1995

MEANING IN METHODS OF SUICIDE

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http://hdl.handle.net/10026.1/1641

http://dx.doi.org/10.24382/3206

University of Plymouth

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MEANING IN METHODS OF SUICIDE

by

GEORGIA CATHERINE JONES

A thesis submitted to the University of Plymouth in partial fulfilment for the degree of

DOCTOR OF CLINICAL PSYCHOLOGY

Department of Psychology
Faculty of Human Sciences

In collaboration with Plymouth Community Services NHS Trust

July 1995
ABSTRACT

"Meaning in methods of suicide"
Georgia Catherine Jones

It is possible to identify two broad approaches within research regarding suicide behaviour. The first aims to clarify individual sociodemographic or psychological characteristics that identify "at risk" individuals. The second recognises the importance of understanding the meaning that suicide behaviour has for the individuals concerned. This study aimed to elaborate recent research that has identified the importance of understanding the meaning that people give to using particular suicide methods. This study investigated the relationship between the meanings that suicide attempters give to suicide methods and the meanings that they attach to living and dying. Eight people who had made suicide attempts were each asked to list eight methods of suicide - four that they were likely to use and four that they were unlikely to use. They then ranked the methods in order of how likely they were to use them. Using Repertory Grid Technique, participants generated constructs regarding the suicide methods. They then rated the methods according to the poles of the constructs they produced. Using the same constructs, participants were then asked to rate additional grid elements regarding dying and living. The construct rating patterns of the grid elements were then correlated using Kendall's Tau-B correlation. The results of this study indicate that different people view different suicide methods differently. Also, the relationship between the meanings attached to particular methods was found to be a function of the degree to which methods differed in their acceptability rankings. In addition, the results from this small sample indicated that the meaning that suicide attempters give to using their most preferred suicide method is associated with the meaning they attach to living and dying. For some individuals, this association was apparent only at a more fundamental level of construing. Interpretations of these results are offered and their clinical implications discussed. Limitations of the current study are acknowledged and suggestions to improve the approach to this research question are given.
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ACKNOWLEDGEMENTS

I would like to thank my field supervisor Ron Wood, Chartered Clinical Psychologist, for his help in planning and carrying out this research project and for his personal support. I particularly value his willingness to take an active part in its procedure by offering follow-up appointments to participants.

In addition, I would like to express my appreciation to my academic tutors, Dr. A.T. Carr and Dr. R. Morris, of the Clinical Teaching Unit, Plymouth. Time spent in discussion with Dr. Carr during the early stages of the research was invaluable and Dr. Morris' patience with me regarding statistical analysis was more than anyone has the right to expect.

Finally, I would like to acknowledge the personal contributions of the individual participants.
AUTHOR'S DECLARATION

At no time during the registration for the degree of Doctor of Clinical Psychology has the author been registered for any other University award.

The contents of this bound volume are identical to the volume submitted for examination in temporary binding except for the amendments requested at the examination.

This study was conducted while the author was a Trainee Clinical Psychologist in the South West Region based in PlymOUTH Community Services NHS Trust, with which the research was conducted in collaboration.

signed ........................

date 17.3.95
1. INTRODUCTION

Despite suicide behaviour remaining a relatively rare occurrence, it has been given considerable attention by theorists and researchers of many disciplines. While suicide accounts for only 1% of all deaths annually (NHS Health Advisory Service, 1994), the current government considers it sufficiently important that in the Health of the Nation White Paper (1992), two of the three targets refer to reducing suicide rates. A reduction of at least 15% in the overall suicide rate is called for along with a reduction of at least 33% in the rate among severely mentally ill people by the year 2000.

The long-standing aim to predict and prevent suicide behaviour has proliferated research within two broad approaches. First, is the search for correlates which identify "at risk" groups. This work has concentrated on the sociological, demographic, economic and health status of suicide and parasuicide populations. More recent research has focused on individual psychological characteristics. Second, is the view that we can understand suicidal behaviour only when we understand the meaning that the behaviour has for the individual. We begin by considering the first of these approaches.

1.1 Demographic characteristics of "at risk" individuals

In England and Wales in 1990, the male:female ratio was 2:1. In this year, there were 14.8 per 100,000 male suicides and 7 per 100,000 female suicides. Between 1970 and 1990, the suicide rate for men rose while that for women fell (Charlton, Kelly, Dunnell, Evans, Jenkins & Wallis, 1992).
Sex differences in suicide rates vary over the life cycle. Female vulnerability for suicide tends to rise linearly but very slightly with increasing age while, for males, the rate rises from 12 per 1000,000 for ages 15-24 to 16.5 per 100,000 aged 25-74. It falls again to 14 per 100,000 between 55-74 then rises again to 19 per 100,000 for the over 75's. Williams and Pollock (1993) suggest that there is an increase in the suicide rate for elderly males because of the burden of loss of loved ones suffered by men in this group. There is evidence to support this view. Men over 65 who are married have a suicide rate of only 13 per 100,000 while those who are widowed have a rate of 51 per 100,000. However, young men whose wives die have the highest rates of all - 86 per 100,000 age 15-24 and 76 per 100,000 ages 25-34 (Asgard, 1990; Bulusu and Alderson, 1984). Women who are widowed young are also at an increased risk of suicide (18 per 100,000 for 25-34 ages) but the increase is less dramatic. Consequently, while men of all ages seem vulnerable to suicide after the death of a wife, it is unclear why the effect of bereavement on men is more marked or why the impact of the bereavement should be shown through suicide.

Regarding social class, suicide is more common among unskilled (Class V) manual workers than other groupings (Charlton, Kelly, Dunnell, Evans & Jenkins, 1993). However, these generalisations appear to be of little use even in identifying "at risk" occupational groups. The highest suicide rates for men, ages 16-64, 1979-1980, by occupation show that vets, dental practitioners and pharmacists have the three highest proportional mortality ratios (Charlton et al., 1993) and, clearly, these professions are not examples of Class V occupations. Unemployment appears to make suicide more likely. Moser, Fox & Jones (1984) found that, after controlling for social class, unemployed men aged 15-64 have 69% excess mortality by suicide and related death. Data for Edinburgh show that for men unemployed for over a year, the rate was about 19 times that for the unemployed (Kreitman, 1977). However, it has been argued that
the relationship between unemployment and suicide may not be simple, as some people may be vulnerable to unemployment and suicide (Platt, Micciolo & Tansalla, 1992). In addition, it is not clear that other demographic "at risk" factors have been considered when describing the relationship between unemployment and suicide e.g. the impact of bereavement.

Mental health status has also been identified as an important factor in assessing suicide risk. King (1994) found that of the 286 suicide or open verdict deaths in a particular catchment area, 84% suffered from schizophrenia, affective psychosis or a depressive illness. These findings are consistent with earlier research on the medical/psychiatric risk factors for suicide. Barraclough, Bunch, Nelson & Sainsbury (1974) reported that post-suicide psychological autopsy revealed 70% suffered with depression. Using a similar methodology, Flood & Saeger (1968) showed that 30% suffered with schizophrenia, although Roy (1982) found that people with schizophrenia only had an increased vulnerability to suicide if they had a history of depressive features during the period of discharge from hospital. Other mental health conditions have also been associated with increased suicide rates - bipolar affective disorder (Jamison, 1986), previous deliberate self-harm (Flood & Saeger, 1968), a threat of suicide (Barraclough et al, 1974; Robins, Murphy, Wilkinson, Gassner & Kayes, 1959), physical illness (Myers & Neal, 1978) and neuroses and personality disorder (Pokorny, 1964). Alcohol and drugs misuse also appear to be significant risk factors for suicide. According to James (1967), the risk of suicide among heroin addicts is 20 times that of the general population. Hawton (1987) suggests that 15% of alcoholics may eventually commit suicide. However, the nature of the relationship between alcohol/drugs and suicide behaviour is unclear - their use may make suicide attempts more likely to succeed or impair capacity for individuals to change their minds.
In addition to problems specifying the nature of the relationship between various mental illnesses and suicidal behaviour, results from studies using psychological autopsy need to be treated with particular caution. Reliability of diagnosis has long been a concern (e.g. Weissman, 1987) and there are difficulties associated with information derived from relatives. Michel (1987) interviewed attempters and their relatives and found 23% disagreement regarding clinical symptoms and 17% disagreement on a suicidal intent scale.

Regarding marital status, suicide rates for both sexes are highest in the divorced, followed by the single and widowed, with married individuals having the lowest rates. At some ages, single men have suicide rates that are almost as high as those for divorced men. However it is unclear whether this suggests a protective effect of marriage for men or indicates that men more prone to suicide are more likely to remain single or become divorced at any age than other men.

While the sociodemographic data for parasuicide is similar to that for completed suicides, a crucial difference is that the sex ratio is reversed. For parasuicides, the higher rate is in females, generally in the region of 1.5-2.5:1. The highest rates are in young females 15-19 ages (e.g. Hawton & Catalan, 1987) and the sex ratio reaches equivalence after about age 50 years.

However interesting these statistics may be, there has been long-standing dissatisfaction with the approach of aiming to prevent suicide by identifying sociodemographic and mental health status risk factors. It is one thing to be able to describe particular groupings of people in terms of their likelihood to commit suicide or attempt suicide - it is quite another to identify particular individuals and effectively treat them. The high number of false positives generated by sociodemographic risk rates has long been
problematic for this approach to understanding suicidal behaviour (Pokorny, 1992). As Duffy (1993) argues, generalisations about the characteristics of people engaging in suicide behaviour do not necessarily apply to individuals anymore than a generalisation about voting preferences of different social classes applies to people who belong to a certain class. In a report of a GP training programme, Michel & Valach (1992) recognise the difficulties in assessing how teaching regarding epidemiology and characteristics of at risk patients can successfully influence risk assessment of the individual.

There has been a discernible shift in the focus of suicide research away from identifying sociodemographic risk factors to describing the psychological variables of people who engage in parasuicide behaviour. As Watts & Morgan (1994) argue, evaluation of behaviour and relationships may give guidance regarding how to identify individuals at immediate high risk. Three main aspects of functioning have been identified: interpersonal problem solving, hopelessness and affective experience.

1:2 Individual psychological characteristics of suicide attempters

Poor Problem-Solving Ability

Studies have found evidence of poor problem-solving ability in a variety of suicidal populations (e.g. Rotheram-Borus, Trautman, Dopkins & Shrout, 1990; Schotte & Clum, 1987). Using the Means-End Problem Solving Test (MEPS, Platt, Spivack & Bloom, 1975), Schotte & Clum (1987) found that suicidal in-patients (those with high suicide ideation scores) generated fewer, less-relevant solutions to problems. Linehan, Camper, Chiles, Strohal & Shearin (1987) found in-patient suicide attempters relied more on others for solutions and were less active in problem-solving than either suicide
ideators or non-suicidal psychiatric in-patients. Their finding of a difference between suicide ideators and parasuicides suggests cautions in interpreting results from other studies which have viewed these two groups interchangeably. MacLeod, Williams & Linehan (1992) suggest that the poorer problem solving shown by suicidal subjects may be explained by a bias in the retrieval of personal memories within parasuicide populations. In a study of people who had taken deliberate overdoses, Williams & Broadbent (1986) identified a phenomenon of over-generalised retrieval. Participants took longer to recall positive events from their lives and tended to recall things in a generalised way. MacLeod et al. (1992) suggest that attempts to use a general category as a database to generate effective solutions will inhibit a person's ability to think of ways of solving a problem.

Hopelessness

The capacity for and nature of future-directed thinking in suicidal individuals has also been identified as an important psychological variable. Earlier work suggested that suicidal individuals were generally less oriented to the future (e.g. Greaves, 1971; Melges & Weisz, 1971; Yufit, Benzie, Font & Fawcett, 1970). More recent research has focused on the concept of "hopelessness" as the defining the link between depression and suicidal intent in parasuicide populations. (e.g. Salter & Platt, 1990; Wetzel, Margulies, Davis & Karam, 1980). Hopelessness has been found to predict repetition of parasuicide six months later (Petrie, Chamberlain & Clarke, 1988) and completed suicide up to ten years later (Beck, Brown & Steer, 1989; Fawcett, Scheftner, Fogg, Clark, Young, Hedeker & Gibbons, 1990). However, the nature of hopelessness is still poorly understood. Abramson, Alloy & Metalsky (1989) suggest that hopelessness is an expectancy that positive outcomes will not occur or that negative outcomes will occur. However, rather than simply being a cognitive deficit, the experience of negative events may underlie this variable. Paykel, Prusoff & Meyers
(1975) found that parasuicides experienced an increase in the occurrence of negative events prior to the episode and Needles & Abramson (1990) have shown that the occurrence of positive events combined with an adaptive attributional style is an important component in recovery from hopelessness.

The usefulness of the research regarding the concept of hopelessness has been limited by the nature and variety of measures. Use of the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester & Trexler, 1974) has persisted despite concerns that it is a global self-report measure likely to be influenced by more general factors such as social desirability (Linehan & Nielson, 1981). It has also been criticised on the basis that it describes rather generalised attitudes about the future rather than uncovering more important factors which underlie such attitudes (MacLeod, Rose and Williams, 1993).

It is not clear that hopelessness and poor interpersonal problem solving are unrelated deficits. Salkovskis, Atha & Storer (1990) found that a brief cognitive behavioural intervention with a problem solving focus delayed the first repetition of parasuicide behaviour and significantly and substantially reduced depression and hopelessness. It may be that these aspects of psychological functioning are closely associated or that there is a third aspect that underlies them and is the mediator for changes in these two.

**Affective experience**

MacLeod et al. (1992) suggest that suicidal individuals may be unable to regulate their own affective responses or experiences of emotional pain. There is evidence that parasuicide patients are more angry, hostile and irritable than non-suicidal psychiatric patients and general population control groups. This relationship appears to hold before the episode (e.g. Paykel & Dienelt, 1971) and afterwards (e.g. Crook, Raskin & Davis, 1975). Interpersonal relationships also appear to be characterised by hostility,
demandingness and conflict (e.g. Asarnow, Carlson & Guthrie, 1987). People who complete suicide appear to have been less angry and appear apathetic and/or indifferent (e.g. Dean, Miskimins, Cook, Wilson & Maley, 1967). Parasuicidal behaviour, suggest MacLeod et al. (1992) may be an effective mechanism of emotion regulation.

This direction of research seems promising particularly with regard to clarifying the cognitive and emotional processes by which suicidal behaviour comes to be enacted. It is unfortunate though that this approach has also been subsumed within the "risk prediction" focus of research. It is not clear whether the search for psychological variables is any different from the search for sociodemographic characteristics. We are still in the position that generalisations are not very useful in individual cases e.g. suicide behaviour does not necessarily involve hopelessness about the future (MacLeod et al., 1993).

Rather than continuing to search for predictor variables, whether socio-demographic or psychological, a more useful approach may be to attempt to understand the meaning the behaviour has for the individual who does it.

"It is first necessary to understand each suicide as it was understood by the one who killed himself, or by those close to him, before looking for a so-called scientific explanation on a macrosociological scale."

Aron (1979), p. xvi

I want to go on to examine theories of suicide that are particularly concerned with the meaning of suicide behaviour. Some theories e.g. Durkheim (1897/1952) are interested in the broad social conditions of suicide rather than the attributes of individual suicides.
Such accounts or typologies may enable us to categorise suicidal behaviour but do little to help us understand it (Shneidman, 1985). The theories I have selected are not exhaustive. I present them as illustrative of the long-standing attention afforded to the meaning of suicide behaviour.

1:3 The significance of the suicide act

"I kept trying to enter his consciousness to understand why he did what he did. I imagined a psychic pain growing inside him that needed a physical outlet. Suicide must have been his attempt to give Pain a body, a representation, to put it outside himself. A need to convert inner torment into some outward tangible wound that all could see. It was almost as though suicide were a last-ditch effort at exorcism, in which the person sacrificed his life in order that the devil inside might die".


Freud (1917/1957)

According to Freud, the primary meaning of suicide is murder. Suicide is a substitute for murdering someone else. It is understood as hostile aggression turned inwards on the self. On this view, suicide is seen as an active event prompted by impulses initially focused on someone else. All suicides involve hostility or a death wish originally directed at an external object.

Studies have been presented that suggest this account is misguided. Research has suggested that suicidal people are not any more intropunitive than control subject
(Levenson & Neuringer, 1970; Farmer, 1987). Baumeister (1990) cites studies researching the effect of suicide on family and other survivors as evidence that the Freudian suicide is incorrect. He holds that such people tend to view the individual who has attempted suicide with sympathy and as a victim, often feeling guilty as though they themselves were responsible for the suicide. This evidence, however, could still be consistent with the Freudian view. Survivors may project sympathy and the victim role onto the dead person. Furthermore, it may be that, people who have been emotionally attached to the dead person may feel ambivalent - viewing the dead person both as murderer and victim, an object of hostility and sympathy.

**Stengel and Cook (1958)**

These authors are representative of the view that suicide behaviour has meaning as a "cry for help". Suicide attempts are the means by which troubled individuals seek to call attention to themselves and their distress in life and thereby attract sympathy and support. Suicide is thus understood as an interpersonal communication. Stengel & Cook (1958) call this the appeal function of suicide behaviour.

The notion of "cry for help" was derived from observations of repeated patterns of behaviour rather than patient report which suggests caution in automatically attributing this meaning to the behaviour. It is also difficult to accept this view against Stengel & Cook's own suggestion that help is often not the outcome of repeated suicide behaviour. Baumeister (1990) argues that the concept of a "cry for help" may be more useful as a way in which a therapist can help an individual label a past suicide attempt than as an adequate explanation of suicide. After all, he argues, if suicide was only as cry for help, one would expect far fewer completed suicides.
Baechler (1975/1979)

According to Baechler, all suicide behaviour shares the characteristic of being a means to solve problems. He proposes a classification of suicidal behaviour that draws together many other theories about the meaning of such behaviour. He suggests that there are four main categories - "escapist", "aggressive", "oblative" (self-sacrificing) or "ludic" (risk-taking). There are three subtypes of "escapist" behaviour, of which the shared intention is to take leave - flight (to avoid an intolerable situation), grief (to deal with a loss) and punishment (to atone for a fault). Aggressive suicides are directed towards others and include vengeance, crime, blackmail and appeal. There are two types of oblative behaviour - sacrifice (to gain a greater value than one's own life) and transfigurational (to obtain a heightened state). Lastly, there are two types of ludic suicides - ordeal (to prove something or solicit the judgement of others) and game (to play with or to risk one's life).

It has been argued that Baechler's important contribution is the recognition and inclusion of ludic suicides (Maris, 1992). However, I have included this theory as it allows for the existence of a number of alternative meanings for suicide behaviour and, as such, allows the possibility of integrating the different theoretical frameworks that are identified in this section.

Baumeister (1990)

Particularly excluding altruistic suicide, ritualistic and honour suicides, Baumeister argues that suicide is often a self-destructive choice associated with a desire to escape from emotional states and from high self-awareness. Suicide is understood as "escape from self" - the appeal of suicide is oblivion.
Baumeister maintains that there is a causal chain of events that produces the motivation to escape from aversive self-awareness. Events fall short of an individual's standards and expectations. These disappointments are understood as failures which are attributed internally, thus making self-awareness painful. Negative affect results. The individual wants to escape from this aversive state and, consequently, tries to achieve a state of "cognitive deconstruction" which helps prevent meaningful self-awareness and emotion. This state is characterised by constricted temporal focus, concrete thinking, immediate or proximal goals, cognitive rigidity and rejection of meaning. This deconstructed state brings irrationality and disinhibition, making drastic measures seems acceptable. Suicide is the final step in an effort to escape from self and world.

Like Buchanan's (1991) theory (below), this is a particularly interesting account as it offers a bridge between the concept of meaning of suicidal behaviour and the research concerning psychological variables that we described earlier. For example, the deconstructed state may be an important framework within which arises the meaning of suicidal behaviour for the individual.

Buchanan (1991)

Buchanan also identifies escape as the underlying meaning to suicide. Her theory is interesting as she explicitly identifies the pivotal role of understanding the meaning in life for an individual in any understanding of the meaning of their suicide behaviour. She argues that suicide needs to be understood as an event and a process. As well as being an act, she maintains that suicidal behaviour is one response of a set of responses that an individual can make to a perceived change.

Crucial to her model is the concept of an individual's evaluation of the meaning in life. She argues that, in response to an occurrence perceived as a change, an individual's
current evaluation of the meaning in life leads to the presence or absence of thoughts of death. This evaluation occurs via a process of thoughts, feelings and behaviours. The experience of feelings of depression and hopelessness, constricted and negatively distorting thoughts and difficulties with problem-solving behaviour brings about a loss of focus in living and in finding solutions to living. A focus on death results.

If an individual cannot find something meaningful in life that gives a purpose to live, then that person is at risk of focusing on the escape route of death. The individual still able to determine a meaning in life will choose to continue living even though they may accept or welcome death.

Buchanan is not sufficiently explicit in illuminating the process by which the feelings, thoughts and behaviours that result in a focus on death come about or how they act within the mechanism of evaluation of life meaning. In addition, her account of the process of suicide is rather abstract. She states that the individual has an endowment of factors such as hereditary, physiological and psychosocial that influence their response set and processes but it is unclear how we might understand the role of this endowment in understanding the suicidal behaviour and in working to reduce its likelihood.

Despite its somewhat arrested exposition, this theory is particularly important. It makes explicit that which remains a theme, hidden to varying degrees, in other theories that we have described. That is, what is important in understanding suicide is that the meaning of suicide is derived from the meaning that an individual attributes to life or the absence of such meaning.
Hendin (1991)
Hendin also argues that suicide can be understood as escape from an intolerable affective state e.g. rage, hopelessness, despair or guilt. Within a psychodynamic framework, he suggests that suicidal patients give a special meaning to death, using death in their adaptation to life. He suggests that there is actual or fantasised use of their own deaths in an effort to control others or to maintain an illusory control over their own lives. It is not clear how this notion is compatible with the concept of suicide as escape and Hendin does not elucidate. He argues, though, that the meanings of suicide can be usefully organised around the conscious and unconscious meanings given to death by the suicidal patient. From his work with adolescents, he proposes that death is understood as reunion, rebirth, retaliatory abandonment, revenge, self-punishment and atonement. He proposes that understanding what meaning an individual gives to death and conveying this to them, can provide "crucial relief" and reduce the short term risk of suicide.

We have already highlighted the theme that the meaning of suicide is derived from the meaning attributed to life. Hendin's theory further extends this idea - namely, that we need also to understand the meaning that individuals give to death if we are to understand the meaning that they attribute to suicidal behaviour.

Shneidman (1993)
According to Shneidman (1993), suicide is "a specific way to stop the unbearable psychical flow of the mind" (p145). He holds that psychache is the individual psychological pain of such experiences as hurt, anguish, loneliness, guilt, shame, humiliation and fear. Such pain is caused by the blockage, thwarting or frustration of psychological needs that are believed by individuals, at certain points in their lives, to be essential for continued life. Shneidman defines such needs as vital needs - those few
psychological needs, the frustration of which that person simply cannot tolerate. As such, suicide can only be understood in relation to individual thresholds for tolerating psychological pain.

In some respects, this theory is compatible with Baumeister's (1990). Shneidman maintains that a necessary condition of the process, by which the experience of psychological stresses results in the suicidal outcome, is the thought or insight that cessation of consciousness is the solution for the unbearable psychache. Death is a means of escape from psychache. Any affective state or sociodemographic characteristic is relevant to an individual's suicide status when and only when it relates to unbearable psychological pain.

So far in this introduction, I hope to have shown that, in understanding and preventing suicide behaviour, the search for sociodemographic and psychological "at risk" factors is fraught with difficulties. By outlining the above theories, I hope to have established that there has been a long-standing recognition of the importance of meaning in suicidal behaviour and that this may be a more promising theme to pursue. From the review of important theories, I have drawn out two main ideas: that, if we are to understand the meaning that individuals attach to suicidal behaviour, we need to understand the meaning that they give to life and the meaning that they give to death.

However, before we further develop this view, the importance of the choice of suicide method needs to be considered. There is considerable research evidence for the view that the choice of suicide method is a significant act. A number of studies suggest that people discriminate between different methods.
1:4 The choice of suicide method

Razors pain you;
Rivers are damp;
Acids stain you:
And drugs cause cramp.
Guns aren't lawful;
Nooses give;
Gas smells awful;
You might as well live.

(Dorothy Parker, 1926)

As with research into the general issue of suicide, a main body of work has focused on correlates of particular methods. A number of factors have been found which relate to individual decisions regarding suicide method.

It has been suggested that an important demographic factor is gender. Women have traditionally used less lethal methods, especially solid and liquid poisons, while males have used more lethal methods, particularly firearms (e.g. Evans & Farberow, 1988). This sex difference remains despite relatively recent increases in the use of firearms among both sexes (Boor, 1981). Data from the National Center for Health Statistics relating to methods of suicide in the USA, 1985-1987, shows that 64.02% of male suicides used firearms as a method compared with 39.91% of females. Data about the use of solid and liquid poisons shows that 25.76% of female suicides used this method compared with 5.7% of males.
Marks (1977) suggests that the sex difference in method choice is best understood via sociocultural explanations. He asked college students about the acceptability of nine different methods of suicide and about which particular methods were used most often by their sex. His results suggested that both sexes found drugs/poison most acceptable, although more so for females. In associating drugs/poison with their sex, females mentioned painlessness, ease of use, accessibility, availability, familiarity and lack of messiness as reasons for acceptability. Marks also found that firearms were acceptable to a lesser degree to more than half the males but only about a third of females. Males considered firearms to be acceptable to their sex on the basis of quickness, ease of use, efficiency, accessibility, availability and familiarity.

However, it seems that any effect of gender on choice of suicide method is unreliable and can be over-ridden by other variables. In a study of U.S. regional differences in suicide method from 1940-1965, Marks & Abernathy (1974) found that Southern women were exceptional in their preference for firearms. They explained this finding by the argument that firearms were an acceptable, available and familiar part of the Southern way of life.

On a related note, the influence of culture on the choice of suicide method has also been investigated. Farmer & Rohde (1980) suggest that cultural attitudes towards particular methods may be significant. For example, the relatively uncommon use of hanging for suicides in England may be because of its association with capital punishment whereby hanging is seen as a dishonourable death. This compares with the relatively high use of hanging as a method of suicide in several Asian cultures (e.g. McIntosh & Santos, 1982).
Age is another important demographic variable that has been associated with preferences for suicide methods. There is evidence that potentially more lethal methods, such as shooting, drowning attempts and jumping from heights, are generally used by older adults (e.g. Hawton & Catalan, 1987). Jarvis & Boldt (1980) found that older people use more lethal methods of suicide such as firearms and hanging. McIntosh & Santos (1986) compiled suicide data by age for 1960-1978 and found that the use of more lethal methods was evident among white males and blacks of both sexes but not among white females. They attributed this finding to the socialisation effect described earlier, whereby older adult females have been socialised to view firearm use as masculine and poisons as feminine to a much greater degree than younger females. For less lethal methods, such as poisoning, there is also evidence of significant age differences. Woolf, Fish, Azzara & Dean (1990) studied the deaths from serious poisoning of older adults in Massachusetts and found that older adults were more likely than the young to die from poisoning-related deaths. Sims (1974) found higher and increased rates for poisoning suicides among the old in Canada from 1959-1969.

In addition to the socialisation argument that we have already encountered, age differences in choice of suicidal method have been explained by arguments of intent and availability. McIntosh & Santos (1986) argue that the choice of more lethal suicide methods by the elderly is due to the greater intent to die among the old compared with the young. Woolf et al. (1990) hold that the higher incidence of physical health problems and depression among the elderly increases the easy availability of drugs which are consequently used in overdose.

We have considered a number of arguments for factors influencing the choice of methods that have used the concept of lethality. However, it is not clear that it is useful to define methods as more or less lethal. All methods are potentially lethal.
Shooting yourself in the foot may be less lethal than a paracetamol overdose. There is a danger that researchers presume lethality to be a given for particular methods.

The effect of intent and availability on choice of suicide method have been investigated more generally. Fox & Weissman (1975) suggested that the intent and motivation of an individual may influence the choice of method. Their study compared suicide attempters using pill ingestion with those using the "violent" methods of shooting, jumping and wristcutting. They found that among those taking pills, the suicide attempt was more impulsive, intent to kill was low and the motivation was more often to get attention from others. For the second group of attempters, actions were more carefully planned, the intent to die was higher and motivation centred on self-directed hostility. Thus the choice of method seemed to be associated with intent to die and desired effect.

The influence of availability on the choice of suicide method is one of the current preoccupations within research into suicide method. Researchers have been concerned with the hypothesis that suicide can be prevented by restricting access to lethal methods.

Clarke & Mayhew (1988) showed the effect of the gradual detoxification of domestic gas in England and Wales on the suicide rate using this method and overall. They report that in 1958, suicides by domestic gas accounted for 2637/5298 suicides in England and Wales i.e. 49.8%. In 1977, as gas was detoxified, the figure was reduced to 8/3944 suicides i.e. 0.2%. The fact that the overall suicide rate decreased as well as the figures for this particular method further suggests that substitution from gas to other methods did not occur. That these results were not replicated in Scotland or the Netherlands has been explained by the fact that suicide rates were rising in these
countries at the time domestic gas was detoxified, whereby the effect of detoxification on the overall suicide rate was masked (Clarke & Mayhew, 1989).

There is also evidence that emission controls and increasing car ownership have influenced the choice of car exhaust as a suicide method. Clarke & Lester (1987) found that the use of this method in the USA levelled off and even slightly declined after 1968, when emission controls were introduced. This compared with the increasing use of the car exhaust method in England and Wales since 1970. Lester & Abe (1989) examined the effects of increasing car ownership in Japan on suicide rate using car exhaust. Between 1965 and 1982, when ownership of cars increased almost linearly, suicides from car exhaust rose from less than 0.02 per 100,000 per year to over 1.33. Suicide by all other methods rose from about 14.68 per 100,000 to 16.18 in the same period. There was a dramatic increase in the proportion of suicides using car exhausts, with little evidence that this was due to switching from other methods.

Other research concerning the availability hypothesis has examined suicide by firearm, medication, jumping and drowning. Examples include Lester's (1989a) study which found that American states adjoining the oceans or Great Lakes had higher suicide rates by drowning, lower rates by firearms but similar rates by all other methods. Lester & Murrell (1980) showed that US states with the strictest handgun laws had the lowest firearm suicide rates and the lowest overall suicide rates both in 1960 and 1970. Lester (1988a) further examined this data and found that restrictions on the selling and purchasing of handguns rather than carrying were the critical aspects of the law associated with the lower suicide rates.

The extent to which people may substitute or alternate between methods of suicide is unclear. Lester & Abe (1989) suggest that there was no displacement from suicide by
domestic gas in Japan from 1969-1982 when gas was detoxified. The use of domestic gas for suicide declined dramatically in the period from the early 70s while the rate of increase in suicide by all other methods was slowed over the same time. Clarke & Lester (1987), however, suggest that the recent dramatic rise in the use of car exhaust for suicide in England and Wales may reflect a switch by those who would have used domestic gas if it was still toxic. In support of substitutability, Rich & Young (1988) found that there was no overall change in the suicide rate of Toronto after a gun control law had been passed there. They found that while there was a drop in the percentage of suicides using guns, the percentage using jumping increased.

While highlighting some correlates of suicide method choice, the available research does not yet provide a coherent framework within to understand the meanings that an individual attaches to particular methods. Some attempts have been made to link suicide method choice with life experiences and psychological characteristics but they have either remained at the theoretical level or been inadequately conceived.

Grof (1985) holds that choice of method is affected by early memories. On this theory, "non-violent" methods are chosen by inhibited depressives who want to eliminate pain by going back to an inter-uterine existence. "Violent" methods are chosen by agitated depressives who want to recreate the birth process and speed liberation. Jacobson, Eklund, Hamburger, Linnarsson, Sedvall & Valerius (1987) concluded that obstetric procedures are risk factors for particular methods of self-destructive behaviour. They found that suicide attempters who chose asphyxia were more likely to have experienced asphyxia at birth. Those choosing "violent" methods were more likely to have been twins or to have experienced mechanical birth trauma. The authors themselves describe these results as "astounding" and issues remain regarding the mechanism whereby birth injury translates as adult suicide behaviour. In addition, the inclusion of hanging and
strangulation in both the asphyxiation and mechanical trauma categories implies caution in accepting these findings.

In order to test the hypothesis that individuals who use different methods are psychologically different, Leenaars (1990) conducted a study of suicide notes, written by people who had used different methods. Individual protocol sentences derived from suicide theories were used to classify notes and, by inference, individuals' psychological characteristics. No differences were found between those letters from people who had used "active" or "passive" methods. This study is problematic for a number of reasons. It is unclear why psychological characteristics thought worthy of assessment should be derived from suicide theories. Also, the use of suicide notes as the basis for assessing individual's psychological characteristics is dubious. In addition, the researcher used his own classification of "active" and "passive" methods. Yet, the message from much of the research we have examined is that individuals perceive different methods of suicide differently and we should be hesitant of using our own understandings of different methods in research classifications. How individuals perceive methods is important, not how researchers do.

Lester (1988b) suggests that the method of suicide as well as the suicide act generally is of significance for an individual. There is evidence that an individual's choice of method is meaningful and that people may have specific preferences even within methods. Seiden & Spence (1984) have shown that suicide attempters prefer to jump off the Golden Gate Bridge in San Francisco compared with the nearby Bay Bridge, which they may even drive over to get to the Golden Gate.

That different people perceive different methods differently seems clear. Lester (1987) presented college students with descriptive rating scales and asked participants to rate
guns and pills on the different dimensions. The results showed that the methods were perceived quite differently on the given dimensions. Suicide by guns was seen as quick, painful, difficult, irreversible, dramatic, masculine and messy while suicide by pills was seen as slow, painless, easy, cowardly, feminine, tidy and planned. In later work, Lester (1993) made a study of how methods of suicide are perceived using a Repertory Grid Technique with student participants. In this study, dimensions were derived from participants rather than given. He identified individuals' perceived similarities between methods of suicide and compared perceptions of different methods across participants. He found that there was little consensus comparing methods across participants but that some individuals perceived different methods similarly.

That there is equivocal evidence concerning the association between choice of method and factors such as age and gender is unsurprising. Our review of the research about suicidal behaviour suggested that the search for sociodemographic correlates was misguided and that efforts to understand the meaning of suicidal behaviour were perhaps more promising. We elaborated the idea that we can understand the meaning of such behaviour only if we understand the meaning that individuals attach to living and to dying. If we accept the view that choice of methods is an important factor in understanding suicidal behaviour, then the questions arise:

1) what meaning do individuals attach to different methods of suicide?
2) how does the meaning that individuals attach to methods of suicide relate to the meaning that they attach to living and dying?

This current study proposes to further develop Lester's (1993) study by involving a clinical population of individuals who have previously attempted suicide. Of particular importance is the attempt to elaborate the relationship between the meaning an
individual attaches to life events, methods of suicide and perceived ideal death. Understanding the meanings an individual attaches to suicide methods is of little clinical significance unless we also understand how those meanings relate to that person's most important constructs about life and their perception of an ideal death.
2. METHOD

2.1 Hypotheses

It is anticipated that individuals will meaningfully rate suicide methods in terms of their acceptability and that participants will identify differentiating characteristics of suicide methods. These will be elicited through the Repertory Grid technique explained in the procedure section below.

It is expected that, for individuals, the acceptability of suicide methods will be related to particular perceived characteristics of such methods. Results are also expected to show that the characteristics of the suicide method most acceptable to an individual will be associated with that person's ideal characteristics of life events and characteristics of his/her "ideal death".

For each individual, the acceptability and construct rating patterns of suicide methods will be correlated. In addition, there will be six further series of correlations: the subordinate and superordinate construct rating patterns of an individual's most acceptable suicide method and "ideal death"; "ideal death" and "how I would like events in my life to be", and most acceptable suicide method and "how I would like events in my life to be".

In order to carry out this research, three assumptions need to be made. First, that people will be able to meaningfully rate methods of suicide in terms of acceptability. Second, that it will be possible to elicit subordinate and superordinate constructs about methods of suicide using the standard method of Repertory Grid Technique, presenting elements in triads (see the Procedure section for the details of this technique). Third,
that it will be possible for individuals to use the poles of their elicited constructs as
descriptive dimensions on which to rate each of the methods, their ideal death and how
they would like events in their life to be.

The specific hypotheses that underlie the general description of expected results are
given below:

1. That there will be a significant positive correlation between the
   construct ratings of an individual's most acceptable methods of suicide.
2. That there will be a significant positive correlation between the
   construct ratings of an individual's least acceptable methods of suicide.
3. That there will be a significant negative correlation between the
   construct ratings of an individual's acceptable and unacceptable methods of suicide.
4. That there will be a significant positive correlation between the
   subordinate and superordinate construct ratings of an individual's most acceptable
   methods of suicide and the construct ratings of his/her "ideal death".
5. That there will be a significant positive correlation between the
   subordinate and superordinate construct ratings of an individual's most acceptable
   methods of suicide and the meanings given to ideal life events.
6. That there will be a significant positive correlation between the
   subordinate and superordinate construct ratings of an individual's "ideal death" and the
   meanings given to ideal life events.
2.2 Participants

Recruitment

It was hoped to involve 10 men and 10 female participants in the study. Participants were recruited via the Adult Mental Health Consultant Psychiatrists of the Plymouth Community Services NHS Trust. The Consultant Psychiatrists were contacted by letter (see Appendix A) and at a group meeting. Five Psychiatrists agreed to contact their patients who met the research criteria, sending them a covering letter, information sheet about the project (Appendix B), consent form (Appendix C) and reply-paid envelope. The replies were returned to the researcher. A copy of the letter to patients and an information sheet was also sent to each person's GP. GPs. were asked by letter (Appendix D) to contact the research worker within two weeks of the date of the letter if they thought that their patient should not be included in the project because of any distress it might cause.

The Consultant Psychiatrists were asked to select participants who met the following research criteria:

1. Are not currently in-patients
2. Are known to have attempted suicide prior to or during their period of contact.
3. In your clinical judgement, would not be adversely affected by participating in the research.
4. In your clinical judgement, are not at present suffering from a severe psychotic or depressive disorder.

From a list of all their patient episodes (i.e. included patients with variety of mental health problems) from January 1993-September 1994, the Consultant Psychiatrists were asked to identify 15 patients who met these criteria. The following number of
patients were selected by individual Consultants: 15 (from 308 episodes), 6 (from 361 episodes), 4 (from 261 episodes), 3 (from 255 episodes) and 2 (from 248 episodes).

Given the small numbers of potential participants initially selected, Consultant Psychiatrists were asked to consider a list of their patient episodes from January 1992-January 1993 and identify any further people who met the research criteria. Only one Psychiatrist selected people from his second list, identifying 5 (from 206 episodes). Of the other Psychiatrists, 2 replied to say that they could not identify anybody else who met the criteria (from 291 and 262 episodes). Another later contacted the researcher to say that he had not managed to do the task while the last Psychiatrist had not contacted the researcher by the time of project completion.

From the patient lists of the five Psychiatrists, 35 potential participants were identified. Consent forms were returned by 14 (40%). One letter was returned as the person no longer lived at the address. Of the 14, 2 were excluded due to concerns that their GPs had about their participation. Of the remaining 12, 4 did not arrive for their appointments or respond to a further letter inviting them to contact the researcher if they wanted another appointment. Consequently, 8 were interviewed.

**Description of participants**

Of the 8 people who participated in the project, there were 5 women and 3 men. They are described in Table 1.
<table>
<thead>
<tr>
<th>No.</th>
<th>Sex</th>
<th>Age</th>
<th>Work Status</th>
<th>Brief history of suicide attempts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>40</td>
<td>Long term sick</td>
<td>Reported history of depression since age 19. Recalled 6 suicide attempts, all using pills, usually with alcohol.</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>30</td>
<td>PT postal worker</td>
<td>Recalled at least 13 suicide attempts since the age of 11. Attempts included use of pills, carbon monoxide, drowning, walking in front of traffic and hanging.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>receptionist</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>54</td>
<td>FT engineer</td>
<td>Had made 4 suicide attempts using pills in the last 6 months following marriage break-up.</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>64</td>
<td>Retired</td>
<td>Alluded to several attempts over the past 15-20 years. Latest attempt was 2 years ago using gas fumes and pills. Described difficulties dealing with an alcoholic and aggressive father.</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>43</td>
<td>PT cleaner</td>
<td>Reported 8 suicide attempts using pills and alcohol over 17 years. Related her difficulties to coping with childhood abuse and a still-birth.</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>38</td>
<td>Unemployed</td>
<td>Recalled at least 8 attempts since late teens. Had attempted suicide through pills overdose, being run over by train and car, setting self alight, jumping from high building, strangulation and wrist-cutting. Suffered physical disabilities through her attempts. Related her difficulties to coping with childhood abuse.</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>45</td>
<td>FT garden</td>
<td>Had attempted suicide through pills overdose and strangulation in the past 14 months. Attempts precipitated by marital difficulties.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>business</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Description of Participants
2.3 Setting/Context of the study

The study was conducted with the approval of the Plymouth Local Research Ethics Committee. It was carried out under the auspices of the Plymouth Community Services NHS Trust and the Clinical Director of Adult Mental Health Services was notified at all stages. Supervisory roles were adopted by a Chartered Clinical Psychologist, Head of the Adult Mental Health Psychology specialty and two members of staff from the Clinical Training Course. Interviews were carried out at a local mental health out-patient facility.

2.4 Design

This study adopted an ipsitive, case-series design, using Repertory Grid Technique. Explanations of some of the key concepts of Repertory Grid Technique are given here.

Repertory Grid Technique is developed from Kelly's (1955) psychology of personal constructs. This approach is designed to link directly to individual personal meaning and to highlight structural aspects of the relationships between an individual's thoughts about different events. It was thereby considered particularly suitable for this study.

The theory is based on constructive alternativism i.e. the belief that there are many workable alternative ways for an individual to construe the world. Kelly (1955) maintains that a person's interactions with the world are characterised by his/her desire to accurately anticipate events through the use of his/her own constructed interpretations. This is done by individuals detecting recurrent themes or replications within their experiences. The interpretations that people place on events are called "constructs". According to this theory, people develop and use a system of bipolar
personal constructs which enable them to organise and attribute meaning to events. An individual chooses which pole of a relevant construct describes a particular object, event, situation or person.

Construct theory views each person's understanding of the world as a direct function of the organisation and content of his/her unique system of personal constructs. Each individual evolves a complex and idiosyncratic system of constructs. The whole of experience is filtered through this matrix of meaning.

Particularly important for our purposes is Kelly's notion that constructs have a range of convenience i.e. that a construct is convenient for the anticipation of a finite range of events only. Constructs are thereby tied to contexts - applicable to some things but not to others. A construct also has a focus of convenience whereby there are particular situations for which it is most useful.

An emphasis in Kelly's theory is the maxim of individuality - the notion that people differ from each other in their constructions of events. This idea is central to the hypotheses of this study which focuses on the significance of the personal meaning that individuals attach to different methods of suicide in relation to the meaning that they give to life and death.

According to personal construct theory, a person's system of constructs is hierarchically organised. Each person develops a system of constructs which are inter-related. The hierarchy is characterised by relationships of superordination and subordination between the constructs. Superordinate constructs tend to be rather more abstract. They subsume or over-ride more subordinate constructs. Among the most superordinate constructs in the system are core constructs. These are crucial to the individual as they
govern a person's maintenance processes. As Bannister and Mair (1968) put it: "they enable him to maintain his identity and sense of continuing existence....they cannot be changed in any way without disturbing the very roots of a person's existence".

Constructs can be elicited in various ways. One of the most used is the triadic method. This involves selecting successive sets of three elements from the total set, in order for a range of constructs to emerge. The individual is asked if there is a way in which two of the elements are similar to and thereby different from the third. If so, the poles of the construct are identified. Having exhausted the constructs in one triad, the individual goes on to consider the elements in another triad. Different triads are repeatedly presented until a fixed number have been considered or until the same constructs are repeated.

Laddering is an elaborative strategy which enables more superordinate constructs to be derived from subordinate ones. Hinkle (1965) describes this process by which more and more abstract areas of the construing system can be reached. In this process, the participant is asked to examine an original construct more closely by deciding which end of the pole is preferable and why. The aim is to generate a series of new constructs from the originals. These new constructs tend to be increasingly fundamental or superordinate for the individual.

2.5 Procedure

In individual sessions which lasted for 1.5-2 hours, the nature of the task was explained to each individual. It was emphasised that participants were free to stop for breaks or to withdraw at any stage of the research.
**Phase 1: Semi-structured interview**

It was emphasised that the researcher did not know anything about the history of the participants who were then asked to describe their current personal circumstances of family/relationships, work, family, health status and contact with mental health service provision. Individuals were then asked to describe the history of their contact with the mental health services and their episodes of suicidal behaviour. The researcher was also interested to understand each person's motivation for taking part in the research.

**Phase 2: Construction of Repertory Grid**

Participants were asked to name 8 methods of suicide (the elements of the grid) - 4 that they would be likely or more likely to use if they were going to attempt suicide and 4 that they would be less likely or unlikely to use. They were then asked to rank these methods in order of how acceptable they were as ways of killing themselves, where:

1 = If I was going to commit suicide I would be most likely to choose this method

and

8 = If I was going to commit suicide I would be least likely to choose this method

Those methods identified by an individual were written on separate pieces of card and labelled 1-8. Participants were then presented with sets of three cards in pre-determined order according to the number given. Elements had equal chances of appearing in triads - each suicide method was represented in 3 triads and eight triads were given. Participants were asked to describe any ways in which two of the methods were similar to and thereby different from the third. Each answer and description of its opposite was recorded as poles of a construct.

The laddering approach was used to derive superordinate constructs. This involved asking participants which pole of their construct was preferable and why. The answer
to this question was recorded as another construct and the process repeated until the participant felt that the question was unanswerable.

When the participant had considered eight sets of cards, they were asked to rate on a scale of 1-5 the methods of suicide in relation to the constructs they had produced. They were also asked to rate "my ideal death" and "how I would like events in my life to be" in relation to the same set of constructs. Participants were instructed to mark rating boxes with an "X" if constructs did not appear relevant for particular elements.

**Phase 3: Conclusion**

At the end of the appointment, individuals were asked how they felt about having participated. The researcher reminded participants about the details of the information sheet and the opportunity for a follow-up interview to discuss aspects of the project or any further help that they felt they needed. With their consent, participants were contacted by phone approximately one week after the appointment in order to assess the impact of involvement in the study. Each was offered a one hour assessment interview with the research worker, under the supervision of a Chartered Clinical Psychologist. Where necessary, appropriate referral for further mental health care was made.

**2.6 Analysis**

The primary analysis of the repertory grid design is correlational. Individuals' construct rating patterns for suicide methods, ideal death and how they would like events in life to be were correlated using Kendall's Tau-B (SPSS-PC, version 6.1).
3. RESULTS

Results were analysed using Kendall's Tau-B test of correlation (1-tailed). The repertory grids produced by participants are given and results reported on an individual basis. In all grids, the methods (elements) have been ordered so that they appear in rank order of acceptability. The method most acceptable to the individual appears in the column on the left hand side of his/her grid. Numbers within grids represent the rating given to elements in relation to the poles of particular constructs. "X" denotes instances where a participant decided a construct was not relevant to an element. Superordinate constructs (i.e. those from which the participant was unable to "ladder" further) are illustrated in bold.

The results are reported in relation to the particular hypotheses described earlier. The results regarding the first three hypotheses are reported together. Hypothesis 1, that there will be a significant positive correlation between the construct ratings of an individual's most acceptable methods of suicide, has been tested by correlating the construct ratings of each participant's most and second most acceptable methods of suicide. Hypothesis 2, that there will be a significant positive correlation between the construct ratings of an individual's least acceptable methods of suicide, has been tested by correlating the construct ratings of each participant's penultimate and least acceptable methods of suicide. Hypothesis 3, that there will be a significant negative correlation between the construct ratings of an individual's acceptable and unacceptable methods of suicide, has been tested by correlating the construct ratings of each participant's most and least acceptable methods of suicide.

Results regarding the last three hypotheses are then reported. Hypothesis 4, that there

\[1\] The assumption of independence made by this test is violated in its use here for within-subjects analysis. While this is inevitable for ipsitive research, the consequent possible weakening of the results needs to be acknowledged.
will be a significant positive correlation between the subordinate and superordinate construct ratings of an individual's most acceptable methods of suicide and the construct ratings of his/her "ideal death", has been tested by separately correlating the subordinate and superordinate construct ratings each participant gave to the most acceptable method and "ideal death" elements within the grid. Hypothesis 5, that there will be a significant positive correlation between the subordinate and superordinate construct ratings of an individual's most acceptable methods of suicide and the meanings given to ideal life events, has been tested by separately correlating the subordinate and superordinate construct ratings each participant gave to the most acceptable method and "how I would like events in my life to be" elements within the grid. Hypothesis 6, that there will be a significant positive correlation between the subordinate and superordinate construct ratings of an individual's "ideal death" and the meanings given to ideal life events, has been tested by separately correlating the subordinate and superordinate construct ratings each participant gave to the "ideal death" and "how I would like events in my life to be" elements within the grid.

3.1 Results for individual participants

Participant 1 (see table 2)

The relationship between acceptability of methods and construct rating patterns

There was a significant positive correlation between the ratings he gave to his most acceptable methods, pills/alcohol and suffocation ($r = .9535; \, df = 5; \, p < .01$). The ratings of his most and least acceptable methods, pills/alcohol and slitting wrists, were significantly negatively correlated ($r = -.8452; \, df = 5; \, p < .05$). There was no significant correlation between the ratings of his least acceptable methods, setting the house on fire and slitting wrists ($r = .5401; \, df = 5; \, p > .05$).
<table>
<thead>
<tr>
<th>CONSTRUCTS</th>
<th>rating</th>
<th>scale</th>
<th>pills and alcohol</th>
<th>suffocation</th>
<th>jump off bridge in front of train</th>
<th>jump off bridge car fumes</th>
<th>jump in front of traffic set house on fire</th>
<th>slitting wrists</th>
<th>my ideal death</th>
<th>how I'd like events in my life to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>not guaranteed to work</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>gets you what you want</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>want to live</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>prolong the agony of life</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>messy</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>avoids pain</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>1</td>
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<td>screws up someone else's life</td>
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Table 2: Participant 1’s repertory grid
The relationship between the construct rating patterns of most acceptable method, "ideal death" and how he would like events in his life to be

The construct ratings of his most acceptable method, pills/alcohol, were significantly perfectly positively correlated with those of his ideal death (r=1.00; df= 5; p<.01) and how he would like events in his life to be (r=1.00; df= 5; p<.01). Clearly, these latter two elements also had significantly positively correlated construct rating patterns (r=1.00; df= 5; p<0.01).

i) The relationships between superordinate construct rating patterns

ii) For superordinate constructs, perfect positive correlations were found between the pairs of rating patterns for most acceptable method, ideal death and how he would like events in his life to be. However, due to the small number of superordinate constructs, the results did not reach significance.

ii) The relationships between subordinate construct rating patterns

All correlational relationships between the pairs of subordinate construct rating patterns for these three elements were significant (r=1.00; df= 2; p<.05).

Participant 2 (see table 3)

The relationship between acceptability of methods and construct rating patterns

There was a significant positive correlation between the ratings she gave to her most acceptable methods, street drug overdose and carbon monoxide poisoning (r= .8767; df= 5; p<.01). Her most and least acceptable methods, street drug overdose and hanging, were significantly negatively correlated (r= -.7912; df= 5; p<.05). There was no significant correlation between the ratings of her least acceptable methods, wrist cutting and hanging (r=.343; df= 5; p>.05).
<table>
<thead>
<tr>
<th>CONSTRUCTS</th>
<th>street</th>
<th>carbon</th>
<th>jumping</th>
<th>shooting</th>
<th>drowning</th>
<th>jumping</th>
<th>wrist-</th>
<th>hanging</th>
<th>my ideal death</th>
<th>how I'd like events in my life to be</th>
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<tr>
<td>relatively painless</td>
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Table 3: Participant 2's repertory grid
The relationship between the construct rating patterns of most acceptable method, "ideal death" and "how she would like events in his life to be"

There was no significant correlation between the construct ratings of her most acceptable method, street drug overdose, and those of either her ideal death or how she would like events in her life to be. The rating patterns for her ideal death and how she would like events in her life to be were significantly positively correlated ($r=.866; df=4; p<0.05$).

i) The relationships between superordinate construct rating patterns

Analysis of her rating patterns by superordinate constructs for the elements most acceptable method, ideal death and how she would like events in her life to be revealed no results of significance. A perfect positive correlation was found between the rating patterns of superordinate constructs for ideal death and how she would like events in her life to be but, again, the numbers of constructs were too small for the result to reach significance.

ii) The relationships between subordinate construct rating patterns

No significant results found for any of the three relationships examined.

"Not relevant" ratings

Participant 2 indicated a single instance in which she considered a construct not to apply to an element (my ideal death).

Participant 3 (see table 4)

The relationship between acceptability of methods and construct rating patterns

There were no significant correlations either between the ratings she gave to her most acceptable methods, shooting and pills/alcohol or her most and least acceptable methods, shooting and swallowing spoons/blades. The rating patterns she gave to her least
<table>
<thead>
<tr>
<th>CONST RUCTS</th>
<th>shooting</th>
<th>pills and alcohol</th>
<th>hanging</th>
<th>car exhaust</th>
<th>jump under train</th>
<th>cut wrists</th>
<th>jump off cliff</th>
<th>swallow spoons/blades</th>
<th>my ideal death</th>
<th>how I'd like events in my life to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>rating</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<tr>
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<td>is doing something and not wanting it to happen</td>
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<tr>
<td>involves other people</td>
<td>do it all by yourself</td>
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<tr>
<td>not fair to put it on someone else</td>
<td>other people should be drawn in</td>
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<tr>
<td>should be responsible for own actions</td>
<td>everybody else should take responsibility for us</td>
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<tr>
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**Table 4: Participant 3’s repertory grid**
shooting and swallowing spoons/blades. The rating patterns she gave to her least acceptable methods, jumping off a cliff and swallowing spoons/blades, were significantly positively correlated \( (r = .7135; \text{df} = 9; p < .01) \).

The relationship between the construct rating patterns of most acceptable method, "ideal death" and "how she would like events in his life to be"

The construct ratings of her most acceptable method, shooting, were significantly positively correlated with those of the way she would like events in her life to be \( (r = .6462; \text{df} = 9; p < .05) \). All other relationships between complete sets of construct ratings for these elements were non significant.

\( i \) The relationships between superordinate construct rating patterns

A significant positive correlation was found between the superordinate construct rating patterns for her most acceptable method and her ideal death \( (r = .8018; \text{df} = 3; p < .005) \). The superordinate construct rating patterns of her most acceptable method and how she would like events in her life to be were also significantly positively correlated \( (r = .9258; \text{df} = 3; p < .05) \) as were those of her ideal death and how she would like events in her life to be \( (r = .8660; \text{df} = 3; p < .05) \).

\( ii \) The relationships between subordinate construct rating patterns

No significant results were found in the correlations for the subordinate rating patterns of these three elements.
**Participant 4 (see table 5)**

The relationship between acceptability of methods and construct rating patterns

There was a significant positive perfect correlation between the ratings he gave to his most acceptable methods, carbon monoxide poisoning and overdose ($r=1.00; \ df=2; \ p<.05$). There was no significant relationship between his most and least acceptable methods, carbon monoxide poisoning and shooting ($r=.5164; \ df=2; \ NS$) or between the ratings of his least acceptable methods, jumping from a building and shooting ($r=.5164; \ df=2; \ NS$).

The relationship between the construct rating patterns of most acceptable method, "ideal death" and "how he would like events in his life to be"

The construct ratings of his most acceptable method, carbon monoxide poisoning, were not significantly correlated with either those of his ideal death ($r=.5164; \ df=2; \ NS$) or how he would like events in his life to be ($r=.5164; \ df=2; \ NS$). Neither were the construct ratings of his ideal death and how he would like events in his life to be significantly correlated.

**i) The relationships between superordinate construct rating patterns**

This participant produced only one superordinate construct, on which he gave the same rating to his most acceptable method, ideal death and how he would like events in his life to be.

**ii) The relationships between subordinate construct rating patterns**

There were no significant relationships between the subordinate construct rating patterns of these three elements.
Table 5: Participant 4's repertory grid

<table>
<thead>
<tr>
<th>CONSTRUCTS</th>
<th>rating scale</th>
<th>carbon monoxide</th>
<th>overdose</th>
<th>suffocation</th>
<th>hanging</th>
<th>wrist cutting</th>
<th>get run over</th>
<th>jump from building</th>
<th>shooting</th>
<th>my ideal death</th>
<th>how I'd like events in my life to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>not painful</td>
<td>painful</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>slow</td>
<td>instant</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>uncertain outcome</td>
<td>definite result</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>gets you out of what's bad</td>
<td>leaves you in a mess</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6: Participant 5's repertory grid

<table>
<thead>
<tr>
<th>CONSTRUCTS</th>
<th>rating scale</th>
<th>pills</th>
<th>hanging</th>
<th>suffocation with car fumes</th>
<th>jump from bridge</th>
<th>drive off cliffs</th>
<th>gas bottle</th>
<th>stabbing</th>
<th>shooting</th>
<th>my ideal death</th>
<th>how I'd like events in my life to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>would cause shock to others</td>
<td>wouldn't cause shock to others</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
**Participant 5 (see table 6)**

The relationship between acceptability of methods and construct rating patterns

Participant 5 produced a single construct. Consequently it was not possible to subject this to formal analysis. However, eye-balling the data reveals that he rated his most acceptable method, pills, on the opposite end of his construct from both his second most acceptable method, hanging and his least acceptable method, shooting.

The relationship between the construct rating patterns of most acceptable method, "ideal death" and "how he would like events in his life to be"

He also rated his ideal death and how he would like events in his life to be as identical to his most acceptable method on this construct.

**Participant 6 (see table 7)**

The relationship between acceptability of methods and construct rating patterns

There was a significant positive perfect correlation between the ratings she gave to her most acceptable methods, carbon monoxide poisoning and pills/alcohol ($r=1.00; \text{df}=7; p<.01$). Her most and least acceptable methods, carbon monoxide poisoning and jumping under a train, were significantly negatively correlated ($r=-.6351; \text{df}=7; p<.05$). There was also a significant positive correlation between the ratings of her least acceptable methods, stabbing and jumping under a train ($r=.7259; \text{df}=7; p<.01$).

The relationship between the construct rating patterns of most acceptable method, "ideal death" and "how she would like events in his life to be"

The construct ratings of her most acceptable method, carbon monoxide poisoning, showed a significant positive perfect correlation with those of her ideal death ($r=1.00; \text{df}=7; p<.01$). They were also significantly positively correlated with those of the
<table>
<thead>
<tr>
<th>Constructs</th>
<th>Carbon monoxide</th>
<th>Pills and alcohol</th>
<th>Crash car</th>
<th>Jump from bridge</th>
<th>Hanging</th>
<th>Shooting</th>
<th>Stabbing</th>
<th>Jump under train</th>
<th>My ideal death</th>
<th>How I'd like events in my life to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutilates the body</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Things should look neat and tidy</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Messy</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Requires physical strength</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Avoids physical pain</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Quick</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Avoids chance to change your mind</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Can't be stopped following through decisions</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gives you freedom</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 7: Participant 6's repertory grid
element how she would like events in her life to be \((r=.8847; \text{df}= 7; \ p<.01)\). The construct rating patterns for the elements of her ideal death and how she would like events in her life to be were also significantly positively related \((r = .8847; \text{df}= 7; \ p<.01)\).

**i) The relationships between superordinate construct rating patterns**

Analysing the patterns by superordinate construct ratings revealed that the sets of ratings were highly correlated for all elements. However, although the superordinate constructs were perfectly positively correlated for all three elements, the numbers were too small for the result to reach significance.

**ii) The relationships between subordinate construct rating patterns**

For subordinate constructs, there were significant positive relationships between the rating patterns of her most acceptable method and ideal death \((r=1.00; \text{df}= 1; \ p<.05)\), most acceptable method and how she would like events in her life to be \((r = .9045; \text{df}= 1; \ p<.05)\) and how she would like events in her life to be and ideal death \((r = .9045; \text{df}= 1; \ p<.05)\).

**Participant 7 (see table 8)**

There were no significant relationships between the construct rating patterns of any of the pairings of elements that we have previously been describing.

"Not relevant" ratings

This participant indicated three instances in which she considered constructs not to be relevant for elements. Two of these related to the element of ideal death, the other to how she would like events in her life to be. Consequently, she did not produce superordinate and subordinate construct rating patterns suitable for further analysis.
<table>
<thead>
<tr>
<th>CONSTRUCTS</th>
<th>rating scale</th>
<th>jump</th>
<th>set self</th>
<th>gas</th>
<th>suffocation</th>
<th>strangulation</th>
<th>overdose</th>
<th>drowning</th>
<th>jump off building</th>
<th>my ideal death</th>
<th>how I'd like events in my life to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>quick</td>
<td>slow</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>chance of not working</td>
<td>better chance of being successful</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>important to make a proper job of it</td>
<td>want to mess it up</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>painful</td>
<td>not painful</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 8: Participant 7’s repertory grid
Participant 8 (see table 9)

The relationship between acceptability of methods and construct rating patterns

All relationships examined were non-significant.

The relationship between the construct rating patterns of most acceptable method and "how she would like events in her life to be"

In the relationships between construct rating patterns that were examined, that of her most acceptable method, pills, and how she would like events in her life to be was significant in a positive direction ($r = .8729; df = 6; p < .01$).

i) The relationships between superordinate construct rating patterns

A significant positive relationship was evident in the superordinate construct rating patterns of these two elements ($r = 1.00; df = 3; p < .05$).

ii) The relationships between subordinate construct rating patterns

No significant relationships were found in the subordinate construct rating patterns.

"Not relevant" ratings

This participant indicated eight instances in which she considered constructs not to be relevant for elements. Seven of these occurred with regard to the element of ideal death. Consequently, there were too few construct ratings for the ideal death element to be analysed.
<table>
<thead>
<tr>
<th>CONSTANTS</th>
<th>rating scale</th>
<th>pills</th>
<th>suffocation</th>
<th>drowning</th>
<th>wrist-cutting</th>
<th>shooting</th>
<th>jumping from bridge</th>
<th>crashing car</th>
<th>poison</th>
<th>my ideal death</th>
<th>how I'd like events in my life to be</th>
</tr>
</thead>
<tbody>
<tr>
<td>passive</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>X</td>
</tr>
<tr>
<td>doesn't need physical energy</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>X</td>
</tr>
<tr>
<td>could hurt someone else</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>X</td>
</tr>
<tr>
<td>doesn't involve hurting someone else</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>X</td>
</tr>
<tr>
<td>doesn't involve blood</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>X</td>
</tr>
<tr>
<td>traumatic for others</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>X</td>
</tr>
<tr>
<td>needs organisation</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>X</td>
</tr>
<tr>
<td>quick</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>reversible</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>causes mental anguish</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>can't change your mind</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>X</td>
</tr>
</tbody>
</table>

Table 9: Participant 8's repertory grid
3.2 Aggregated results

The graph in table 10 illustrates the relationship between methods' construct rating patterns and their acceptability rankings. For each individual participant (except participant 5 who produced a single construct), the construct rating patterns of their rank ordered methods have been correlated with that of their most acceptable method (using Kendall's Tau-B). Kendall Tau-B correlations were converted to a Fisher's Z to obtain an linear scale for the correlation. The graph shows the trend that the correlation between methods' construct rating patterns tends to decline as a function of the difference in acceptability rankings.

Figure 1: The relationship between correlations of suicide methods' construct rating patterns and their acceptability to participants relative to each person's most acceptable method.
3.3 Motivation for participation

Participants were asked why they had decided to take part in the project. Several indicated that it was out of a desire to help other people in similar situations. One said that she thought this was something she could do to help people who "weren't as lucky as I was" (participant 2). She felt some responsibility for the death of a friend through suicide and considered that taking part could help towards preventing other people from dying through suicide. Another said that "if it can help with other people, I'm all for it" (participant 7). Someone else said that she saw participation as "something to help other people" (participant 8). A male participant (participant 5) thought that it "might be helpful" to others if he took part.

Participant 6 felt that she had something to contribute and said that she had responded because she wanted "to do something positive .... life has been so negative".

One of the male participants (participant 1) was motivated towards teaching the researcher about suicide. He said that he had nearly not come to the appointment but "I realise that you've got something to learn". One of the females (participant 3) also saw participation partly as a chance to do something for the researcher as she was "keen to support someone in further studies" like herself. She also saw it as an opportunity to help others who might have the same experience - "if I can help- I will".

One participant said that he saw this as an opportunity to help himself with his current difficulties or to try and get more help (participant 4).
3.3 The effects of participation

At the end of the interview session and again a week later by telephone, participants were asked about their reactions to having taken part in the research. A variety of positive and negative effects were described.

Participant 5 said that he was "appreciative" of the chance to talk and said that he had "relieved his feelings".

At the end of her interview, one female participant (participant 6) said that she had found it "harrowing, ... thought-provoking,...churning". She said that it had uneased her. A week later, she said that although the interview had caught her "unawares" by making her think about suicide again, it had not affected her that much. She said that she was not unhappy about the thoughts and feelings that it had provoked.

One woman (participant 2) said that she had expected to find the interview upsetting and was surprised not to be upset by it. She had, however, been shocked at her own fearful reaction when considering one of the suicide methods she had frequently used.

One of the male participants (participant 1) said that he felt indifferent to having taken part - "it hasn't inspired me to go away and top myself or to live on".

Another of the men (participant 4) said that he had found the session "helpful overall" but that it had been distressing thinking about his family circumstances. He also said that it had given him insight into other methods.

Another participant (participant 7) said that it felt "painful" to remember suicide attempts
from the past and "weird" to be talking about something that she did not usually talk about. This reaction was echoed by another woman (participant 8) who said that it felt "good and bad at the same time ... after all, it's not a normal thing to be doing - talking about these things on a Tuesday afternoon".

"Tired and relieved" were the words of a female participant (participant 3) at the end of her interview. She said that the session "made my brain hurt". A week later, she said that she had found participation "interesting but tiring".
4. DISCUSSION AND CONCLUSIONS

4.1 Acceptability rankings

All participants were able to meaningfully rank methods in terms of their acceptability. Participants identified a variety of sets of suicide methods and differed in the rankings they gave to particular methods. This supports the idea that people view different methods of suicide differently. It also suggests possibilities for clinical work in terms of working towards reducing the number of suicide attempts an individual makes. A possible objective could be to make previously acceptable methods unacceptable to an individual by altering the way that a method is construed. Clearly, the rigidity of an individual's view would be an important issue. Also, how the acceptability or likelihood of using a method are associated with factors such as mood and intent would affect the potential for methods to come to be seen as unacceptable.

Individual differences regarding how acceptable methods are and how stable such preferences may be could help explain the equivocal findings regarding the substitutability hypothesis which was outlined earlier. The substitutability theory has generally been tested with respect to national trends of particular method usage rather than examining individual patterns of switching between suicide methods. The evidence from this study, that people are more or less likely to use particular methods is important and indicates an opening for preventative work with individuals.

Although individuals were able to meaningfully rank how likely they were to use methods, it is unclear how the elicitation and ranking of the methods was influenced by the perceived availability of the method. It is possible that, for example, if an individual thought it was unlikely that they would have access to a gun then they would not select
shooting as one of their eight methods. Alternatively, they may have ranked shooting as a method they were unlikely to use, even though they would actually prefer suicide by this method.

This factor may help to explain some of the results discussed later. The inclusion and rating of a method may have been influenced by the fact that an individual thinks it unlikely that they will be able to use it rather than that they would prefer not to.

4.2 Elicitation of constructs

Generally, it was possible to elicit constructs by using the Repertory Grid Technique, using triad presentation and laddering. However, particular difficulties were encountered when interviewing participant 5. He had a vague and perseverative conversational style and only one construct was produced. It is possible that a more experienced researcher may have been able to work better with him to produce more defined thinking.

A relatively small number of constructs were produced by some participants. This led to some limitations in the analysis that was possible, particularly for analysis involving superordinate constructs. There are a number of possible explanations for the number of constructs produced.

First, it is unclear what is a reasonable number of constructs about suicide methods to expect from participants. Earlier studies have either given pre-selected constructs to participants (e.g. Lester, 1988b) or specified the number of constructs (e.g. Lester, 1993). In this latter study, it is not clear whether student participants were able to
produce as many as the eight constructs that were asked for. Consequently, it is not clear how many constructs it is reasonable to expect individuals to produce.

Second, if we accept the idea that the number of constructs produced was limited, it is possible that this was evidence of constricted thinking associated with mental health difficulties. Individual psychological characteristics of suicide attempters, such as hopelessness and poor problem-solving ability, that were identified earlier, may affect the numbers of constructs that some people were able to produce. Kelly (1955) maintains that constriction is a feature of a variety of mental health problems, including depression and anxiety. He says that constricted thinking is a person's "way of making one's world manageable by shrinking it to a size that he can hold in his own two hands" (p901). It is a shortcoming of this study that no measure of depression or anxiety was made. Information regarding previous diagnoses could have been used to indicate the mental health status of participants, although it is not clear how reliable such information would have been for individuals at the time of participation. However, without data regarding individuals' mental health status, there is no indication of the possible influence of factors such as depression and anxiety on the number of constructs they produced.

Third, features of the researcher and her exchanges with participants may help explain the number of constructs produced. Easterby-Smith (1981) said that Repertory Grid Technique is an exercise of social interchange. It is rightly called a technique. It requires skill and expertise to elicit constructs, identify the key elements in what someone says and enable participants to elucidate the more abstract areas of their construct systems. It is possible that participants may have found it easier to refine their thinking and explore their construct systems with an interviewer more skilled in the technique.
4.3 Rating elements

Generally, participants were able to use the poles of their elicited constructs as descriptive dimensions on which to rate the methods of suicide, their ideal death and how they would like events in their lives to be.

However, as was illustrated earlier, three participants indicated that certain constructs were not relevant to describe particular elements of their grids. Of the five hundred and thirty total ratings made, twelve were marked "not relevant", ten of which were for the element ideal death and two were for the element "how I would like events in my life to be". Participant 8 made eight of the "not relevant" descriptions.

It is difficult to know how to interpret these findings. They suggest limitations in the application of constructs elicited from comparisons of suicide methods to thinking about ideal death. In other words, there is a query about these constructs' range of convenience. Particularly, this casts doubt on the hypothesis that the meaning of suicide methods is associated with that of ideal death. The implication is that the meaning of suicide has no shared basis with beliefs about life and death in general but sits alone in an individual's thinking, and consequently in their action, as separate event.

It is important to note that seven of the ten "not relevant" ratings for ideal death were made by participant 8. This suggests that the range of convenience for constructs related to suicide methods may extend to their ideal death for the majority of people. However, there may be individuals for whom thinking about suicide constitutes an isolated sphere of thoughts and beliefs, maintained separately from thoughts and beliefs about death in general. From the results of this study, it is not clear how this is achieved. For example, participant 8 decided that even fairly concrete constructs, such
as "doesn't involve blood ... bloody", "passive ... aggressively violent" were not relevant to the meaning of her ideal death. A possible explanation is that this individual was denying the possibility of a natural death and could not or would not elucidate her thinking about it. Clearly, individual factors would need to be explored in greater detail to help explain these findings.

4.4 Associations between construct ratings of suicide methods

The graph in figure 10 indicated the general trend that methods ranked more closely to that of the most acceptable method had more similar construct rating patterns i.e. shared more similar meanings. This suggests that how people construe methods - the meanings they attach to them - is important regarding how likely they would be to use that method.

However, this was not a clearly established pattern. For instance, while six participants showed a positive correlation between the construct rating patterns of their two most acceptable methods, one showed no relationship and another a negative relationship. Similarly, five participants showed a negative correlation between the construct rating patterns of their most and least acceptable methods, while three showed a positive one.

A clear association between the construct ratings of methods and their acceptability rankings should perhaps not be expected. This is because constructs are not equally important for a method's acceptability to an individual. Clearly, an individual's superordinate constructs should be expected to be more important for a method's acceptability.
These results can also partly be understood in relation to a feature of this study's design. Methods were rank ordered for acceptability. Clearly, for individuals, the difference in acceptability between methods ranked one and six, for example, is likely to be different. Also, for any one individual, the difference in acceptability between pairs of methods that differ by one rank may vary. If methods had been rated for acceptability rather than ranked, a clearer pattern may have been evident in the relationship between methods' construct rating patterns and acceptability scores.

As with the acceptability rankings discussed earlier, it is not clear how the construct ratings given by individuals might relate to factors such as mood and intent. Put simply, we do not know how stable the individuals' constructions are. There is no measure of the reliability or stability of the acceptability rankings or constructs. This is a shortcoming of the present study but it is not clear how an adequate measure of reliability might have been achieved.

One possibility would be to repeat the procedure over time. However, this may have created a rather onerous task for participants. It is quite likely that there would have been a high drop-out rate between procedures and, perhaps, participants would have been less likely to want to take part in the first place if they knew that two interviews were involved.

Given the queries that have been raised in this section regarding the influence of the interviewer on the quantity and nature of constructs produced, it would have been an interesting test of the validity and reliability of results to have repeated the procedure with another interviewer. Again, though, this would have had implications for the participants in terms of the time demands upon them and does not seem practical.
Issues regarding the stability of the elements and their acceptability rankings also need to be considered. I am mindful of the comments of participant 2, who implied that it may be a method's acceptability ranking that is liable to change rather than the meaning that it holds:

"this is the frame of mind I'm in at the moment, mellow. If I'm feeling angry, I'm more likely to think about destructive methods".

4.5 The meaning of ideal death

The construct rating patterns of seven of the participants showed a positive correlation between the most acceptable method and ideal death. The other participant gave seven "not relevant" ratings to this element. Problems with the numbers of constructs as well as with the strength of the relationship meant that only two of these correlations reached significance. Nevertheless, the trend is evident.

What this suggests is that there is some association between the meaning an individual gives to the suicide method he/she is most likely to use and the meaning attached to their ideal death. Clearly, for individuals this meaning is different. For participant 2, for example, her ideal death is one, which like her preferred method of street drug overdose, is relatively painless, where physical pain is not needed to offset emotional pain and is a positive statement. For participant 6, her ideal death is like her preferred method of carbon monoxide poisoning as both involve no visible damage to the body, are neat and tidy, quick and would give freedom.

What sense can be made of this shared meaning? A possible explanation is that
individuals tend to prefer suicide methods that entail the meaning of their ideal death. What they may achieve through their choice of suicide method is some control over what their death means. Important aspects of the meaning of their ideal death can be realised. This raises issues about how choice of suicide may be related to death anxiety in that death by suicide may give an individual some control over the conditions of an experience of death that is otherwise lacking. For participant 2, for example, taking a street drug overdose is construed as a positive statement, consistent with her ideal death. Consequently, she avoids death as withdrawal, which is how she understands suicide by carbon monoxide poisoning. This idea of suicide as control of the meaning that an individual attaches to dying can be associated with Hendin's (1991) suggestion that individuals may use death in an effort to maintain control over life.

It would have been interesting to have designed this study so that constructs could have been derived about ways of dying and suicide methods rated accordingly. Such a design may have produced more constructs about death and enable a richer description of the meaning that participants attach to their ideal deaths. The approach taken by this study may have been too limited as a way of generating constructs about death. There may be more to the meaning an individual gives to dying than that which is shared with the meaning attached to his/her most preferred suicide method.

Unfortunately, the limitations of the number of superordinate and subordinate constructs produced make it difficult to take this analysis further. However it is particularly interesting to examine the grid of participant 3, where a non-significant positive relationship between the construct rating patterns of most acceptable method and ideal death masked a significant positive correlation between the superordinate constructs of these two elements. This indicates that the meanings attached to most acceptable method and ideal death are related at a higher level of construing. From our
earlier discussions, this indicates that the most acceptable method of suicide and ideal death derive from a shared level of meaning that is fundamental for the individual.

4.6 The meaning of ideal life events

Except for participant 7, whose construct rating patterns showed no relationship between most acceptable suicide method and how she would like events in her life to be, all other participants showed a positive relationship between the construct rating patterns of these two elements. Four of these relationships reached statistical significance.

These results suggest that generally people find most acceptable that suicide method in which the qualities that they strive for in their life events are also realised. For example, a number of participants who identified a "pain ... painless" construct preferred a suicide method to be as painless as they hoped events in their lives to be. One participant identified "looks after the body" as an important shared quality of her most preferred method, shooting and what she hoped for from life events. This same participant understood both shooting and ideal life events as meaning responsibility for her own actions. Another, for whom "things should look neat and tidy" was important, thought that this was realised in suicide by the most acceptable method carbon monoxide poisoning as well as characterising ideal life events.

It is perhaps a weakness of this study that specification of the element "how I would like events in my life to be" is rather vague. It is not very clear what type of event participants should have or did consider within this element e.g. going shopping, career prospects, suffering a bereavement. There is no way of knowing what events people
were thinking about when they made their ratings. Consequently, these results should be interpreted with caution.

This aspect of the research could have been improved in a number of ways. First, participants could have been asked what kind of events they were considering. Second, they could have been presented with a range of typical life events. Third, they could have been asked to generate a number of positive and negative examples of what they considered to be important life events. Fourth, and perhaps ideally, participants could have been asked to produce a life events grid and derive constructs to be compared with those from their suicide methods grid. This would have given some idea not only of the association between the meanings attached to suicide and living but would also have given an indication of whether there are meanings attached to living that are not shared with thoughts about suicide.

The data produced by this research is insufficient to enable us to reach conclusions about the relationships between superordinate and subordinate construing about ideal life events and suicide methods. However, there are some interesting results from two of the grids. Participants 3 and 8 showed significant positive associations between the construct rating patterns of these two elements. When the patterns were examined by superordinate and subordinate constructs, it was shown that this significant positive association was maintained between the superordinate constructs only.

This suggests that, for these two participants, preferred suicide methods and life events have a shared meaning at a higher level of construing. There may appear to be no obvious association at a more immediate level of thinking but they share an underlying common meaning. An example is that, for participant 3, her most preferred method, shooting differs from how she would like events in her life to be on the "takes courage..."
... is an easy way out" subordinate construct. However, on the superordinate construct "don't like being hurt ... like being hurt", which is laddered from it, both elements are rated identically.

The shared meaning that seems to exist between the meaning given to preferred suicide method and life events may not always be immediately evident in an individual's construing.

4.7 The meanings of ideal death and life events

Excluding participant 8, who made seven "not relevant" rating for the ideal death element, all other participants showed a positive association between their construct rating patterns for these two elements. For four of the participants, this relationship reached significance.

That there is this trend of a shared meaning between ideal death and how individuals would like events in their life to be is unsurprising given that we have so far established that there appears to be a shared meaning attached to preferred suicide method and ideal death, and to preferred suicide method and how individuals would like life events to be.

Earlier in this section, concerns were expressed about the sampling of the elements concerning ideal death and life events. Clearly, these reservations influence the extent to which conclusions can be made about the existence and nature of a shared meaning attached to living and dying.
Nevertheless, the implication is that individuals tend to construe ideal life events and death similarly. Again, the actual meaning attached to such events is very different for individuals. For example, the construct "screws up someone else's life ... doesn't screw up someone else's life" was important for participant 1 who rated both elements identically on this dimension. Participant 4 identified the construct "slow ... instant" as important in the meaning of her ideal death and life events, rating both elements as "instant". One of the few common constructs across participants involved the experience of pain. Six participants identified this construct as relevant to their understanding of ideal death and life events and each individual rated these elements similarly on this construct.

What this suggests is that individuals have unique understandings of their own life events and death but that within each person there is a tendency towards a common meaning for living and dying. People seek a way of dying that is consistent with the way in which they seek to live. Earlier in this discussion, it was speculated that individuals may seek to control the nature of their death, perhaps in a response to heightened death anxiety, through choosing a particular method of suicide. This idea may also be relevant here. It is possible that when the meaning derived from life events is inconsistent with that which is hoped for, suicide may be seen as a way of re-asserting personal control. It may be that people look to achieve an ideal death, through their preferred method of suicide, when the experience of life events is significantly different from that which is hoped for. This is reminiscent of Baecher (1979) who suggested a view of suicide as a means to solve life problems. However, what I am suggesting is that death may be a way of re-instating the individual meaning that is missing from a person's experience of life events. Rather than, or perhaps as well as, being understood as an "escape" from the self (e.g. Baumeister, 1990; Buchanan, 1991) suicide attempts may be seen as an attempt to achieve the meaning an
individual desires from living that has been thwarted.

4.8 Motivation for and effects of participation

This was not an area of investigation initially envisaged for this study. However, particularly given concerns that were expressed by some local mental health practitioners about the possible effects of participation on potentially vulnerable individuals, this aspect of the research emerged as one important to consider.

Only one participant clearly stated that he was specifically looking for further help. The majority of people saw participation as an opportunity to make a positive contribution to the welfare of other people experiencing similar difficulties. This was a striking aspect of meeting with the participants. They were people with evidently painful histories, some of whom were clearly still struggling to cope in difficult circumstances. Yet their motivation was towards helping other people in difficulty. Whether participants felt that they had contributed towards helping others at the end of the project is unclear. However, it seems important to recognise that people who have made suicide attempts are often negatively stereotyped within health services and yet, at least a subgroup of them, have a desire to improve the lot of others with similar problems. There may well be better ways than taking part in a research project for clients to realise their desire to help others. It may be a potentially useful aspect of service provision to consider ways in which such clients may be able to make a positive contribution to the welfare of others.

From the comments that participants made about the effects of taking part, several appeared to find the experience distressing in some respects. However, it seems that
this effect was not long-lasting. No participant was unduly concerned about having taking part when they were contacted a week after the interview. There were also some positive effects described but, again, these did not appear to be particularly dramatic. These effects seem to suggest that there does not appear to be anything inherently damaging about talking with people who have made suicide attempts about their thoughts and experiences of such events. Clearly some individuals are likely to be more distressed than others and appropriate safeguards need to be in place. The potentially cathartic effects of such dialogue also need to be recognised but not overrated.

4.9 Summary

This study has a number of limitations. These relate to the number of participants engaged and aspects of the methodology particularly relating to the sampling of the life events and ideal death elements within the repertory grid. Shortcomings of the analysis have also been identified, especially with regard to the suitability of the test used and the numbers of constructs available. Issues regarding the stability of individual's constructs in relation to factors such as mood, intent and access to suicide methods are also outstanding.

Nevertheless, a number of interesting results suggest that issues concerning the meanings that suicide attempters attach to suicide, living and dying are important areas for investigation for those working with this client group. If the meanings that individuals attach to suicide attempts are to be better understood, the results of this study indicate that the context of an individual's thinking about living and dying may be crucial. This study has raised the issue of the potential for preventative work regarding
how acceptable certain methods are to an individual. In addition, the possible interplay between a person's experience of life events, fear of and ideals about dying and control over the circumstances of death through suicide has been highlighted as an intriguing and potentially useful area in which the meaning of an individual's suicide attempts can begin to be understood.
## APPENDICES

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Appendix A

Dear (name of consultant),

As part of my clinical psychology training, I am conducting a research project, supervised by Ron Wood (Mental Health Services) and Reg Morris (University of Plymouth). I would like to enlist your support to access participants for this project.

The project focuses on the relationship between the meanings that suicide attempters associate with suicide method and life events. You will have already received a full copy of my research proposal which gives more detail about the study.

I am hoping that you can help me access potential participants who meet the following criteria:

1. adults who have been discharged from care within the last year.
2. adults who you know to have attempted suicide prior to or during your contact with them.
3. adults who, in your clinical judgement, would not be adversely affected by participating in the research.
4. adults who, in your clinical judgement, are not at present suffering from a severe psychotic or depressive disorder.

I would like you to consider compiling a list of your ex-patients who meet these criteria and sending each of them a copy of the enclosed letter and information sheet inviting them to contact me. I would also ask you to send the enclosed correspondence to their GPs. I will of course be happy to help administer these tasks.

I am hoping to engage 20 participants altogether and will contact you in the next couple of weeks to see whether you are willing and able to help. If you have any questions or comments in the meantime, please contact me or Ron Wood, Clinical Psychologist, who is supervising the study. Our contact details are given below.

Georgia Jones, Clinical Teaching Unit, 4/5 Rowe Street, University of Plymouth, Drakes Circus, Plymouth. Tel: 233161.

Ron Wood, Westbourne Unit, Scott Hospital, Beacon Park Road, Plymouth. Tel: 550741 x3257.

Yours sincerely,

Georgia Jones
Appendix B

INFORMATION SHEET FOR PARTICIPANTS  September 1994

I am looking for people to participate in a study which aims to look at how people who have attempted suicide think about different suicide methods. To help you decide whether you would like to take part, here are some details about what to expect.

I would ask you to come to an individual session with me at the Nuffield Clinic or Westbourne Unit, which would last for about 90 minutes.

You would be asked to think about different ways people attempt to commit suicide and discuss what you think about them. For example, I would ask you to put methods of suicide in order of how acceptable they are to you. I would keep a record of your responses but it would be confidential in that nobody except me would be able to link you with these responses. Taking part in the study may be a positive opportunity to talk about issues to do with suicide but it may also raise issues that are distressing.

A week after you had finished your involvement in the study, and unless you had any objections, I would contact you by phone to ask about your reactions to having taken part. If at this stage, you would like an opportunity to talk through your thoughts and feelings about the study, I will arrange a further interview. At least part of this appointment could be used to discuss whether you feel you want any further help at this stage.

I have asked the psychiatrist who was previously responsible for your treatment to contact potential participants and to let your GP know that he has done so.

I would be very happy to talk with you about the study if you want to know more before deciding whether to take part and returning the consent form to me. You can contact me via the Clinical Teaching Unit, University of Plymouth, Drakes Circus, Plymouth. The telephone number is 233161. If we did meet to discuss the project, you would of course be under no obligation to take part in the study - any participant is free to withdraw from the project at any time without giving a reason.

There are other people you could talk to about the study. Ron Wood is the Clinical Psychologist supervising the project. You can contact him at the Westbourne Unit, Scott Hospital, Beacon Park Road, Plymouth. His telephone number is 550741 x3257.

If you wanted to make comments about the project to people not directly involved with the study, you could contact the Research Ethics Committee, Building 1, Plymouth and Torbay Health Authority, Locality Office, Brest Road, Plymouth. The telephone number is 787465.

Thank you for taking the time to read this sheet.

Georgia Jones  Trainee Clinical Psychologist
Appendix C

CONSENT FORM

To: Georgia Jones

I am willing to take part in the research project described in your information sheet dated September 1994.

I understand that the study involves talking about what I think about different methods of suicide.

I know that I am free to withdraw from the study at any time and do not have to give a reason for my decision if I should choose to do so.

Please write your details below in CAPITAL LETTERS

Name ........................................................................................................

Address ...................................................................................................
..................................................................................................................
..................................................................................................................
..................................................................................................................

Telephone number .................................................................

signed ........................................

date ..........................................

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Appendix D

Dear (name of GP),

Re: name and contact details of patient

Please find enclosed a copy of my recent letter to the above patient.

If you should have any concerns about the patient's involvement in this project, please contact either of the project workers named on the information sheet and they will exclude the patient from the study.

If the project workers do not hear from you within two weeks of the date of this letter, they will assume that you have no objections to this patient being included.

Yours sincerely,

(name of consultant psychiatrist)
Consultant Psychiatrist
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