reliance** **New & unfamiliar roles** **Forcing the hand of the 'System'**

No longer recognising husband **Demanding help** **Relief from burden of care** **"I could breath"** **Protecting husband's feelings** **Strong feelings of hatred toward her husband** **Hatred for 'System'**	P1: And I said emm...I love him to bits but I says 'he's a zombie, he needs to see somebody'. 'Oh there's a waiting list'. 'Well I'm going nowhere'. 'I'm going nowhere 'til he's seen' I said. 'This is the third day now'. I says 'this happened Monday'. This was Thursday actually. And I says 'how dare yez send me home'. But this...I says 'I...I can't'...'I can't' I said. 'Either put him away somewhere' I said 'or talk to him, do somethin''. And with that then Packie came out and he brought him in and that was the start of it then. He was up twice...twice a week for...three months and it went down to once...once a week for... R: And how did you feel once the counselling started? P1: I felt...when I dropped him up I could breath. R: You could breath? P1: I could breath. Cos I knew he was in someone else's care that shouldn't let anythin' happen him and I was hoping that he was talking. But I could breath. I just felt as if at that stage if I could come across another mountain and scream I would've because I didn't want to do any of this in front of him to upset him again...emm... R: uh huh. You talked a lot about not wanting to upset your husband. P1: Uh huh R: Could you talk to me a little bit about what the impact of this suicide attempt was on you personally? P1: I can't even describe it...I just...I really can't...I..I...even to this day I look back and I don't think it hit me for two days because I was trying to get help for him. I hated him for doing it, for trying it. I absolutely hated him.	**Needing to fight for support** **Screaming from the mountain top** **An indescribable impact**

"Doors slammed in my face" **Exasperated/overwhelmed by enormity of burden** **Surrenduring to the realisation that she was powerless to stop husband killing himself/wanting to escape the burden** **Feeling ill-equipped to deal with the situation on her own/without professional support** **Mental/physical exhaustion trying to understand husband's motivation for suicide** **Relationship Imbalance-she's given him everything with no reciprocity** **Feeling on the verge of her own "breakdown"** **Acknowledging her powerlessness**	Then I hated the...the hospital because they done nothing for him. I was just fed up getting doors slammed in my face. There was...there was no help. And I think I got to a stage then that if you know if he hadn't of got the help I was...as I said to you before I got to a stage 'oh look if you want to do it just do it'. That's how far nearly it got me because I just felt as if nobody wanted to know, nobody wanted to listen. He was a man 'oh shake yourself together, pull yourself together you'll be alright'. They didn't realise he's a human being and he was sick and he was very sick. But it was alright to send him home to me that knew absolutely nothing about mental ill...well...in a man form about mental illness, especially my husband. What was I meant to do? R: So tell me about what you mentioned there about you got to a point where you said you know what if you're going to do it, do it. Can you describe that to me? P1: I killed me to say it but I was so fed up tryin'. I was so fed up tryin' to...pull the words from his mouth for him to talk, for him to try and tell me was there a reason, if there was a reason, could he talk about it? For me to get me head around it, I wanted answers from him. And I just felt like you know 'I've...I've given you everything, I can't, I'm exhausted. I'm going to take a break down myself...if something's not done'. 'And if you want to go ahead and do it', you know, 'there's nothing I can do, I can't stop you'.	**Delayed Shock** **Hatred/Anger/** **Resentment** **Self preservation** **Traumatised but feeling obligation to manage** **Ill-equipped & Ill-prepared** **An exhausting search for answers** **'Breaking-down'**

Step 2: Initial Noting	**Step 1: Reading & Re-reading Interview extract from participant Tanya**	**Step 3: Developing Emergent Themes**
	R: If you think about from experiencing your husband's suicide attempt until the present day, could you describe the impact that the experience has had on you personally since then? P2:	
Questioning authenticity of knowing each other, friendship, soulmates	I lived with a person that I thought I knew inside out, I thought we had great friendship, you're soulmates, we were good together and I found out then that the person I lived with and loved did not turn to me during his - what you would call the greatest crisis in his life and I remember trying to tell people at the time, to varying reactions, that I saw this as a	**Questioning assumptions** **Recognising a Disconnect** **Rejection**
Ultimate betrayal on a par with adultery, gambling etc.	complete and utter ultimate betrayal of our relationship which I put on a par with - I said to friends your husband, you know, runs off with another woman, runs off with another man, runs off, gambles the house from under you, various scenarios, or commits suicide, like, where would you put it? And different people, obviously in the heightened emotion of the situation, had different reactions but I would pretty much have put suicide - I would have put suicide up there quite highly	**Betrayal**
Husband reached a pivotal stage in his life and chose NOT to consult her	because to me it means that somebody had reached the stage of their lives without having consulted you, turned to you, spoken to you, asked you for help, explained to you - so, somewhere along the line he made a decision to carry this alone, now they say that I	**Feeling Ousted/ Out of the Loop**
Continues to live with her after making suicide plan	suppose he doesn't - he has said that he didn't make the decision to carry it alone but somehow he makes *and* reinforces the decision not to tell me what's torturing him. He makes the decision, I don't know if you make it in a split-second or over time, he makes the decision to put in place a plan to die, he lives with me, he, you know, has dinner, shares a bed, whatever way you want	
Assumes she would be the first person he	to put it, having *made* the decision and never once chooses to take the option of either	

would turn to	breaking down in front of me, reaching out to me, reaching out to anyone else, be it other members of his family, professional help, whatever, reaching - but anyway, he doesn't reach out to me which you assume should be the first person he'd talk to. R: What meaning did you take from that? That he didn't reach out to you? P2:	
Breaking of trust	As far as I'm concerned he broke our trust, he broke our trust in just the same way had he run off with someone else or had he gambled the house or had he done all these other things that shockingly happen to people. It was, he	**Bond of trust destroyed**
Betrayal	betrayed us totally. That's how I feel, I feel quite strongly about it, other people couldn't	**Betrayal akin to infidelity/gambling**
Non 'pc' response	understand it, they were quite annoyed with me over it but I would still say and use the words that we had a relationship, he had	**Not understood by others/Lonely experience**
Chose to leave both her and their daughter	choices, we had a relationship and the most important person in the whole world in all of this to *me* was our daughter, more important than me. And he chose to leave her and shocking as it as that he would choose to	
Daughter as innocent victim/casualty	leave *me*, at least I was a grown adult and I had chosen to marry and be with him, she did not ask to be left without a father at ten years of age and I think I became very angry, more on her behalf possibly, maybe not, compounded by the fact that I lost my own	
Childhood memory compounded impact of her husband's decision to kill himself	father at 8 1/2 by - and through an accident and with the Guards arriving at the door and	**Difficult childhood experiences resurfacing**
Images of what might have been	witnessed the Guards arriving at the door and he knew how - that's an awful thing to happen to an 8 1/2 year old and I could picture a scenario that had he succeeded, had he succeeded the Guards would have arrived at my door, our door, you know, and our daughter could have witnessed it.	

	R: Just on that note and I'm conscious that you've spoken for quite a long amount of time so we'll finish quite soon but in terms of the relationship, you mentioned earlier that you feel the suicide attempt has impacted the relationship dreadfully. Could you tell me a little bit about what you mean by that, for you personally? P2:	
Permanent change **Trust as basis for everything**	*[thinks]* I don't think it'll ever be the same again. Me personally there is just this part of me that will always not a hundred per cent trust and that has to be the basis of everything, like, really. R: Trust? P2:	**Losing 'essence' of the relationship**
Trust as fundamental to ALL relationships **Holding back** **Being 'natural' in relationship gone** **Importance of sharing by reflex** **Husband no longer first person she turns to/shares with** **Holding back** **He has only improved since/benefited from suicide attempt**	Yeah, you know, be it your relationship with your, you know, your friends, siblings, never mind the person you choose to spend your life with. Trust in all that it encompasses, I think there's part of me that's held back emotionally somewhat since, things you would have automatically said before this, moaned about *[pauses]*, I say moaned about, I don't know why I say moaned about … R: Are you saying there … P2: Things that you would have, like, shared by reflex, you know, that you would have … R: Mmm. P2: … he was the first person you'd tell, you know, when you hear a certain joke there's always "God, I have to tell so-and-so that", and sometimes it's your brother or sometimes it's your lover *[laughs]*, you know that kind of way, so I would have reflexely almost, like Pavlov's dog, told him, probably to the extent of rabbiting on, practically everything that I felt, thought, jokes heard on the radio, you know, the mundane and the deep soulful stuff. Now, I think there's just a part of me always	**Automatic behaviours in relationship disrupted** **Reflex to share is gone** **Connection of 'souls' broken**

Cost of suicide attempt was ultimately Tanya's	holds back and it's not to protect him because his mental health is intact, it's not as if the impact - the impact on him was that was his lowest point and he only got better after it because it all came out in the open, it was all established and he became stronger and better. The night of the suicide was only the start of my downward journey and back up - does that make sense? R:When you say back up, what does that mean to you? P2:Right, my physical health left me debilitated in the months following it, coupled with emotional health, as in the two went hand in hand and that effect of just being totally dragged down and I was going off my head. There was the, you know the kind of "What doesn't kill you makes you stronger" mentality? R:Mmm. P2:*[pause]* It can sometimes take a while, it didn't kill him but it make him stronger but as I said, it absolutely ripped my heart and soul out at a certain - it shifted the whole world on its axis and it's taken me quite a while to build myself back up emotionally but I think we're both different people after it and had anyone asked me five years ago, you know, to pick words to encapsulate my relationship with him I think they're different to the words I'd pick now, I think I'm more guarded, I don't automatically tell him everything. I resent - I had a relationship with his family that was probably quite superficial looking back, oh it was loving and good and - but never went beyond a certain point to be thrown into an emotional situation where everybody spoke openly and honestly, then the walls went back up and I resent that and I do not know if he had to choose, what he would choose, if he was ever forced to choose between me and his parents, siblings for whatever reason, nothing that I can every thinking of but if he was forced to I cannot with 100 per cent honesty say that he'd choose us. And that's not a nice place to me.	**Suicide attempt as a downward journey for partner**
Debilitated physically + emotionally **'Dragged down'** **'Off my head'**		**What doesn't kill you makes you stronger?**
Husband stronger but it ripped her heart and soul out!		**It shifted the whole world on its axis**
Change in how she encapsulates the relationship now		**Process of rebuilding self**
More guarded in relationship		**Qualitative deterioration in how partner relates to attempter**
Resentment of him?/In-laws?		
Walls of husband and in-laws coming back up		**Doubting how important partner is to attempter**
Sad/sobering realisation that he could choose family of origin over her		**Unsettled in relationship now**

Appendix I: Individual Table of Themes for Participant 1 and 2

Participant 1 (Steps 4-5)

Superordinate Theme	Subordinate themes	Clusters
Screaming from the Mountain Tops	Questioning Everything	Conflicting Emotions
		Searching for Answers
		Internalising/Externalising Blame
	Searching for a Role	Failing in the Line of Duty
		Fight or Flight?
	Re-evaluation of the Relationship	Putting the Pieces Together Again
		A Burden Imposed
		My Trust Betrayed

Participant 2 (Steps 4-5)

Superordinate Theme	Subordinate Themes	Clusters
Shifting the Whole World on its Axis	Shock and Awe	A Waking Nightmare
		The 'Elephant in the Room'
	A drama unfolding	Fearing Appearing the Fool
		The 'Prime Suspect'
		The Casualty of the Drama?
	Re-evaluation of the Relationship	Who, What, When, How...but "Why?"
		The Ultimate Betrayal
		The Fallacy of Returning to 'Normality'

Appendix J: Development of Master Table (Step 6)

Super-ordinate Theme	Sub-ordinate Themes	Clusters	Emergent Themes
"I'm Not the Same Person I Was": Transformations for Better, for Worse	"It Put Nearly Ten Years on My Life": Suffering the Trauma of the Attempt	**"It's a Shock that Comes in Waves"**	**-Survival mode** **-The world is supposed to be normal today/playing a part/unreal/show stopper** **-Delayed shock** **-Ill-equipped and ill-prepared** **-Breaking down**
		The Walking Wounded	**-Needing to fight for support** **-Hatred/anger/resentment/ betrayal/rejection/pity/ compassion** **-Picking up the pieces** **-Cost to self** **-Self reliance**
		A Desperate Search for Answers	**-An exhausting search for answers** **-Questioning assumptions** **-Fear of not knowing**
	"It Shifted the Whole World on Its Axis": Adjusting in the Wake of the Attempt	**The Blame Game**	**-Self blame/the 'prime suspect'/guilt/failed partner/** **-Failure of the system** **-Self imposed/inflicted**
		Countering the "Torment": Strategies for Self Preservation	**-Screaming from the mountain top/mantra** **-Forcing the hand of the system/partner** **-Advocating for partner** **-Reconnecting/boundaries in relationship**
	"It Never Ever Goes Away": The Legacy of the Attempt	**What Lies Beneath**	**-Resurfacing of difficult childhood experiences/ physical deterioration** **-Reflex to share gone** **-Fear of re-engaging/ frightened to get comfortable/hyper-vigilance/ holding back** **-It 'pings' in my head**
		Transcending Death-Enhancing Life	**-Enhanced strength of character** **-Increased awareness** **-Reinvesting in relationship** **-Growth/metamorphosis**