PSYCHOLOGICAL EXPERIENCES OF SUICIDE BEREAVEMENT BY FAMILY MEMBERS IN LIMPOPO PROVINCE

By

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A THESIS

Submitted in fulfilment of the requirement for the degree of

DOCTOR OF PHILOSOPHY

in

PSYCHOLOGY

in the

FACULTY OF HUMANITIES

(School of Social Sciences)

at the

UNIVERSITY OF LIMPOPO

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2020

DECLARATION

I declare that the thesis titled, **Psychological experiences of suicide bereavement by family members in Limpopo**, hereby submitted to the University of Limpopo for the degree of Doctor of Philosophy in Psychology, has not previously been submitted by me for a degree at this or any other university; that it is my work in design and execution, and that all material contained herein has been duly acknowledged.

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Mokgoadi BD Date

DEDICATION

This thesis is dedicated to my family; my husband Makgoane and my two sons, Lesedi and Kagiso. I am deeply grateful for their overwhelming support throughout my Journey.

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to:

- My Supervisor, Professor T. Sodi, and Co-Supervisor Dr S.E. Nkoana for the guidance, encouragement, support and mentorship throughout the journey of completing this thesis. The experience has been invaluable.
- My family for the continuous support, encouragement and fruitful discussions.
- This research is dedicated to my late parents, especially my late mother who was always by my side (Ke a leboga Mahlako).
- I wish to thank all the families who allowed me into their sacred spaces, who shared their experiences with me during this study. I am forever grateful to you.
- Lastly, I would like to thank every person who contributed in their special way, Elizabeth, Linah and Mr Kekana for always encouraging me when the times were tough.

Thank you all!!

ABSTRACT

Suicide is one of the major global public health challenges, with evidence showing that an interplay of multiple factors leads to someone taking their life. While suicide is often a solitary act, its impact on other people is far-reaching. When someone commits suicide, family and friends are almost always left behind to grieve, trying to understand the reasons for the suicide and having to learn to continue with their lives. Because suicide happens within families, its impact on the remaining members is of paramount importance. Understanding the impact of suicide on the surviving family members is a critical step in determining how to assist survivors. The study comprised eleven (11) participants who were all nuclear family members bereaved by suicide in the Capricorn District of Limpopo Province, South Africa. They were all from the Sepedi-speaking ethnic group. Data was collected through in-depth, semi-structured, individual face-to-face interviews. Data analysis was done through the use of Hycner's phenomenological explication process. The following themes were extracted from the participants' case studies: knowledge of suicide; causes of suicide; methods used in the act; the impact of suicide on the family; prevention of suicide; coping strategies; grief following suicide and grief following other causes of death; concerns about the topic of suicide; and, suggestions in terms of support for suicide bereaved families.

The current study reveals that there is still a lot of secrecy around psychological problems which lead people to suicide with the survivors not knowing who or what to blame. It is also evident from the findings that suicide bereaved people tended to be psychologically disturbed, less likeable and more blameworthy than non-suicidally bereaved. The psychological impact experienced includes depression, self-blame, aggression, suicidal ideations and also resulting in hospitalisation for some. Suicide can lead to longer and more complicated grief reactions because family members cannot share their experiences or thoughts, particularly the feelings of guilt that they are struggling with. The stigma from society does not make it any easier for survivors to deal with their grief, leading them to isolate themselves with fear of being judged.

Based on the study findings, a culturally informed psychological model of suicide bereavement was developed to explain the lived experiences of African family

members bereaved by suicide. The model incorporates some ideas from Bowen's structural family theory and the Afrocentric theory. This model proposes that suicide may cause a break-up within the family system and that cultural beliefs may be unfavourable in some instances. For instance, in this study, it was found that some Africans still believe that suicide is a taboo and a curse, which contradicts the psychological importance of viewing the victim's body by family members. Being unable to view the deceased causes complications in the bereavement process, which leads to psychological problems. It further proposes that African culture is broad and still follows the norms and values in most situations, while these norms and values also play a role in the outcome of the bereavement process. These norms and values may lead to a breakdown of the family structure, leaving them with conflicts or complicated grief, leading to more psychological problems.

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CHAPTER 1

INTRODUCTION

1.1 Introduction

The purpose of this study was to investigate the lived experiences of nuclear family members bereaved by suicide. One of the main objectives of the present study was to explore the meanings that close family members attach to the suicide bereavement process, including their grief experiences. Additionally, the study sought to determine the psychological strategies that bereaved family members use in coping with suicide bereavement. Finally, the study developed a culturally informed psychological model aimed at explaining the lived experiences of nuclear family members bereaved by suicide.

1.2 Background to the study

Suicide is said to be one of the top ten leading causes of death across all age groups worldwide, with nearly one million people dying by suicide globally each year (Young, Iglewicz & Zisook, 2012). According to Gibb and Tsypes (2019), suicide rates rose by approximately 34% between 1999 and 2017, which makes suicide the second leading cause of death among individuals 10 to 34 years of age; the fourth among individuals 35 to 54 years of age, and the tenth leading cause of death across all age groups. Survivors of suicide may find themselves caught up in a range of mixed emotions such as depression, anxiety, and suicidal ideations and attempts (Cerel, McIntosh, Neimeyer, Maple & Marshall; 2014). Suicide does not end the pain; it only shifts the pain from the victim to the survivors, consequently leading to difficulties in recovery for those who are left behind (Schlebusch, 2005). It is in this vein that the present study seeks to explore the psychological experiences of suicide bereavement by family members in Limpopo Province with a particular focus on suicide bereaved families.

The World Health Organization (WHO) estimates that approximately one million people die from suicide every year (WHO, 2014). This represents a global mortality rate of 16 people per 100,000 (WHO, 2014). Around 70% of global suicide occurred in low and middle-income countries in 2012 (WHO, 2014). In South Africa, suicide

was found to be the fourth leading cause of death accounting for approximately 10% of all non-natural deaths (Cerel, Jordan & Duberstein, 2008). Nearly 70% of all suicide victims in South Africa were reported to be aged between 15 and 44 years of age, with suicide deaths being the highest among the youth aged 15 to 29 years of age (Rontiris, 2014).

While an individual suicide is often a solitary act, family and friends are almost always left behind to grieve as they try to understand the reasons behind the death and trying to figure out how to carry on with their lives (Cerel et al., 2008). Suicide, therefore, constitutes a tragic event with strong emotional repercussions for the families of its victims. When a suicide occurs, it almost always leads to a crisis for the survivors closely associated with the deceased person. Those closely related to the victim include among others, spouse, children, parents and relatives (Young et al., 2012).

Barrett and Scott (1990) have identified four types of reactions which suicide survivors experience. Firstly, survivors commonly experience grief reactions that are a normal result of losing a family member. Secondly, the reactions that result from experiencing a death other than by natural causes and perceived as having being avoidable, including feeling stigmatized and ashamed by the death. Thirdly, survivors go through grief reactions that result from the shock and pain of experiencing a sudden death, including searching for an acceptable explanation for the death. Fourthly, the additional trauma of dealing with the suicidal nature of the death, including feeling rejected by the deceased, feeling embarrassment over the mode of the death often accompanied by concealment of the mode of death. It is these reactions and other psychological phenomena that motivated the researcher in this study to focus on the psychological experiences of suicide bereavement by family members.

1.3 Problem statement

There are limited studies on the impact of suicide and suicide bereavement on the entire family system when compared to studies that have tended to focus on individual reactions (Foggin et al., 2016). Most studies on suicide tend to focus only on one type of survivor, for example, a parent, child, siblings or spouse. Often these

studies do not take into account how the reaction of each family member towards the suicide influences the reaction of the other members, including the tone of family communication. For example, Ali (2014) found parents bereaved by suicide to have the most severe forms of grief, comprising complex patterns of guilt, feelings of loss of control, and anxiety; while Foggin et al., (2016) found that parents bereaved by suicide less frequently access care compared with other bereaved parents. In another study by Dyregrov et al., (2011), the children who were bereaved by suicide were referred to as the forgotten bereaved, and these bereaved siblings were said to suffer from post-traumatic stress reactions, complicated grief responses, depression, and anxiety. Additionally, the quality of the relationships within the family is rarely determined, making it difficult to comment on the specific implications of the death on family relationships and communications in the aftermath of the suicide (Cerel et al., 2008). Research within suicide bereavement is limited largely due to the lack of robust methodologically qualitative studies involving those bereaved through suicide (Ali, 2014). The current study, therefore, sets to explore the phenomenon of suicide bereavement with particular focus on the entire family system of the bereaved.

1.4 Purpose of the study

1.4.1 Aim of the study

The study aimed to explore the psychological experiences of suicide bereavement by family members

1.4.2 Objectives of the Study

- To understand the grief experienced by family members after suicide
- To explore the meaning that family members attach to suicide bereavement.
- To determine the strategies that surviving family members use to cope with suicide bereavement.
- To identify and describe the resilience factors associated with suicide bereavement by the surviving family members.

- To develop a culturally informed psychological model on suicide bereavement which will be informed by integrating the emerging findings and the theoretical framework.

1.5 Significance of the study

The present study could serve as a good basis for intervention programmes for family members to cope with suicide. The study could also assist mental health practitioners to develop culturally relevant strategies to help family members bereaved by suicide. Finally, the study could also contribute to the growing body of knowledge on African psychology as it explores suicide bereavement in an African cultural context.

1.6 Operational definition of concepts

- **Suicide:** This is defined by De Leo et al., (2004) as an act with a lethal outcome, which the deceased intentionally performs with the knowledge or expectation of the lethality of such an action. It will be understood in this research as the killing of oneself.

- **Bereavement:** It is the state of having lost a relative or close friend because they have died (Hornby, 2007). In the context of this study, bereavement will be understood as the death of a relative due to suicide.

- **Suicide bereavement:** This is the bereavement experienced by those who have lost someone to suicide (Ali, 2015). Suicide bereavement will be understood in the context of this study as the loss of a loved one due to them killing themselves.

- **Suicide survivors:** People who have lost someone they love and care about through suicide (Jordan, 2018). In this thesis suicide survivors shall mean family members who have lost their loved one by means of suicide.

- **Nuclear family:** A family comprising of parents and dependant biological or legal offspring living together (Garcimartin, 2012). This, in the current study, will be understood as very close family members, either through biological or legal ties.

1.7 Thesis layout

The thesis consists of eight chapters. In **Chapter 1,** a background to the study together with the research problem was presented. This was followed by **Chapter 2,** which provides a review of literature relevant to the phenomenon in question, namely, suicide. This is done by first presenting the global prevalence statistics of suicide, followed by **Chapter 3,** which presents the theoretical framework of the study, namely, Bowen's Family Systems Theory and the Afrocentric viewpoint. It looks at the current rates of suicide and factors influencing suicide prevalence. It then progresses to reviewing the literature on attitudes, beliefs and knowledge of society regarding suicide, culture and suicide bereavement and also its impact on family members.

Chapter 3 reiterates the theories used in the study. Firstly it outlays Bowen's Family Systems Theory of Bereavement and then the Afrocentric Perspective. In both theories, the history and contribution to suicide bereavement are critically discussed.

Chapter 4 provides a detailed method of the study, including detailed explanations of the research design, the sampling and the methods of data collection and analysis. The inclusion and exclusion criteria, the protesting methods and quality of the research are also covered in this chapter.

Chapter 5 outlines the results of the study, **Chapter 6** discusses the results of the study, **Chapter 7** outlines a culturally informed model of suicide bereavement, and **Chapter 8** discusses the limitations, contributions and recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

In this chapter, suicide and its historical background will be presented followed by the prevalence of suicide. The factors influencing suicide prevalence and the risk factors of suicide will then follow, making way for the attitudes, beliefs and knowledge of society regarding suicide. Subsequently, the impact of culture on suicide and the effects of suicide bereavement on family members are discussed in this chapter. Finally, strategies for coping with suicide bereavement and the prevention and intervention strategies are presented.

2.2 Suicide

Suicide is a serious and ever-challenging public health problem worldwide, one which cannot be ignored. Suicide is devastating and the effects it has on family members and the loved ones of the person who has died by suicide can be severe and far-reaching. Those left behind by suicide are often known as suicide survivors.

Death is defined as suicide when it occurs as a consequence of an intentionally self-inflicted injury (Kuzmanić, 2011). It has also been suggested that suicide be defined as an act with a lethal outcome, which the deceased intentionally performs with the knowledge or expectation of the lethality of such an action (De Leo et al., 2004). Leenaars and Wenckstern (2004) refers to suicide as a complex phenomenon which ought to be explored multi-disciplinarily, that is based on different scientific, theoretical and methodological approaches as it encompasses psychological, sociological, biological, philosophical, anthropological, genetic, legal, ethical and other aspects.

2.3 Historical overview of suicide

In the 18th century in Europe, the suicide victim's body was dragged through the streets, with some decapitated, thrown to wild beasts or hung upside down. The body would be denied a proper burial, and would usually be placed in a sewer or brought to the side of the road with a stake through the heart and covered with

stones. Also, survivors were forced to leave their home without goods or property (Perlin, 1975). Suicide among the ancient Greeks and Romans was only deemed acceptable if it was done for the maintenance of one's honour. The spread of Christianity though, lead to the discouragement of suicide and the act was condemned by many Christian churches, due to their belief that life is sacred (Perlin, 1975). Following Christianity's lead, most Western countries illegalised the act of suicide, dispensing harsh punishments to surviving individuals and their family members. In the 18th century, when convicted of suicide, bodies were desecrated through public hanging and unceremoniously disposed of (Dunne, McIntosh & Dunne-Maxim, 1987).

2.4 Global prevalence of suicide

Globally, close to 800 000 people die due to suicide every year and it is the third leading cause of death in 15 to 19-year-olds and the second leading cause of death among 15 to 29-year-olds. 79% of global suicides occur in low- and middle-income countries (WHO, 2019). Worldwide, suicide ranks among the three leading causes of death among adolescents and young adults. There were an estimated 793 000 suicide deaths worldwide in 2016, which indicates an annual global age-standardized rate of 10.5 per 100 000 population (WHO, 2019). In South Africa, the rate of suicide for both genders was 12.8%, with males at 21.7% and females at 5.1 % per 100 000 population (WHO, 2019). In 2017 alone, 47,173 people in the United States died by suicide (CDC, 2019) and it is estimated that an average of 135 people is exposed to each suicide death (Cerel, Brown, Maple et al., 2018). These suicide survivors include immediate and extended family members, friends, co-workers, classmates, and any others who were close to the diseased (CDC, 2019).

According to Mars et al., (2014), higher suicide incident rates have been reported in 16 countries in Africa, which together accounted for approximately 60% of the total population of Africa. Although national-level suicide data is lacking for most of these countries, there was considerable variation in the rates reported, both within and across countries. Suicide rates in urban South Africa were reported to be much higher than in the other countries (Mars et al, 2014). Ani, Ross and Campbell (2017) reported that between 9.5% and 11% of all non-natural deaths in South Africa are suicide-related. They added that 3 428 people committed suicide in South Africa in

2007 at 13.4 per 100 000 members of the population. A qualitative study by Shilubane et al., (2012) on adolescents in Limpopo concluded that a lack of knowledge of the availability of counsellors, conflict in interpersonal relationships, perceived accusations of negative behaviour, inadequate social support, past family and peer suicide attempts, as well as poor living circumstances, were associated with attempted suicide.

2.5 Factors influencing suicide prevalence

Multiple factors can play a significant role in terms of influencing suicide prevalence, for example; gender, geographical location, religion and cultural factors.

2.5.1 Gender

In terms of gender, research in South Africa is in line with international standards wherein suicide rates are higher in males than in females (Burrows & Laflamme, 2006). According to Maskill and Hodges (2005), males show consistently higher completed suicide rates than females across all age groups in the English-speaking Western countries, while Females have higher rates of suicide ideation and attempted suicide. Gender roles or identity are considered to exert a major influence on suicidal behaviour (Stack, 2000). Being female and reaching puberty is said by Crowe, Ward, Dunnachie and Roberts (2006) to increase teenagers risk for suicide attempts and the risk of becoming depressed. Holliday (2012) also postulated that depression in childhood is rare, but after puberty is reached, there is a steep rise in depression for both sexes, which doubles for females compared to males. With this rise in the rate of depression, females have an increased rate of suicidal behaviour but do not complete the suicide act as often as males. Males largely use more lethal forms of suicide (Stack, 2000). According to Yip, Callanan and Yuen (2000), in those developing countries where female rates of completed suicide exceed those of males, more females tend to use highly lethal methods, largely agricultural poisons such as insecticides and weed-killers. Stack (2000) stipulates that an explanation for more completed suicide rates among males than females focus on the impact of the masculine stereotype in which males are required to be strong, decisive and competitive, resulting in men reacting more strongly to actual or perceived loss or failure in their primary adult male role.

2.5.2 Geographical location

Suicide rates tend to vary according to demographic settings. Population density has been suggested as the factor behind the difference. Suicide rates are said to be higher among rural areas as compared to densely populated cities, which has been linked to issues regarding access to health care and the proportion of psychiatrists and other mental health care workers to the overall population (Holliday, 2012).

2.5.3 Religion

Religion can also play a role in the prevalence of suicide in terms of how it is perceived. Prevalence may be high within religions that are more tolerant of suicide and lower within religions that have strong religious sanctions against it. According to Maharajh and Abdool (2005), Islam, Judaism, and Christianity have low suicide rates as taking one's life in these religions is considered a transgression against God's law. The Judeo-Christian teachings also disapproved of the burial of suicide victims according to the Talmud (Mishnah) and death by suicide was said to prevent the individual from eternal happiness. Hinduism was reported to have a higher prevalence of suicide as it is more tolerant of suicide; it also has prescriptions for the wandering of the soul in disruptions of the cycles of birth and death in reincarnation. Ritualistic suicide of *suttee*, now illegal, allowed the wife to throw herself into her husband's funeral pyre. The early Christian voluntary killing is currently being adopted by followers of Islam. It seems as though religion has a meaningful part to play in the lives of individuals and is associated with socially acceptable behaviour (Maharajh & Abdool, 2005).

2.5.4 Cultural context

Cultural theories suggest that in societies or communities where there are strong cultural, religious or legal sanctions against suicide, suicide rates can be expected to be relatively low. Conversely, where cultural values are tolerant of suicide, suicide rates may be higher. Maharajh and Abdool (2005) support the above notion by stating that the effect of culture on human behaviour is equivocal with opposing views of both protective and destructive tendencies. They add that culture may provide a support system to an individual's vulnerability and defences related to ego-functioning, or on the other hand, may perpetuate an ecologically unhealthy

environment. The impact of cultural beliefs and practices can be confused by other factors, such as economic development or modernisation, and not all patterns of suicide among different groups appear to be due to the groups' norms and beliefs about suicide (Maskill & Hodges, 2005). The transgenerational loss of the old culture will result in conflicts between the customs of the traditional culture and the expectations of the modernising society. Thus, renunciation of the old culture without assimilation of the new predisposes individuals to behavioural disturbances such as suicide (Maharajh and Abdool, 2005).

2.6 Risk factors of suicide

Sher, Oquendo, and Mann (2001) succinctly summarise risk factors as anything that places the individual at a greater potential for suicidal behaviour. In terms of a stress diathesis model of suicidal behaviour, risk factors can be viewed as creating a predisposing diathesis that determines an individual's response to a stressor. Risk factors for suicide include a history of substance abuse, depression, post-traumatic-stress-disorder, anxiety, relationship problems, people with a recent death in the family, and chronic medical illnesses (Canetto, 2015). Canetto (2015) reported that older adults have higher suicide rates than other age-groups globally and that it is predominantly men who die of suicide in late adulthood, with variability by culture.

According to WHO (2014) risk factors associated with the health system and society at large include difficulties in accessing health care and in receiving the care needed together with easy availability of the means for committing suicide. Inappropriate media reporting that sensationalises suicide and increases the risk of "copycat" suicides, and stigma attached to people who seek help for suicidal behaviours, or mental health and substance abuse problems also lead to suicide (WHO. 2014). Risks linked to the community and relationships include war and disaster, stresses of acculturation (such as among indigenous peoples or displaced persons), discrimination, a sense of isolation, abuse, violence and conflictual relationships. Risk factors at the individual level include previous suicide attempts, mental disorders, harmful use of alcohol, financial loss, chronic pain and a family history of suicide (WHO, 2014).

In South Africa, hanging is one of the most frequently employed methods of fatal suicidal behaviour. This is followed by shooting, poisoning, overdosing, gassing and burning. A variety of other methods include the use of sharp objects, suffocation, electrocution, drowning and fenestration (jumping off high areas). Common in non-fatal suicidal behaviour is overdose with medication (often with over-the-counter analgesics and prescription-only available medications like benzodiazepines and anti-depressants), ingestion of household poisons and cleaning agents and self-injury such as self-cutting (Schlebusch, 2005).

2.7 Attitudes, beliefs and knowledge of the society about suicide

Society tends to blame the survivors and offers less grief support than it does for survivors of natural death (Clark, 2001). Survivors may therefore set themselves apart from those around them because of the blame, rejection and lack of understanding on the part of society (Calhoun & Allen, 1991). Calhoun and Allen (1991) found that suicide survivors tended to be more psychologically disturbed, less likeable and more blameworthy than nonsuicidal bereaved.

According to Rontiris (2014), one approach to advancing understanding in the area of suicide is to explore the views and beliefs that people hold about suicidal behaviour. Hjelmeland and Knizek (2004) support this approach arguing that certain views and beliefs held about suicidal behaviour can hinder people from reading or acting upon the subtle signals suicidal people send out. Furthermore, signals may be underestimated and not taken seriously. Rontiris (2014) also argued that meaning precedes ideation and action and those individuals who commit suicide do so about cultural-normative specific values and attitudes. Colucci (2006) emphasised that suicide has different meanings for people belonging to different socio-cultural backgrounds.

2.8 Culture and suicide bereavement

Distinct cultural practices, including coping styles, family ties and religious beliefs, influence people’s willingness to seek help and their ability to respond to mental health services (Thapa et al., 2015). They also state that some students showed higher reluctance towards the use of counselling services for mental illnesses, and a

preference to reject or exclude persons with mental illnesses due to the higher relevance of stigma being attached to these students.

Culture frequently determines how people react to suicide. Many cultural meanings may be present in the culture, and different cultural meanings may exist for different subgroups of the culture (Lester & Lester, 2011). For example in most Western communities, people bereaved by suicide will often accept that mental illness or intrapersonal conflicts could have led the person to commit suicide (Carnetto, 2015).In most African societies suicide has been perceived as taboo, self-inflicted pain, immoral, unforgivable and a shortcut to hell, thus leading to ostracization of family members bereaved by suicide (Lester, 2008). It is in this regard that the bereaved families often hide the cause of death, thus avoiding seeking professional and societal support (Stack, 1998).

When a person commits suicide, the family may pretend that the suicide never took place, or that the death was caused by other means, e.g. a car accident, illness, etc (Barnes, 2006). This is due to the stigma that is still attached to suicide, even though there are many support networks to turn to. Cultures inevitably affect the way individuals express emotional distress and also influence the method of suicide and the underlying attitudes to self-harm and suicide. According to Colucci and Lester (2013), religion, rooted within the culture, plays a key role in social attitudes to suicide and suicidal attempts. They further pointed out that sometimes suicidal behaviour is legally proscribed across cultures making it impossible to understand the factors leading to suicide and also putting preventive strategies in place. According to Stack, (1998), religion plays a huge role in the manner in which Africans view suicide. Stack posits that other Africans view suicide as a ‘white thing’. Suicide in some African cultures was also viewed as unpardonable, unforgivable and unthinkable and thus seen as a curse (Stack, 1998). In other countries in Africa people who commit suicide have no right to a befitting burial (Early, 1992). Families of the deceased are ostracised, hence suicide deaths are often hidden and not reported as such. According to WHO (2014), suicide research in Africa is limited by a lack of systematic data collection with less than 10% of African countries reporting mortality data to WHO.

Jensen (2011) speculates that there may be one cultural meaning of suicide in any given culture which may influence young adults' transition to adulthood. This in turn makes the development of their identity important. Young adulthood is a time of life with openness to diverse cultural beliefs and behaviours. Often young adults have not settled on particular beliefs and views at this stage and therefore when exposed to local and international cultures, identity confusion may take the form of bouncing between different cultural identities across situations and contexts (Jensen, 2011).

According to Hjelmeland, Akotia, Owens, Knizek, Nordvik, Schroeder, et al., (2008), there is a severity of suicide in South Africa amongst young adults in particular; thus meaning that suicide is viewed very differently by various cultural groups. They (Hjelmeland et al., 2008) stated that individuals in a developing country often have more restrictive views towards suicidal behaviour when compared with individuals from a more Western world. In a western world, suicide may be seen as a right, a cry for help and less taboo, while in developing countries it is often considered a taboo or a way of obtaining revenge or to punish someone (Hjelmeland et al., 2008; Schlebusch, 2005).

2.9 Effects of suicide bereavement on family members

2.9.1 Psychological effects

When someone dies by suicide, the people impacted most dramatically are those closest to the person who died, the family being the most affected. Suicide-bereaved children also reported less acceptance and relief than children bereaved by causes other than suicide. In another study, two profiles of grief responses were identified: A sad, guilt-laden, and withdrawn response, (Cerel et al, 2008) and an angry, hostile, and defiant response.

Fogging et al., (2016) reported that suicide is devastating for the loved ones of the deceased and leaves up to 50 people affected and at risk of suicide themselves as well as psychosomatic, mental, and physical illness. Suicide survivors often face unique challenges that differ from those who have been bereaved by other types of death. In addition to the inevitable grief, sadness, and disbelief typical of all grief, overwhelming guilt, confusion, rejection, shame, and anger are also often prominent (Jordan, 2001). These psychologically painful experiences may further be

complicated by the effects of stigma and trauma. For these reasons, the grief experienced by suicide survivors may be qualitatively different than grief after other causes of death (Young et al., 2012).

As stated by Sands and Tennant (2010), suicide death leaves those bereaved experiencing all the grief reactions provoked by a death due to unintended causes, but further overwhelmed with a range of difficult individual and social grief issues related to the intentional nature of the death. The suicide bereaved are left to find a way to understand the meaning of the knowledge that the suicide occurred due to the deliberate actions of the deceased. Since the bereaved shared a relationship with the deceased, the intentional nature of the death challenges the bereaved person's understanding of the relationship or continuing bond with the deceased (Sands & Tennant, 2010).

2.9.2 Social effects

Families experience extreme guilt, failure, anger or resentment at the person who chose to take his own life, while also being confused. Distress over unresolved issues may hamper closure (Tracy, 2014). A death in the family involves multiple losses in numerous relationships, functional roles, the family unit, and the hopes and dreams for all that might have been. Death can disrupt a family's functional equilibrium. The emotional shock waves ripple throughout an entire family network. While most bereavement research focuses on the impact of death for an individual child, or a parent or a sibling, losses are simultaneously experienced from multiple perspectives in the three-generational family systems. For example, the death of a child affects both parents and their relationship, siblings, grandparents, and other extended kin. The death of a parent for children may also involve spousal loss for a parent and the loss of a child for grandparents. All of their reactions reverberate in a circular chain of influences. Distress may stem not only from grief but also from the realignment of the family's emotional field (Walsh & McGoldrick, 2013).

According to Young et al., (2012), survivors of suicide bereavement are often viewed more negatively resulting in social isolation and feelings of rejection. They are often deprived of appropriate social and religious rituals required for healthy confirmation of the death and mourning. Besides, Jordan (2001) stated that suicide bereavement

is distinct in three significant ways: the thematic content of the grief, the social process surrounding the survivor and the impact suicide has on family systems.

Sands and Tennant (2010) concluded that the argument that suicide causes disintegration in the bereaved person's assumptive world, with a range of consequences related to family breakdown, social processes, health issues, depression, and poor work functioning. The prevailing stigma is thus one of religious and moral taboos, the chaos of mental illness, disapproval, guilt, and shame. In the search for meaning and healing, the suicide bereaved is thrust into this discourse and its assumptive world. It is in this context that the processes of meaning-making and healing commence among those bereaved by suicide. A suicide death clearly can provoke a crisis among the suicide bereaved, who may in many cases move quickly to discount the intentionality of the act. Given the complexity of issues associated with a suicide death, the bereaved can become stuck or unable for many reasons to reconstruct the death story.

According to Dyregrov et al, (2005) the younger siblings living at home experience the most difficulties in the wake of the suicide; more than their older siblings as well as their parents. Explaining this, they mentioned that the family burden of the younger siblings is greater than for the older ones, who spend less time with their parents. The older siblings are said to be protected by their age, marital status, and life circumstances as they avoid intimate exposure to their parents' despair and all the reminders of their dead sibling, the younger siblings' adolescent development may be hampered by emotional neglect from parents due to grief and trauma reactions. Suicide can lead to longer and more complicated grief reactions because family members cannot share their experiences or thoughts, particularly the feelings of guilt that they are struggling with (Dyregrov et al, 2005). Perhaps the most deleterious impact of suicide on social networks is the distortion of communicational processes that may occur after death, particularly around the issue of blame (Cerel et al, 2008).

Suicide is a confusing death. Its causes are complex, multi-determined, and poorly understood. This ambiguity seems to increase the need within a social network to affix blame. Indeed, suicide survivors are judged more negatively than survivors of other types of loss. They are seen as more disturbed and more deserving of blame

for the suicide, and this is particularly true of parents who lose a child to suicide. Blame may be overtly expressed or covertly communicated through nonverbal cues and social withdrawal, straining and even rupturing the cohesiveness of a family or extended social network as survivors blame each other for the death (Cerel et al., 2008).

A second communicational distortion is the development of secrecy around the cause of death. Historically, survivors have been more likely to hide the cause of death from certain members of the family, such as children, or people outside the immediate family. They also report being expected by outsiders to provide a more detailed explanation of the reasons for the death than in other types of losses (Cerel et al, 2008). While suicide is perhaps less likely to be a family secret now than in the past in many industrialised and Western societies, survivors who have recently discovered this secret in the family may also struggle with confronting the secret and giving voice to their experience (Cerel et al., 2008).

Shame may make it exceptionally difficult for family and community members to broach the topic of suicide. Most groups' social norms do not prescribe appropriate social responses to a suicide loss, creating awkwardness and avoidance in communications with survivors. Extended family and community members may also feel the need to protect those most profoundly affected by the death, becoming wary of discussing the suicide out of fear of reminding the closest survivors of their loss and further upsetting them. Even when they are not avoided by others, survivors may incorrectly expect to be judged harshly by others and thus withdraw from their social networks, a process referred to as self-stigmatisation (Cerel et al., 2008).

Suicide survivors reported greater levels of stigmatisation, shame, sense of rejection (feeling deserted by the deceased), and unique reactions (e.g., feeling that the deceased was getting even, a desire to hide the mode of death of the deceased, the only subscale to distinguish the groups was a sense of rejection and unique reactions (Cerel et al, 2008).

2.9.3 Stigma associated with suicide bereavement

In developing societies, it is likely that suicides' stigma varies tremendously and, in many places, continues to represent a significant source of distress for many

survivors. The issues of blame and secrecy after suicides also contribute to a third form of communicational distortion: Social ostracism and self-isolation by survivors. Suicide has a long history of stigmatisation within Western cultures, and the families of suicide survivors were often punished and ostracised by their communities in the middle ages (Cerel et al, 2008)

The under-utilisation of formal mental health services may be attributed to stigma and social shame caused by mental health problems and the different traditional explanations for their problems. Limited fluency in English, delays in reaching out and the limited availability of culturally-competent mental health professionals also hinder the use of formal mental health services (Thapa et al, 2015). Additionally, the stigma associated with depression and suicidal risk was found by Thapa et al.,,(2015) to pose unique challenges to some people, they may be particularly hesitant to seek professional help for their emotional problems.

2.10 Coping with suicide bereavement

Social support after any type of loss appears to be a crucial factor in determining bereavement outcome following any manner of death and these effects may be more pronounced following a suicide. Factors that interfere with the ability of a social group, whether a nuclear or extended family, or a setting such as a school, workplace, or church, to provide support to survivors may have a direct bearing on their mourning trajectory (Cerel et al, 2008)

Briggs (2010) stipulates that reducing the stigma or taboo associated with suicidal behaviour in society, and training community-based professionals (including those in schools, for example) to be able to encourage talking about suicide is something which may help prevent suicide rather than constituting a dangerous intervention which might ‘put ideas in people’s minds’ and make the problem worse. Winston, O’ Driscoll and O’Connor (2010) postulate that while it may sometimes be difficult to be with family and friends when grieving, one should try not to isolate oneself, missing out on the support other people can offer.

Talking to people who understand the situation better or even joining suicide bereavement groups where one can meet people in the same situation as they help people cope better with the bereavement process. They also added that a person’s

spirituality, beliefs or religious faith can be their source of strength and may give them hope and comfort, and can help understand and make sense of the loss. Many people believe in a spiritual afterlife and this helps them to maintain a bond with the person who has died. The bereaved person can talk to them about the person who has died and about how they are feeling and it is good to have one or two people to trust and confide in (Winston et al, 2010). According to Winston et al.,,(2010), one should not hide their emotions and try not to distance themself from the support of their family and friends. They added that one should not compare themself to others in terms of how they coped with their loss as people experience the pain of grief differently. Sudden death robs the bereaved person of the chance to say goodbye, to finish unfinished business or prepare for the loss of someone close. It can be especially distressing if they parted badly or feel in some way responsible. The physical and emotional shock can last for a long time and the normal feelings of grief, the emotions and reactions they have to cope with maybe more intense (Winston et al.,, 2010).

Barnes (2006) states that some African Americans continue to deny that suicide is a problem within the black community, mostly since suicide is a relatively rare behaviour among all ethnic groups. This community denial is said by Barnes (2006) to be what makes it difficult for families to heal when they have lost someone to suicide. According to Barnes (2006), an important first step to the healing of survivors is making the word suicide a part of the language of the African American community. This language change is said to facilitate the development of effective community-based and institutionally based services for African American survivors as well as prevention and intervention services within the broader community. If the rise of suicide in African American communities is addressed and talked about along with numerous other social ills, perhaps more educational awareness would be welcomed and instituted in facilities that address risk factors such as substance abuse, domestic violence, and youth violence (Barnes, 2006).

Agerbo (2004) stipulates that Conjugal bereavement has an impact on the mortality among surviving spouses, and that spousal suicide bereavement might increase the suicide risk in both genders more than bereavement after other modes of death.

2.11 Prevention and intervention

2.11.1 Primary prevention programs

2.11.1.1 Crisis and community-based programmes / universal prevention strategies

These prevention programs are aimed at preventing people from attempting and completing suicide. Primary prevention programs to reduce suicide are mainly public education and awareness messages or campaigns aimed at people in the community but can also be school-based. Crisis lines or other resources available for suicidal teens reaching out for help are also considered primary prevention strategies (Holliday, 2012). According to WHO (2014), these strategies are designed to reach an entire population to maximize health and minimize suicide risk by removing barriers to care and increasing access to help, by strengthening the protective processes such as social support and altering the physical environment.

2.11.1.2 Educational training for health professionals / selective prevention strategies

Selective prevention strategies target vulnerable groups within a population-based on characteristics such as age, sex, occupational status or family history. While individuals may not currently express suicidal behaviours, they may be at an elevated level of biological, psychological or socioeconomic risk (WHO, 2014). It has been reported that the majority of people who complete suicide have visited a health care provider in the month previous to their suicide, thus it is logical to target healthcare providers to intervene and watch for warning signs of mental health disorders. Since depression is a common risk factor for suicidal behaviour, educating providers about screening for depression is important. Educational training programs for health professionals' increase the chances of professionals asking young people about suicidal ideation but repeated interventions are needed to maintain their mental health (Holliday, 2012). The vulnerable group includes persons who have suffered trauma or abuse, those affected by conflict or disaster, refugees and migrants, and persons bereaved by suicide (WHO, 2012).

2.11.2 Secondary prevention / indicated prevention strategies

Secondary prevention is aimed at preventing those that have attempted suicide from going on to complete the suicide. Emergency departments(ED) in clinics and

hospitals can serve as a possible link in the suicide prevention field as they are considered the gateways to the community (Holliday, 2012). These prevention strategies target specific vulnerable individuals within the population − e.g. those displaying early signs of suicide potential or who have made a suicide attempt (WHO, 2012).

2.12 Summary

Although it is sometimes referred to as ‘a cry for help’, suicide is said to be a very selfish act which leaves family and friends with many unanswered questions as to what the cause was. Many people die every day due to suicide and males were found to have higher rates of completed suicide than females. This is said to be due to the biological makeup of the genders. Different religions and cultures have different views on suicide, thus having different influences on the prevalence of suicide. Risk factors include psychological factors such as depression and psychotic disorders, medical conditions, and also insecurities or the inability to deal with stressors. The following chapter is the theoretical framework.

CHAPTER 3

ROLE OF THEORY IN THE STUDY

3.1 Introduction

Several theories have sought to explain suicide and suicide bereavement. For example, Sigmund Freud's Psychodynamic Theory of Suicide (Freud, 1917), posited that suicide is the outcome of the relations between the ego and the sadistic superego. Aaron Beck's Cognitive-Theory of Suicide (Beck, 1971), suggests that people who exhibit suicidal ideations viewed their life problems as too serious with no way out.

The Cultural Model of Suicide (Chu, Goldblum, Floyd, & Bongar; 2011), states that culture affects how suicidal thoughts, intent, plans, and attempts are expressed and that it also affects the types of stressors that lead to suicidal behaviour. In the present study, the researcher will use both the Family Systems Theory and the Afrocentric perspective as the theoretical frameworks to understand the experiences of family members bereaved through suicide. Whilst the Family systems Theory will assist the researcher to understand the experiences of bereavement associated with suicide, the Afrocentric perspective, on the other hand, will assist the researcher to interpret these experiences taking into account the cultural realities of the bereaved family members.

This chapter gives a background of Bowen's Family Systems Theory and the Afrocentric theory as the two lenses through which this study will be viewed.

3.2 Theoretical perspectives on suicide bereavement

3.2.1 The Dual Process Model (DPM)

Many psychological theories explain bereavement and the Dual Process Model (DPM) is one of them. The DPM of Bereavement is understood to be a taxonomy that describes ways that people come to terms with the loss of a loved one (Stroebe & Schut, 2010). A fundamental contrast with earlier models reflects the position that the DPM defines two categories of stressors associated with bereavement. Grief is viewed as a dynamic process in which there is an alternation between focusing on the loss of the person who has died (loss orientation) and avoiding that focus

(restoration orientation). The loss orientation encompasses grief work, while the restoration orientation involves dealing with secondary losses as a result of the death (Dent, 2005).

The Dual Process Model puts more emphasis on better descriptions of coping and prediction of the stressful life event. By so doing, the Model seeks to better understand individual differences in the ways that people come to terms with bereavement (Stroebe & Schut, 2010). For bereavement to be resolved an individual finds himself in a dual dynamic process, that of having to deal with the impact of the loss from an emotional processing orientation (for instance, shock, loneliness, sadness, anger), while on the other hand, the person has to troubleshoot some challenges that arise as a result of the loss (such as financial losses, caring for children, lost joint future plans, familial conflicts and so forth). All these processes become more difficult when the person is bereaved through suicide as everything is a surprise and thus more shocking.

3.2.2 Psychoanalytic theory

According to psychoanalytical theories, suicide is anger or hate turned inward. Freud (1856-1939) is known in psychology for beliefs about the importance of the unconscious and how the unconscious impacts human behaviour. He believed humans have a death instinct or an inner wish to die and suicide is evidence of this death instinct. Freud posited that suicide is the appearance of the death instinct but turned towards self, while murder and other forms of aggression manifest as the death instinct acting away from us (Holiday, 2012).

According to Holliday (2012), Karl Menninger (1893-1990) was a psychoanalyst who believed suicide and homicide were related through three wishes that are inherent in everybody: the person’s wish to kill, the wish to be killed and the person’s wish to die. Menninger speculates that in every suicide all three wishes are present. The instinctual destructive tendency is turned inward instead of outward, which is the difference between suicide and homicide. His basic premise is that when self-destructive tendencies or impulses exceed constructive impulses the result is self-destruction, i.e. suicide (Holiday 2012). Psychoanalytic theories also propose that suicide is caused by unconscious drives, intense affective states, the desire for

escape from psychological pain, existential drives for meaning, and disturbed attachment (Van Orden, Witte, Cukrowicz, Braithwaite, Selby & Joiner Jr, 2010).

3.2.3 Cognitive theory

Aaron Beck (born in 1921) is an American psychiatrist who is widely known as the father of cognitive therapy. Clinically, he observed that depressed people who exhibit suicidal ideation viewed their life problems as too serious with no way out. Beck believed that the construct of hopelessness was the link between depression and suicide (Holiday 2012). According to Beck's cognitive model, acutely suicidal individuals have active suicide schemas, and consequently, their attention is preferentially drawn to suicide-relevant information. Poor cognitive control over suicide-related stimuli is hypothesized to lead suicidal individuals to fixate on suicide as their only option or escape and, ultimately, to attempt suicide. In this model, poor cognitive control is a proximal risk factor for attempted suicide; the inability to disengage from suicide stimuli prolongs distress, exacerbates negative emotional states, and may culminate in suicidal acts. Outside of suicidal crises, poor cognitive control over suicide-related stimuli also may reflect a more easily activated suicide schema and therefore may be a marker of suicide vulnerability (Stewart, Glenn, Esposito, Cha, Nock & Auerbach; 2017 and Baucom et al.,, 2017).

3.2.4 Psychosocial theory

Erik Erikson (1902-1994) is well known for his construction of the eight stages of psychosocial development. He believed in the concept of epigenetics, which is that there are psychological crises or critical steps related to each stage of development and that to move onto the next stage one must resolve the psychological crises or master the challenges presented in the current stage. Erikson suggests suicide is a phenomenon occurring across the life-span of an individual and that those who exhibit suicidal behaviour or commit suicide are developmentally stagnated or stuck (Holiday, 2012).

3.2.5 Interpersonal theory

The Interpersonal theory posits that the most dangerous form of suicidal desire is caused by the simultaneous presence of two interpersonal constructs; thwarted belongingness and perceived burdensomeness (and hopelessness about these

states). Further, that the capability to engage in suicidal behaviour is separate from the desire to engage in suicidal behaviour Orden et al.,,(2010). According to the theory, exposure to and encounter with previous painful experiences increases an individual's tolerance for the physical-pain aspects of self-harm through habituation processes (O'Connor & Nock, 2014; Ribeiro & Joiner, 2009).

3.2.6 Motivational-volitional theory

This theory conceptualises suicide as behaviour (rather than a by-product of mental disorders) that develops through motivational and volitional phases. The motivational phase describes the factors that govern the development of suicidal ideation and intent, whereas the volitional phase outlines the factors that determine whether an individual attempts suicide. This model integrates the key factors from earlier theories into a detailed map of the suicidal process from thoughts to acts of suicide. Whereas belongingness and burdensomeness are paramount in the final common pathway to suicide in the interpersonal theory, feelings of defeat (i.e., feeling defeated after triggering circumstances) and entrapment (i.e., unable to escape from stressful, humiliating, or defeating circumstances) are posited to be of the most important within the integrated motivational-volitional model (O'Connor & Nock, 2014). When an individual feels both defeated and trapped, the likelihood that suicidal ideation will emerge increases when motivational moderators (e.g., low levels of social support) are present. Whereas the interpersonal theory of suicide posits that acquired capability establishes behavioural enaction (i.e., suicide attempts), it is just one of several (volitional phase) factors within the integrated motivational-volitional model theorized to increase the likelihood of a suicide attempt. Such factors include exposure to the suicidal behaviour of others, impulsivity, and having access to the means of committing suicide (O'Connor & Nock, 2014).

3.3 Theoretical framework for the present study

The researcher in this study adopted Bowen's Family Systems Theory and the Afrocentric theory as the two lenses through which the lived experiences of nuclear family members bereaved by suicide was viewed.

3.3.1 Bowen's Family Systems Theory of bereavement

This study will adopt Bowen's Family Systems Theory as a lens to view the phenomenon under investigation. This theory was pioneered by Dr Murray Bowen (1913-1990) in 1974 as one of the first comprehensive theories of family systems functioning. The theory suggests that an individual cannot be completely understood in isolation from those around him or her, but rather that the family forms a system which comprises of independent individuals who can only be understood collectively with their broader system (Kerr, 2000). This theory is relevant to the current study as it focuses on how one individual's actions can impact the whole family system. If an individual takes his or her life, the whole family is left overwhelmed and the family structure may become dysfunctional. This seeks to understand the impact of suicide on the suicide bereaved nuclear family members and how they are affected emotionally as well as how the family system continues to function despite the loss

According to Kerr (2000), families profoundly affect their members' thoughts, feelings, and actions, to the point that it seems as if people are living under the same emotional skin. They solicit each other's attention, approval, and support and react to each other's needs, expectations, and upsets. Rockwell (2010) asserts that he had found Bowen's Family Systems Theory helpful in family and work situations and that it has provided him with insights and leverage points relating to conflicts and emotional dilemmas he had faced as a husband, father, pastor and consultant. The main focus of this theory is the patterns which families develop to resolve anxiety, brought about by current levels of external stress and sensitivities within the system. The anxiety may also develop when a perception of either too much closeness or too great a distance in relationships persist (Kerr, 2000). Even in therapeutic or consulting relationships, it is very easy to become emotionally enmeshed in the system to the degree that one becomes significantly unable to provide help and it is in the most emotionally unstable environments that one is most apt to lose objectivity and yet the most important ones to remain differentiated within (Rockwell, 2010).

Bowen's focus was on patterns that develop in families to defuse anxiety. A key generator of anxiety in families is the perception of either too much closeness or too great a distance in a relationship. The degree of anxiety in any one family will be determined by the current levels of external stress and the sensitivities to particular

themes that have been transmitted down the generations. If family members cannot think through their responses to relationship dilemmas, but rather react anxiously to perceived emotional demands, a state of chronic anxiety or reactivity may be set in place. The main goal of the Bowenian therapy is to reduce chronic anxiety by facilitating awareness of how the emotional system functions; and increasing levels of differentiation, where the focus is on making changes for the self rather than on trying to change others (Brown, 1999). Bowen identified the following seven interlocking concepts that make up his theory:

3.3.1.1 Emotional Fusion and Differentiation of Self

According to Brown (1999), fusion or lack of differentiation is when an individual's personal choices are set aside in the service of achieving harmony within the system. Bowen's research led him to suggest that varying degrees of fusion are discernible in all families. Differentiation, by contrast, is described as the capacity of the individual to function autonomously by making self-directed choices, while remaining emotionally connected to the intensity of a significant relationship system (Brown, 1999).

3.3.1.2. Triangles

Bowen described triangles as the smallest stable relationship unit that occurs when the inevitable anxiety in a dyad is relieved by involving a vulnerable third party who either takes sides or provides a detour for the anxiety. Under stress, the triangling process feeds on itself and interlocking triangles are formed throughout the system. This can spill over into the wider community when family members find allies, or enemies to unite against, such as doctors, teachers and therapists. Triangles are linked closely with Bowen's concept of differentiation, in that the greater the degree of fusion in a relationship, the more heightened is the pull to preserve emotional stability by forming a triangle. Triangling can become problematic when a third party's involvement distracts the members of a dyad from resolving their relationship impasse (Brown, 1999).

3.3.1.3. Nuclear Family Emotional System

As asserted by Brown (1999), Bowen focuses on the impact of undifferentiation on the emotional functioning of a single generation family and proclaims that relationship fusion, which leads to triangling, is the fuel for symptom formation which is manifested in one of three categories. The first is couple conflict which according to Brown (1999) will be at approximately equal levels of differentiation. Bowen believed that permission to disagree is one of the most important contracts between individuals in an intimate relationship. In a fused relationship, partners interpret the emotional state of the other as their responsibility, and the other's stated disagreement as a personal affront to them. The second are symptoms in a spouse, where each partner looks to the other's qualities to fit his / her learned manner of relating to significant others. A pattern of reciprocity can be set in motion that pushes each spouse's role to opposite extremes. Drawing from his analytic background, Bowen described this fusion as 'the reciprocal side of each spouse's transference'. Lastly are the symptoms in a child, which explains that a child develops behavioural or emotional problems. This comes under Bowen's fourth theoretical concept, the Family Projection Process (Brown, 1999).

3.3.1.4. Family Projection Process

The family projection process describes how children develop symptoms when they get caught up in the previous generation's anxiety about relationships. The child with the least emotional separation from his/her parents is said to be the most vulnerable to developing symptoms. Bowen describes this as occurring when a child responds anxiously to the tension in the parents' relationship, which in turn is mistaken for a problem in the child. A detouring triangle is thus set in motion, as attention and protectiveness are shifted to the child. Within this cycle of reciprocal anxiety, a child becomes more demanding or more impaired (Brown, 1999).

3.3.1.5. Emotional Cutoff

According to Brown (1999), Bowen describes emotional cutoff as the way people manage the intensity of fusion between the generations which can be achieved through physical distance or forms of emotional withdrawal. Growing away is viewed as part of differentiation where adult family members follow independent goals while

also recognising that they are part of their family system, while a cutoff is more like an escape, where people decide to be completely different to their family of origin (Brown, 1999).

3.3.1.6. Multi-generational Transmission Process

This concept of Bowen's theory describes how patterns, themes and positions (roles) in a triangle are passed down from generation to generation through the projection from the parent to the child, which was described earlier. The impact will be different for each child depending on the degree of triangling they have with their parents (Brown, 1999).

3.3.1.7. Sibling Positions

Bowen considered that a sibling's position could provide useful information in understanding the roles individuals tend to take in relationships and he was especially interested in which sibling position in a family is most vulnerable to triangling with parents. If one sibling in the previous generation suffered a serious illness or died, it is more likely that the child of the present generation in the same sibling position will be viewed as more vulnerable and therefore more likely to detour tensions from the parental dyad (Brown, 1999).

3.3.2. Critique of Bowen's Family Systems Theory

Rockwell (2010) elucidates that he conceptually and practically finds a handful of problems with Bowen's Family Systems Theory. He (Rockwell, 2010) states that the theory is hard to read as Bowen sometimes lapses into extended metaphor and esoteric explanations and he realizes that this is a common characteristic of systems language but it often complicates, rather than clarifies, Bowen's Family Systems Theory principles.

Bowen seems quite negative in his language about marriage because his discussions of marriage are always in the context of fusion and undifferentiation. He is almost always using the marital bond as a negative example, but it strikes as a misplaced illustration of enmeshed relationships when he uses marriage as his exclusive negative example (Rockwell, 2010). Rockwell (2010) added that Bowen also employs sexist language throughout his writings, and this fact, coupled with his

choice to use negative examples of dominant maternal figures in schizophrenic patients' families, adds to the impression that he is allowing some personal biases to colour his observations.

The value of objectivity over empathy that the theory provides may under-emphasize the importance of feelings, especially if clients have different goals than the therapist. Bowen's Family Systems Theory is also under-referenced by organisation and leadership theorists and his ideas, although quite original and ground-breaking, are common-sense and generic-sounding once they have circulated through a few publications (Rockwell, 2010).

The Family Systems Theory further highlights the importance of functional roles and emotional relationships among members of the family. Thus, this theory will allow the researcher to explore the psychological experiences of suicide bereavement by surviving family members. According to Brown (1999), Bowen's model pays attention to the emotional interaction of therapists and their clients and expects that the process of therapy must in some way be applied to the therapists' own lives so that they can remain meta to the client family system. Brown (1999) asserts that the wider focus of Bowen's model can be a drawback in that many clients want only to address symptom relief in the nuclear family. For the Bowenian therapist, symptom-reduction is seen only as the groundwork, from which families can proceed less anxiously towards working on detriangling and improved levels of differentiation. Herein lies a clear danger of discrepancies in client and therapist goals (Brown, 1999). Another criticism by Brown (1999) is that Bowen pays too much attention to the mother's contribution to symptom development in the child.

Murray Bowen failed to contextualise maternal behaviour and patriarchal assumptions about male / female roles and family organisation are not acknowledged or critiqued, which leaves women vulnerable to having their socially prescribed roles pathologised. Women are readily labelled as 'over-concerned', and their active, relational role in families too easily labelled as 'fused' and 'undifferentiated'. There is no questioning of societal norms that can be seen to '[school] females into undifferentiation by teaching them always to put others' needs first' (Brown, 1999). Brown (1999) stated that the women's project in family therapy asserts that a model such as Bowen's pressures the woman to 'back off' while

placating and courting the distant male. This is not only biased against women, but disrespectful of men since the model assumes men's limitations in terms of emotional engagement in therapy and family relationships (Brown, 1999).

3.3.3 The Afrocentric perspective

Since Bowen's Family Systems Theory is more western in terms of analysis, the Afrocentric perspective will be used in conjunction with it as the study will be in a more African environment with the participants also being Africans. The Afrocentric perspective espouses a commitment to African values, morals and beliefs, which leads to a positive self-persona and positive ethnic association (Asante, 1995). The Afrocentric perspective was born out of a need to preserve and empower the African ways of knowing or of analysing data (Asante, 1990), while on the one hand, rejecting the universalist notion of Eurocentrism, more especially positivism' which is a philosophical paradigm that originated in the 19th century and dominated the early 20th century (Kaboub, 2008).

Afrocentricity is defined in terms of the methodology, theory, and ideology that should be employed to achieve its objectives towards attaining the proposed change. Methodologically, Afrocentricity is intended as an answer to the intellectual colonialism that undergirds and serves to validate political and economic colonialism. In regards to theory, it places African people at the centre of any analysis of African phenomena in terms of action and behaviour. It is described as a devotion to the idea that what is in the best interest of African consciousness is at the heart of ethical behaviour and seeks to cherish the idea that "Africanness" itself is an ensemble of ethics (Chawane, 2016).

According to Chawane (2016), Afrocentricity as an ideology represents the continued longing among Africans for some set of ideas that would bind them together as a community. These set of ideas should offer some alternative to assimilation that is either excluded by Europeans or seen by Africans as an admission of inferiority and defeat; and as an academic phenomenon. Afrocentricity serves the purpose of binding together the various elements of African and African-American studies and transforming them from an interdisciplinary assortment into a unified discipline (Chawane, 2016).

There are three aspects to the Afrocentric paradigm which are the affective, cognitive, conative; the structural; and the functional. The affective, cognitive, conative aspect is understood as the navigating principles that function as the basis for inquiry into African phenomena (Pellerin, 2012). Afrocentricity constitutes a systematic approach to Africana phenomena where culture is emphasized as essential for the collective liberation of African people. It is therefore imperative that Afrocentric methodologies are generated for and applied to the construction of research projects as well as the interpretation of research on Africana people. This is epistemological centeredness which involves placing Africans as self-willed agents instead of objects of investigations (Mazama, 2003).

Chawane (2016) stipulates that the historical tendency of paying attention to Africa from an African perspective can be found in the USA in the early 1800s when it made one of its first appearances in an 1827 editorial in Freedom's Journal, the first black newspaper in the USA, which alleged a relationship between Africans and the ancient Egyptians. During the 20th century, Frederick Douglass (1953) and David Walker (1996) attempted to explain the reasons for the abolition of slavery in part on the achievements of the Nile Valley Africans (Chawane, 2016).

Afrocentricity also has its roots in the great Afro-American tendency of seeking mental health through right living and right believing. Afrocentrists made the connection between black history and black education, properly construed, and black self-esteem, long before the word "self-esteem" was a "cannot" word in the interpretation of African culture. Marcus Garvey, a Pan-Africanist of Jamaican origin, is venerated by most Afrocentrists as one of the early Afrocentrists to claim that ancient Egypt gave to the world civilisation (Chawane, 2016). The Afrocentricity idea gained momentum during the earlier forms of Black Nationalist thought, Negritude and Pan-Africanism, in the various forms it has taken since the 18th century, the Black Power Movement of the 1960s and the Black is Beautiful Movement of the 1970s.

Asante (1998) asserted that Afrocentricity is only one of several cultural perspectives from which multiculturalism in education is derived, noting that Afrocentricity is not the opposite of Eurocentricity, nor does it seek to replace Eurocentricity. According to him, Afrocentricity is constructive primarily because it does not deny others their

place. It is based on the harmonious coexistence of an endless variety of cultures. Equally, there can be no true multiculturalism without Afrocentrism. Afrocentrists believe that the study of Africa and African people, wherever they live or have lived, necessitates distinct approaches because so much of their civilisations were intentionally destroyed or distorted by invaders, interrupted by the transatlantic slave trade, or not written or codified. Furthermore, they generally maintain that for decades much of Western scholarship was subverted by racism and cultural arrogance (Chawane, 2016). Asante states that Afrocentricity serves as the establishment of the subject place of Africans and the destruction of the compliance with the European ideas and concepts of Africans (Asante, 1988).

The prioritisation of African people's customs, beliefs, motifs, values, and conceptualisations is the rubric by which the application of an Afrocentric methodology operates. According to Modupe (2003) Afrocentricity is the continental and diasporic African collective cognitive will to cultural and psychic liberation with the ultimate goal being Africana existence on Africana terms Modupe, (2003). Therefore, Afrocentric methodologies must operate as valid and reliable research aimed towards the freeing of Africana peoples' thoughts and realities. Thus, Afrocentricity is the social science inquiry basis of African cultural phenomenon in practice (Pellerin, 2012).

The Afrocentric perspective requires the researcher to not simply describe a phenomenon, but to also provide culturally infused descriptions and explanations of an African phenomenon. Pellerin (2012) suggested that analysis of an Afrocentric social science research project depends heavily on the researcher's ability to produce sophisticated data analysis rooted in the insights gained from not only observing, but also comprehending African reality from an African perspective. The researcher in the present study will thus consider these kinds of suggestions when conducting the investigation. The researcher in this study was constantly aware of those dynamics and suggestions during participation with participants.

This perspective promotes an alternative social science paradigm more reflective of the cultural and political reality of the African people. Looking at the study with an Afrocentric lens will help to incorporate new strategies that are harmonious with the particular cultural styles, experiences, traditions, and interpretations of the African

people, which can lead to more effective human services practice. It is, therefore vitally critical to use a perspective that is grounded on traditional African philosophical assumptions. The Afrocentric perspective is therefore appropriate for the study in that there is a need for a conceptual paradigm that reflects the cultural background and reality of the African people. This study was conducted in an African setting where Afrocentric ways of doing things are valued. The social values and norms play a role in the day to day lives.

3.3.4 Critique of Afrocentrism

The first criticism of Afrocentrism according to Ebede-Ndi (2016) lies in the definition of Afrocentrism, which entails that Afrocentrism is the study of African peoples using an Africa-centered lens. Ebede-Ndi (2016) explained that the problem with this definition is the placement of Africa at the centre of any analysis of African history and culture, including the African American experience. Afrocentricity is criticised for the findings which are said to be arrived at in an unscholarly fashion, noting that the academic credentials of many Afrocentrists are in fields other than African studies.

According to Chawane, (2016) critics continue to challenge the route taken by these scholars to establish the validity of the findings of Afrocentric scholarship and call for a need to examine this route.

Adeleke (2009) as cited by Ebede-Ndi (2016) criticizes that Afrocentrism as an ideology offers little more than a psychological and therapeutic feel-good-together philosophy or a new reconstruction of world history full of historical myths and legends. Afrocentrism is also seen as a form of fragmentation, desegregation, and tribalisation of American life standing, as opposed to the ideal of multiculturalism. It is contended that the Afrocentric curriculum removes blacks from America in favour of a fictitious connection with Africa; that many black American families have been in America for a long time (Ebede-Ndi, 2016)

Afrocentricity is criticised for its recommendation that Swahili should be adopted as an Afrocentric language, the reason being that people who were taken to America during the transatlantic slave trade did not speak or even know the language (Chawane, 2016). The same can be said about Africans in Africa where there is a multitude of languages, which raises questions of the acceptability of the

recommendation. Some opponents of Afrocentricity have a problem with its approach to knowledge that is Africanised and prefers what they see as a universal approach to knowledge (Chawane, 2016).

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

In this chapter, the researcher details the method through which the study was carried out. Firstly, qualitative research, as the main approach through which the study is directed, is explained, including the motive behind it. This chapter also entails the methods used for sampling participants, description of the population from which the sample was derived and the sample itself and also the method used for data collection. The researcher also explains Hycner's explicitation method, which is the method that was used for analysing collected data in this study. Also included in this chapter are the quality criteria for ensuring the quality of the data and the ethics that were considered throughout the study.

4.2 Qualitative research

The study was qualitative and sought to capture the lived experiences of families post suicide bereavement. Qualitative research projects are informed by the interpretivists paradigm or philosophy. Interpretivism refers to the approaches which emphasise the meaningful nature of people's character and participation in both social and cultural life (Elster, 2007). It denotes that the methods of the research which adopt the position that people's knowledge of reality is a social construction by human actors, and so it distinctively rules out the methods of natural science (Eliaeson, 2002). It has its roots in the philosophical traditions of hermeneutics and phenomenology, and the German sociologist Max Weber is generally credited with being the central influence (Chowdhury, 2014).

The interpretivist paradigm is originally rooted in the fact that the methods used to understanding knowledge related to human and social sciences cannot be the same as its usage in physical sciences because humans interpret their world and then act based on such interpretation while the world does not (Hammersley, 2013). Consequently, interpretivists adopt a relativist ontology in which a single phenomenon may have multiple interpretations rather than a truth that can be determined by a process of measurement (Pham, 2018). This relativist ontology

relates to the nature of reality and its characteristics. The researcher embraces the idea of multiple realities and reports on these realities by exploring multiple forms of evidence from different individual's perspectives and experiences (Creswell, 2012).

According to Babbie (2007), qualitative studies are aimed at answering the question of why things are the way they are and how they came to be like that. Tewksbury (2009) explains that because of the differences in the data, how data is collected and analysed, and what the data and analyses can tell us about our subjects of study; the knowledge gained through qualitative investigations is more informative, richer and offers enhanced understandings compared to that which can be obtained via quantitative research. Tewksbury (2009) asserts that the superiority of qualitative research arises from the core differences in what qualitative and quantitative research are, and what they can contribute to bodies of knowledge.

The rationale behind the choice of qualitative research was for the researcher to gain an in-depth understanding of how families viewed suicide and the psychological experiences they experienced, and the understanding of how they eventually coped with the aftermath. The conceptualisation of suicide bereavement and the meanings attached to it are mostly culture laden (Pellerin 2012). Another reason for the researcher to utilise the qualitative research approach was to understand multiple constructed realities in the present context (Creswell, 2012).

4.3 Research design

These are inductive, emerging views and are shaped by the researcher's experience in collecting and analyzing the data (Creswell, 2012). The case study design method was being employed, where the researcher was able to be closer to families being studied in their own home, in their African way of living. Qualitative research is a scientific method of observation to gather non-numerical data. It is the type of research that refers to the meanings, concepts definitions, characteristics, metaphors, symbols and description of things and not to their counts or measure (Creswell, 1998). At the core, qualitative research focuses on the meanings, traits and defining characteristics of events, people, interactions, settings/cultures and experience. As one leading proponent of qualitative methods has explained; quality refers to the what, how, when, and where of a thing– its essence and ambience.

4.3.1 The case study design

The case study design was adopted as the method to guide this study and to better unearth the psychological experiences of nuclear families affected by suicide bereavement. A case study method enables a researcher to closely examine the data within a specific context. In most cases, a case study method selects a small geographical area or a very limited number of individuals as the subjects of the study. Case studies, in their true essence, explore and investigate contemporary real-life phenomenon through detailed contextual analysis of a limited number of events or conditions, and their relationships (Zaidah, 2007). Yin (2003) defines the case study research method as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not evident; and in which multiple sources of evidence are used.

A case study can either be a single-case or multiple-case design depending on the issue in question. In cases where there are no other cases available for replication, the researcher can adopt the single-case design. However, the drawback of a single-case design is its inability to provide a generalising conclusion, in particular when the events are rare. One way of overcoming this is by triangulating the study with other methods to confirm the validity of the process. The multiple-case design, on the other hand, can be adopted with real-life events that show numerous sources of evidence through replication rather than sampling logic (Zaidah, 2007). According to Yin (2003), the generalisation of results from case studies, from either single or multiple designs, stems on theory rather than on populations. By replicating the case through pattern-matching, a technique linking several pieces of information from the same case to some theoretical proposition (Zaidah, 2007), the multiple-case design enhances and supports the previous results.

4.3.1.1 Categories of case study methods

There are several categories of case study methods used in research. These methods include:

a) Exploratory case studies set to explore any phenomenon in the data which serves as a point of interest to the researcher. In this case study, prior fieldwork and small scale data collection may be conducted before the

research questions and hypotheses are proposed. As a prelude, this initial work helps prepare a framework of the study. A pilot study is considered an example of an exploratory case study (Yin, 2003) and is crucial in determining the protocol that will be used (Yin, 2003).

b) Descriptive case studies are set to describe the natural phenomena which occur within the data in question, for instance, what different strategies are used by a reader and how the reader uses them. The goal set by the researcher is to describe the data as they occur. The challenge of a descriptive case study is that the researcher must begin with a descriptive theory to support the description of the phenomenon or story. If this fails there is the possibility that the description lacks rigour and that problems may occur during the project (Yin, 2003).

c) Explanatory case studies examine the data closely both at a surface and deep level to explain the phenomena in the data. Based on the data, the researcher may then form a theory and set to test this theory (Yin, 2003). Explanatory cases are also deployed for causal studies where pattern-matching can be used to investigate certain phenomena in very complex and multivariate cases (Zaidah, 2007).

d) Multiple-case (collective case) studies enable the researcher to explore differences within and between cases. The goal is to replicate findings across cases. Because comparisons will be drawn, the cases must be chosen carefully so that the researcher can predict similar results across cases, or predict contrasting results based on a theory (Yin, 2003).

e) Intrinsic case studies are used when the intent is to better understand the case. It is not undertaken primarily because the case represents other cases or because it illustrates a particular trait or problem, but because in all its particularity and ordinariness, the case itself is of interest. The purpose is NOT to come to understand some abstract construct or generic phenomenon (Stake, 1995).

f) Instrumental case studies are used to accomplish something other than understanding a particular situation. It provides insight into an issue or helps

to refine a theory. The case is of secondary interest; it plays a supportive role, facilitating our understanding of something else. The case is often looked at in-depth, its contexts scrutinized, its ordinary activities detailed because it helps the researcher pursue the external interest. The case may or may not be seen as typical of other cases (Stake, 1995).

The researcher in the current study adopted the exploratory case study method to explore the experiences of nuclear family members bereaved by suicide. The phenomenon of suicide bereavement was of interest to the researcher and it is advantageous as it yields more information than was initially expected through the use of semi-structured interviews that allow for probing.

4.3.1.2 Disadvantages of case studies

According to Yin (1984), case studies are often accused of a lack of rigour. Yin (1984) notes that too many times, the case study investigator has been sloppy, and has allowed equivocal evidence or biased views to influence the direction of the findings and conclusions. Secondly, case studies provide very little basis for scientific generalisation since they use a small number of subjects, some conducted with only one subject (Yin, 1984:21).

The third disadvantage is that case studies are often labelled as being too long, difficult to conduct and producing a massive amount of documentation (Yin, 1984). In particular, case studies of ethnographic or longitudinal nature can elicit a great deal of data over some time. The danger comes when the data are not managed and organised systematically (Zaidah, 2007). Lastly, a common criticism of the case study method is its dependency on a single case exploration making it difficult to reach a generalising conclusion (Zaidah, 2007).

4.4 Location of study

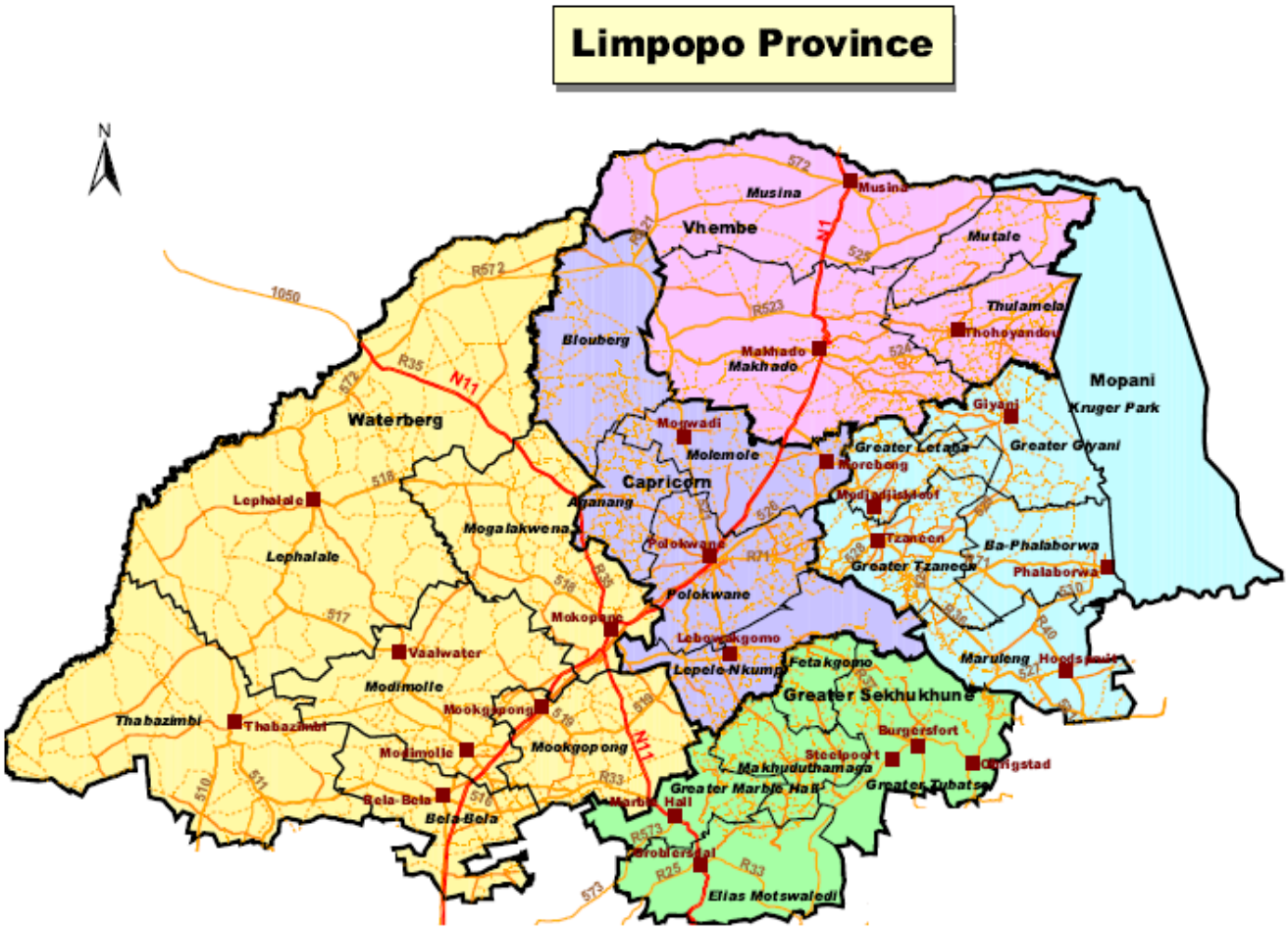

Figure: 4.4.1 Map of Limpopo Province (Limpopo Provincial Government, Strategic Information Management (GIS) & Research; 2019)

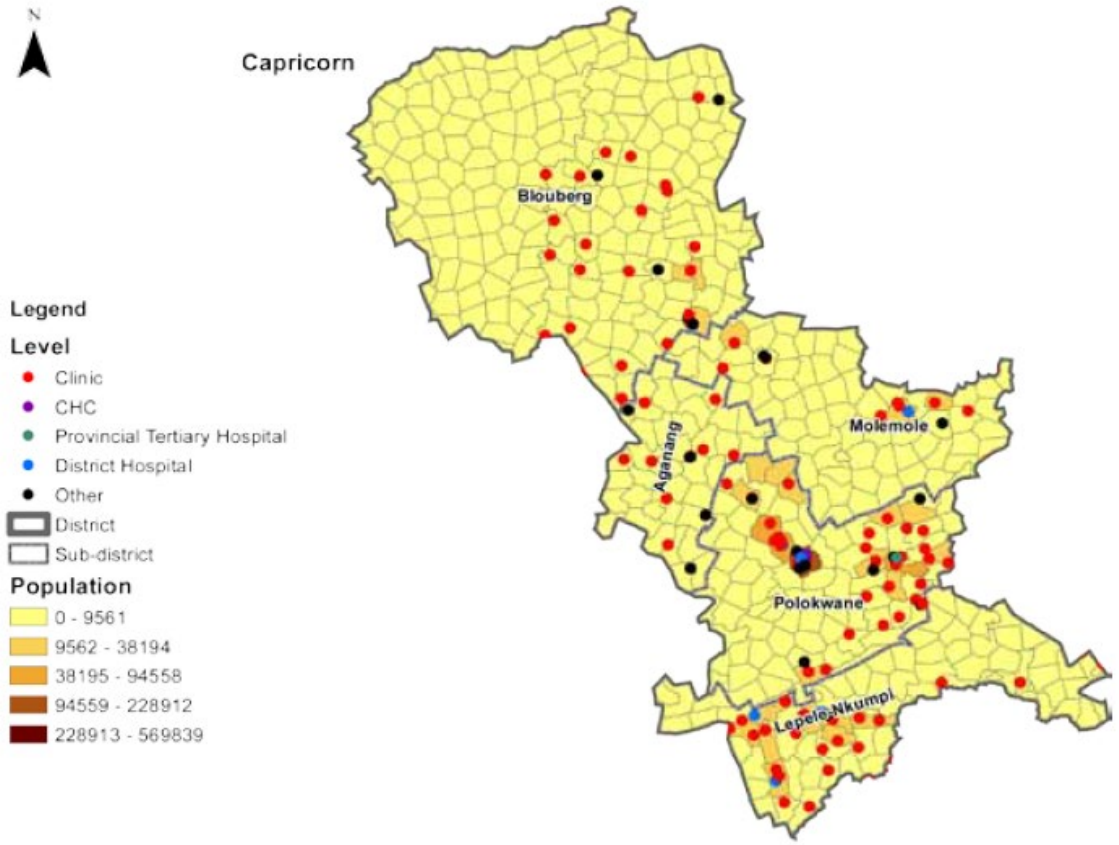

Figure 4.4.2: Map of the Capricorn District (Statistics South Africa. Census 2011. Municipal fact sheet. Report No. 03-01-58. Pretoria: Statistics SA; 2012)

The study participants were sourced from the Capricorn District, which is located in the central part of Limpopo Province, in the North of South Africa. The district has five local municipalities, namely Aganang, Blouberg, Lepelle-Nkumpi, Molemole and Polokwane. Capricorn district forms a gateway to Botswana, Zimbabwe and Mozambique (Statistics South Africa, 2012). The families identified were drawn from Northern Sotho speaking people. The language spoken by the identified families was of paramount importance for both the researcher and the participants to better understand each other, and not to omit important themes that could emerge during the interview**.**

4.5 Population

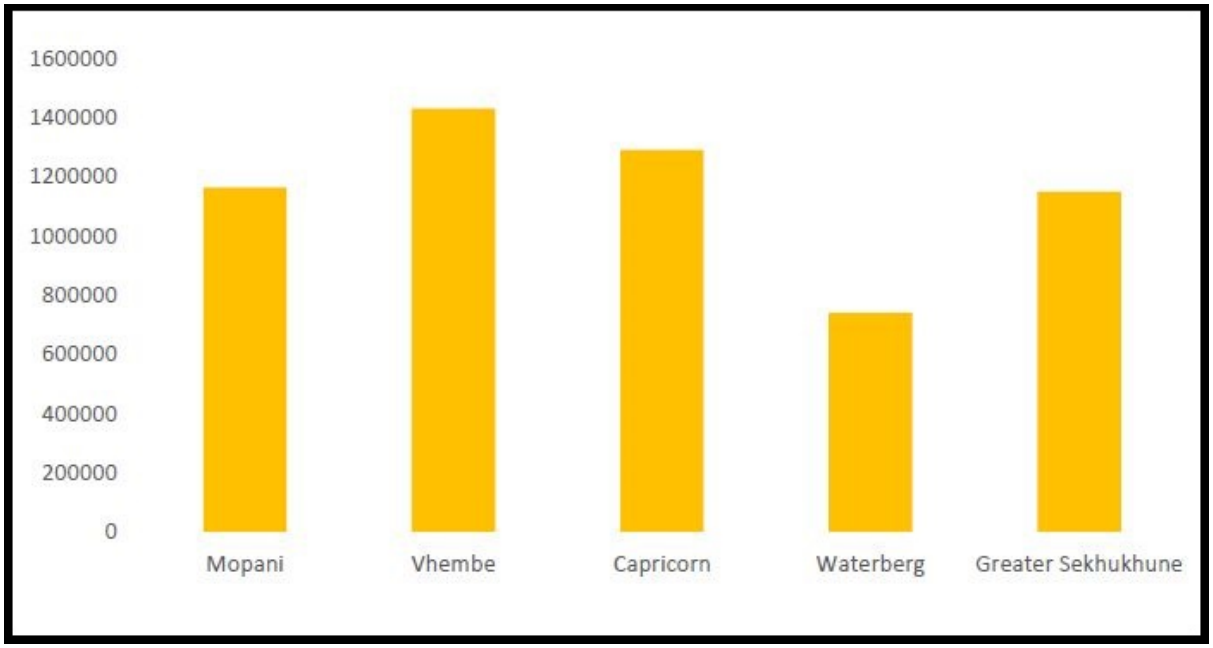

Figure 4.5.1: Limpopo Provincial population by district (Statistics South Africa, 2012)

Limpopo has an overall population of approximately 5.8 million, which represents 10.2 percent of the national population. This province has experienced positive growth in its population over a period from 2002 to 2017. In 2002 the provincial population was recorded at 5.0 million and it rose by around 800 thousand to 5.8 million in 2017 (Limpopo Socio-Economic Review and Outlook, 2019).

The above diagram (Figure 4.5.1: Limpopo Provincial population by district) shows the provincial population by district with Vhembe at (1.43 Million) and Capricorn at (1.29 million), is the second biggest in terms of the provincial population share, followed by Mopani (1.16 Million), Greater Sekhukhune (1.29 Million) and Waterberg (740 thousand) respectively (Limpopo Socio-Economic Review and Outlook, 2019). With a population density of 59.7 persons per km^2, Capricorn district falls in socioeconomic Quintile 2, among the poorer districts (Statistics South Africa, 2012).

4.6 Sampling

The study sample was selected through non-probability strategies. The non-probability sampling theory suggests that, unlike with the probability theory, each unit in a sampling frame does not have an equal chance of being selected for participation (Silverman, 2000). Although several non-probability sampling strategies are usable, in this study, the research adopted the purposive sampling method. The purposive sampling method is a sampling method wherein a particular case is chosen because it illustrates some feature or process that is of interest for a particular study (Babbie, 2007). This type of sampling is based entirely on the judgment of the researcher, in that, a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population that serve the purpose of the study best. Hence, the most informative respondents were selected to participate in the study (Silverman, 2000).

For this study, the participants had to be nuclear family members who were bereaved by suicide, residing in the Capricorn district and were above the age of 18. Extended family members were excluded from the study due to family dynamics. Also excluded by the researcher were nuclear family members of the deceased who were under the age of 18, residing outside the Capricorn district of Limpopo province, and those that were not willing to participate in the study. Nuclear families members that were bereaved through any other cause of death other than suicide were also excluded in this study. Participants who met the criteria were then identified for participation. A total of five families were envisaged for the present study.

4.7 Entry negotiation

It is very important to choose the right strategy and proper planning to gain access to the field to obtain high response rates and relevant information for the research. It is equally important to be flexible and adaptable to the changes which occur at the research site. There are three ways to complete entry negotiation: One can benefit formally, where an agreement should be achieved between the organisation and the researcher on a specific condition in terms of what, when and how empirical data are collected and what might be the return. An individual can also gain through personal access, where the researcher knows the relevant executives, managers and

individuals in the organisation. Lastly, it can be through a third type, where the researcher can foster individual rapport where a good understanding is developed and there is collaboration between the researcher and the organisation (Johl & Renganathan, 2010).

The first type, which is formal access, was used in the current study. The researcher obtained access by writing formal letters to the organisations involved in the project. Firstly, the researched proposal was cleared by the Faculty of Humanities of the University of Limpopo (see Appendix 3: Faculty approval of proposal), and then cleared again by the Turfloop Research Ethics Committee (see Appendix 4: TREC ethical clearance certificate). The participants in the study were then given an informed consent letter and form (see Appendix 2a- English version and 2b- Sepedi version) before they could participate and the ethical considerations were read to them.

4.8 Data collection and procedure

Data was collected through semi-structured interviews consisting of open-ended questions to collect data from suicide bereaved nuclear family members (see Appendix 1a: Interview guide – English version, and Appendix 1b: Interview guide – Sepedi version, on pages 148 and 150). According to Babbie (2007), semi-structured interviews are useful in that they allow the participant to speak for him/herself rather than to provide him/her with a set of fixed hypothesis-based questions. The open-ended questions start with broad questions and move on to more specific, narrow questions as the interview progresses. Flexibility is imperative for this type of study as it provides the opportunity to explore issues working with interviewee responses (Greenop & Thomas, 2008). The interview guide contains fourteen open-ended questions that allow for probing the participants' understanding of suicide and the causes and psychological coping strategies. The questions seek to put to light the stigma and societal reactions associated with suicide bereavement. The open-ended questions also seek to understand the participants' experiences concerning their religious beliefs.

According to Gill, Stewart, Treasure and Chadwick (2008), face-to-face interviews are most appropriate in instances where participants may not want to talk about their

issues or experiences in a group environment. Face-to-face semi-structured interviews allow the interviewer or interviewee to diverge to pursue an idea or response in more detail. This interview format is flexible as it allows for the discovery or elaboration of information that is important but may not have been previously thought of as pertinent by the research team (Gill et al.,, 2008). The face-to-face interview responses about the participants' experiences of suicide bereavement were audio recorded during the interaction. All interviews were later transcribed verbatim and the accuracy between the digital audio-recordings and the transcripts were checked. The transcriptions were translated from Sepedi to English by a translator.

4.9 Pretesting

Casper, Peytcheva, Yan, Lee, Liu and Hu (2016) define a pretest as the collection of the qualitative and quantitative techniques and activities that allow researchers to evaluate survey questions and survey procedures before data collection begins. It is regarded as an effective technique for improving credibility in qualitative data collection procedures and the interpretation of findings (Hurst, Arulogun, Owolabi, Akinyemi, Uvere, Warth, & Ovbiagele; 2015). According to Hurst et al.,, (2015), pretesting involves simulating the formal data collection process on a small scale to identify practical problems concerning the data collection instruments, sessions, and methodology. It also provides an opportunity to make revisions to the study materials and data collection procedures to ensure that appropriate questions are being asked and that questions do not confuse or make respondents uncomfortable.

In the current study, the researcher pretested the semi-structured interview guide by interviewing two people initially and discussed the responses received with the supervisor. In light of that, the researcher was then given the go-ahead, with advice to probe more to gather as much information as possible about the experiences of suicide bereavement. With this advice in mind, the researcher proceeded and conducted all the other interviews.

4.10 Data analysis

The researcher used the phenomenology approach as the method of data analysis. This approach was founded by Edmund Husserl (1859-1938) who rejected the belief

that objects in the external world exist independently and that the information about objects is reliable (Groenewald, 2004). Some phenomenologists (Martin Heidegger, Alfred Schultz, Jean-Paul Sartre and Maurice Merleau-Ponty, to name a few) subsequently came forward and contributed greatly to this approach (Groenewald, 2004). The researcher adopted Hycner's explicitation process which is an investigation of a phenomenon while keeping the context of the whole, to analyse the responses gathered from the participants. The explicitation process has five steps, which are listed as follows (Groenewald, 2004):

4.10.1 Bracketing and phenomenological reduction

In this step, the researcher suspends or brackets his/her prior knowledge about the phenomenon by attempting to bring the interviewees knowledge to the surface (Hayes, 2000). This means using the matrices of that person's world-view to understand the meaning of what that person is saying, rather than what the researcher expects that person to say (Makgahlela, 2016). The researcher in the present study ensured that her assumptions were bracketed before listening to each participant's interview several times to get the general sense and the quality of the interview conducted with each participant. This was also done to gain an in-depth understanding, especially from the participant's vantage point, of their personal experiences of the phenomena under investigation. The audios were then transcribed, translated and then reviewed to identify any loss of meaning that could have been suffered during the translations. Where a loss of meaning was identified, the researcher re-captured the true essence of the statements, by also listening to the original audio interviews once again.

4.10.2 Delineating units of meaning

During this step, units of meaning that are identified as having significance about the phenomenon being studied are identified and isolated (Groenewald, 2004). The researcher in this study went over every word, phrase, sentence, paragraph and noted significant nonverbal communication in the transcript to define the participant's meanings. Meanings that were repeated were coded to come up with units of meaning that emerged from all the transcripts.

4.10.3 Clustering of units to form themes

The researcher here tried to elicit the essence of the meaning of units within the holistic context. In other words, whether there seems to be some common theme or essence that unites several discrete units of relevant meaning. Clusters of themes are typically formed by grouping units of meaning together (Creswell, 1998; King, 1994; Moustakas, 1994) and the researcher identifies significant topics, also called units of significance (Sadala & Adorno, 2001). The researcher in the present study clustered the relevant units of meaning in line with the study objectives for each study participant. Units of meaning that were repeated or were redundant were eliminated. At this stage it started to emerge that some units of meaning were converging, thus supporting specific themes for each participant.

4.10.4 Summarising each interview, validating it and where necessary modifying it

According to Groenewald (2004), the researcher in this step conducts a validity check by returning to the informant to determine if the essence of the interview has been correctly captured, and any necessary modification is done as a result. In the present study, the researcher summarised each transcript, went back to the participant to validate the information to retain the essence of the initial interviews conducted and also with a view that each participant should be able to relate to the summary of the interview. All the summaries were endorsed by the participants as a true reflection of their lived experiences.

4.10.5 Extracting general and unique themes from all the interviews and making a composite summary

During this step, the researcher looks for the themes common to most or all of the interviews as well as the individual variations. The researcher must also be careful not to cluster common themes if significant differences exist (Groenewald, 2004). The researcher in this step then developed a composite summary for all transcripts. The researcher identified the general and unique themes that were identified from all the interviews. Each of the themes retained the individual participant‘s coded relevant units of meaning in the form of quotations or excerpts. Under every general

or unique theme, some individual participants' coded quotations were then retained for illustrative purposes.

4.11 Development of a psychological model

Wacker (1998) suggested that theory building rests upon four stages that are not necessarily sequential since they interact with each other. The researcher in the current study used these stages to develop a culturally informed psychological model of suicide. These stages are:

a) Definition of variables - This stage involves conceptual definitions from the literature (Wacker, 1998). The researcher in this study defined the major and sub-concepts of the model to enlighten the reader about their meanings as used in this study. The major concepts included causes of suicide, the loss of a family member to suicide and the individual characteristics and experiences. The sub-concepts of the model, which are the social and psychological impacts, how the family structure is affected and also the overestimation of responsibilities, were clarified. All these concepts were defined as to what they mean in the concept of suicide bereavement.

b) Domain specification - In the domain specification stage, the generalisability virtue is important because the more domains in which a theory can be applied, the more important the theory is. The domains are developed from the cases studied (Wacker, 1998). At this stage, the researcher carefully presented the conditions for when and where the results apply. The developed model applies to a suicide bereaved family, African and also dwelling in an African society.

c) Relationship (model) building - In the relationship-building step, parsimony, fecundity, and abstraction virtues enhance the theory by using only necessary relationships, offering new areas for investigation, and integrating relationships for a higher abstraction level. Also in this stage, internal consistency is important to verify which relationships are logically compatible with each other. Generally, as more internally consistent relationships are integrated into a theory, the theory can explain more, therefore raising the theory's abstraction level. This stage includes combining relationships

discovered from the cases involved (Wacker, 1998). In this stage, the researcher describes the relationship between the concepts of the model. This includes how the social and psychological impacts on the surviving family members relate to the causes of suicide or how the loss of a family member to suicide can affect the family structure as a whole or can lead to overestimation of responsibilities.

d) Theory predictions and empirical support - In the theory prediction step, the importance of internal consistency and empirical riskiness are both needed for the theory to make predictions. The theory predictions are supported by the case studies (Wacker, 1998). This step indicates that one concept can directly or indirectly be caused by another. Here, based on the findings of this study, the researcher states that suicide bereavement leads to an overestimation of responsibilities, psychological problems and a disruption of the family structure, which leads to more psychological problems, complicated grief and suicide.

	Purpose of this step	**Common question**	**Good theory virtues emphasised**
Definition of variables	Defines who and what is included and what is specifically excluded in the definition.	Who? What?	Uniqueness, conservation
Limiting the domain	Observes and limits the conditions by when and where the subsequent events are expected to occur.	When? Where?	Generalisability
Relationship (model) building	Logically assembles the reasoning for each relationship for internal consistency.	Why? How?	Parsimony, fecundity, internal consistency, abstractness
Theory	Gives specific predictions.	Could the event	Empirical tests

predictions and empirical support	Important for setting conditions where a theory predicts. Tests model by criteria to give empirical verification for the theory. The riskiness of the test is an important consideration.	occur? Should the event occur? Would the event occur?	refutability

Table 4.1: A general procedure for theory-building and the empirical support for theory (Wacker, 1998)

4.12 Trustworthiness of the study

To ensure that the results of the contemplated study are trustworthy, the following quality criteria will be observed:

4.12.1 Credibility

This is the alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (De Vos, Strydom, Fouche & Delport; 2005). In the present study, credibility was assured by engaging in an ongoing discussion of the findings with a non-contractually involved peer to be able to get a thorough description of the suicide bereaved experience.

4.12.2 Transferability

Lincoln and Guba (2000) propose this as the alternative to external validity or generalisability, in which the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who would make the transfer. In the present study, transferability was ensured by selecting participants purposefully, that is, to select participants or cases that are information-rich. In this case, nuclear family members of the deceased who are 18 years and older were seen as the ones who can describe their experiences better, which was more important to the outcome of the study.

4.12.3 Dependability

This is the alternative to reliability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for study as well as changes in the design created by an increasingly refined understanding of the setting. This represents the set of assumptions very different from those shaping the concept of reliability (De Vos et al.,, 2005). Different types of data are collected and different conclusions were reached to ensure dependability.

4.12.4 Confirmability

The final construct, confirmability, captures the traditional concept of the objectivity. Lincoln and Guba stress the need to ask whether the findings of the study could be confirmed by another (De Vos et al.,, 2005). To ensure confirmability data, interpretations, and findings were attached to individuals and contexts apart from the researcher.

4.13 Ethical considerations

4.13.1 Permission to conduct the study

The researcher submitted the research proposal through the relevant university's research and ethics committees for approval before embarking on the study. Ethical approval was obtained from the University of Limpopo's Turfloop Research Ethics Committee (see Appendix 4: Ethical clearance certificate).

4.13.2 Informed consent

To ensure the issue of informed consent, the researcher informed the participants about the reason, aims, and purpose of the investigation into their experiences of suicide bereavement and also about what will be involved and what will happen to the data they generate. The researcher also had the participants sign a consent form which explains all the above without any coercion (see Appendix 2a: Informed consent letter and form-English version and Appendix 2b: Informed consent letter and form- Sepedi version).

4.13.3 Anonymity and confidentiality

The researcher ensured the participants' anonymity by not disclosing their identities or revealing their real names throughout the report and also assuring them that this will not change. Pseudonyms were assigned to all participants to protect the suicide bereaved participants and their families.

4.13.4 Aftercare for participants

Participants who showed emotional distress as a result of their participation in the study were referred to mental health practitioners for assistance. Regular follow-up visits would be done to ensure that participants are coping well following exposure to the research process.

4.14 Summary

This chapter shed light on qualitative research as the main research method utilised for this study. As Tewksbury (2009) puts it, qualitative research focuses on the meanings, traits and defining characteristics of events, people, interactions, settings/cultures and experience. Qualitative research aims to dig for in-depth information about the lived experiences of family members bereaved by suicide as they experienced it. Now that the plan is outlined, the next chapter presents the results of this study and then the discussion section where the results will be discussed in terms of the literature explored in this study, using Hycner's explicitation method of data analysis.

CHAPTER 5

RESULTS

5.1 Introduction

The study aimed to explore the psychological experiences of family members' bereavement who have lost family members through suicide in the Capricorn District of the Limpopo Province. Hysner's explicitation method was used to make sense of the raw data from the case of each research participant. The researcher's strategy involved attending closely to the data and deriving themes from it. In this chapter, the demographic information of the participants is provided. The profiles and a brief description of the cases are also presented. These profiles aim to impart a little information about them before getting deeper into the experiences of the bereaved family members. The experiences are divided into themes to make the information clear to the reader.

5.2 Profile of participants

In total, 11 participants from 5 families were interviewed. Three were males and the other 8 were females. The first family consists of the mother and brother, the second family is the wife, the mother and the brother, in the third family it is the mother and the sister of the deceased, the fourth family is the wife and the daughter, and the last family is the aunt (father's sister who was the legal guardian) and the son. Participants were all Africans over the age of 18 years and residing in the Capricorn District of Limpopo Province. All participants were given pseudonyms to protect their identity and to maintain confidentiality. The participants' demographic information is laid out in Table 5.1 below.

Table 5.1: Demographic information

Pseudonym of deceased family member	Pseudonym of bereaved family members	Age	Gender	Relationship to deceased	Religion	Area of residence	Years since the incidence
1.Thabo (16 years, male)	Maria	44	Female	Mother	Christian	Area 1	2 years & 8 months
	Tumelo	27	Male	Brother			
2.Phuti (37 years, male)	Mmatlou	30	Female	Wife	Christian	Area 2	2 years
	Choene	35	Male	Brother			
	Rosina	60	Female	Mother			
3.Lesly (34 years, male)	Evelyn	62	Female	Mother	Christian	Area 3	5 years
	Boitshepo	31	Female	Sister			
4. Thebe (48 years, male)	Raisibe	59	Female	Wife	Christian	Area 4	10 years
	Lesego	32	Female	Daughter			
5. Wilson (38 years, male)	Metja	46	Female	Sister	Christian	Area 5	11 years
	Lucky	25	Male	Son			

5.3 Brief description of the cases

5.3.1 Thabo's family

Thabo was a 16-year-old scholar staying in Bendor (Polokwane). He hung himself in the study at home after realising that the family was about to find out that he failed the June exams and faked a report. They were waiting for the end of year report when they decided to go to his school to enquire. He locked himself in the study in the morning, while he was supposed to accompany his mother and brother to school. He hung himself using an electric cable tied to a cupboard. The family members searched for him until the brother broke the study door and found him.

Tumelo (the brother) was a medical student. He tried resuscitating him while waiting for the paramedics. Tumelo was also saving up to buy Thabo a guitar for his birthday, which was in December, as he loved music. He is now a general practitioner and indicates that the loss of his brother affects his work.

His mother (Maria) couldn't believe it when the paramedic certified her son's death. She didn't even cry until after they had buried him. She then had a breakdown and was admitted to the hospital for a minimum of three weeks. She couldn't even talk about it without crying. She has now accepted it and can talk about him freely and look at pictures of him. She has repainted the study and put some mementoes of him in there. Thabo's father still does not feel comfortable talking about it and the other siblings do not meet the inclusion criteria.

5.3.2 Phuti's family

Phuti was 37 years old and married with a son when he took his life. He was just diagnosed with depression, was given antidepressants and also booked for therapy. Phuti overdosed on the antidepressants, drinking them with alcohol. He then fell, hit a corner of the table and died. He was found by his wife on the floor, in a pool of blood. No one knew about this except his brother, Choene, who blames the wife for his brother's suicide, alleging that she is the one who caused the depression. Choene hasn't done anything about his own psychological state since the loss and says even after two years it still feels like it just happened. He also blames himself

for not being there for his brother as he was the only one who knew about his mental state.

Mmatlou (Phuti's wife) was admitted to a psychiatric ward after the loss of her husband and therefore attended therapy with her son. She has accepted the loss but is sometimes worried about the lack of unity in the family. She also feels like her in-laws are also hampering her son's recovery as they are still stuck in the hurt. The son does not meet the inclusion criteria. His mother (Rosina) also didn't know about her son's problem. It is still hard for her to accept, but she is trying. She likes going to church even though she thinks the other people at church judge her and talk about her. She consoles herself with her grandson.

Phuti's wife, brother and mother feel like he didn't get the respect he deserved because his body was not allowed into the yard and they were not allowed to see it. It is said to be a curse to see someone who had killed themselves. His mother feels that it would have felt better if she had seen him for the last time, but they had to follow norms and get it over with so they can move on with life.

5.3.3 Lesly's family

Lesly's family resides in Polokwane and have their own businesses. Lesly was called by his father to assist with the family businesses as he could not find employment after graduating. They noticed that the profits were going down, but it only came to their attention after his death that he was using drugs and were involved in a wrong group of people. On the day of his suicide, he argued with a petrol attendant and shot him in the leg. The police went looking for him and found him at a friend's house. He started running when he saw them, tried escaping, but they chased him and when he noticed that they were about to catch up to him he took out his gun and shot himself in the head.

The parents were called by the police that evening. They could not believe it as they never thought he was capable of even thinking about something like that. He was 34 years old at the time and the parents thought of him as a responsible adult. The family found out that the drug dealers he was involved with were blackmailing him. He left a note stating that he did it to protect his parents. Before he took his life he used to lock himself in the room and would talk about people following him, but only

the caretaker knew about that, the family did not know. The caretaker also did not take him seriously because she thought it was hallucinations from the drugs.

Lesly's father died a few years later from heart problems. His mother (Evelyn) underwent therapy and his younger sister (Boitshepo) was admitted for depression. The other sister stays outside the country. Even though they talk about Lesly as a family, they have accepted the loss and are moving on with life. Evelyn goes to church but feels that people still talk about her behind her back and think of the incident as entertainment.

5.3.4 Thebe's family

Thebe was a lecturer at a college, residing at his place of work. He was faced with taking responsibility for his brothers', sisters', and his children. No one in the family ever thought that this may be overwhelming to him until he took his life. He strangled himself and some of the family members attributed this to witchcraft by a family member. In his diary, he had written that some of the older children in the family are threatening to kill him and he thought it would be better for him to kill himself so that his family would be able to bury him. He wrote that the people threatening to kill him may hide his body and the family will not be able to bury him.

Raisibe, Thebe's wife, was a stay at home mom who then had to find employment to provide for their children. She was informed about the incident by the victim's colleagues while at home and far away from him. She couldn't believe it and kept asking herself what the problem could have been.

Lesego was still young at the time and her mother had hidden the real cause of the death from her and the younger siblings. She had to hear the story from people in the neighbourhood who would refer to her as "the daughter of the man who committed suicide". When she was at university she asked for her father's diary from her mother and that was when everything was revealed.

5.3.5 Wilson's family

In this family, the story is a homicide/suicide. Wilson, the husband, shot his wife and then shot himself. He is reported to have come home drunk one evening and was shouting, then he took out his gun, shot his wife and then himself. They were with

the children, and even the eldest (Lucky), was too young to understand what was going on.

It was so sad for the children to have experienced that, and their aunt (Metja) decided to take them to stay with her. The community wouldn't even allow the deceased to be buried in the community cemetery, claiming they are cruel and cursed. Metja had to fight for her brother and sister-in-law to be buried and also had to take the responsibility of explaining to Lucky and the children what had happened to their parents. Lucky was very young at the time of the incident and explains it from what his aunt told him. He also hates his father for denying him and his younger sister the opportunity of being raised by their mother.

5.4 Emerging themes

Using the fifth and last step of Hysner's explicitation method, general and unique themes from all the interviews were extracted to make a composite summary for all transcripts. The identified general and unique themes from all the interviews were retained and individual participant's coded relevant units of meaning in the form of quotations or excerpts. The themes are tabulated below and were used to analyse data gathered from the participants of this study.

Table 5.2: Emerging themes

Themes	**Sub- themes**
1. Knowledge of suicide	a) Participants' knowledge of suicide b) Participants' personal views on suicide
2. Causes of suicide	a) Participants' perception of the causes of suicide b) Cause of suicide in the case of the participant's family member
3. The method used by victims to take their lives	a) The method used by the victims to take their lives
4. Impact of the suicide on the bereaved family members	a) Psychological impact b) Social impact c) Financial impact

5. Prevention of suicide	a) The perceptions of the participants on what they could have done to prevent the incident b) The perception of family members on what their loved ones could have done to prevent taking their lives
6. Coping strategies	a) Participant's strategies of coping with the loss b) Participant's perceptions of what could have helped with the grief c) Forms of support that were available for the participants d) Strategies participants believe worked most in coping
7. Grief following suicide and grief following other causes of death	a) Participants share their views on the similarities and differences between suicide bereavement and bereavement following other causes of death
8. Concerns about the topic	a) Participants' feelings about the topic b) Participants' expressions about the topic
9. Suggestions from participants in terms of support for suicide bereaved	a) Participants share their suggestions in terms of support for the suicide bereaved

5.5 Participants' descriptions of experiences

5.5.1 Knowledge of suicide

5.5.1.1 Participants' knowledge of suicide

Participants in this study were found to know what suicide is. Some participants explained that suicide is when a person takes their own life or kills themselves.

> *"Suicide is when people take their own lives due to different stressors they are confronted with"* ***Tumelo, 27, male***

"*I know that people take their lives. They kill themselves"* ***Mmatlou, 30, female***

"Suicide, according to me, is when a person kills himself or herself. The person wants to escape the troubles of life by causing his or her own death. It happens a lot, it was always there even when we were growing up. You hear that so and so hanged himself" ***Rosina, 60, female***

"It is when a person kills him/ herself" ***Evelyn, 62, female***

"*Suicide is when somebody takes their life or kills themselves."* ***Boitshepo, 31, female***

"Suicide is when a person kills him or herself" ***Lesego, 32, female***

"*It is when a person takes his or her life"* ***Metja, 46, female***

"*Suicide is killing one's self"* ***Lucky, 25, male***

While **Maria, 44 years, female** explained suicide in a way of the feeling at the time, **Choene, 35, male** saw it as a last resort and a way out. This is what they had to say.

"According to me, suicide is something that comes unexpectedly. It comes when you are not even thinking that the person can even do something like that. It's something that surprises you and it's already done at that time, you just feel shocked." ***Maria, 44 years, female***

"To me suicide is a last resort…when you don't have any other way out. Better dead than alive." ***Choene, 35, male***

"Suicide is a very shocking and unexpected thing that you cannot reverse." ***Raisibe, 59, female***

Based on the above extracts, it does appear that the interviewed participants are well aware of suicide. They know what it is and what happens when a person commits suicide.

5.5.1.2 Participants' personal views on suicide

Everyone has a different view of every situation. Below are the personal views of the participants as extracted from their cases. It was found that some people view suicide as a personal choice rather than a selfish act, as seen by others. Suicide was also found to be accompanied by a lot of problems that the victim believes cannot be resolved, therefore resorting to suicide as the last option. The following extracts bear testimony that suicide is a cry for help; it's the victim's way of seeking help for the problems overwhelming them.

> *"Suicide is a personal choice and I tell myself that it means that the person has been planning it for some time. I don't know…according to me, I don't know what to say. Or it is a decision that one takes at that time and say 'I want to do this'. And you may find that the person has something bothering him but is unable to talk about it. The person sees suicide as the only solution."* ***Maria, 44 years, female***

> *"I think people become too stressed that they see suicide as the only solution to their problems. They forget about all the good things in life and only see the worst of every situation. They even forget about how their acts would hurt those that are left behind. I won't say it is selfish because I have never been in their shoes and therefore don't know how they feel to make them consider suicide. But on my side I don't think I can ever do that to my family."* ***Tumelo, 27, male***

> *"After my brother did that, I feel that the person doesn't deliberately want to hurt others, but is simply trying to run away from their own pain. I know what he was going through and I can only imagine what I could have done to escape. Maybe I would have done the same thing and forgot about everyone. It is like the mind just switches off and you forget about anything or anyone else. I don't blame my brother for anything."* ***Choene, 35, male***

> *"I personally don't believe in suicide, or maybe I have never been pushed by depression to such an extent of thinking of suicide. I think it's true when someone seeks help if they feel overwhelmed. I am not in their shoes, so I don't know what pushes them. But I am not judging anyone. I just tell myself*

that when a person reaches that stage it means that something is not right mentally." ***Evelyn, 62, female***

"I don't know what to say, I believe that everyone has their own way of dealing with their problems. We are not the same. I don't mean that it is fine to take your own life…but we need to put ourselves in the victim's shoes and try to understand his or her situation." ***Raisibe, 59, female***

Even though some see suicide as a cry for help, the following participants express that it is a selfish act, that the victim does not consider the feelings of those they are leaving behind. They reveal that suicide leaves the bereaved with many questions without anyone to answer, which makes it hard to find closure. These participants view suicide as a sign of weakness when faced with challenges.

"To me, suicide is a very selfish act. People who commit suicide only think of themselves and care less about the people they leave behind. They leave us with so many questions with no one to answer them, making it hard for us to find closure. If they knew that the pain they leave with those many loved ones is even worse as compared to what they feel they need to escape." ***Mmatlou, 30, female***

"I think suicide is a bad thing to think of. People should know better than to kill themselves. I have been through so much pain because of my son. I think people should be warned about it, people should be taught to stand up and seek help than to commit suicide. It is really bad. I personally am against it. I don't know if I am just being judgemental without knowing what he was going through, but still, suicide never solves any problems…in fact it adds more problems to us who are left behind." ***Rosina, 60, female***

"With the experience I had, suicide is not a good escape from life. I have been hospitalised due to the depression and inability to deal with the pain I was going through. Suicide is a very terrible revenge to the loved ones. After all it is the person's choice. Our parents raised us in a very good way, in a way that we never thought one of us would get involved in drugs or even worse, end their own life. But I accepted that it was his choice to make. I

personally don't like it and wish it never crosses my mind." ***Boitshepo, 31, female***

"To me suicide is a symbol of weakness. The person is too weak to face his or her problems. It is also selfish because you do not consider how the ones you leave behind will feel about it. People need to face their problems." ***Lesego, 32, female***

"When one is bewitched they can't see anything. I won't say people are weak or selfish…people are pushed by different things to commit suicide." ***Metja, 46, female***

"I think suicide is a personal choice. The person chooses to run from their problems by creating more problems for those he or she leaves behind. It also shows weakness. There are things people face every day and still live on, but some will just kill themselves for simple things." ***Lucky, 25, male***

Based on the above extracts, it is evident that people attach meanings and perceptions to certain situations in terms of how they feel about them. If a person is still hurt about an incident, it is more likely for the person to see it as very negative and wrong. The more one heals, the easier it becomes for them to have a different view. In the above cases, it may be concluded that the participants who still believe that the suicide was a selfish act may not have healed from the grief. The ones who are better understand that every person has their own way of absorbing and reacting to stimuli they encounter and it is not for them to judge as we differ in cognition as people.

5.5.2 Causes of suicide

5.5.2.1 Participants' perception of the causes of suicide

The participants in this study mentioned a variety of factors that are seen as triggers contributing towards one taking their life. I will be using the term "taking one's life" rather than "committing suicide" to try to make it sound less criminal as it is not a crime. This will also help bereaved family members to feel free to talk about it and to be assured that they did not do anything wrong and are therefore not blame themselves. Stress and depression that people do not talk about were found to be

the main causes of suicide. Some participants mentioned life regrets, unemployment, relationship problems, and hopelessness about finding help with problems. Desperation, pride, revenge, mental illnesses, financial problems and a weak personality, when faced with challenges, were also amongst the causes of suicide. Witchcraft was also revealed as one of the causes of suicide.

> *"I actually don't know the cause. It's like the person has problems eating him/her alone and is not talking, I think. And that time you yourself don't know anything, you just see the person as being happy. You just see things as normal until he/she surprises you"* ***Maria, 44 years, female***

> *"There are many causes of suicide. It can be stress beyond one's comprehension, might be mental problems, or even financial problems. Sometimes suicide is also caused by personality problems; you find that the person is naturally weak when faced with some life challenges."* ***Tumelo, 27, male***

> *"I think suicide is caused by stress and depression. You find that the person has a lot of stress and doesn't talk about it, they try solving their problems by killing themselves."* ***Mmatlou, 30, female***

> *"Depression, desperation, pride, revenge on horrible family members and wishing to be somebody else. You just feel like those family members that maltreat you and there is nothing you can do to please or make them feel what you are going through. You just feel like the only way to revenge yourself is through suicide"* ***Choene, 35, male***

> *"You may find that the person has been pushed beyond limits and cannot tolerate anymore. The person has lost hope that anyone would be able to help him or her with his or her problems"* ***Rosina, 60, female***

> *"It may be unemployment, relationships that do not go well, and having other heavy problems in life"* ***Evelyn, 62, female***

> *"Some causes of suicide I think are financial problems, isolation from community or people that used to care about you, life regrets, not sharing your problems, and sometimes depression"* ***Boitshepo, 31, female***

"Suicide is caused by having many problems in life and being unable to deal with them. They become too much and weigh down on you" ***Raisibe, 59, female***

"There are many causes of suicide. Some people are not able to tolerate too much stress in their lives. They may be depressed or have other mental problems. Sometimes they feel they don't have any other option to solve their problems" ***Lesego, 32, female***

"I don't think a normal person can take his or her life. Suicide is caused by witches who are envious of your successes in life. They make you go crazy and you end up doing things unconsciously" ***Metja, 46, female***

"I heard that suicide is mostly caused by depression and you can't talk to anyone about it. Everything becomes too much for you to handle and then you see suicide as a way out" ***Lucky, 25, male***

The above extracts reveal that there are a variety of factors that may push people to end their lives. The causes may be psychological, social, financial or even religious. Psychological factors include stress and depression, life regrets, desperation, pride, revenge, mental illnesses, weak personality when faced with challenges and hopelessness; while financial factors include unemployment and financial problems. Relationship problems and witchcraft form social and religious factors respectively. People do not open up about their problems, believing they will not find help or any form of support, they see their chances of overcoming their problems as hopeless and therefore resort to suicide.

5.5.2.2 Cause of suicide in the case of the participants' family members

All the victims in all the families affected seemed to be secretive with what was troubling them because all participants did not know what the problem was with the victim, except for **Choene, 35, male** who knew about his brother's depression and claimed to know the cause of that depression.

With Thabo's family, both his mother and brother said that his problem was academic and that came to their attention after he had taken his life. His mother reported that he had failed and faked results for the first semester and the principal

told them he was not attending classes. His brother, **Tumelo, 27, male**, said his brother couldn't tell the truth and compared himself to others.

> *"For him it was academic problems, he had failed."… "And the principal at his school had just told us that he was not attending some classes, there are classes he was not attending. We only knew all that in December, while we were waiting for his results, we didn't even have a problem. It also had come to our attention then that he had failed in June. I thought to myself: how come because he brought home results and we saw that he had passed, only to find they were not real. The results were even enclosed in an envelope and we thought they were from the school."* ***Maria, 44 years, female***

> *"I feel like it was just difficult for him to say the truth, he was dishonest. I just feel like it was academic stress and also comparing himself with others"* ***Tumelo, 27, male***

Mmatlou, 30, female and **Rosina, 60, female** believe that Phuti couldn't handle the problems he had that they were unaware of. They also found out after his death that he had depression. Despite being the deceased's wife, **Mmatlou, 30, female** knew nothing about Phuti seeing a therapist and taking antidepressants.

> *"I only found out the day he died that he was seeing a therapist and was taking antidepressants. Meaning he had depression and didn't even tell me anything. I think he had a lot to deal with, but he should have spoken to me. The only thing I knew he had a problem with was headaches"* ***Mmatlou, 30, female***

> *"My son couldn't stand all the problems he was having in his family. He had a lot of problems that he didn't even want us to know about."* ***Rosina, 60, female***

Choene, 35, male is the only one of all the participants who mentioned knowing about his brother's (Phuti) problems and the depression but didn't know it was going to end that way. He still blames **Mmatlou, 30, female** (Phuti's wife) for the suicide.

> *"He was depressed and just wanted to escape life and sucking wife. That woman is so controlling and demanding. She wanted everything to be done*

whenever she wanted. She didn't care about my brother's feelings; she couldn't even notice that he was drowning in depression." ***Choene, 35, male***

In Lesly's case, **Evelyn, 62, female** mentioned that the cause of the suicide was drug use and maybe depression that they were unaware of. His sister believes that he may also have had financial stress due to drug use. They also found out after the loss that he was using drugs.

"For me, the way I understand it, it was caused by drugs and he may also have suffered from depression that we were not aware of" ***Evelyn, 62, female***

"From the way I hear people talking, my brother was using drugs and was involved in a wrong group of people that we never knew about, he had started living in fear, having to watch over his back all the time. It might also be financial stress, like debts, and had pride that he couldn't accept the financial blunders he made." ***Boitshepo, 31, female***

Thebe's family only knew that he was depressed judging from the things he wrote in his diary and the note he left. **Lesego, 32, female** claims that the note shows that her father was also terrified as the handwriting looks like he was trembling when he was writing it. **Raisibe, 59, female** does not know what to believe, whether it was witchcraft as some of the family members say, or if he was depressed.

"*My husband was staying far and he would come home at the end of the month or during school holidays. This made it harder for us to notice all the stress he had. We all thought he had everything under control as he always looked happy. His diary shows that he was very overwhelmed and scared, he was depressed. His brother thought he was bewitched by his other brother's wife who was said to be jealous of him"* ***Raisibe, 59, female***

When growing up I thought it was witchcraft as everyone in the neighbourhood would say. But now with my background in psychology and notes I found in his diary, I believe my father had depression and because of the stigma attached to mental illnesses, he shied away from finding help" ***Lesego, 32, female***

In Wilson's case, his sister, **Metja, 46, female**, believes that her brother was bewitched. Even though rumours say that the wife was cheating, she believes that her brother would never have done something like that. She has also convinced the children to believe the witchcraft story.

> *"My brother was a very good man who loved his family. He was bewitched because he had everything he always wanted, a big house and many cars. He had a lot of money and people were jealous of him. They wanted to see his children suffer and so they made him kill his wife and himself. He loved his wife and he would never hurt her"* ***Metja, 46, female***

> *"Anger issues…I think my father was just very angry. I was young, but I could see and hear from the way he was shouting that he was angry. People say my mother was cheating on him. No man would stand for that, but my aunt says it was witchcraft. I don't really believe it"* ***Lucky, 25, male***

Based on all the above cases, the cause of suicide is psychological. All the victims had some mental problems they were dealing with and somehow they felt that they did not have solutions for these problems. The mental problems include stress, depression and may be caused by financial problems. Some participants also believe that witchcraft was the cause of suicide for their family members.

5.5.3 Method used by victims to take their lives.

There are a variety of methods used by people to end their lives. The most frequently used method is by hanging where the victim usually makes use of a strong rope, cable, or anything strong enough to support their body weight and prevent oxygen passing through into the lungs, causing deprivation of oxygen and eventually death. Other methods include shooting oneself, drinking poison, overdosing on medication and cutting oneself to cause heavy bleeding that results in death. This is to mention only a few. Below are the cases of Thabo, Phuti, Lesly, Thebe and Wilson.

> *"I looked for him inside the house but he was not there. I was with his brother still surprised about the failing issue. I asked his sisters where he was. His brother looked in the outside rooms and the gym, thinking that maybe he is in the gym. We were not even thinking of such things. His sisters said he went*

into the study room; they were in the sitting room next to the study room. His brother said okay, and tried opening the door, but it was locked. That time I was busy calling his name to no answer. Then his brother just said he must be in the study room. He tried opening the door with a screwdriver and the door opened. When the door finally opens, his brother finds him on the floor, hanging from the cupboard. I still don't understand how. There were cupboards in the study room, so he had tied an electric cable on one of the hinges on the sides of the cupboard." ***Maria, 44 years, female***

"He hung himself with an electric cable in the study room. He tied the cable on the side of the cupboard and hung himself with the door locked" ***Tumelo, 27, male***

Phuti overdosed on his first medication from the therapist, drinking it with alcohol. He was alone at home.

"He overdosed on antidepressants and sleeping pills with alcohol" ***Mmatlou, 30, female***

"He was taking antidepressants without the wife knowing. So that day he drank all the medication he was given by the doctor sand died from overdose. They say he fell, I think he was feeling dizzy from the overdose. He was even bleeding from the mouth and nose. I got there before the paramedics arrived; it was really heart-breaking to see him like that." ***Choene, 35, male***

"He drank all his pills with alcohol…its dangerous you know, it can kill you" ***Rosina, 60, female***

Lesly shot himself when police were about to arrest him for shooting a petrol attendant.

"He shot himself" ***Evelyn, 62, female***

"He shot himself" ***Boitshepo, 31, female***

Just like in the case of Thabo, Thebe also strangled himself in his place of residence in the college. His family was not staying with him at that time.

"They said he strangled himself using a rope. He was found hanging from the roof in his room" ***Raisibe, 59, female***

"My father strangled himself" ***Lesego, 32, female***

Wilson's case is similar to Lesly's, differing in that Wilson shot his wife first before shooting himself.

> *Their neighbour called me that night and told me there were gunshots in my brother's house. When I went there I found the police and they said my brother shot his wife and then himself. It was shocking. There was blood everywhere"* ***Metja, 46, female***

"My father shot himself" ***Lucky, 25, male***

From the above extracts, victims of suicide employ methods that they believe will still the pain sooner. This is the reason why they resort to hanging and shooting because they believe that they will not have to feel any more pain afterwards. Unlike using poisonous concoctions that will make them sick for days, adding to the hurt they already enduring, hanging and shooting are quicker and causes less pain to the victim. It was also revealed that the victims choose to be alone when carrying out the act. This may be because they don't want to be saved and do not have to see their loved ones hurt by their actions.

5.5.4 Impact of the suicide on the bereaved family members

5.5.4.1 Psychological impacts

All participants reported that they have been affected psychologically by the loss of their family member through suicide. The psychological impact experienced included depression, self-blame, aggression, suicidal ideations and also resulted in hospitalisation for some. Some participants reported being overwhelmed by the experience and others had anger issues. The following extracts bear testimony to the amount of psychological strain brought on by the suicide for the close family members.

> *"I ended up in being admitted at Unicare and spent three weeks or three months there, I can't remember well. When I came back from Unicare I was feeling lonely. He was very active. The sisters are younger. Whenever I would speak in this house it would be with him. He was active, he liked cooking and*

music. So loneliness, I felt like a bad parent but now I am okay." ***Maria, 44 years, female***

"It was so depressed and had to study for my examinations at the same time. I had to suppress the experience for me to be able to study. I couldn't even speak to my family about it because it always made everyone emotional. I had to forget about it and move on. I had to go back to school and act as if all is going well." ***Tumelo, 27, male***

"I fell into depression and was admitted to hospital. I was seen as a threat to myself. I felt betrayed by the person I loved. I had suicidal thoughts because of the hatred I experienced from his family and friends. I blamed myself for everything that had happened. I blamed myself for not being there for him. I was crying most of the time and felt hopeless. I didn't want to wake up. I didn't want to see my son. Seeing him enduring so much pain made me worse. I hated every moment of my life" ***Mmatlou, 30, female***

"It affected me a lot. Whenever I think of him I cry. I sometimes wish I could see him, sometimes I feel like he is calling me. I can still hear his voice. His image is still clear in my mind. When I miss him I even get aggressive towards my wife, even my children look at me in a strange way, like I am sick or something. I hate feeling so helpless." ***Choene, 35, male***

"I can feel the pain slowly fading away. It was very overwhelming, but I got through it. I knew I wasn't the first or last to experience such a thing. It did affect me badly, but I have to be strong for those he left behind. It is not easy dealing with such incident and I don't wish anything like it to anyone. My heart was just torn apart." ***Rosina, 60, female***

"It affected us. We were confused. That's the reason I forced myself to go see a psychiatrist…to ask her…to ask for help…to ask her to help me to move on. "It was like I could wake him up and say that I am sorry for the last time. So it still affects me even now. Sometimes I still blame myself, even though the doctor says we should not always blame ourselves because it was going to happen anyway. They say I must be grateful for the 33 years he lived and that

God gave you that gift. I understand that it's not only me and if it has happened it has happened and there is no turning back" ***Evelyn, 62, female***

"It affected me in a way that I was even diagnosed with depression and was admitted for it. I couldn't cope with not having him around. He was my only brother and we were very close. I needed closure, but there was no one who could answer all the questions I had. I couldn't focus on anything, I just cried. So it was bad." ***Boitshepo, 31, female***

"The experience was very hard to accept. I would cry whenever the children needed something and I could not provide. The aunts and uncles depressed me more by talks of witchcraft. I was emotional most of the time and couldn't think of anything else but him" ***Raisibe, 59, female***

"The loss of my father left me with a huge hole inside my heart. Seeing my siblings, I had to hide my feelings and pretend to be okay. When I went to tertiary things just fell apart. I knew I needed to get closure. I would get too attached to my male friends because I missed my father's love. I would think of him and start crying. I had to see a professional to help me deal with the loss and learn to live with it." Lesego, 32, female

"I still cry in my corner when I see their children. I still miss him, he used to help e with a lot of things. I am still afraid to leave even the children alone in case they think of doing the same. I made a habit of calling and talking to my other sisters and brothers almost daily, just to make sure they are well. I take every day as it comes. The pain is too deep." ***Metja, 46, female***

"I am always angry, I lose my temper on small things. I still want to be alone most of the time. Even at school I can't concentrate. I fail a lot and that makes me angrier. I wish I could wake my father up so he can explain what really happened, why he killed my mother, and why he killed himself. I feel I don't deserve good things in my life, like I live to be hurt. It's painful having to live with such big experiences." ***Lucky, 25, male***

a) Participants' feelings when they found out about the incident

Based on the extracts below, there are differences in their psychological feelings from when they found out about the death compared to the present time. The cases below reveal that suicide comes as a surprise, something they were not expecting. Numbness, disbelief, confusion and shock are usually associated with trauma. These were some of the experiences expressed by participants in this study when they first found out about the loss of their loved ones due to suicide. They also mentioned hopelessness, embarrassment, carelessness, shame and hurt. Blaming the victim, other people and themself were also evident in the study. The participants alerted that it even felt like a dream and all of them never cried until the burial and afterwards.

> *"He was only 16, he was still young… It was a shock. Like… I was really shocked. I didn't even know what to do or say. You know when you just don't believe? The shock at that time, even when they were leaving with him I didn't even cry. I cried long after they had left, after they had taken him with them."*
> *"…at first I used to feel a shame like, you understand? ... I felt like I was not a good mother. I also had that thing, like when someone is looking at me, even though I didn't know what he/she is saying, I just felt like they are blaming me, I felt like they were talking about me. I had that shame, I lost hope. I stopped praying and told myself there is no God"* ***Maria, 44 years, female***
>
> *"Yoo….it was very difficult for me as I was writing exams. I was just numb, I didn't know how to feel or how to react at that time. I felt like I had failed to save my brother's life. I blamed myself for letting it happen. I couldn't cope at all. I tried so hard to study and ended up suppressing the whole experience."* ***Tumelo, 27, male***
>
> *"I was cold and numb, confused. I never thought he could even think of doing something like that. I didn't know which one was more painful. The fact that he knew he had depression and didn't even tell me about it, he couldn't trust me enough as his wife to tell me he was attending therapy and taking antidepressantsor the fact that he just took his life. I blamed myself for not noticing that he had problems. I mean, we stayed under the same roof, used the same bed, but I still didn't see it coming. It felt like I didn't love and care*

enough. I didn't know whether I should cry or scream, or just convince myself that it is just a dream. I didn't even have time to listen to my thoughts and the pain I was going through. I felt like switching my life off for some time." ***Mmatlou, 30, female***

"I felt numb. There were no tears for me to cry out. I felt like I would wake up from the dream. It only felt real on the Saturday we buried him. That was when I came to realise that he was really gone, for good. I had so much hatred towards his wife. I blamed myself; I still blame myself for not doing anything about the situation while I was the only person who knew about the situation. He trusted me, but I failed him." ***Choene, 35, male***

"I don't know hey…I lost so many people in my life, but none of them caused me so much pain. I felt embarrassed, what will people say about me, about my family. It's like a curse. My son wasn't supposed to die that way. He was very decent. As a mother I blamed myself for not being able to save him from whatever that was troubling him. I couldn't even shed a tear. I kept myself busy because I thought if we could just finish the burial part then all pain will be gone. "It never went away. I had to learn to live it." ***Rosina, 60, female***

"Hee! You know what? It was like a dream. Can you imagine just sitting and one moment they tell you that your son shot himself? You get shocked…so hurt…it's like…I just got confused and asked myself what happened. So I was just shocked. I was so confused and hurt. I even asked them which X are they referring to…you understand? Because I didn't think they were referring to mine the way I knew and raised him. I didn't even believe that he knew that a person can shoot and kill himself." ***Evelyn, 62, female***

"When my father told me over the phone, I couldn't believe. I had so many emotions all at once that I couldn't even cry. I blamed him for his selfish act. I also blamed myself for not caring enough to know what was bothering him. It was like a bad joke, you don't know whether to cry or let go. I couldn't sleep. I felt like pinching myself to see if I was indeed in the real world." ***Boitshepo, 31, female***

"I felt like I was dreaming. I had no tears to cry because I couldn't even believe it. I thought my mind was just playing tricks on me. I felt like he would come back and tell me he is still alive, that the whole thing was just a joke…but that didn't happen until we buried him. It was so painful" ***Raisibe, 59, female***

"When my uncle was telling us, I couldn't believe it. But my mother's condition confirmed it. But I couldn't feel anything. It was like my life was shut. I still can't explain what I felt. And when I saw many people in our home I was still fine until when my father never returned home to see us, with gifts and everything. That was when reality broke that I am never going to see him again" ***Lesego, 32, female***

"I still can't believe my brother did that. It was so painful and traumatising to see so much blood. And the children…just looking with no clue on what had just happened and how life was going to be from then. It made the situation more painful…I was crying for my brother and sister in law…I was confused…I had so many questions on why my brother did that…but then I had to take care of the children. It was really hard to digest" ***Metja, 46, female***

"Honestly speaking, I didn't feel anything…I didn't know what was happening. Just too many people in the house screaming and crying. I didn't even understand why they were behaving that way. It only started hitting me when I got older and started asking my aunt questions about my parents" ***Lucky, 25, male***

b) Participants' feelings about the incident now

Some participants expressed that they have changed for the better and now feel better about what had happened. They have accepted that anyone can take their life anytime and that they are not the only ones to ever experience it. This helped them to forgive themselves and the lost loved ones for the suicide and they mentioned that they are even able to go to the grave and the scene of the incident with less distress. The extracts below are what the participants had to say:

"Now I just told myself that this thing can happen to anyone. Now I can even talk about him without crying. I can go into his bedroom and the study room,

at first I couldn't go in there. I avoided even family gatherings, I was afraid to attend funerals because I didn't want to see a casket or anything like it. I am fine now I can even look at his pictures." ***Maria, 44 years, female***

"I am much better now. I can now talk about the whole situation without crying. I couldn't face anyone and didn't want to come out of my room. Now I am better, no more flashbacks, I can even look at his pictures and go visit his grave. I am glad I had my sisters by my side, giving me all the support I needed. A lot has changed. I learnt to forgive him and myself. I feel confident about myself and have moved on from that point." ***Mmatlou, 30, female***

"We do not forget… we don't forget him… we miss him…but we were able to move on. Sometimes I pray God and thank him for giving me strength. Maybe God has saved him from other troubles that we didn't know about because later on we started discovering from some of the friends that there were Nigerians that were using him since he was running businesses." ***Evelyn, 62, female***

"I have been to hospital and that helped me deal with the situation much better. I am well now. I do think of him, but I never get stressed. I don't have any blames on myself or anyone. Although I don't talk much about him because I don't know how the others would feel about it. But I don't have any problem with not having him around anymore. I guess I even got used to the whole situation." ***Boitshepo, 31, female***

"I have made peace with the loss and managed to raise our children alone. I have accepted that it was his time and that is how God wanted him to leave us. Now I am always happy because our children are educated and working well. They are able to take care of me and this gives me so much pride when I think of him. I wouldn't have these supportive children if it wasn't for him. I never blamed him for anything, I still love him." ***Raisibe, 59, female***

"I miss him sometimes, but with time I have managed to heal. We didn't know about counselling, so being there for each other as a family really helped. I have learnt to live without him and have accepted." ***Lesego, 32, female***

"His children remind me of my brother, more especially the son. But I have made peace with the loss. I only get angered by the community when they talk bad about him sometimes. It was time for them to return to the creator." ***Metja, 46, female***

Tumelo, 27, male expressed that he had accepted his brother's suicide, but whenever he fails to save a patient's life in his work as a general practitioner, the experience of his brother's suicide awakens and makes him feel like a failure. Although he had accepted the situation, he seems to still have some unresolved issues.

"You know I made peace with losing him now, but I can't say I forgot what happened. Even in my area of work now as a doctor I feel like I failed him if it happens that I don't succeed in saving a life. I can say I am fine now except such situations that awaken the experience" ***Tumelo, 27, male***

In the cases below, **Choene, 35, male** and his mother, **Rosina, 60, female**, have not yet moved on. They are both still blaming themselves and **Choene, 35, male** expressed that he still can't forgive his brother's wife for the incident. They both still experience a lot of distress whenever they think of Phuti. **Lucky, 25, male** cannot forgive his father for denying him the chance of being raised by his biological parents.

"Nothing much has changed. I try by all means to forget about the whole thing, but I can't. I want to forgive his wife, but whenever I see her I see a picture of my brother's lifeless body and then remember that she was the cause of the depression. She didn't even want him to go watch soccer games with us, not even to visit our mother. I know my brother was a womaniser but he still didn't deserve all that control. She is evil." ***Choene, 35, male***

"Eish! I am still trying to forget, but the pain just won't go away. Maybe I will get better with time. Talking about him is still a problem to me. When his son is here I get emotional, sometimes I can't stand looking at him. He looks like him and keeps reminding me of him." ***Rosina, 60, female***

"I still can't forgive that man. I don't know how it feels like to be raised by a mother or father, or both parents. Maybe if he had killed only himself, then I

would have experienced my mother's love. I can't even make friends, am easily angered even by small issues. Some of the community members don't want their children to be friends with me, they call me names and refer to me as a son of a murderer. I wish I could get over these overwhelming feelings, but it's hard." ***Lucky, 25, male***

c) Participants' perceptions regarding when to seek help

People experience and deal with grief in different ways. It sometimes gets to a point where someone cannot deal with it by themselves and therefore need help from other people. There are professionals trained to deal with such experiences. Most participants in this study revealed that they were helped by professionals as well as close family and friends in dealing with their grief. They shared that when they felt depressed or did not feel like being in contact with other people, always crying, and displaying abnormal behaviour were some of the signs to look out for during the grief process. The extracts below show how one can know when it is time to seek help:

"You know you need a professional when there is a change in behaviour I think. This thing taught me, I didn't know or see such things before, or because he was always happy. But for now the children I am left with here at home, I am able to monitor them, their movements and what is happening. I look at the face to see if she is happy or not. Sometimes I feel like I am overdoing it. Isn't it that you can never know a person? I am not a psychiatrist but I try to monitor them. I don't even want my children to touch anything or work. I am the one doing the chores" ***Maria, 44 years, female***

"For me when I went to the doctor for the first time I was depressed, shy, still shocked. I couldn't understand that in my house there is actually a child who can think of suicide and even kill himself. So after the doctor showed me that I am not the only one, children go through things like that and some things you find that the parents do not know." ***Evelyn, 62, female***

"I was always crying. I wanted to be left alone. I felt like I just couldn't deal with the pain I was feeling. The accusations against me made me worse. I was so depressed. I couldn't eat. I felt betrayed by my own husband. I was

angry at him and missing him at the same time. And with my son so young I realised I had to face the situation and deal with it." ***Mmatlou, 30, female***

"You know people are not the same. Some people find it easy to deal with even the worst situations. One should act all tough trying to impress others. Every person is the judge of his/ her own feelings. If you feel you are overwhelmed by what you faced with, just seek help. We show different symptoms as people. Some will cry, some lack energy because of lack of appetite and even faint. As for me I couldn't even leave my room for days until my parents got me admitted. I had lost weight and thinking of myself as useless since I couldn't help my brother. There are many warning signs, but one should just pay attention to the changes there are going through to see if they are manageable on their own or they need a professional to help them through." ***Boitshepo, 31, female***

"For me I only realised years later that I was actually acting in an abnormal way. I would cry hysterically in my room and tended to depend a lot on my male friends. I had only recently discovered my father's diary and I would always have it under my pillow when I sleep, or in my bag wherever I go. I used to read a lot and that actually opened my mind. I went to the college's counselling centre to seek help. I think every individual should get counselling because we tend to suppress or hide our feelings, act like all is well while deep inside the problems are eating us." ***Lesego, 32, female***

The extracts above bear testimony that it takes time and acceptance to heal. The participants experienced different reactions from the time they found out about the suicide incident up to the time of the interview. This makes it evident that the duration since the loss and the coping strategies employed play a role in the bereavement process. Initially, the participants mentioned being shocked and numb, filled with disbelief. As the burial proceeded they were hurt, cried a lot and experienced self-blame as they came to terms with the reality of the suicide. Some of the participants had to get professional help to cope with the depression and trauma they had to go through, but after some time, most of them accepted and made peace with the loss and overcame their fears.

5.5.4.2 Social impacts

a) Reaction experienced from society

Just as society can console you in a tough situation, their behaviour around you also determines how empathetic or sympathetic they are. You can see if they are acting only to make you feel better or if they truly do feel for you. The society's behaviour also contributes to the healing process of the bereaved and their feelings towards their experience. The following participants reveal that society's reaction towards their experience made it difficult for them to heal and led to them isolating themselves. The participants revealed that they received strange looks from the members of their society and also felt that they blamed them for the suicide of their family members. Even though they never directly made any negative remarks in the presence of the bereaved, there were mumblings and rumours made in their absence.

> *"The society looked at me as if I were a killer. They gossiped about me and said all horrible things about me. My husband's body was not even allowed to enter the gate and we couldn't see him for the last time. Even now they still look at me in a terrible way. Some members of the society still don't talk to me. They told me I shouldn't mourn my husband because I am the one who led him to kill himself."* ***Mmatlou, 30, female***

> *"The society blamed the death on a lot of things. They blamed us as uncaring family members, some said he was bewitched because he was doing well for himself and some blamed the wife. Very few of them thought he was selfish to have caused so much pain to us. We all never thought he could do something like that. Even today, after two years, the society still discusses the death of my brother. Whenever they see anyone of the family members they start that topic."* ***Choene, 35, male***

> *"The society gossips a lot. You are not even able to go to church or society gatherings without them saying anything related to the suicide. The society can make you isolate yourself if you are not strong enough to ignore the gossip."* ***Rosina, 60, female***

"The people we live within the community, especially at church, I like going to church, you feel like behind your back they say: don't see her like that…beautiful and all, they say her son was using drugs. Others you can hear that they are talking. The other one will say: have you seen the drugs that were in there. When they look at you just don't know whether they are still judging you or you are the one who is just feeling that guilty. You ask yourself what is it that other people knew all along that you don't know. You feel ashamed. You feel pain. After seeking help, the support groups and all, I started telling myself that it's okay…what has happened has happened…it is done. I can't change anything. So whoever talks about it will be bored and out of topics to talk about. I just told myself that I did not contribute in any way. He is still my son. What has happened has happened." ***Evelyn, 62, female***

"Society will make the pain worse. They add more blames and hearsays while you are still down. They look at you with pity like they really are empathetic, while behind your back they say all bad things." ***Boitshepo, 31, female***

"The society will make the pain to sink in. I couldn't go out after-school to play. I was always afraid they will call me the daughter of the man who killed himself. Not that they blamed me, but it is just painful to always be reminded of how your father died. It is painful enough that he passed away." ***Lesego, 32, female***

"The society is cruel…listen…they didn't want me to bury my brother and sister-in-law in the community's graveyard. I had to run around while mourning. It was painful. And to add to that they will say a lot of things about the deceased that don't even exist…confusing the children even more." ***Metja, 46, female***

"I am always afraid of going out in the community…my aunt knows that already. She doesn't send me to the shops unless I go with her. The society will treat you like a murderer even when they know for sure that you did not do anything. I was very young when my parents died but treated like I played a part in the whole thing." ***Lucky, 25, male***

Maria, 44 years, female believes that the society doesn't talk about her, but she feels like they do whenever they look at her. She feels this is due to the judgements and blame she puts on herself. **Tumelo, 27, male** also expressed that he could not see or hear anything from society because he was hurting. **Raisibe, 59, female** also mentioned that society was good to her.

> *"The society…it's just you yourself feel the shame…but I won't say the society had a problem. You can see where we stay, I can't say I saw this and this, and there are high walls everywhere. It's just that when you see a person looking at you, you start thinking that he / she is talking about you. But to say that I saw someone doing this or saying this I would be lying. More especially in a place like this one we are staying in"* ***Maria, 44 years, female***
>
> *"It is difficult to say. When you are going through that much pain it is difficult to pay attention to what other people are saying or doing"* ***Tumelo, 27, male***
>
> *"The society gave me all the support I needed, even though they were gossiping, whatever they were saying were not directed to me. I didn't have a problem with them."* ***Raisibe, 59, female***

Based on the above extracts, the society that one lives in can either help or hinder in the grieving process. They do not need to utter any harmful words but just their behaviour is enough to break you. It is experienced that the surviving family members are blamed for the loss and seen as careless. All these negative behaviours lead to complications with working through the grieving process.

b) <u>Impact on participants</u>

Some of the bereaved family members expressed that they isolated themselves as they felt that the society was judgemental of them. **Evelyn, 62, female** reported that she started looking differently at friends, family and relatives as she felt they blamed her. **Choene, 35, male** lost trust in people and distanced himself from even his friends and family. **Rosina, 60, female** likes attending church and feels that she has to endure being at such gatherings because she believes the other women talk about her behind her back. Even though **Mmatlou, 30, female**'s family and friends are supportive, the community still calls her names and this sometimes makes her afraid to go out. **Metja, 46, female** had to go to court for the community to allow her

to bury her brother and sister-in-law in the community graveyard. The following extracts reveal their feelings.

> *"Socially it affected me in a way that I didn't want to be around people. I didn't want to go out. I only attended gatherings of close family members only, but now, I remember…I don't know if its two years back. This other lady had lost her child, also through suicide, a daughter. But I was able to stand up and go to see her, for prayers. I had strength…mind you in the beginning even if it was just a funeral of a family member at that time I wouldn't go. By then it was still fresh and I was afraid to go to funerals. I didn't want to see a casket or hearse, or anything to do with a funeral. But as time went on I was able to go, and that lady was in the same situation as mine, you see? Even when I went there, you know you have to look first; you don't just start talking while the person is not ready to talk. So I just gave her time for her to open up and it was easy for me to relate."* ***Maria, 44 years, female***

> *"I isolated myself from other people; I felt they could see the embarrassment I had. I could only speak to my professor because I felt he was the only person who did not judge me. I distanced myself from my friends…I felt they judged me and blamed me for not protecting my brother. I felt like everyone was talking about me and laughing at me behind my back."* ***Tumelo, 27, male***

> *"Well my family and friends have always been there for me, giving me all the support I needed, except for his family. They believe I am the cause of the whole thing. They say I caused him all the stress; that I am selfish and he wanted to escape me. As for the community, they still refer to me as the wife of the man who killed himself. They sometimes make it hard for me to go out, but I am slowly getting used to it"* ***Mmatlou, 30, female***

> *"I lost trust in people. I isolated myself from the society with fear of being asked about him. I believe my family and the friends we shared blame me because I was very close to him but couldn't see it coming. I spend most of my time alone; I don't even go to soccer matches anymore. I can't even spend much time with my wife and children"* ***Choene, 35, male***

"I dread going to stokvels with other ladies, even at church. It's like everyone is talking about you and how you failed as a mother. It's like their lives are perfect, no mistakes, like nothing like that will ever happen to them. I don't know…you should see how they look at me; it's like I am the one who told my son to kill himself. Having to meet up with people is still a problem…you will even hate having to greet your neighbours" ***Rosina, 60, female***

"You know how it affected me socially? I started looking at friends, the community, the relatives as I was…I was a bad mother or my children's upbringing that maybe I was careless. Self-blame, that maybe I am the cause...that maybe that day when I shouted at him I made him angry." ***Evelyn, 62, female***

"Well my colleagues were very supportive and were always there for me. As for the community back home I can't say much because I don't spend much time there. Even mother doesn't talk about the suicide when we call, so I don't think there is a problem there" ***Boitshepo, 31, female***

"His brothers and sisters were supportive to me, although they fought against each other…it was like they are fighting over me. All of them wanted to be closer to me and then the other would be jealous. There were so much rumours about my husband's loss in the community…but none were against me. My husband had a nice job and we didn't lack anything, so the witchcraft story sticked. I didn't like the way they pitied me…it was too much and it disturbed my healing process." ***Raisibe, 59, female***

"The community called us the children of the man who was made to commit suicide. They wouldn't care if you are listening. This made me want to be alone most of the time. I wouldn't go playing out with other children, I no longer had friends." ***Lesego, 32, female***

Yhoo…it was very bad. Our society is evil. They bewitched my brother and then they didn't allow me to bury him in the community's graveyard. It was painful. Even those I called my friends had turned against me, talking about me behind my back, saying I will bury my brother alone because he is a killer. I had to go to court for the community to allow me to bury my brother.

Imagine…I was mourning…having to endure all the pain…running around with the police. The community is cruel I tell you…it is so cruel. As you see me now I don't have any friends, I just go to stokvels and funerals…because I have to. I don't trust them." ***Metja, 46, female***

"Even now, years later, I still spend most of the time alone. It is like I am the one who killed my parents. The parents in the community don't allow their children to be friends with me. They say I have a short temper and may be like my father. I even dread going to school or anywhere around the community…people look at me in a bad way. They don't like me at all." ***Lucky, 25, male***

According to the above extracts, society plays a huge role in the healing process. Some participants were driven to isolation by the behaviour of some members of society, which in turn led to complications in the grieving process. Instead of offering support, they caused the bereaved to blame themselves.

c) Impact on family structure

The following extracts suggest that the family unit was shattered; the structure was broken and therefore dysfunctional. In Thabo's family, the father had to take over the mother's duties as she was admitted. And **Tumelo, 27, male** had to toughen up for his examinations and therefore couldn't help his father with the other children.

"Here at home it disturbed us, more especially his brother. His brother saw him as his pal, like he was the same age as him, they grew like twin brothers. It affected him a lot, but he was the one who was comforting me. Whenever he called me most of the time he would try to comfort me." ***Maria, 44 years, female***

"My mother was admitted to unicare…I had to go back to school to study for my examinations. So my father had to act strong and take care of my sisters. They were still young and I don't think they understood what exactly was going on at that time. It's like the family structure was broken. My father had to take over my mother's duties and his also, and I couldn't help because I had examinations behind the door. I just had to toughen up and face life. My mother couldn't function at all. It was that bad" ***Tumelo, 27, male***

Phuti's death divided his and his wife's families. **Mmatlou, 30, female** was blamed for being the cause of the depression that led to him taking his life. She no longer gets along with her in-laws and feels sorry for her son who is always exposed to their pity when she visits them. **Choene, 35, male** also states that the family is broken and his mother hurts because of the distance between her and the daughter-in-law. **Raisibe, 59, female**'s in-laws were also devided due to the accusations.

> *"I lost my in-laws because of the incident. All of them, they believe I am the cause. We were very close until it happened, but I have moved on. Listening to them filled my soul with so much pain and self-blame. I want peace. I feel sorry for my son because he is caught in between the conflict. I sometimes feel like not allowing him to go near his paternal family because whenever he visits them he comes back in a bad state, but I can't deny him that. They haven't moved past the suicide, they don't talk about it, they are not even doing anything to help themselves. I distanced myself from them and they seem happy about it. I am closer to my parents and sisters now more than ever and their support helped me a lot."* ***Mmatlou, 30, female***
>
> *"The family is shattered. I feel like my mother blames me because she doesn't talk about him with me. I can't spend time with my wife and children. His wife is distant and I feel I failed his son and am reluctant to see him. The wife's family is also distant because of all the blame on their daughter. Nothing is working out still…even after two years he has been gone…his death divided the whole family."* ***Choene, 35, male***
>
> *"We avoid talking about him…the memories of him bring a lot of pain. His wife doesn't come here anymore, and my other children don't visit much. So most of the time I am alone…I can't stop thinking about him. Our family and hers don't get along anymore."* ***Rosina, 60, female***
>
> *"My in-laws were divided into three. Some said the other aunt bewitched him and the others said it wasn't witchcraft. Others were just lurking in the middle. It was bad for the children also because they would hear stories from the elders and would get confused. There was no family anymore. The elders would even engage in physical fights in front of the children."* ***Raisibe, 59, female***

Although Lesly's family was never disrupted, the parents started blaming each other for their son's suicide. They all received counselling and have moved on with life, despite not talking about the incident as a family. **Metja, 46, female**, on the other hand, just assumed the deceased' duties and moved on with her life.

> *"Everyone…the family…the extended family members, like the aunts, they don't talk about it. But here at home and the children were very affected, to an extent that we started blaming each other. Whenever I was sitting with their father talking about it I would say to him: but you as a man didn't you see any sign, why didn't you talk to our son when you noticed that he was always closing himself inside his room and not going to work, why didn't you talk to him man to man. So he also wanted to start blaming himself, saying that it means he is to blame and started having guilty feelings. The sisters also sometimes would say: but mother doesn't talk about him with us. I have been quiet about it until today. They would say: mother doesn't talk about it over the phone when we call her. They think that maybe I am not concerned, maybe they want me to say: do you remember he was doing this and that. I just feel like he is at rest, why should I complain. I told myself that maybe it is because of the way he died, we are still scared."* ***Evelyn, 62, female***

> *"Our family is still intact after everything. We have received counselling and all learnt to move on with life. Even though we don't talk about it anymore, but the family is fine. My mother and sister have moved on, so no complaints."* ***Boitshepo, 31, female***

> *"We only had a misunderstanding with the sister-in-law's family in the beginning, but they ended up understanding we got on well together from there. We buried together and they also agreed to let me raise the children. We don't have any problems, our families are fine. The children go to visit whenever they want during holidays and sometimes their aunts and uncles come to visit like they used to when their sister was still alive."* ***Metja, 46, female***

> *"I don't have both parents and that is not something I would wish on any child. Not that I lack anything, but just to have my own parent. I don't even know*

how it would have felt like to be raised by my own parents…a real family." ***Lucky, 25, male***

Suicide can leave a lot of disruptions in the family structure. Some family members fight, blaming one another for the loss. In some families, there may be no fights but an inability to perform some duties as it used to be. The children may also be left without biological parents. All this leads to a delay in the healing process, leading to psychological problems.

d) Participant families' strategies of coping with societal reactions

The following extracts reveal that the participants had to deal with the stigma and judgements individually rather than as a family unit, because in a family, like Phuti's, there was no longer a family unit at all. The suicide had left the families with hatred towards each other. In terms of the norm, they just had to follow and do as they were told just to get it over with.

"There was no longer a family, everyone was on their own. I remained strong for my son and agreed to everything that was said, just so we could have everything over and done with. My psychologist is the one who helped me cope with the situation." ***Mmatlou, 30, female***

"We just obeyed all orders that were given. We couldn't talk about anything related to the suicide as a family, we couldn't talk to each other." ***Choene, 35, male***

"There is still a lot to be dealt with when it comes to the stigma and judgements from the society. I still can't tolerate their looks sometimes and it's hard." ***Rosina, 60, female***

Evelyn, 62, female did not confront the people talking about her. She believed that not approaching them will help her cope. Her daughter, **Boitshepo, 31, female** suggested that she should just forget about society and move on with her life.

"You know because I didn't hear them, I can't approach them. You just leave them. You will have that bad feeling when you look at them but you just leave them and tell yourself to just pretend. Isn't it they are not saying to your face? You just hear from hearsays that it was like this and that. It may be true, it

may not be true. You just feel bad and you are stuck. You stay away from them." ***Evelyn, 62, female***

"I forgot about the society and moved on with my life." ***Boitshepo, 31, female***

Metja, 46, female"s family was still intact irrespective of all that they had been through. This helped them to cope and deal with the situation that they were faced with.

"If we hadn't stood together as a family things would have fallen further apart. There was no way I would get the court to help us with the community and I don't know what we would have done with the dead bodies. Irrespective of the fights, we fought the community together as a family unit. ***Metja, 46, female***

Based on the above extracts, it appears that family is the most crucial support system when faced with a problem. A united family can overcome any challenge, including suicide bereavement and harsh treatment from the external society. A bereaved individual needs family support to feel that he or she is not alone in the process. The more an individual is not supported, the harder it is to accept and the harder it is to fight challenges from the society. Some of the participating family members could not even talk about their feelings about suicide, which led them to just forget about the societal stigma without fighting.

5.5.4.3 Financial impacts

All three of the families conveyed that the suicide of their loved ones did not have any financial impact. They all had funeral policies that were up to date and therefore paid for all funeral arrangements. This gave them some peace of mind. The following extracts are testimony.

"It's just that our burial arrangements were okay financially, the funeral policies were up to date with payments. ***Lucky, 25, male*** *Enough we didn't have financial problems. We didn't even rely on anyone and we buried him in a casket that satisfied us."* ***Maria, 44 years, female***

"It didn't affect us much. Everything was paid for by the funeral policy. We only added here and there, so it wasn't much of a problem. We had to pay for therapy, for me and my son, but still can't complain." ***Mmatlou, 30, female***

"Financially it didn't affect us at all. He was working and had a funeral policy. The wife was also working, so we only patched here and there, maybe only for our own transportation. Everything was covered financially" ***Choene, 35, male***

"You know these policies help…imagine if there was no policy and something like that happen, unexpectedly. So it was a great thing he had it, or else we would have had to ask for donations from people." ***Rosina, 60, female***

"We never struggled financially as we have businesses. We only noticed financial problems when he was still alive and living here with us. He was studying in Gauteng and then his father said he should come join us in the businesses because he couldn't find a job. The business started to deteriorate but we understood. Isn't it that you cannot tell your son that he is stealing or ask why the profit is deteriorating? We could see that we are not doing well financially, like we used to before he came. The business was not doing well but we couldn't point fingers. After he died we carried on working for ourselves, even though the economy went down, but it is better." ***Evelyn, 62, female***

"We were not affected financially. My parents handled everything. Even if there was no policy I don't think there was going to be much of a problem because they have businesses. So the incident didn't affect us at all." ***Boitshepo, 31, female***

"My husband had policies and I am also engaged in stokvels here in the community, so we had no financial problems. Just that after all that, there was no income…we had to live on the money we got from the college he was working at. I had to look for a job to take care of the children…it wasn't that bad because we never went to bed hungry, only that we had to cut off on some things that we did not need." ***Raisibe, 59, female***

"Financially we were not affected at all. As I said he was working well, he had funeral policies and even saved some money for the children's education. And even now because they are not old enough to claim the money, I am able to provide for them. My children are all older and working so I don't count them

on my budget. My sister-in-law was also well financially…we didn't have problems and we still don't have problems." ***Metja, 46, female***

The above extracts bear testimony that finances can be a burden during funerals, especially in suicides as they come unexpectedly. Luckily, for these families, they were all financially covered for funerals and this helped reduce the burden. They did not have to stress about finances, leaving them with a peace of mind regarding the burial of their loved one(s).

5.5.5 Prevention of suicide

5.5.5.1 Perceptions of participants on what they could have done to prevent the incident

Communication is said to be powerful in solving problems. The following extracts bear testimony to this as the participants believe that they could have helped and offered support to the family member had they told them about their problems.

"Only if we knew that his first results were not real. So hiding the secret all by himself. So what I can say I could have done if I knew that he had problems at school…they said he was not attending and you know we can't stand up for our children even when they are doing wrong things. He was going to school and was being dropped at the gate but he was not attending. You see when you know that your child has a problem of some kind you are able to encourage him here and there. Like with his brother, his brother was able to tell us that he was not good with natural sciences, that it was giving him problems. He said that with mathematics he is very good, but when it came to natural sciences he wasn't getting the results he wanted. We hired a tutor to help him in the afternoons and some weekends and we paid him until he said now I am fine. A person needs to speak up so that we can help. ***Maria, 44 years, female***

"I think he should have talked to me. I would have talked to our parents for him if he was scared, and I think we would have helped him with his studies. They helped me before and they could help him too. Even if they couldn't, I would have tutored him myself. Besides, our parents were planning of taking him to technical college the following year after they found out that he had

failed. He should have talked to us and we would have saved his life" ***Tumelo, 27, male***

"Maybe if he could have spoken to me about what was bothering, I would have given him the support he needed. I would have accompanied him to his therapy sessions, I would have reminded him to take his antidepressant, and I would have monitored his behaviour. I would have been there for him. I don't know. I would have done all I could to prevent the situation. Maybe if I knew I would have kept an eye on him to make sure it doesn't happen, or even lock up the pills in a safe place. I loved him that much. He should have spoken to me" ***Mmatlou, 30, female***

"I would have talked to him, tell him that that is no way of solving problems. I would have told him how much it was going to hurt the family and maybe it would have made sense to him." ***Rosina, 60, female***

"I feel like, maybe if there had been communication when we noticed that he was no longer waking up and going to work. Sometimes closing himself in his room and hanging out with people we didn't know, he grew up with other people but later on we didn't know the people he was going out with. We told ourselves that he is an adult. When you ask a 33 years old adult who hangs around with, where he is going, following him, no. You just feel like he is responsible." ***Evelyn, 62, female***

"Maybe I could have talked to him like a sister. I would have tried to understand what he was going through, and help him seek help on how to deal with the whole burden without having to take his life. Make him realise how selfish his actions are, and maybe he wouldn't have done it." ***Boitshepo, 31, female***

"I didn't spend a lot of time with my husband, I would see him after a month. Maybe I would have noticed that he had problems. Maybe if he was open enough to talk to me about all that he was faced with. Maybe it would have helped to fight it together, we may have succeeded. Or called the police on those people who were threatening him. He was a good man." ***Raisibe, 59, female***

"Young as I was, my mother had taught me to speak when I had any problems. Maybe I would have tried encouraging my father to speak about what was bothering him. Not that I would have a solution to his problems…but he would have released some of the burden and that would have enabled him to focus on finding a different solution himself." ***Lesego, 32, female***

"I wish I saw it coming…maybe if I knew what was going on between him and his wife. I was close to them but still never saw them fight even once. These witches destroyed my brother's family. I would have taken him to a traditional healer to strengthen him against all these bad spirits…he was possessed. He would never in his right mind kill a person. It is painful just to think of what happened that day." ***Metja, 46, female***

Even though all participants believe that they could have helped to prevent the incident from occurring by talking to the victim, **Choene, 35, male** and **Lucky, 25, male** expressed that they do not know what they could have done.

"I knew he had depression but never thought he could commit suicide. I forced him to go see a professional which he did, but overdosed on his medication. I spent so much time with him, but still couldn't help him, couldn't prevent the suicide. I don't know what it is that I could have done and I hate the thought. I feel useless." ***Choene, 35, male***

"I was young…I couldn't even understand what was happening. Even if I knew, I have no idea what I would have done. Maybe if I was older…maybe he would talk to me instead…but still." ***Lucky, 25, male***

5.5.5.2 Perception of family members on what their loved ones could have done to prevent taking their lives

The participants perceive that the best way to solve problems is by talking. They believe that if the victims had spoken, this could have prevented them from taking their lives. **Rosina, 60, female** feels that what her son has done shows weakness and that he should have faced his problems.

"A person needs to speak up that he/she is having a problem" ***Maria, 44 years, female***

"He should have talked and asked for help" ***Tumelo, 27, male***

"He should have just told me. I know its hard talking about such things but I am his wife. I deserved his honesty. He should have just tried me then and see how I would have taken it, or just continued with the therapy until he was better and stronger enough to can talk about it. At least he was able to speak to his brother and the doctor, why didn't he send his brother to tell me. He could have at least used his brother's support and stay with us for longer, not to leave us just like that." ***Mmatlou, 30, female***

"He could have stayed strong and face his problems like a man. This is a sign of weakness. He should have just taken his medicine and asked people to help him deal with his problems." ***Rosina, 60, female***

"He should have communicated with us, or anyone else who could have been able to help." ***Evelyn, 62, female***

"My brother and I used to talk about almost everything, he could have told me. Together we could have prevented all the pain everyone had to go through." ***Boitshepo, 31, female***

"He could have spoken about what was bothering him. I know I would have supported him in any way I could…he should have just told me or anyone he trusted." ***Raisibe, 59, female***

"My father was educated…obviously he knew about counselling and therapy. I think he should have gone to see a professional other than take his life. He obviously didn't trust anyone enough to discuss his private matters with." ***Lesego, 32, female***

"I can't think of anything else he could have done. There was no way he could be that successful and survive. A witch is very jealous and will make sure you don't see anything. He should have been careful from the start and strengthen himself and his family…that is how we grew up...it's what our parents taught us. I mean how can a good person like him just wake up with a different personality…a person cannot change overnight…unless he or she is bewitched." ***Metja, 46, female***

Contrary to the other subjects interviewed, **Choene, 35, male** and **Lucky, 25, male** believe that walking away, or divorce would have been the best idea.

> *"He should have continued with his medicine and therapy, he had taken the first step. He could have divorced the woman and continued taking care of his son. He would have understood. My brother took his life for her, but she has already moved on. Only two years after his death, she already goes out partying with friends…who does that? It's like she is celebrating my brother's death."* ***Choene, 35, male***

> *"If it is true that my mother was cheating, my father should have just divorced her…not kill her. Even though he was hurt, it didn't give him the right to kill her. People divorce every now and then but don't kill each other, they still live happily. They both should have sat down and discuss the matter like adults…I mean…if it is true because my aunt doesn't believe it. I only heard from rumours…which makes living even harder."* ***Lucky, 25, male***

Based on the extracts in 5.5.5.1 and 5.5.5.2 above, it was established that communication is considered a key to good relationships. If the deceased had communicated their problems with their family members, their suicide might have been prevented. The victims used the actual act as a cry for help instead of asking for help from their loved ones. Their feelings of hopelessness about finding help with their problems made them act impulsively without saying anything to their family members. The surviving family members brought to light the fact that one should seek help for your problems. Even if it does not involve speaking to a professional, but just trying to speak to someone and asking for guidance and help.

5.5.6 Coping strategies

5.5.6.1 Participant's strategies of coping with the loss

According to the participants in this study, there are many strategies of coping with a loss. The coping strategies are the same for those people whose relatives died from natural causes. Support from friends and family and counselling were some of the most helpful strategies mentioned by the participants. **Maria, 44 years, female** expresses that cherishing all the good memories spent with the deceased also help

in healing, and not doubting the love you gave them helps prevent regrets and blame. The following extracts are what the participants expressed.

> *"To be with family more my family supported me a lot. Like they would come on weekends sometimes and take me out, just to be with people. Also to just go to church and pray, it gave me strength I don't want to lie. Like there is no one who can help me if I do not try myself. Though you need other people's company…back then I felt like being with people so that I don't think too much, but I couldn't be with any person outside the family. And knowing that, even if you don't feel like it, that such things happen and I am not a bad person. That it was his decision, one that he took for himself alone. Knowing also that if I was there maybe I would have saved him somehow… if he had spoken. I also cherish all the moments we had and the time I spent with him, the travels we made to Cape Town, Gold Reef City and all the other places, the parties we made for him on his birthdays. Those good moments and showing him motherly love as much as I could are what healed me. He died knowing that his mother loves him and that I have no doubt about. I don't even regret anything. I don't want to lie. That time it was still fresh I had so many questions. There was nothing I could do."* ***Maria, 44 years, female***

> *"I go to the psychiatrist whenever I feel like I am too stressed or miss him more than I think I should. There is nothing better than that. Having my son next to me also gives me peace because I see my husband through him, they are very much alike. I just tell myself that at least he left me with someone, I am not alone. Sometimes I go and visit friends or my sisters to get comfort when I feel down. I go to church and also avoid being around negative people, like my in-laws. Going to therapy taught me to just ignore them in order to be able to heal and move on with my life."* ***Mmatlou, 30, female***

> *"Having his son around comforts me. I try not to take other people to heart when they talk and laugh behind my back. Thinking about my other children also consoles me and keeps me going."* ***Rosina, 60, female***

> *"It's going to seek help from a professional. Another thing is to pray and start engaging in many activities at church, meet with other women. Even though with coping, when you see those that he grew up with getting married and*

being successful in life and then you become hurt. You sometimes say: God it's not that I am jealous but I also get hurt that I should have had a child like this or that. You see that it brings…I don't have any hard feelings with them; I am always happy when I meet them and they say mama. I just wish he had also been happy. But sometimes I thank God and say: Father he is at rest from all that was bothering him that we didn't even know about. Maybe the Nigerians would have killed us all, or ended up without our businesses, or maybe they would have killed him, or he would be a drug addict. I am just grateful to God for doing his will." ***Evelyn, 62, female***

"I used to pray God in my own corner. I received counselling as I was not coping and admitted to hospital. I also got support from my family and colleagues at work." ***Boitshepo, 31, female***

"Seeing my children succeed kept me going. Even now I am still strong and I thank God every day for giving me the strength to deal with the situation. The support I get from the family and my children also helps me cope." ***Raisibe, 59, female***

"I went for counselling, even though it was years after the loss, it helped me a lot because my life was a mess. I pray and go to church and also do talks on suicide in the church and schools." ***Lesego, 32, female***

While most of the female participants face their pain and deal with it, the male participants expressed that they just shift their focus from the actual pain and focus on studies or work. Only **Metja, 46, female** seconds the male participants.

"I had to suppress everything and move on with my life. There was nothing else I could do. I was tired of crying and I couldn't waste any more time dealing with the loss. I had examinations to write. So that also helped me quickly shift my focus from the experience." ***Tumelo, 27, male***

"I try to forget it, but am always filled with shame, pain and a lot of regrets. Going to work is the only thing that helps." ***Choene, 35, male***

"I study more, and I smoke to relieve my stress. My aunt doesn't know yet and I fear what would happen if she found out. I am an artistic person, at least that

helps sometimes. I would just focus on writing or drawing to make myself forget." ***Lucky, 25, male***

"I always keep myself busy so that I don't stress myself much about the loss. I am at work every weekday and on weekends I go to church and do other household chores that I can't do during the week. I can clean the whole house and yard, and if I am done and still have time I can go to the shops. I don't want to sit and listen to my thoughts…they will remind me of them because isn't it the children are here with me." ***Metja, 46, female***

5.5.6.2 Participant's perceptions of what could have helped with the grief

Support groups are usually groups comprising of people in similar situations. One can feel a sense of belonging and feel free from judgement. As the group of people would have gone through similar experiences, it is easy for a person to be assured that things like this can happen to anyone. The extracts below reveal that participants believe support groups, or being with people of the same experience would have helped.

"I think that thing of having family nearby, but then my family is far. I was just alone. Okay, my husband goes to work and the children go to school, and I will be left alone. So I feel that a person who experienced something like this should have somebody to keep them company, but also seek professional help" ***Maria, 44 years, female***

"I think if there was family therapy for families who lost their loved ones to suicide, and for free as most families cannot afford it. Or maybe also support groups where we could share with others in the same situation." ***Tumelo, 27, male***

"I didn't have any support, but I feel like therapy could have helped me." ***Choene, 35, male***

"I think if I was able to afford counselling, maybe they would have helped me with the grief" ***Rosina, 60, female***

"At that time, if there were places where people could meet socially and talk about things like drugs, how you can see if your child is using them, the signs

and what you can do when you notice that, things like that. Do you maybe call the police or the security to see what they can deal with him because he was an adult? So we needed such things and we still don't know them even now. ***Evelyn, 62, female***

"I believe if there were support groups because it's not all of us who can afford professional help. Suicide bereavement is very difficult and family support is very vital at this time." ***Boitshepo, 31, female***

I don't know…but I think the government should do something. The society should know that we as bereaved children have nothing to do with our parents' death. They should not treat us like murders. We are nothing like our parents and will never do what they did. I really don't like the treatment I get from them. My family is fine…just the community I live in…they need to be educated about such things." ***Lucky, 25, male***

5.5.6.3 Forms of support that were available for the participants

Participants highlighted that a supportive family is great to have in times of grief. Having them around gives one a sense of belonging and that someone cares about you. In African culture, society members usually come over to pour out their condolences. This puts the family at ease, giving them a shoulder to cry on and assuring them that they are not alone during the tough time.

"My family was there for me, my husband, my brothers and sisters. I even got help from a psychologist and psychiatrist" ***Maria, 44 years, female***

"My professor, my cousins, family and my friends" ***Tumelo, 27, male***

"During that time I had support from my friends and family, so even when my in-laws maltreated me, I had people to lean on. They are the ones who encouraged me to go for therapy" ***Mmatlou, 30, female***

"Prayer and keeping myself busy. Having his son around also helped me cope. My other children were also supportive even though they were far" ***Rosina, 60, female***

"At that time it was just us as a family, going to work and coming back. Some days we would talk briefly about it. There was no support until one day I went to this other church for bereaved parents. I was called by a cousin who had also lost a child to go there and share with them. They showed us videos. We attended the sessions for a year. They were white and most of them lost their children through suicide. So you are able to see that you are not the only one. You begin to notice that there are many people who are also going through such things." ***Evelyn, 62, female***

"I have received so much support from the family, the church and the community. They have always been there for me." ***Raisibe, 59, female***

"At that time I guess I just suppressed the whole emotions. I only realised when I got to tertiary that I had a lot of unresolved issues. It was then that I saw a counsellor in the campus." ***Lesego, 32, female***

"The whole community was against my family, I got support mostly from my family. Even the church didn't want to get involved in the situation." ***Metja, 46, female***

"My aunt has always been my pillar. Even the school tried to intervene…it is just hard to live with in this community. They judge you for things you don't even know. My aunt is still good to us." ***Lucky, 25, male***

5.5.6.4 Strategies participants believe worked most in coping

Therapists can help people deal with bereavement before it becomes complicated.

The therapists help take the bereaved family members through all the stages of grief until they accept the loss and move on with their lives. For some participants, therapy was seen as being important to help them accept their situation. **Maria, 44 years, female**, **Mmatlou, 30, female**, **Evelyn, 62, female** and **Boitshepo, 31, female** have been to therapy and the following are their expressions.

"I can talk about the psychologist and family on my side" ***Maria, 44 years, female***

"Therapy and being around people who want to see me happy, who are supportive and do not blame me for my husband's death" ***Mmatlou, 30, female***

"I called church people to pray with us. The Bishop explained to us that he is with God and he is happy where he is. He is at rest and that everybody has their time and own way of leaving this earth." ***Evelyn, 62, female***

"I think it was seeing a professional and being around people who understood what I was going through and supported me in dealing with the grief." ***Boitshepo, 31, female***

"Psychological counselling and family support" ***Lesego, 32, female***

Even though **Tumelo, 27, male** did not receive counselling, he still gained support from talking to someone he trusted and that helped him cope with his loss.

"My professor was my pillar. He was always there for me when I was down and needed a shoulder to cry on. I also prayed silently to gain strength from God" ***Tumelo, 27, male***

Choene, 35, male does not talk about his relative's suicide as he believes it takes him back to the incident and brings him a lot of pain. **Choene, 35, male** and **Lucky, 25, male** resorted to alcohol and substance abuse to help them cope with their stress.

"Talking about it brings me so much pain, so to help myself I just go drinking to forget about it. Sometimes I just pretend that the death was as a result of some illness like cancer or heart failure rather than suicide" ***Choene, 35, male***

"Smoking helps me refresh my mind from the feelings I get when I think of my parents. If I don't smoke I think too much and get irritated and angry. Sometimes I draw or write to shift my mind from the thoughts…smoking doesn't help much because it only helps you forget for that moment and when it gets out of your system is back to start." ***Lucky, 25, male***

Some participants believe in the power of prayer. **Rosina, 60, female**, **Raisibe, 59, female** and **Metja, 46, female** below believe that their prayers to God for His healing were answered.

> *"Whenever I think about it, I just pray God to heal me inside, it helps me sleep. During the day I keep myself busy to avoid thinking about it"* ***Rosina, 60, female***

> *"Prayer heals…and family support. Even the community's support works."****Raisibe, 59, female***

> *"I pray to God for his healing…it takes time, but it will work."* ***Metja, 46, female***

In light of all the extracts under 5.5.6, there are many strategies that people can employ to cope with loss. Strategies include praying, sharing feelings with family and friends and also seeking counselling or joining support groups. Some people also experience peace from seeing the children they were left with succeed and by keeping themselves busy. It was also revealed that cherishing the good memories shared with the deceased helps in reducing the self-blame. Avoiding negativity and shifting the focus from the hurt to a more positive activity also helps in coping.

5.5.7 Grief following suicide and grief following other causes of death

Grief is a feeling of great sadness after the loss of a loved one. The feelings and strategies of coping with it differ from one individual to the next. For some, the feelings of loss and rejection take a lot longer to fade, while others find it easy to move on. The following extracts express the perceptions participants have regarding the difference in grief for death by suicide and death by other means.

> *"Suicide grief…like at the beginning there is shame. You feel like people look at you in a different way. You feel like you are not a good parent. But with natural death, okay death is death. It doesn't matter what the cause is but you just wish that he had said you know mother I had this kind of a problem. This one of suicide is…like when my mother died it didn't affect me like this one of my son. It was hard. I would ask myself so many questions, but here I am now. I couldn't talk about it without crying, but I am used to it now."* ***Maria, 44 years, female***

“Other causes of death are better accepted as people know that death does exist. With suicide it is so sudden, it is unexpected, it carries a lot of stigma. Suicide is unacceptable and does not have any closure; hence it is so difficult to comprehend.” ***Tumelo, 27, male***

“Suicide loss is hard to accept. You find that the person was still fresh and healthy; it’s like a very terrible surprise. You may even feel like also committing suicide to escape the pain you will be going through at that time. When a person is sick you are able to prepare yourself for the worst. You even wish the person could rest because you see how much pain they are going through. With suicide it is very traumatising because you may find that culture doesn’t even allow you to see the deceased for the last time, the deceased is not even allowed to come inside the yard simply because society believes it is a curse to the whole family to die that way. With natural death you accept without any regrets because you know you have done all you could to help the person.” ***Mmatlou, 30, female***

”I feel grief following suicide is very hard to deal with. If a person dies from an illness at least there won’t be any self-blames or blaming others. It is easier to accept that through suicide, with less anger towards the victim and others. There is so much pain involved, and it is continuous, doesn’t want to stop. I wouldn’t wish anyone to experience it” ***Choene, 35, male***

“You know my husband died from heart problems and I knew from seeing how much pain he was experiencing that he was ultimately going to leave me and I had already made peace with it. It was painful but I could console myself because I saw him, I was there for him, taking care of him until the very last day. I was even able to pay my last respects to him before going to the graveyards. With this one it was very different. I knew from the time I was told about his death that it was going to be tough. I was not going to see him at all, except from the tombstone erected upon him. We do not see a body of someone who killed themselves. I don’t have a picture of my dead son in my brain, so to me it’s like he would come in any moment and tell me it was a joke. It is painful. Even people look at you like you are the reason he died, like it’s contagious. It is embarrassing and shameful to lose someone that way. I

rather have my children get sick before they die, just to prepare me emotionally." ***Rosina, 60, female***

"The difficulties are that, since I have experience for both. My husband died from heart attack, I was with him and was able to help him. I saw him and even when the doctor came to certify him I understood because he had high blood pressure. I just thought to myself that maybe it's time to go, maybe it's because I had to deal with preparing for the burial so that I can finish with it as it was weighing me down. You miss him but you tell yourself that he was old and I am also old I can go anytime. But suicide I think he was still young, still growing, it's shocking, embarrassing, financially draining and you don't forget." ***Evelyn, 62, female***

"Suicide is stigmatised, it leaves you without closure, and you blame yourself and feel guilty for no reason. All these make it even harder to deal with. You even get blamed by others for that and they call you names simply because a member of your family died by suicide. It is more complicated to explain or to understand than death by other causes." ***Boitshepo, 31, female***

"Even though I have accepted that whatever happened has happened, it was not easier to accept than when a person has died from other sicknesses. It is very hard to deal with." ***Raisibe, 59, female***

"Suicide leaves you with so many questions than answers…and then the community also judges you. It is more painful bereaving for a suicide loss than any other. You blame yourself for things you also don't know about. It's like you could wake the person just to say goodbye. I would rather nurse my sick mother than have her take her own life. It would be hard but I will be prepared for when the time comes." ***Lesego, 32, female***

"People…I have seen people die am telling you…that was the worst bereavement I had ever gone through. Even now I still get anxious when I think of it. That is why I don't even talk about it. I don't want to think about it. You know when you are not expecting something to happen…you don't even think that someone would do that, not even thinking about suicide. You know

the worst surprise. Suicide bereavement is very hard to endure." ***Metja, 46, female***

"…there are people who died after my parents…I was there seeing everything and even running some errands in preparation for the burial…but I have already forgotten about them. I don't know if it's because I am longing for my parents or what, but suicide is harder than when a person was sick and you also saw that now it's the end." ***Lucky, 25, male***

Based on the above extracts, it was revealed that although a loss is a loss, irrespective of how the person died, there is a difference in intensity of the pain endured when a death is from suicide. The participants expressed that the grief following other causes of death is easier to understand and heal from. Since you have seen how the person was struggling with whatever illnesses they were living with, being there for them and helping them where possible until the end. One can make peace when the person is finally at rest and free from pain. When the person is sick, it serves as a mental preparation of what might happen, and even if the person dies you know that you have tried. With suicide, it is a different story. Some participants describe it as a very bad surprise which is often accompanied by shock. It leaves many questions unanswered, which lead self-blame and blaming others. Suicide grief was revealed as being the most intense as there is no time for mental preparation. It is unforeseen and the deceased are usually very healthy and not expected to die soon.

5.5.8 Concerns about the topic of suicide

5.5.8.1 Participants feelings concerning the topic

Participants in this study expressed that they regard the topic of suicide as very important, but feels that it is least talked about. This might be because of the stigma attached to it and also the judgement experienced by society. Participants revealed that they felt lighter after the interview since it is not something that they usually discuss. For some, like **Choene, 35, male** and **Rosina, 60, female**, it is the first time they spoke about the incident with anyone and they felt relieved as they never thought that they would be able to do it.

"This is a topic that should be talked about a lot. To be honest, children should know that suicide is not an option. Even at schools children should stop bullying each other because they don't know the other children's mental states. A person may laugh and do all other positive things, but you don't know their mental state. According to us we usually believe that mental illness is that of a person picking papers on the streets, while there are many different illnesses." ***Maria, 44 years, female***

"It is a very important topic to discuss, but it is very painful as it takes you back to that moment you try so hard to forget." ***Tumelo, 27, male***

"It is heart provoking, painful, but very important. People refrain from talking about it, but then more awareness should be made about it and it starts with talking about it." ***Mmatlou, 30, female***

"This is a very painful topic. It is not easy to talk about and more awareness is needed concerning this topic. People should be made aware that suicide is there but there are other great ways of dealing with our problems." ***Choene, 35, male***

"I don't know. I just feel like I only lost my son yesterday and I also feel a bit relieved that I was able to talk about it for the first time since he was gone. It is painful but it is something we need to talk to our children about." ***Rosina, 60, female***

"I feel…because I am not a person who has friends and don't usually talk about him, I feel very relieved that now I can talk about it. I even want someone who can also tell me that I am not the first…to do this…pray…or go to the graveyard, take some flowers…or whatever that can heal me. I don't know what it is that I can do that can make me feel better, but I feel…I feel much better when I talk about it. Even now I feel relieved because I have spent a lot of time not talking about it. When you don't talk about it you just think alone that 'eish…I wonder how grown he would be if he was here'." ***Evelyn, 62, female***

"This is an important topic to talk about and yet so painful. More workshops are needed to work on prevention methods." ***Boitshepo, 31, female***

"People need to be taught of the importance of speaking up when they feel they can't deal with life's challenges anymore. This can be done by firstly raising topics like this." ***Raisibe, 59, female***

"To me it I know it is very important and I have already started with suicide awareness campaigns in surrounding schools and at church. We should get used to talking about suicide openly." ***Lesego, 32, female***

"It's a very disturbing topic, but then people should be aware of it." ***Metja, 46, female***

"Maybe if topics like this were raised more often, people wouldn't treat us bereaved by suicide the way they do. It takes one back but also revealing to speak about it. I never openly talked to someone about my feelings so I feel relieved now." ***Lucky, 25, male***

5.5.8.2 Participant's expressions about the topic

The participants conveyed that topics like this should be talked about more often and that professionals should enlighten people on what signs to be on the lookout for and how to prevent someone from taking their life. **Maria, 44 years, female** warned that even children should be taught about suicide as it affects them and they should also be taught to feel free to communicate with their parents about things that affect them. All the five victims in this study were males, and **Boitshepo, 31, female** suggest that they should be encouraged to speak out about their problems. The extracts below reveal the participants' responses.

"What I can say about it is that if something like this happens to a person, the way it happens, the support of the family is very important. And we should teach our children that they should be open. If a child is talking to you, you should listen, so that he/she will be able to talk about anything. Children should have access to their parents and know how to approach their parents. You should not find that a child is afraid that if he/she tries talking the parent will respond negatively. We should let our children to be open to talk to us, we should listen and correct them where we see that this is not right. We should also know that it doesn't only happen to children; even older people need to be educated. It also taught me to look at people's behaviours. Sometimes

when the children come back from school I can ask how they feel, why are they sad, what happened or is happening. ***Maria, 44 years, female***

"To me this is an important topic to tackle. Topics like this will be able to shed some light to other people on why people commit suicide? What can be done to prevent suicide and also, more importantly, how to cope if you find yourself in that situation." ***Tumelo, 27, male***

"What I can say is that suicide affects anyone, any race and any age group. People need to talk about it a lot, more especially with their loved ones. It will be great to know what each member of the family thinks about it. Family members should also keep a check on each other to notice emotions and behaviours that are not usual and that may seem to stress the other person. Support and prevention start at home. We should make ourselves available for the other person and make ourselves hard to approach." ***Mmatlou, 30, female***

"I never thought I could ever talk about the experience with anyone ever. I couldn't even talk to my family. This topic hurts a lot. It brings out things I don't want to remember. It is like it just happened yesterday." ***Choene, 35, male***

"Nothing" ***Rosina, 60, female***

"The best thing is to pray and to accept that God's will have been done. He was rescuing those children from troubles that they were not going to be able to come out of. So the biggest thing is to just pray or go seek professional help. ***Evelyn, 62, female***

"You know what? I think more still needs to be done to encourage men to talk and to come out of their shells when they feel they are overwhelmed by whatever they may be going through." ***Boitshepo, 31, female***

"I always talk about it with my children and we don't have a problem anymore. Everyone is open to talk about it. God knows all our journeys and everything is his will. We just have to accept and ask Him to give us strength." ***Raisibe, 59, female***

"People should know that suicide affects anyone, it does not choose, any age or race…rich or poor. Our children should be taught by us, and us as elders should empower each other and help each other when we are down. Our children will do the same after us." ***Lesego, 32, female***

"I don't know what to say…none." ***Metja, 46, female***

"I wish people in this community that I live in still have a lot to learn. I don't know if its culture or what, but it has to change. Topics like this should be raised everywhere and then maybe the society will be able to treat us like human…not discriminate us." ***Lucky, 25, male***

5.5.9 Suggestions from participants in terms of support for suicide bereaved

All the participants in this study have experienced suicide bereavement. All suggestions they conveyed are what they feel they needed to help them through their grief. These participants had so much to say and their suggestions are as follows.

"People, support. I am going to talk about my experience. For me the support I needed…okay I was able to get professional help, but what I needed more was family support. Close family, but my brothers and sister were very far, they are the ones who were trying to come visit me at least for a weekend. I think a person should be with someone next to them, they must not be alone. You can't be alone; you must have a shoulder to cry on. When you are with someone you heal. That is why even now when I talk to someone, even if I don't know them, I am not afraid to say that my son died from suicide. I don't feel ashamed about it anymore. I can talk about it because I made peace with what had happened" ***Maria, 44 years, female***

"I think the family should be educated about the topic. There must be more campaigns about suicide prevention and churches should also play a role in offering support to affected families. Mental health practitioners should also be involved in equipping people on signs and what to do if someone they know is suicidal." ***Tumelo, 27, male***

"Families bereaved by suicide should try and unite in order to beat the stresses suicide brings along. They should stop pointing fingers and consider family therapy. Individuals without supportive family members should join support groups for people in similar situations to help them heal. There are also organisations helping people in dealing with their problems, even though most of them still need to be implemented." ***Mmatlou, 30, female***

"I think there should be more helplines for depressed people and they should be made available to the public. Television adverts, more literature from medical and psychological associations talking about issues like stress, depression, suicide and so on. Family members also need to be taught how to deal with the loss together as a unit." ***Choene, 35, male***

"If it would be possible for family members who lost someone to suicide to get free counselling. The grief is very overwhelming and it is not all of us who can afford professionals." ***Rosina, 60, female***

"I don't know. The most important and biggest thing that maybe you can help with is that a person heals spiritually and move on. I know that you won't forget him/her. The pain is in the deep. The kind of help you need is up to you, whether you want to talk about it or just leave it. When you keep talking about one thing time and again you get used to it and get healed. That way you are able to move on." ***Evelyn, 62, female***

"I think we should start with workshops to encourage people to seek help when they have problems. Churches should also help in encouraging people as they are able to reach more people. Family members should be supportive to one another and not blame each other as this prolongs the grief process." ***Boitshepo, 31, female***

"I think everything starts in the family. Everyone in the family should be supportive to one another at all times. Support from people outside should just be additional. We should listen to each other's feelings about the suicide and comfort them." ***Raisibe, 59, female***

"It would be great for the government to implement a program whereby people in rural areas get free grief family counselling, more especially with suicide

bereavement. We should also stick together as a family and offer support as a society. There should also be more suicide awareness campaigns educating people on prevention and causes of suicide. " ***Lesego, 32, female***

"A Sepedi proverb goes 'tau tša hloka seboka di šitwa ke nare e hlotša', meaning that if the family is not united they can lose even the simplest battles. Nothing beats a united family." ***Metja, 46, female***

"The society we live in plays an important role in our life, whether directly or indirectly. Their support means a lot to our wellbeing. Even prayer helps a lot when one is faced with difficult situations. When faced with hardships one needs the family for comfort, so the family should be able provide that." ***Lucky, 25, male***

Based on the above extracts, it is obvious that a lot still needs to be done in dealing with suicide grief. It is suggested that a bereaved person should not be alone, therefore the family, friends, and the community as a whole should try offering their support to the person. It is also suggested that free counselling should be arranged for disadvantaged families bereaved by suicide. The extracts suggest that more awareness campaigns should be implemented to educate people regarding suicide, the causes and prevention, and therefore reduce the pre-conceived ideas held by society about suicide.

5.6 Summary

This chapter conveyed a lot of information from suicide bereaved family members. They expressed that there are a variety of causes for suicide, with depression as the leading factor. People take their lives in different ways and all five victims in the current study used different methods to commit suicide. The people who took their lives in this study were all males and some of the participants in this study suggest that males should be encouraged to speak out about their problems and that acknowledging they have a problem does not in any way mean that they are weak. The family was seen as the most important source of support in times of grief and also counselling played a huge role to those who felt they could not deal with the overwhelming situation by themselves. Death by suicide was found to leave the family members without closure and being judged by members of the society they

live in. In the next chapter, the researcher will use the Afrocentric theory and Bowen's Family Systems Theory of bereavement for analysis.

CHAPTER 6

DISCUSSION OF RESULTS

6.1 Introduction

The following chapter provides an analysis of the results from Chapter 5. The emerging themes, an overall summary of the findings, the contributions of this study, its limitations and also its recommendations are included.

6.2 Discussion of experiences

6.2.1 Participants' knowledge of suicide

The findings of this study show that the participants are well aware of what suicide is. They explained that suicide is when a person takes their own life or kill themselves, which supports the suggestion by De Leo et al., (2004) that suicide is an act with a lethal outcome, which the deceased intentionally performs with the knowledge or expectation of the lethality of such action.

6.2.2 Causes of suicide

Stress and depression that people do not talk about were found to be the main cause of suicide in this study. Some participants mentioned life regrets, unemployment, relationship problems, and hopelessness about finding help with problems. Desperation, pride, revenge, mental illnesses, financial problems and a weak personality, when faced with challenges, were also amongst the causes of suicide. These support the findings by Canetto (2015) that risk factors for suicide include people with a history of substance abuse, people who suffer from depression, post-traumatic-stress-disorder, anxiety, people with relationship problems, people with a recent death in the family, and those with chronic medical illnesses.

Maskill and Hodges (2005) alerted that males show consistently higher completed suicide rates than females across all age groups in the English-speaking Western countries, while females have higher rates of suicide ideation and attempted suicide. Gender roles or identity are considered to exert a major influence on suicidal behaviour (Stack, 2000). This was also evident in the findings of this study as all the

victims were males, with not a single female. This might be because males largely use more lethal forms of suicide. Stack (2000) and Maskil and Hodges (2005) found that even when females use the same methods as males they tend to be less successful at completing suicide.

Stack (2000) also asserted that an explanation for more completed suicide rates among males than females focus on the impact of the masculine stereotype in which males are required to be strong, decisive and competitive, resulting in men reacting more strongly to actual or perceived loss or failure in their primary adult male role. This might also be the reason all the victims in the families affected seemed to be secretive about what was troubling them as all participants claim to not know what the problems were that the victims were experiencing.

As Jensen (2011) put it, young adulthood is a time of life with an openness to diverse cultural beliefs and behaviours. Often young adults have not settled on particular beliefs and views at this stage and therefore when exposed to local and international cultures, identity confusion may take the form of bouncing between different cultural identities across situations and contexts (Jensen, 2011). This finding is also evident in the outcome of this study as one of the five victims was a minor. All the other victims were in their young adulthood stage. Hjelmeland, Akotia, Owens, Knizek, Nordvik, Schroeder, et al.,,(2008), also support this finding by stating that suicide is prevalent in South Africa amongst young adults in particular. Psychoanalytic theories also propose that suicide is caused by unconscious drives, intense affective states, a desire for escape from psychological pain, existential drives for meaning, and disturbed attachment (Van Orden et al.,, 2010).

The motivational-volitional model integrates the key factors from earlier theories into a detailed map of the suicidal process from thoughts to acts of suicide. Whereas belongingness and burdensomeness are paramount in the final common pathway to suicide in the interpersonal theory, feelings of defeat (ie, feeling defeated after triggering circumstances) and entrapment (i.e., being unable to escape from stressful, humiliating, or defeating circumstances) are suggested to be of most importance within the integrated motivational-volitional model (O'Connor & Nock, 2014). When an individual feels both defeated and trapped, the likelihood that suicidal ideation will emerge increases when motivational moderators (e.g., low

levels of social support) are present. Whereas the interpersonal theory of suicide theorises that acquired capability establishes behavioural enaction (i.e., suicide attempts), it is just one of several (volitional phase) factors within the integrated motivational-volitional model suggested to increase the likelihood of a suicide attempt. Such factors include exposure to the suicidal behaviour of others, impulsivity, and having access to the means of suicide (O'Connor & Nock, 2014).

6.2.3 Method used by victims to take their lives.

In South Africa, hanging is one of the most frequently employed methods of fatal suicidal behaviour. This is followed by shooting, poisoning, overdosing, gassing and burning. A variety of other methods include the use of sharp objects, suffocation, electrocutions, drowning and fenestration (jumping off high areas). Common in non-fatal suicidal behaviour is overdose with medication (often with over-the-counter analgesics and prescription-only available medications like benzodiazepines and anti-depressants), ingestion of household poisons and cleaning agents and self-injury such as self-cutting (Schlebusch, 2005).

The most commonly used method is hanging where the victim usually uses a strong rope, cable, or anything strong enough to prevent oxygen from passing through into the lungs, causing deprivation of oxygen and then death. Other methods include shooting oneself, drinking poison, overdosing on medication and cutting oneself to cause heavy bleeding that results in death. In this study, two of the victims hung themselves, one overdosed on medication and the other two used a gun. One shot himself while the other first shot his wife before shooting himself. WHO (2019) also revealed that around 20% of global suicides are due to pesticides self-poisoning, most of which occur in rural agricultural areas in low- and middle-income countries, while other common methods include suicide by hanging.

6.2.4 Impact of suicide on the family

6.2.4.1 Psychological impacts

Numbness, disbelief, confusion and shock are usually associated with trauma. These were some of the experiences expressed by participants in this study when they first found out about the loss of their loved ones due to suicide. They also mentioned feelings of hopelessness, embarrassment, carelessness, shame and hurt.

Blaming the victim, other people and one's self were also evident in the study. The participants told that it even felt like a dream and all of them never cried until at the burial or afterwards. Having to witness the incident was also found to leave the survivors with a lot of emotional trauma.

Calhoun and Allen (1991) found that suicide survivors tended to be more psychologically disturbed, less likeable and more blameworthy than non-suicidal bereaved people. All participants reported that they have been affected psychologically by the loss of their family member due to suicide. The psychological impact experienced included depression, self-blame, aggression, suicidal ideations and also resulted in hospitalisation for some. Some participants reported being overwhelmed by the experience and others had anger issues. Suicide can lead to longer and more complicated grief reactions because family members are unable to share their experiences or thoughts, particularly the feelings of guilt that they are struggling with (Dyregrov et al., 2005).

Some participants expressed that they have changed for the better and now feel better about what had happened. They have accepted that anyone can take their life anytime and that they are not the only ones to ever experience it. This helped them to forgive themselves and the lost loved ones for the suicide and they mentioned that they are even able to go to the grave and the scene of the incident with less distress.

6.2.4.2 Social impact of suicide

Suicide survivors are judged more negatively than survivors of other types of loss. They are seen as more disturbed and more deserving of blame for the suicide, and this is particularly true of parents who lose a child to suicide (Cerel et al, 2008). Some of the bereaved family members expressed that they isolated themselves as they felt that their society was judgemental of them. Evelyn reported that she started looking at friends, family and relatives as she felt they blamed her. Rosina likes attending church and endures being at such gatherings even though she believes that the other women talk about her behind her back. Even though Mmatlou's family and friends are supportive, the community still calls her names and this sometimes makes her afraid to go out. Blame may be overtly expressed or covertly communicated through nonverbal cues and social withdrawal, straining and even

rupturing the cohesiveness of a family or extended social network as survivors blame each other for the death (Cerel et al, 2008). The social structure need not utter words to show their judgement towards bereaved families, their judgement is seen through their actions. This judgement leads to some survivors losing trust in people and distancing themselves from even friends and family.

As stipulated by Stack, (1998), religion plays a huge role in the manner in which Africans view suicide. Stack speculates that some Africans view suicide as a 'white thing'. Suicide in some African cultures was also viewed as unpardonable, unforgivable and unthinkable and thus seen as a curse (Stack, 1998). In some countries in Africa people who commit suicide have no right to a befitting burial (Early, 1992). This was also evident in the findings of this study where a participant (Metja) had to go to court for the community to allow her to bury her brother and sister-in-law in the community graveyard. It was also emphasised by Colucci (2006) that suicide has different meanings to people belonging to different socio-cultural backgrounds.

Many cultural meanings may be present in the culture, and different cultural meanings may exist for different subgroups of the culture (Lester & Lester, 2011). For example in most Western communities, people bereaved by suicide will often accept that mental illness or intrapersonal conflicts could have led the person to commit suicide (Carnetto, 2015).In most African societies suicide has been perceived as taboo, self-inflicted pain, immoral, unforgivable and a shortcut to hell, thus leading to ostracisation of family members bereaved by the suicide (Lester, 2008). It is in this regard that the bereaved families often hide the cause of death, thus even avoiding seeking professional and societal support (Stack, 1998).

Walsh and McGoldrick (2013) asserted that a death in the family involves multiple losses in numerous relationships, functional roles, the family unit, and hopes and dreams for all that might have been. Death can disrupt a family's functional equilibrium. When the incident happened in Thabo's family, the father had to take over the mother's duties as she was admitted to a facility for treatment. And Tumelo, 27, male, had to toughen up for his examinations and therefore could not help his father with caring for the other children. All of the family's reactions, according to Walsh and McGoldrick, (2013), reverberate in a circular chain of influences. Distress

may stem not only from grief but also from the realignment of the family's emotional field. Metja, on the other hand, had to assume her brother and sister in law's duties of raising their children as the children were now orphaned and very young. Phuti's death divided his and his wife's families. Mmatlou no longer gets along with her in-laws and is blamed for her husband's death. Choene also states that the family is broken and his mother is hurt because of the distance between her and the daughter-in-law. Raisibe's in-laws were divided because of the accusations of witchcraft and jealousy.

6.2.5 Stigma attached to suicide

Society tends to blame the survivors and offers less grief support than it does for survivors of natural death (Clark, 2001). When a person commits suicide, the family may pretend that suicide never took place, or that the death was caused by other means, e.g. car accident, illness, etc. (Barnes, 2006). This is due to the stigma still attached to suicide, even though there are many support networks to turn to for help. Cultures inevitably affect the way individuals express emotional distress. and influences the method of suicide and the underlying attitudes to self-harm and suicide.

Hjelmeland et al.,, (2008) stated that individuals in a developing country often have more restrictive views towards suicidal behaviour when compared with individuals from a more Western world. In a western world, suicide may be seen as a right, a cry for help and less taboo, while in developing countries it is often considered a taboo or a way of obtaining revenge or to punish someone (Hjelmeland et al.,, 2008; Schlebusch, 2005). Views like these led the community members to not wanting to allow Metja to bury her brother and sister-in-law in the community graveyard as suicide is viewed as a bad thing.

Suicide survivors reported greater levels of stigmatisation, shame and a sense of rejection (feeling deserted by the deceased). They also had unique reactions (e.g., feeling that the deceased was getting even) and a desire to hide the mode of death of the deceased. The subscale to distinguish the groups was the sense of rejection and the unique reactions (Cerel et al, 2008). This supports the findings of this study

as the participants also mentioned the stigma against them and rejection by society. They felt judged by other family members, friends and community members.

6.2.6 Perceptions of participants on prevention

Communication is said to be powerful in solving problems. The participants in this study mentioned that they could have helped and offered support to the family member had they told them about their problems. They sound disappointed that their loved ones would not trust them with their burdens. They believe that if the victims had spoken, it could have prevented them from taking their lives. It is also evident from the findings of this study that people fear talking about their problems because they don't want to be judged. The participants highlighted that parents should be open to their children and offer them all the support they need so that they will know that they can rely on them should bigger problems arise. They also mentioned that as people we should monitor our loved ones in case any changes in their behaviour is out of the ordinary or any clues about their feelings can be interpreted as a cry for help.

Primary prevention programs to reduce suicide are mainly public education and awareness messages or campaigns aimed at people in the community but can also be school-based. Crisis lines or other resources available for suicidal teens reaching out for help are also considered primary prevention strategies (Holliday, 2012). According to WHO (2014) these strategies are designed to reach an entire population in an effort to maximise health and minimise suicide risk by removing barriers to care and increasing access to help, strengthening protective processes such as social support and altering the physical environment.

Selective prevention strategies target vulnerable groups within a population, based on characteristics such as age, sex, occupational status or family history. While individuals may not currently express suicidal behaviours, they may be at an elevated level of biological, psychological or socioeconomic risk (WHO, 2014). It has been reported that the majority of people who complete suicide have visited a health care provider in the month prior to their suicide, thus it is logical to target healthcare providers to intervene and watch for warning signs of mental health disorders. Since depression is a common risk factor for suicidal behaviour, educating providers about

screening for depression is important. Educational training programs for health professionals increase the chances of professionals asking young people about suicidal ideation but repeated interventions are needed to maintain vigilance (Holliday, 2012). The vulnerable group includes persons who have suffered trauma or abuse, those affected by conflict or disaster, refugees and migrants, and persons bereaved by suicide (WHO, 2012).

6.2.7 Coping strategies

According to Thapa et al.,,(2015), distinct cultural practices, including coping styles, family ties and religious beliefs, influence people's willingness to seek help and their ability to respond to mental health services. According to the participants in this study, there are many strategies for coping with a loss. The coping strategies are the same as those of people who died of natural causes.

Briggs (2010) stipulates that reducing the stigma or taboo associated with suicidal behaviour in society, and training community-based professionals (including those in schools, for example) to be able to encourage talking about suicide is something which may help prevent suicide rather than constituting a dangerous intervention which might 'put ideas in people's minds' and make the problem worse. Winston, O'Driscoll, and O'Connor (2010) suggest that while it may sometimes be difficult to be with family and friends when grieving, one should try not to isolate themself, missing out on the support other people can offer.

Talking to people who understand the situation better or even joining suicide bereavement groups where one can meet people in the same situation as them helps one cope better with the bereavement process. They also added that a person's spirituality, beliefs or religious faith can be their source of strength and may give them hope and comfort, and can help them to understand and make sense of the loss. Many people believe in a spiritual afterlife and this helps them to maintain a bond with the person who has died. The bereaved person can talk about the person who has died and about how they are feeling and it is good to have one or two people to trust to confide in (Winston et al, 2010).

Participants highlighted that a supportive family is great to have in times of grief. Having them around gives one a sense of belonging and that someone cares about

you. In the African culture, the community usually comes over to the bereaved family to pour out condolences. This puts the family at ease, giving them a shoulder to cry on and assuring them that they are not alone during the tough time. Even so, some participants in this study were sent from pillar to post for their family members to be buried. This shows a lack of support by the community and therefore leads to more grief than support to the family members.

Support groups are usually groups comprising of people in similar situations. One can feel a sense of belonging and be free from judgements. As the group of people would have gone through similar experiences, it is easy for a person to be assured that things like this can happen to anyone. The extracts below reveal that participants believe support groups, or being with people of the same experience, would have helped.

6.2.8 Grief following suicide and grief following other causes of death

Grief is a feeling of great sadness after the loss of a loved one. The feelings and strategies of coping with it differ with each individual. For some, the feeling takes a lot longer to fade, while others find it easier to handle. Suicide-bereaved children report less acceptance and relief than children bereaved from causes other than suicide, like Lucky in this study. In another study, two profiles of grief responses were identified: A sad, guilt-laden, and withdrawn response, (Cerel et al, 2008) and an angry, hostile, and defiant response.

Suicide survivors often face unique challenges that differ from those who have been bereaved by other types of death. In addition to the inevitable grief, sadness, and disbelief typical of all grief, overwhelming guilt, confusion, rejection, shame, and anger are also often prominent (Jordan, 2001). These psychologically painful experiences may further be complicated by the effects of stigma and trauma. For these reasons, the grief experienced by suicide survivors may be qualitatively different than grief after other causes of death (Young et al.,, 2012).

As stated by Sands and Tennant (2010), suicide death leaves those bereaved experiencing all the grief reactions provoked by death due to unintended causes, but further overwhelmed with a range of difficult individual and social grief issues related to the intentional nature of the death. The suicide bereaved are left to find a way to

find meaning in the knowledge that the suicide occurred due to the deliberate actions of the deceased. Since the bereaved shared a relationship with the deceased, the intentional nature of the death challenges the bereaved person's understanding of the relationship or continuing bond with the deceased (Sands & Tennant, 2010).

6.2.9 Participants' concerns about the topic of suicide

Participants in this study expressed that the topic of suicide is very important, but yet it is least talked about. This might be because of the stigma attached to it and also the judgement from society. Participants revealed that they felt lighter after the interview since they do not usually talk about the suicide. For some, like Choene and Rosina, it is the first time they spoke about the incident with anyone and they felt relieved as they never thought they would be able to do it. The participants conveyed that topics like this should be talked about more and professionals should enlighten people on what signs to look out for and how to prevent one from taking their life

6.2.10 Bowen's Family Systems Theory and the Afrocentric perspective

According to Kerr (2000), families profoundly affect their members' thoughts, feelings, and actions to the extent that it seems as if the people are living under the same emotional skin. They solicit each other's attention, approval, and support and react to each other's needs, expectations, and upsets (Rockwell, 2010). This theory is also supported by the findings of this study in that family members share ties that bind them together through different emotional encounters. Family plays a very vital role in offering support to an affected other, in this case, supporting each other through the bereavement process over the loss of a loved one. The main focus of this theory is the patterns which families develop to resolve anxiety brought about by current levels of external stress and sensitivities within the system. The anxiety may also develop when the perception of either too much closeness or too great a distance in relationships persist (Kerr, 2000). When a family member dies, there is huge anxiety developing as the person is now too far for the survivors' to reach.

The prioritisation of African people's customs, beliefs, motives, values, and conceptualisations is the rubric by which the application of an Afrocentric methodology operates. According to Modupe (2003) Afrocentricity is the continental and diasporic African collective cognitive will to cultural and psychic liberation with

the ultimate goal being Africana existence on Africana terms (Modupe, 2003). This African customs, beliefs, motives, values and conceptualisations may either favour or clash with an individual's interests. It was found in this study that some of the indigenous African customs do not favour the suicide bereaved. There is a stigma attached to them and also an inability to find closure. Suicide is viewed by some as a sin and considered immoral, therefore some communities still do not allow a decent burial. Some do not allow the loved ones to view or say their farewells to the deceased as it is regarded as a curse.

CHAPTER 7

A CULTURALLY INFORMED PSYCHOLOGICAL MODEL OF SUICIDE BEREAVEMENT

7.1 Introduction

The findings of this study reveal important elements that are experienced by suicide bereaved African families. The participants in the study were all suicide bereaved nuclear family members of African descent. All the participants in the study came from different areas within the province of Limpopo, Capricorn district. From the findings of the current study, it was clear that there are many causes to suicide. After the loss of a family member to suicide, there are a lot of things happening as the family strives to heal and say their farewell to their lost loved ones. Cultural influences have a role to play in the process, determining the outcome of the healing process. Even though Africans have norms and values, some of these norms and values may be in contradiction of others, like the ones revealed in this study where some families were not allowed to pay their final respects to their loved ones as suicide is still seen as bringing bad luck and is considered taboo.

The loss of a family member to suicide has an impact on the social life, the family's psychological well being and the family structure as a whole; and can also lead to overestimation of responsibilities. All of these mentioned outcomes can influence each other. For example, a negative social or psychological impact may result in an overestimation of responsibilities or have an impact on the family structure.

As it was already pointed out in the methodology section, the researcher opted to use Wacker's (1998) four-step guidelines to develop a culturally informed psychological model of suicide to explain this unique journey. To develop the model, the researcher defined the major concepts and the sub-concepts that form the basis of the study. The researcher also had to specify the domain of the model, as to when or where the model applies. Then a relationship was built from the different concepts and the specific domains of the model. Lastly, the researcher had to come up with predictions of the model that were drawn from the relationship between the concepts and were supported by the cases in this study.

7.2 A culturally informed psychological model of suicide

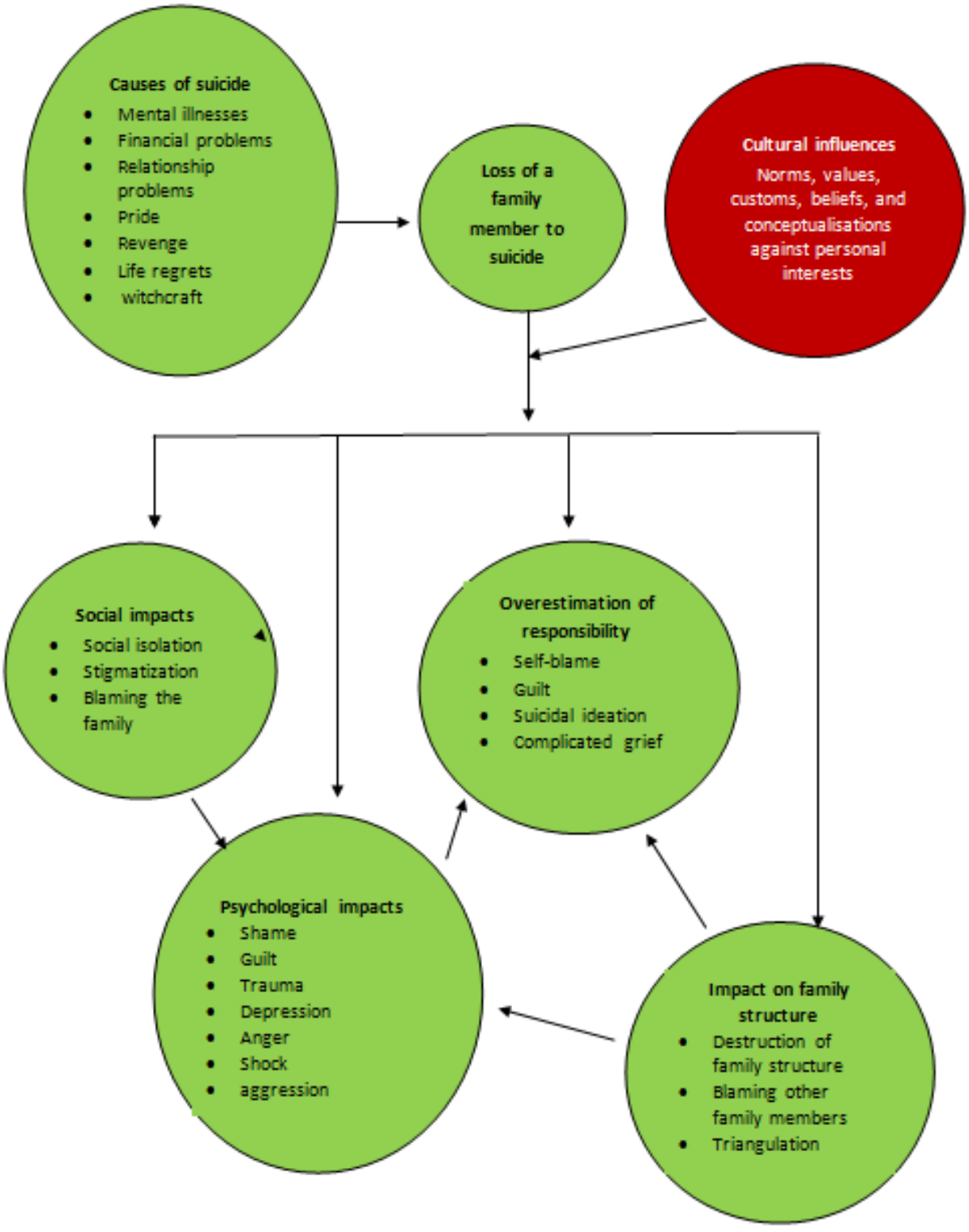

Figure 7.1: A culturally informed psychological model of suicide bereavement

7.2.1 Description of the model

7.2.1.1 Major concepts of the model

The model incorporates ideas derived from Bowen's Family Systems Theory and the Afrocentric perspective. Bowen's Family Systems Theory proposes that families affect their members' thoughts, feelings and actions. It suggests that they ask for each other's attention, approval and support and also reacts to each other's needs. The family system is a very crucial support system in the bereavement journey. Suicide bereavement destroys the family structure and places blame within the family system. Some family members triangulate, seeking third party support. One idea of the Afrocentric perspective is that it places the African in his or her natural context, trying to understand him or her together with the cultural values, norms, beliefs and customs he or she holds. The Afrocentric perspective diverges from this study in that some customs and norms are not in favour of the participants' interests. Both these theories, with the African family structure at the core, suggest that the behaviour of each family member affects the other. The way cultural customs are carried out determines the outcome of the bereavement process.

a) Causes of suicide

   These are the internal and external underlying factors that drive the victim to have suicidal ideations and eventually they succeed in completing the act. Internal factors include psychological problems and how one reacts or behaves when faced with life-threatening events. Psychological problems may be trauma, depression, anxiety or grief. External factors refer to the environmental stimuli that may be challenging to the individual. These include maltreatment from the community, stigma or discrimination.

b) Loss of a family member to suicide

   This explains the reaction of the surviving family members to the death of a family member as a result of suicide. It explains feelings involved through the bereavement process, the mechanisms used in coping and the outcome of the grief.

c) Individual characteristics and experiences

These relate to prior behaviours concerning a state of being mentally unwell. People have different experiences and personalities that lead them to behave in particular ways. A bad experience may lead one to end their life, depending on the person's ability or inability to cope under stressful situations.

7.2.1.2 Sub-concepts of the model

The social and psychological impacts, the impact on the family structure and the overestimation of responsibilities form the category of sub-concepts of the model. These factors predict the outcome of the loss of a family member to suicide, i.e. how the individual behaves afterwards.

a) Social impacts

These are the external societal reactions and the stigma they attach to incidents. They include social isolation, stigmatisation and blaming the family members for the loss.

b) Psychological impacts

Psychological impacts include the shame, guilt, trauma, aggression, anger, shock and depression that surviving family members are left with after the suicide loss.

c) Impact on the family structure

These include the destruction of the family structure, blaming each other and triangulation.

d) Overestimation of responsibilities

These are elevated feelings or behaviours manifested by suicide bereaved individuals. They include self-blame, guilt, suicidal ideation and complicated grief.

7.2.2 Assumptions of the model

There are several assumptions inherent in the proposed culturally informed psychological model of suicide bereavement. These are:

a) People lead different lifestyles and react differently towards situations they encounter in their daily lives.

b) People in all their biopsychosocial complexity interact with the environment, progressively transforming the environment and being transformed by the environment.

c) The society that people live in positively or negatively affect an individual.

d) People's mental state or views of personal challenges are essential to behaviour change.

7.2.3 Propositions of the model

The following are the propositions of the proposed model:

a) Prior behaviour and reaction to life events influence beliefs, affect, and portrayal of the final life-threatening behaviour. The way one reacts to certain stimuli influences how the person will behave if faced with life-threatening behaviour. If one, for example, attempts suicide or threatens to commit suicide whenever they are saddened by simple life challenges; they may resort to suicide when faced with more life-threatening challenges.

b) People commit to engaging in behaviours that they view as best solutions to the life events they find themselves in. When one is faced with a life-threatening challenge that they feel they cannot escape, they often view suicide as the only solution and commit to carrying it out.

c) The more the individual views their solution as specific for the challenge, the greater the likelihood to portray it. The more the individual views suicide as the best solutions in the event, the more they believe it and the chances of carrying it out increases.

d) The surviving family members are then left with different reactions that affect them psychologically. All the stigma, self- and other blaming, and cultural beliefs and norms involved may lead the surviving family members to psychological problems. These psychological problems include trauma, depression, shock and aggression.

e) The external society also reacts to the suicide in a way they feel is right, therefore leaving the bereaved family with more hurt. Blaming the bereaved family for not being careful with the deceased inflicts more hurt on them. The stigma leads them to isolation and fear of social contact.

f) The family structural equilibrium suffers the impact of the suicide. The family unit disintegrates as family members seek answers. When one dies by suicide, he or she leaves the family members with questions. Each family member struggles to get answers for themselves and this causes fights and a rift within the family.

g) Triangles are formed within and outside the family structure as bereaved family members seek comfort and a sense of belonging. Each member of the family associates himself or herself with someone who understands him or her, whether within or outside the family. This happens as the bereaved tries to find comfort and to feel wanted.

h) Families and healthcare providers are important sources of interpersonal influence that can increase or decrease the psychological impact of the event. The way the family members behave or interact with each other through the bereavement process may help in healing or lead to complicated grief. If the family members blame each other for the death, the family structure will break and the members may get complicated reactions towards the loss. Healthcare providers also assist with counselling and therapy to aid the mourners through the bereavement process.

i) The individual, family and society all play a role in the outcome of the bereavement. If an individual does not receive the needed support and comfort, they may end up with an overestimation of responsibilities. These overestimation of responsibilities are tragedies of the reactions towards the grief which include feelings of guilt, complicated grief and suicidal ideations.

7.3 The Afrocentric dimension of the model

The model is a representation of suicide bereavement as experienced by the participants in the study. It consists of various dimensions that may manifest both

internally and externally. The model suggests that the cultural norms, values and beliefs may have a negative influence where suicide is involved. Psychologically, people need to pay their final respects to the deceased in order to find closure. In contrast to this, some cultures believe that suicide is a taboo and is unforgivable. It is therefore a custom to not attach any decency to the funeral or pay respects to the deceased. These actions cause more pain and lack of closure to the nuclear family members, which leads to psychological problems such as trauma and complicated grief. The participants in the study revealed similar experiences concerning some psychological and social issues. Social unity is said to provide a sense of belonging to the nuclear family members. Absence of social support to the bereaved also leaves them with pain and leads to social isolation. The belief that suicide is a sin or taboo may lead to a lack of social support. The family structural issues were also common for some, while the commonality was also manifested in the coping strategies.

7.3.1 Suicide bereavement

Of the five families bereaved by suicide, two had social misunderstandings with the external family and society. In their African tradition, suicide was still considered as unforgivable and taboo. They still held the belief that having someone end their life in the family is a curse to the family and the victim's body does not deserve to be treated with decency, it should be disposed of without any proper funeral arrangement or last respects. This causes a huge impact in a grieving individual's psychological wellbeing as viewing of the body is seen as a chance to say your farewell and also help in the healing process. In one family, the victim's body was not allowed to enter the gate as it was believed that it will bring bad luck to the family, while in the other family, the bereaved had to seek a court order for the community members to allow them to bury their deceased in the community cemetery.

7.3.2 The causes of suicide

Although most participants in the study revealed some psychological factors as causes of suicide, some gave non-psychological causes. All the deceased from the families that participated in this study were males. In the African culture, men are supposed to act masculine, they are socialised not to cry out as it is seen as a sign of weakness. This explains why men don't usually talk about their problems and why

there is a high statistic of completed suicide amongst men. Some participants also view suicide as a result of witchcraft as they do not understand how a person in his right mind can resort to suicide.

7.3.3 Coping strategies

For the participants in the study, the coping strategies were an integration of western, African and religious practices. The strategies mentioned by the participants to cope with the loss included counselling, family support and prayer. In the African culture, support from family, friends and society plays a huge role in the healing process. It is believed that their being there is a sign that you are not alone as a bereaved individual or family, and those with similar experiences signify that you can overcome the tragedy like they did.

7.4 Psychological matters

All the participants in the study had a level of psychological problems provoked by the suicide loss. They acknowledged that the loss left them with scars that affected their daily lives. All of the participants experienced shock, numbness and disbelief when they learnt about the suicide. All other emotions like depression and trauma followed afterwards with feelings of guilt and self-blame. The participants had to learn to cope psychologically with their suicide bereavement experiences.

7.5 Summary

The model incorporates aspects of Bowen's Family Systems Theory as well as the Afrocentric perspective. The Afrocentric perspective gives the adapted Bowen family structural perspective an Afrocentric touch in that cultural norms and values are also looked at. African customs also play a role within family structures and therefore influences the outcome of the bereavement process in the nuclear family. While Bowen's family structural perspective focuses mainly on how the structure of the family is affected by the suicide loss, the Afrocentric perspective touches on the norms, values and beliefs that build the family and places the family in the context of a culture and society. This makes the model applicable within the African context thereby increasing its relevancy and applicability.

CHAPTER 8

SUMMARY OF FINDINGS, CONTRIBUTIONS, IMPLICATIONS AND RECOMMENDATIONS

8.1 Introduction

This chapter starts with the presentation of the summary of the study results. Secondly, the implications of the study are outlined. Thirdly, the contribution and recommendations of the study are presented, followed by the limitations of the study.

8.2 Summary of findings

The layout of this chapter was guided by the research objectives of this study. This summary, therefore, answers some of the research objectives laid out at the beginning of the study and also discusses some of the important themes extracted from the cases. The current study reveals that people are knowledgeable about what suicide is and its causes, but lack knowledge on how to prevent it. There is still a lot of secrecy surrounding psychological problems that lead people to commit suicide, leaving the survivors not knowing who or what to blame. This then leads to the whole family blaming themselves and other family members for not seeing the prelude to the incident. Most importantly, this study revealed the daily experiences of suicide bereavement. The stigma from society does not enable the survivors to deal with their grief, forcing them to isolate themselves for fear of being judged. The participants mentioned that they lacked social support during the funerals as they felt they were being judged. They also felt that they were failures for not noticing that their lost loved one had problems, that may lead them to take their life. It was also revealed in this study that males are the ones most often committing suicide as all the victims in this study were males.

8.2.1 The participants' knowledge of and views on suicide

This study revealed that people are well aware of what suicide is. Even so, the views they hold about suicide differ from person to person. This study reveals that people attach meanings and perceptions to certain situations in terms of how they feel and experience them. Those who have not yet healed from the loss are more likely to view it as very negative and wrong. The more one heals, the easier it becomes for

them to have a different view. Participants who still believe that the suicide was a selfish act may not have healed from the grief and the view may also depend on the kind of treatment received from the family and/or society. The ones who are better understand that every person has their way of absorbing and reacting to stimuli they encounter, and it is not for them to judge as we differ in cognition as people.

8.2.2 The causes of suicide

There are a variety of factors that may push people to end their lives. The causes may be psychological, social, financial or even spiritual/religious. Psychological factors include stress and depression, life regrets, desperation, pride, revenge, mental illnesses, a weak personality when faced with challenges and hopelessness; while financial factors include unemployment and financial problems. Relationship problems and witchcraft form the social and spiritual factors respectively. It is evident that people do not open up about their problems, believing they will not find help or any form of support, they see their chances of overcoming their problems as hopeless and therefore resort to suicide.

8.2.3 The impact of suicide bereavement on individual and nuclear family members

The experiences of suicide bereavement can affect both an individual and the whole family structure. Suicide bereaved individuals experience different reactions from the time they find out about the suicide incident, up to the time they learn to live with the loss. The moment they learn about the loss, the individual may experience shock, disbelief and numbness. As the reality of the loss sinks in, feelings include stress, trauma, helplessness, depression and self-blame. Acceptance usually comes a lot later, after the funeral, when the bereaved individuals get to learn than that their loved ones are never coming back.

The society that one lives in can either help in the grief process or make it worse. They do not need to utter any harmful words, but just their behaviour is enough to break you. It was revealed that the surviving family members were blamed for the loss and seen as being careless. All these negative behaviours lead to complications through the grieving process.

Family is the most crucial support system when faced with a problem. Suicide can leave a lot of disruptions in the family structure. Some family members fight, blaming one another for the loss. In some families, there may be no fights but an inability to perform some duties as before. The children may also be left without biological parents. Family members tend to triangulate, that is, seek a third party that they can lean on and confide in. A bereaved individual needs family support to feel that he or she is not alone in the process. The more an individual is not supported, the more difficult it is to accept the suicide, and the more difficult it is to fight challenges from the society.

8.2.4 The grief experiences of those bereaved by suicide

Based on the above extracts, it was revealed that although a loss is a loss, irrespective of how the person died, there is a difference in the intensity of the pain endured. The participants expressed that grief following other causes of death is easier to understand and heal from. This is because you have seen how the deceased person was struggling with whatever illnesses they were living with, being there for them and helping them where possible, until they died. One can make peace when the person is finally at rest and free from pain. When the person is sick, it serves as mental preparation of what might happen, and even if the person dies you know that you have tried to help them. With suicide, it is a different story. Some participants describe it as a very bad surprise, which is often accompanied by shock. It leaves many questions unanswered, which leads to blaming yourself and others. Suicide grief was revealed as the most intense as there is no time for mental preparation. It is unforeseen and the deceased are usually healthy and thus not expected to die.

8.2.5 The strategies that surviving family members use to cope with suicide bereavement

Considering the extracts under 5.5.6, there are many strategies that people can use when coping with the loss. Strategies include praying, sharing feelings with family and friends and also seeking counselling or joining support groups. Some people derive peace from seeing the children they were left succeed, and by keeping busy. It was stated that cherishing the good memories made with the deceased helps in

reducing the self-blame. Avoiding negativity and shifting the focus from the hurt to a more positive activity also helps in coping with the grief.

8.2 Implications of the study.

Bereaved family members face different challenges regarding their lived experiences with suicide bereavement (Cerel et al, 2018). People's response to bereavement is guided by their culture, making it critical for cultural factors to be recognised (Foggin et al., 2016). People hold different beliefs, attitudes and knowledge about suicide and bereavement. The lived experiences of suicide bereaved people are sometimes affected by cultural factors that need to be factored into any endeavour to fully understand their journey (Lester & Lester, 2011). These factors affect the coping strategies that the bereaved may resort to and impact their openness to speak out about the experience (Thapa et al., 2015). Spirituality/religion is an important factor in the lives of people of African descent and should therefore be acknowledged with the utmost sensibility.

The main implication of the study is that there is an immediate need to create an awareness of the symptoms, causes and how to prevent suicide at different levels. The first should be within the family, to reduce the stigma within the family setting, and at the society level, to reduce the stigmatising and ostracising behaviour towards victims and their families.

8.2.1 Implications for policy

This study provides insight for health care providers on the challenges faced by the bereaved in their social settings and also coping strategies used by the patients. The findings of the present study can help policymakers have a deeper understanding of the experiences of suicide bereavement and assist in developing and implementing informed interventions. The research findings can also provide insights to intervene and develop programmes for community psycho-education on suicide. This can be done by educating people about the psychological challenges that suicide bereaved family members go through and how to cope with them.

8.2.2 Implications for practice

The proposed culturally informed model sheds both a positive and negative insight into the importance of cultural issues in the experiences of suicide bereaved family members. The model incorporates the elements of Bowen's Family Systems Theory and the Afrocentric theory. Bowen's Family Systems Theory provides a useful framework for understanding people's responses when faced with grief for a loved one, but it does not account for cultural or normative factors. The Afrocentric viewpoint allows for a culturally-based relevance and dimension that is lacking in Bowen's Family Systems Theory but may be criticised for supporting some cultural beliefs that go against the interests of the bereaved at some point. One family from this study revealed that they were not allowed to view and say their final farewells to their deceased loved ones, while another was not even allowed to use the community graveyard, all in the name of African cultural norms. Practising healthcare providers will get insight into the norms, values and beliefs that impacts negatively on the bereavement process and be able to develop ways of dealing with them. They will also be able to come up with programs for psycho-education that will speak to the African cultural customs, norms, values and beliefs involved.

8.2.3 Implications for theory

The positive side of the Afrocentric perspective in this study was that, even though there were stigmatisations involved, the society still gathered to offer support to the bereaved which is very important in the African culture to assure the bereaved that they are not alone in the process. The model can be applied as part of the intervention strategies in the broad health psychology field to help people with different chronic medical conditions. The culturally informed psychological model of suicide bereavement has demonstrated the importance of people's cultural background, including beliefs on how they deal with experiences. It stresses the influence that African cultural customs, norms and values hold within the family structure and how the family is placed within the society. The model proposes that one individual's actions can impact the whole family system. If an individual takes his or her life, the whole family is left overwhelmed and the family structure may become dysfunctional. The family system's commitment to African values, morals and beliefs, may either strengthen or destruct it. Clinical psychology, as a profession, should

embrace this if it were to be relevant to the majority of South Africans. Cultural competence is essential to all five elements of patient/client management, namely, evaluation, diagnosis, treatment, and rehabilitation. Developing rapport, collecting and synthesizing patient data, recognizing personal concerns about function, and developing the plan of care for a particular patient requires cultural competence. Psychological interventions geared toward the people identified as African should include culturally tailored services. By providing culturally appropriate services to people with diverse belief systems, the possibility of their achieving a better quality of life and more positive health outcomes will be enhanced.

8.3 Limitations of the study

There are considerable limitations in this study and the researcher is aware of them. Firstly, the translation of the raw data from Sepedi to English may have caused the omission of the original rich material provided by the participants. Secondly, this study relied on the perceptions of a few suicide bereaved families, mostly from suburban areas where culture is not followed much like in rural settings and therefore their perceptions cannot represent all suicide bereaved families. Thirdly, demographic information such as education, religion and socio-economic status were not considered when analysing and drawing conclusions in this study. Fourthly, the data was not collected in the same area, which may affect the Afrocentric outcome of the results. Most of the affected families interviewed are developed and may not follow cultural norms. Finally, the results of this study cannot be generalised to a larger population since the study was conducted on a limited sample.

8.4 Recommendations

Based on the findings of the study, the following recommendations are made:

- This study suggests that suicide bereaved families should be offered counselling as a family to break the secrecy around the cause of death and to accommodate each other's feelings concerning the incident. This will also help the family to deal with the grief together and reduce the blame towards themselves and others. Bereaved family members will also be able to deal with societal stigma about suicide together and hold each other's hands through the healing process.

- It is recommended that the interventions offered to the bereaved are unfolded through an educational approach, so the individuals do not feel alienated or feel the need to struggle in isolation. Approaches to deal with individuals' concerns should be structured in a way that offers them the assurance that they are not alone in the grief process and are welcome to voice their feelings.

- It is recommended that future studies cover a larger sample consisting of suicide bereaved families from different areas and also taking into consideration all the other demographic information missed in this study. People from lower socioeconomic groups differ in approach from those in middle or higher socioeconomic groups. This might affect the way they respond to a suicide incident and the level of stigma. People in rural and in urban areas also hold different views of suicide in terms of causes and coping mechanisms.

- It is also recommended that group interviews are used in future research.

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APPENDICES

APPENDIX 1a: Semi-structured interview guide – English version

Objective	Questions
1. To investigate the meanings that family members attach to suicide bereavement.	1. As a suicide bereaved yourself, may you kindly share with me your knowledge pertaining to suicide? 2. In your understanding, what are the causes of suicide? 3. In your own opinion, what do you think could have caused the suicide of your family member? 4. May you kindly share with me your personal views on suicide
2. To determine the strategies that surviving members use to cope with the loss of their loved one.	5. May you share with me your own strategies of coping with the loss? 6. Kindly share with me what worked for you the most as a coping mechanism. 7. Please share with me the forms of support that were available for you at that time of the loss if there was any?
3. To identify and describe the resilience factors associated with suicide bereavement by the surviving family members.	8. kindly share with me, looking at your own experiences, the difficulties of grief following suicide as compared to grief following other causes of death. 9. Could u please describe how people reacted to the loss of your family member? 10. Kindly explain to me how you managed those reactions as a family.

Closure and debriefing	11. Kindly tell me if you have anything to say about this topic. 12. Could you share with me your feelings concerning this topic? 13. Is there perhaps anything you wished could have been done differently during the interview? 14. Share with me any suggestions you have in terms of support that is needed.

APPENDIX 1(b): Semi-Structured interview guide – Sepedi version

Objective	Questions
1. To investigate the meanings that family members attach to suicide bereavement.	1. Bjale ka motho yo a kweleng bohloko ka go hlokofalelwa ke yo le moratang ka go e tseela bophelo, tsebo ya lena mabapi le batho ba ba itseelang bophelo ke efe? 2. Go ya ka kwesiso ya lena, ke eng set se ka bang se hlohleletsa motho go itseela bophelo 3. Go ya ka kgopolo ya lena, ke eng se se dirilego gore wa lapa la lena ba itseele bophelo. 4. Ka boikokobetso, lena ka tsebo ya lena, go itseela bophelo go hlola ke eng?
2. To determine the strategies that surviving members use to cope with the loss of their loved one.	5. Ka boikokobetso, nkanegeleng gore le tlo kgona go tswela pele byang ka tahlego 6. Ka boikokobetso, nnyetleleng gore ke eng seo se le kgontsitseng go amogela lehu. 7. Ke kgopela le nkanegeleng gore ke thusho e fe ye leilego la e hwetsa, ge e le gore e bile gona, ka nako ya bothata bjo.
3. To identify and describe the resilience factors associated with suicide bereavement by the surviving family members.	8. Ka boikokobetso, ke kgopela gore le nnyetlele ka boripana gore le bapetsa bjang bohloko bja lehu la ge motho a etseetse bophelo, le lehu la ge motho a hlokagetse ka mabaka a mangwe ao a ka hlolago lehu. 9. Ke kgopela gore le nkanegele ka

	mokgwa wo batho ba ilego ba itswara ka gona mabapi le go la tlegelwa ga le lapa la lena. 10. Ka boikokobetso, nkanegeleng gore bjalo ka le lapa, ke kgonne bjang go phela ka gare ga dipolelo step.
Closure and debriefing	11. Ka boikokobetso, ke kgopela le nkanegele ge e le gore go na le selo se sengwe se le nyakago go se bolela mabapi le poledisano ye. 12. Le ka nnyetlela go ya ka maikutlo a lena mabapi le poledisano ye. 13. Naa e ka ba go na le se sengwe se le bego le ratile se dirwa go fapana le ka mokgwa wo se dirilwego ka gona mo poledisanong ye. 14. Nkanegeleng ka tšhišinyo ye e ka bago gona ba keng sa go thusa mo go nyakegago.

APPENDIX 2a: PARTICIPANT CONSENT LETTER AND FORM – ENGLISH VERSION

Consent letter

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga, 0727

Date: _____

Dear participant

Thank you for demonstrating interest in this qualitative study on the Psychological experiences of suicide bereavement on family members in Limpopo Province, South Africa. Your responses to this focus group interview will remain strictly confidential. The researcher will not attempt to identify you with your responses to disclose your name as a participant in the study. Please be advised that participating in this study is voluntary and that you have the right to withdraw your participation at any time. Kindly answer all the questions and reflect your true reaction .Your participation in this research is very important.

Thank you for your time

Sincerely

_____ _____

(Name) PhD Student Date

_____ _____

(Supervisor) Date

Consent Form

I _____ hereby agree to participate in a PhD research project under the topic: A qualitative study on the Psychological experiences of suicide bereavement on family members in Limpopo Province, South Africa. The purpose of the study has been fully explained to me. I further understand that I am participating freely and without being forced in any way to do so. I also understand that I can withdraw my participation in this study at any point should I not want to continue and that this decision will not in any way affect me negatively. I understand that this is a research project, whose purpose is not necessarily to benefit me personally. I understand that my details as they appear in this consent form will not be linked to the interview schedule, and that my responses will remain confidential.

Signature: _____

Date: _____

APPENDIX 2b: PARTICIPANT CONSENT LETTER AND FORM – SEPEDI VERSION
Consent letter

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga, 0727

Date: _____

Thobela Motseakarolo

Ke leboga go bontšha kgahlego ga lena go lesolo la go nyakišiša ka botlalo maikutlo a ba lelapa ba ga hlanang le o na ge o mongwe wa le lapa a hlokagetše / hlokofetše ka go itšeela bophelo. Diputšišo tsa lena, le dikarabo tša lena di tla tshwarwa ka mokgwa wa sephiri. Monyakišiši o tla like ka mešegofela gore a seke a le amanya le dikarabo tše le tla difago, le ge ele go se utulle maina a lena bjalo ka batsea karolo lesolong le. Le tsebišwa gore go tšea karolo ga lena go lesolo le go dirwa ka boithaopo, le gore le na le tokelo ya go ikgogela morago nako efe ge le nyaka. Le kgopelwa go araba diputšišo tše ka botshephegi bjo bogolo. Go tšea karolo ga lena go lesolo le go bohlokwa kudu.

Ke leboga nako le sebaka se le mphilego sona go ba le lena.

Wa lena ka boikokobetšo.

_____ _____

(Leina) PhD Moithuti Letšatšikgwedi

_____ _____

(Molehill) Letšatšikgwedi

Letlakala la tumelelano

Nna _____ ke dumela go tšea karolo nyakišišong ya thuto you bongaka yeo hlogo ya yona e rego: A qualitative study on the Psychological experiences of suicide bereavement on family members in Limpopo Province, South Africa. Mohola wa nyakišišo ye ke o hlalošeditswe ka botlalo, ebile ke a kwešiša gore ke tšea karolo ka bolokologi legona kesa gapeletšwe ka mokgwa ofe goba ofe. Ke a kwešiša gore nka ikgogela morago go nyakišišo ye nako efe goba efe ge nka ikwa ke sesa nyaka go tšwela pele le gore sephetho seo saka seka se nkame gampe. Ke a kwešiša gore nyakišišo ye, you maikemišetšo a yona esego go hola nna kabonna. Ke a kwešiša le gore mabitšo aka ao alego mo letlakaleng le la tumelelano, aka se amanywe le nyakišišo abele dikarabo tšaka etlaba sephiri.

Mosaeno: _____

Letšatšikgwedi : _____

APPENDIX 3: ETHICAL CLEARANCE CERTIFICATE

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING:	**05 July 2018**
PROJECT NUMBER:	**TREC/189/2018: PG**
PROJECT:	
Title:	Psychological experiences of suicide bereavement by family members in Limpopo Province.
Researcher:	BD Mokgoadi
Supervisor:	Prof T Sodi
Co-Supervisor/s:	Dr SE Nkoana
	Prof SL Govender
School:	Social Sciences
Degree:	PhD Psychology

PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii) **The budget for the research will be considered separately from the protocol.**
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa