A combined psychological autopsy and narrative approach was used to study the completed suicides of 67 Israeli soldiers. Three issues were addressed. First, the authors examined the typology of the life narratives of suicide completed during active army duty. Second, focusing on the last 3 weeks of the soldiers’ lives, they sought to examine their triggers for suicide, emotional state of mind, army duty functioning, and communication of suicidal intent. Finally, they examined military responses to communication of intent, help provision, and help acceptance. Four types of narratives were identified: regressive, stable, tragic (progression and sudden collapse), and romantic (ups and downs). During the last days of life, suicide completers exhibited a split between an emotional state of mind (evidencing an emotional deterioration) and a behavioral military functioning, which was mostly stable. The analysis also revealed a resistance to receive help and a resistance to provide help, both of which impeded intervention. The gap between functioning and emotional distress in suicidal individuals and the incongruence between crisis and help are highlighted. The need to educate military personnel to look beyond duty functioning and the need to develop clear guideline about referrals to professional helps are discussed.
Most of the clinical studies of suicide are based on populations that have made non-fatal (yet serious) suicide attempts, or on persons who were in some form of psychological treatment prior to their suicide. Clearly, the best method to study suicide would be a prospective longitudinal design. However, well-controlled prospective studies remain prohibitive in terms of time, sample size, and cost. Thus, psychological autopsy may be one of the best available methods to examine completed suicide.

Psychological autopsy is aimed at reconstructing an individual’s psychological makeup: the lifestyle, thoughts, feelings, behaviors, intentions, motivations, psychodynamics and life circumstances, as well as the mode and details of the suicidal act (Hawton, Houston, Malmberg, & Simkin, 2003; Jacobs & Klein-Benheim, 1995; Shneidman, 1980). The psychological autopsy is usually based on personal interviews with acquaintances, review and analysis of records describing the deceased, analysis of suicide notes, and a comprehensive case formulation by one or more mental health experts (Clark & Horton-Deutsch, 1992). In some psychological autopsy studies, a control group is included for a more careful delineation of the characteristics that are specific to the suicidal group (e.g., Appellby, Cooper, Amos, & Faragher, 1999; Cavanagh, Carson, Sharpe, & Lawrie, 2003).

Indeed, the psychological autopsy method is extensively used in the study of suicide, and between January 1990 and January 2007, more than 250 publications of psychological autopsies appeared in the literature (for reviews, see Cavanagh et al., 2003; Isometsä, 2001). Most of the autopsy studies focused on diagnosis, risk factors, and intent communications (see Cavanagh et al., 2003). For example, Brent, Perper, Kolko, & Zelenak (1988) compared psychological autopsies of 27 adolescent suicide completers with 56 psychiatric participants who (unsuccessfully) attempted suicide. Their findings identified risk factors specifically linked to completed suicides while implicating other risk factors common to participants from both groups (see also Apter et al., 1993).

Even though psychological autopsy may be accredited as a useful, diverse, and widespread research tool, there are several methodological issues concerning the validity and reliability of data derived from psychological autopsies. It has been claimed
that the grief and distress of the informants may influence information provided and that the time lag between death and autopsy interviews may influence the recollections and reports given by informants. However, the studies of Brent et al. (1988) have dissipated these concerns, noting similarities between the reporting of symptoms in depressed completers and depressed patients, and finding no association between time lag and parental reporting of psychiatric symptoms of suicide victims, and no association between existence of an affective disorder in the reporting parent and the information given during the interview. Thus, psychological autopsy is a valid and useful tool to address completed suicide.

Closely related to the psychological autopsy approach is the narrative study approach. The narrative method is a qualitative method using actual and symbolic descriptions of the individual’s actions and experiences over time (Sarbin, 1986). The narrative can be based on a life story told or written by the individual him/herself as well as on diaries, letters, newspapers, and other documents pertaining to the individual’s life, in addition to descriptions provided by observers (Lieblich, Tuval-Maschiach, & Zilbert, 1998). The qualitative analysis of a life’s narrative may provide a more integrative and holistic understanding of the human experience and its meaning compared with quantitative methods (Bruner, 1986; Hauser, Golden, & Allen, 2006).

A narrative analysis can be performed along two main independent dimensions: (a) categorical versus holistic, relating to whether or not the narrative is regarded as a whole or whether parts are abstracted from the complete text, and (b) content versus form, referring to the dichotomy of reading the explicit content compared to examining the implicit structure.

Seven holistic analyses of a life story have been identified as archetypes of the developmental sequence of a narrative: (a) stable—a plot characterized by having no changes over time; (b) progressive—a plot characterized by slow, progressive positive changes; (c) regressive—a plot characterized by an intensification of negative changes; (d) tragic—a plot that begins with positive changes followed by a drastic negative change; (e) tragic-comic—a plot beginning with a negative change followed by a drastic positive change; (f) happy-ever-after—a plot that begins with a very positive change with no negative changes; (g) romantic—a plot
characterized by positive and negative changes following each other (see Lieblich et al., 1998).

In the present study we aimed to combine the autopsy methodology and the narrative methodology in order to study of some aspects of the lives of young men and women serving as soldiers in the Israeli Defense Forces (IDF) who committed suicide during their military service. This combination allows researchers to exploit advantages inherent in the narrative arrangement of the life histories, while providing a rich context for the interpretation of the life events and behaviors of the suicide completer. Specifically, we reviewed the data regarding the suicidal individual and his/her last three weeks of life based on the post-suicidal autopsy conducted by military’s police. Clearly, this methodology does not provide an account of the last three weeks of life from the suicides’ subjective perspective, but an approximation of an internal perspective and a context to understanding the behavior and events of this period. In addition, by recreating life narratives for the present young adults we were able to examine specific and general components regarding the last three weeks of life of the suicidal individual. Such components were examined along multiple dimensions: narrative structure, emotional state prior to suicide, synchrony between subjective experience and outer communication, army duty functioning and its relatedness to emotional state, specific difficulties and stressors related to the suicidal trajectory, suicide-intent communications, and the military’s response to the suicidal intent.

The present study is unique in several respects. The majority of suicide narrative studies use limited sources for the content analysis (e.g., such as suicide notes; see Leenaars et al., 1992). In contrast, the present study contains multiple sources of information. Clearly, a large number of informants would be able to provide a comprehensive account of the changes the suicide completer have experienced during the last weeks and days of life. Thus, the present analysis was based on information provided by family, friends, army commanders, and peers. In addition, the focus on the military authorities’ response to the observed difficulties and intentions in the last three weeks of life is intended to allow us to form clinical recommendations with regards to military staff education.
Method

Participants

The sample consisted of 67 (49 men and 18 women) suicide completers. The soldiers’ age ranged from 18 to 21 years at the time of death. They all committed suicide while enlisted in compulsory military service during the 1990s. Causes of death were determined by the IDF legal corps and were based on an extensive official investigation. The sample included all cases in which the cause of death was unambiguously attributed to suicide.

Materials

The psychological autopsy was based on all available pre-recruitment data as well as active service data, and on interviews with family, friends, peers, and commanders. The pre-recruitment data included medical evaluations, psychological evaluations, and psychometric evaluations. The active service data included records of the soldiers’ course of duty as described by their commanding officers and medical and mental health officers. Our psychological autopsy was also based on the routine extensive investigation conducted by the military’s police for every case of suicide that occurs during military service. The military police investigators used a standard protocol developed and supervised by an IDF psychiatrist. In this protocol, information regarding the circumstances of suicide and the participant’s personality and psychological situation prior to suicide are obtained by a psychological autopsy that draws on both the deceased’s records and standardized postmortem interviews with individuals who knew him or her.

The standardized postmortem interview elicits information regarding the deceased: life history, psychosocial functioning, recent lifetime events, symptoms, and traits (including signs of anxiety, depression, conduct difficulties, substance abuse, and psychosis). In addition, information is gathered regarding army functioning, emotional functioning, and behavior in general. Family members are interviewed following the traditional Jewish seven days of mourning, depending on the family’s consent and ability to collaborate. The friends, unit comrades, former teachers, and officers of the deceased are interviewed within a short time frame.
following death. In the 67 cases reported herein, an average of 10 acquaintances was interviewed; in no case were there fewer than five acquaintances interviewed. Most potential informants cooperated. We made no contact with any of the informants, and the analysis was based solely on the material made available by the army authorities. This study was approved by the IDF’s ethical research committee.

**Procedure**

In this study, we combined a psychological autopsy analysis approach and a narrative analysis approach. Following J. Jacobs (1971), we performed a screening analysis by arranging all data according to a chronological timeline. We then organized the material to include the date of the identified event, the factual description of the event, and a detailed report and reflection on the event. Next, we constructed a narrative by connecting dates, events, and presumed emotional reactions and motives. The results of this procedure were combined into a comprehensive life story (see Table 4 for an example).

The 67 narratives that emerged then underwent (a) structural analysis of narrative development (Lieblich et al., 1998; the time frame for this analysis began with recruitment and ended with suicide); and (b) content analysis regarding triggers, emotional state of mind, army functioning, communications about intent, and military response. The content analysis pertained to observed behavior during the last three weeks of life.

The above analyses were performed by H. Ofek. To examine the reliability of this analysis, an independent judge re-analyzed a randomly chosen a sample of five records of the raw data. Thus, two sets of chronologies for each of the five suicide completers were obtained. A third judge rated the degree of similarity between each of pair of chronologies on a scale of 1 (*not similar at all*) to 5 (*very similar*). The average score of the degree of similarity was 4.4. The third judge also compared the number of the specific events and details that appeared in each of the pairs, and found almost absolute congruence in this measure. In all cases we adopted the analyses constructed by H. Ofek.

A second reliability check was applied to the categorization into narrative type (e.g., regressive, stable) and to content analysis
Twenty-one of the 67 narratives that were arranged by H. Ofek were categorized and analyzed anew by an independent reviewer. Another independent judge estimated the degree of congruence between these two analyses for narrative type, emotional changes, triggers, army duty functioning, communication of intent, and IDF officials’ response to the communication. The percentages of congruence on these behaviors ranged from 80% to 95%. Again, in cases of discrepancies, we followed the analyses performed by H. Ofek.

Results

Four types of narratives were identified on the basis of Gergen’s typology (see Liblich et al., 1998): regressive (47%), stable (21%), tragic (21%), and romantic (11%). A chi-square analysis of the narrative frequencies revealed a non-random pattern, $\chi^2(4, N = 67) = 11.1, p < 0.05$.

The regressive type of narrative (21 men, 11 women) is characterized by an accumulation of negative events (as inferred from the informant accounts) and a gradual deterioration in mental state, self-perception, functioning, and coping. E’s story reflected a typical regressive narrative. He began his service in the army as an excellent soldier, distinguished for his functioning in a technical service unit. He then requested a transfer to a combat unit, which was granted. There, he encountered difficulties in adjusting to basic training, suffered from somatic problems, and did not get along with his peers. A gradual deterioration in his mood and self-evaluation was noted. His superiors described him as quiet, socially aloof, depressed, and confused. He asked for another transfer, which was also granted. He had difficulties adjusting to his new unit, and was then transferred again to an administrative duty. He was very disappointed by this unsolicited change. At this time, he engaged in a series of disciplinary violations and provocative behaviors for which he was punished. There was an entry in his service file at this time, describing him as suffering from an emotional crisis and instability. His peers later reported that E was, at the time, expressing feelings of inferiority and discontent with his environment. The peers perceived E as restless and insecure. E requested to return to his original unit, and at the same time persisted in absenteeism and disciplinary violations for which
he was punished and even imprisoned. Shortly after he was informed that his chances to return to his original unit were slim, E committed suicide.

The stable narrative was identified in about 21% (12 men, 2 women) of the sample. This type of narrative can incorporate a positive or negative life story, but with no significant changes in either direction. One such typical narrative is the life story of D, who was described as a quiet young adult. He was described as friendly but did not have a wide social network. He fulfilled his duties to the satisfaction of his superiors, and no major changes in his behavior occurred during his military service. There were no outstanding events except for one unsuccessful attempt to establish a relationship with a young woman also serving as a soldier in the IDF. He committed suicide during mid-service with no apparent signs of deterioration or distress and did not communicate his suicidal intentions.

The tragic narrative was found in about 21% of the sample (11 men, 3 women). This narrative starts with gradual success and experiences of well-being and satisfaction, leading to excellent functioning and superior achievement, and then descends dramatically and rapidly, usually due to a negative life event. The story of F is an example of such a trajectory. When F was drafted, she was full of expectations and hopes. She did very well in basic training and was sent to an officer’s course. As an officer, she was socially involved, enjoyed a good relationship with her boyfriend, was liked by her subordinates, and was appreciated by her commanders. It seemed that she was enjoying a soaring military career. She then began a new training course involving a more difficult group of trainees who exhibited more disciplinary problems than usual. This caused F to become depressed. A few weeks into her tenure as an officer in the new training course, she committed suicide.

The romantic narrative was identified in approximately 11% of the total sample (5 men, 2 women). The romantic narrative is characterized by fluctuations between a progressive and a regressive narrative, with extreme ups and downs in mental state and behavior. S’s army service narrative was labeled as romantic. He started his service in the army with a great deal of performance anxiety. He was described as distressed and anxious during basic training. However, following great effort on his part he completed
basic training with a satisfactory evaluation. He was assigned to paramedical training in which he did very well. At the end of the course, he was appointed to be a training instructor. At this time, he enjoyed great success and was feeling confident and competent. S was highly appreciated by his superiors. Then, during his service as an instructor, S’s girlfriend left him. He became depressed, and his functioning deteriorated. When a new training course began, S seemed to awaken with new energies and enjoyed the 3-month course. For a brief period of time, he began a relationship with a new girlfriend, but this relationship did not last long. Depressive moods and self-devaluation were noted again. He committed suicide a week after he had begun instructing yet another training course.

Table 1 presents the classification of triggers purportedly related to suicide, and information about the emotional state of individuals in the weeks prior to the suicide. In 69% (46) of the cases triggers could be classified, whereas in the other 31% no apparent trigger was identified. The categories were environmental stressors, interpersonal difficulties, and achievement failures. Two subcategories of environmental stressors were conflicts with army authorities (e.g., disobedience to authority and to the law, such as refusal to obey an order, suspicion of stealing) and change of environment (e.g., being moved to another unit). Two subcategories of interpersonal triggers were identified: romantic rejection and separation (e.g., a break-up with a girlfriend) and conflict with a close associate (e.g., fight with a family member, insult by a friend). Achievement failures included such events as failure in a course and disappointment over assignments to army duties. Our findings indicate a relative high proportion of the suicides were triggered by environmental stressor, findings that could possibly be unique to the particulars of the military system.

Table 2 presents the reports about emotional states and changes in duty functioning during the three weeks prior to the suicides. Five main emotional patterns were identified with respect to the observed emotional state prior to suicide: depression, agitation, mood swings, anxiety, and elation (positive mood). Chi-square analysis revealed a non-random pattern, $\chi^2 (5, N = 67) = 9.44, p < .05$, such that the most commonly identified emotional state was depression. Although most of the sample (71%) exhibited predominantly negative mood (depression, agitation, or anxiety),
**TABLE 1** Reported Triggers for Suicidal Crisis

<table>
<thead>
<tr>
<th>Narrative</th>
<th>Environment (Army) demands</th>
<th>Interpersonal relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Conflict with authority</td>
<td>Romantic rejection-separation</td>
</tr>
<tr>
<td></td>
<td>Change of environment</td>
<td></td>
</tr>
<tr>
<td>Regressive</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Stable</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Tragic</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Romantic</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>%</td>
<td>25.5</td>
<td>10.5</td>
</tr>
</tbody>
</table>
a surprising 29% of the sample did not exhibit such a pattern but rather exhibited mood swings and elation.

Depression was reflected in social isolation, decreased functioning, lethargy, expression of worthlessness, loss of appetite, disordered sleeping, and a tendency to cry. Agitation was manifested in tension, anger, hypersensitivity, hyper-reactivity, confusion, difficulties in concentration, catastrophic thinking, and outbursts. Anxiety was expressed through obsessive worrying, hyperventilation, fear of punishment, and anxiety regarding fulfilling one’s duty. Mood swings were characterized by swings between optimism and pessimism, complaints and satisfaction, social isolation, and social involvement. Elation was exhibited by signs of a positive mood and in communicating optimism and satisfaction.

Table 2 also presents changes in military duty functioning (i.e., the performance of various army duties such as training, commanding, guard duties, scholastic duties, etc.) during the last three weeks of life. Notably, no changes in army duty functioning were reported in the majority of the individuals who committed suicide (36 men, 12 women; about 71.5% of the sample). In other words, military duty functioning was judged as normal and appropriate by several different informants in the personal files. Only about 16% of the sample (7 men, 4 women) exhibited a significant deterioration in functioning. A surprising 12% of the sample (6 men, 2 women) appeared to be improving performance.

Table 3 presents the number and percentage of soldiers who communicated a direct suicidal intent (e.g., “I will shoot myself

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>Reports about Emotional State and Duty Functioning Three Weeks Prior to Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional state</td>
<td>Changes in duty functioning</td>
</tr>
<tr>
<td>Narrative</td>
<td>Depression</td>
</tr>
<tr>
<td>Regressive</td>
<td>18</td>
</tr>
<tr>
<td>Stable</td>
<td>4</td>
</tr>
<tr>
<td>Tragic</td>
<td>5</td>
</tr>
<tr>
<td>Romantic</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
</tr>
<tr>
<td>%</td>
<td>43</td>
</tr>
</tbody>
</table>
in the head’’; “this bullet is intended for my head”), indirect communication (e.g., “there is no reason to fear death”; “Somebody may kill himself”), or no suicidal intent. In some cases of direct communication, the soldiers denied any intent when questioned regarding their communication. As can be seen from our data, a wide majority of individuals (79%) expressed their intent either directly or indirectly. Table 3 also presents the number of cases in which there was an official referral or no referral by the military to mental health services, as well as the number of individuals who sought psychological help by themselves. In the majority of cases (64%), there was no psychological help provided within the military system. In some of these cases there was unofficial support provided by commanders who were in direct contact with the soldier, mostly through verbal encouragement, without further referral to a higher ranking officer. In 14 cases (21% of the sample), soldiers referred themselves to a mental health professional, but an ambivalent attitude toward professional help was noted in most of these cases. In 10 cases there was a referral to a mental health professional, and in 2 of these cases other steps were taken in order to prevent the soldiers from killing themselves.

We have also reviewed the detailed narratives in an attempt to assess the degree of congruence between the specific crises presented by the suicide attempters and the military official’s response. We were able to trace 16 cases of incongruence between the identified crisis and the action taken by the military among those who were not referred or did not seek mental health services by themselves. In 6 of the cases the soldiers exhibited coping

**Table 3** Reported Communication about Suicidal Intent and Military Response to Crisis

<table>
<thead>
<tr>
<th>Narrative</th>
<th>Direct</th>
<th>Indirect</th>
<th>None</th>
<th>Referred</th>
<th>None</th>
<th>Self-referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regressive</td>
<td>12</td>
<td>15</td>
<td>5</td>
<td>6</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Stable</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Tragic</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Romantic</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>28</td>
<td>14</td>
<td>10</td>
<td>43</td>
<td>14</td>
</tr>
<tr>
<td>%</td>
<td>37</td>
<td>42</td>
<td>21</td>
<td>15</td>
<td>64</td>
<td>21</td>
</tr>
</tbody>
</table>
difficulties and were invited for an interview with an officer in charge with no specific action taken. In 1 case a soldier was promoted to a higher rank and in another the soldier was promised to be transferred to a desired unit but the promise was not kept. In 4 cases of conflict with authorities (all of which accompanied by suicidal threats), two soldiers were put under peer watch only and two other soldiers were subjected to disciplinary actions. We also identified four soldiers with interpersonal problems with family, friends, and peers. All four received a temporary relief from army duty. Two additional cases of incongruence were found among those who experienced a failure in a course with noted depressive reactions. Both were transferred to different units without any kind of support. One soldier who was in deep mourning over a friend who died in combat received a temporary relief from his army duties. In many other cases we could identify appropriate but insufficient responses such as encouragements and friendly gestures. In the relatively small numbers of cases referred to a mental health officer we were unable to judge the extent of incongruence between the crisis and the therapeutic response. One exception is the case of H (see Table 4). H was training to be an officer and was struggling to complete her course. The mental health officer was mostly concerned with her mental status. No attempt was made on the part of the mental health officer to address her crisis by, for example, discussing her strong desire to become an officer or other possibilities to achieve her goal or parts of it.

**Discussion**

This study examined the last three weeks of life of 67 young suicide completers serving in the IDF, combining autopsy and narrative methodologies. The findings highlight the great variability of the types of life narratives leading to suicide and the asynchrony between the emotional state of an individual and his or her military duty functioning.

Regressive and romantic narratives, the most frequently identified narrative in our sample, are well known in the study of suicidal behavior and completed suicide (e.g., Fawcett et al., 1990; Graves & Thomas, 1991). Stable and the tragic narratives are reported less frequently and are documented in only a few case
**TABLE 4 Excerpts of H’s Life Story**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Details and impressions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>H was the second born in her family</td>
<td>Since adolescence, H suffered from eating disorders (anorexia). She did not get along with her parents. She had fights with her mother and was emotionally distant from her father (a military officer). It was reported that the relationship between the parents was also distant. She had no close friends, never had a boyfriend, and never had sexual relationships. She was reported to have a low self-image. The impression was that H had high self-expectations, was rigid and introverted. When her father became ill H became very close to him. (Source: personal files; army social workers who treated the family during the father’s illness.)</td>
</tr>
<tr>
<td>Adolescence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 1992</td>
<td>H’s father died of his illness.</td>
<td>From the moment her father died, H adopted his role in the family. Her life dream was to become an Army officer. (Source: social work officer.)</td>
</tr>
<tr>
<td>July 1996</td>
<td>H enlisted in the Army</td>
<td>H loved the service in the army just like her father. (Source: mother) During her military service, she had no notable disciplinary problems (Source: army personnel files.)</td>
</tr>
<tr>
<td>October 1997</td>
<td>H’s lieutenant informed H that her participation in the officer course was postponed for the time being.</td>
<td>According to her mother, when H received notice of being held back from the course, H cried a lot and stated that she would do her utmost to return to the course.</td>
</tr>
</tbody>
</table>
February 1998

H began the officer course. The files indicated that the commander’s evaluation was very good, but that H was slightly introverted. In the course, H functioned accordingly. A disparity was detected between her day’s routine conduct, characterized by a lack of self-assurance, and her performance of tasks, characterized by an ability to demonstrate a reasonable degree of efficiency (source: personnel file.) According to her course mates, H claimed on some occasions that the course was not important to her, and in other instances she stated, “If I will not become an officer, I will die.” Her friends described her as depressive and spoke of her crying a number of times. (Source: autopsy investigation.)

March 1998

Performance evaluation interview by the class counselor

According to the class counselor, during feedback for her performance, H made no eye contact throughout the entire conversation and appeared to be very concerned about the evaluation. The class counselor consulted with the mental health officer regarding H, and it was decided to grant H less difficult tasks, as well as to assist her as much as possible. (Source: report by class counselor.)

H had meetings with the head of the staff team.

H expressed concerns regarding her chances at completing the course and emphasized how important it was for her to be an officer.

(Continued)
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Details and impressions</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 22, 1998</td>
<td>H called G, her friend.</td>
<td>In the conversation, H said that she loved her very much and that she had been a very</td>
</tr>
<tr>
<td></td>
<td></td>
<td>good friend to her. In retrospect, G understood that H was saying goodbye. (Source:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>autopsy investigation.)</td>
</tr>
<tr>
<td>March 25, 1998</td>
<td>The team head informed H’s team that re-evaluation was going to take place in the following days.</td>
<td>H started to cry as she heard about the re-evaluations. (Source: personnel files.) H’s friends related that during the last three days, she often cried, (source: autopsy investigation.)</td>
</tr>
<tr>
<td></td>
<td>The head of the team, T, initiated an interview with H.</td>
<td>T noticed that H was stricken with sporadic outbursts of laughter, weeping, and anger. H said that the army meant everything to her and that she did not intend to complete her military service as a simple soldier. In light of this unusual behavior, she was referred to the commander of the battalion. (Source: report by the head of the team.)</td>
</tr>
<tr>
<td></td>
<td>The commander spoke with H and referred her to a mental health officer stationed at the base.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H left G (her friend) a message, asking to speak to her urgently.</td>
<td>In the message, H sounded nervous. (Source: autopsy investigation.)</td>
</tr>
</tbody>
</table>
The mental health officer met with H that night at 8 pm. During the meeting, H was emotionally detached, but not depressed and not suicidal. However, the impression was that she was under severe emotional stress. He was impressed that H experienced the re-evaluation process as a narcissistic injury and that succeeding in the course was a life or death issue for her. As a precaution, the officer recommended that H be placed under constant supervision by two peers. (Source: report by mental health officer.)

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 25, 1998 (at night)</td>
<td>At night, H behaved unusually. She frequently awoke, walked around the base and, at one point, wrote on a placard “the poem of bravery” and hung it by the entrance to the living facilities. The poem of bravery spoke of the willpower of man. (Source: autopsy investigation.)</td>
</tr>
<tr>
<td>April 1, 1998 (10:00 AM)</td>
<td>In the morning, H was invited to the second stage of the re-evaluation. She was notified that she was rejected from the course. H was referred for an additional meeting with the mental health officer. H did not demonstrate unusual behavior. At the end of the conversation, H said that she was surprised to find that the staff was successful at raising her problem so accurately. She was disappointed by the peers’ opinion (Source: summary by the base commander.)</td>
</tr>
</tbody>
</table>
### TABLE 4  Continued

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Details and impressions</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 1998 (11:09 AM)</td>
<td>Upon leaving the commander’s office, H ran in the direction of her charge dormitory on the 4th floor. Two of the peers who supervised her ran after her. Suddenly she grabbed a rifle from another soldier and ran into the ladies’ room and locked the door.</td>
<td>H agreed to speak only to the commander and told him: “I am nothing, I have no home or friends and the only thing that is important to me is to become an officer—otherwise there is no value to my life.” She added that she did not believe promises that she would become an officer because she was mentally disturbed. The possibility of breaking into the bathroom was considered. However, it was discovered that she was sitting on the toilet with the gun aimed at her throat. That possibility was ruled out. (Source: autopsy investigation.)</td>
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<tr>
<td>April 1, 1998 (1:30 PM)</td>
<td>At 1:30 PM, the commander asked H if she would like to tell him something. H said “thank you.” When asked for what, H muttered something, and a few moments later a string of shots was heard. H was found shot in the head. H was 21 years old at the time of her death.</td>
<td>When searching through H’s closet following her death, a pocket notebook was found where it was written: “H, may she rest in peace, was born in 1976. She was an outstanding officer in the military and went on to the field of medicine.” On her bed a sheet of paper was found with the “poem of bravery” on it. On the table in her room, a will was found. In it she left all her possessions to her little sister. (Source: autopsy investigation.)</td>
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*Details and circumstances were changed to insure anonymity.* H’s narrative was categorized as a progressive narrative, her suicide triggered by a personal failure. She was depressed; her duty functioning was characterized by a negative change. She made direct communications about suicide and was referred for psychological help.
studies (e.g., Maltsberger, 1997). In contrast to the first two narrative types, in the stable and tragic narratives suicide comes as a surprise, either because the individual discloses no sign of distress or depressive symptoms, or because the emotional state and functioning seem to be intact despite such symptoms. An apparent stability in functioning and even states of elation prior to suicide have also been identified by Maltsberger, who claimed that in some cases suicide can even be executed during ecstatic and hypomanic states. In these suicides, there is usually no acknowledgment of experiences of depression and the wish to die, nor are there obvious signs of significant risks or identifiable stressors or triggers. Thus, in addition to the more familiar paths of depression and impulsive acting out, some suicides emerge with no dysphoric warning.

The observations of positive changes in emotional state and in functioning during a suicidal crisis reported in our study call for further explanation. It is possible that external positive communications reflect a purposeful effort to hide the suicidal crisis and suicidal intentions in order to prevent any interference with the suicidal plan. Another possibility is that the expressions of positive affect are not directed at the environment, but rather serve an internal affect-regulatory function. Individuals may exert extra energy for self-regulation in this emotional state, attempting to elevate themselves above experiences of deterioration and disintegration. In fact, self-encouragement and an attempt to preserve a positive mood may reflect the attempt to cope with the suicidal crisis. When this coping mechanism is ineffective, they may turn to suicide.

Perhaps the most important aspect of our findings pertains to the frequent asynchrony between the emotional state of an individual and his or her military duty functioning during the last three weeks of life. The analysis of emotional state, when juxtaposed with the analysis of military functioning, suggests that although most of the suicide completers exhibited clear signs of emotional distress their duty functioning was hardly affected: 83% continued to function with no change and some even improved.

A somewhat similar phenomenon has been documented in inpatient suicide completers. In a recent study, Cassells, Paterson, Dowding, & Morrison (2005) found that approximately 50% of patients exhibited signs of improvements prior to committing suicide. The emergence of the improvement occurred mostly during
mixed states of bipolar disorders and during early stages of remission from major depression. Cassells and colleagues suggest that the return of normal levels of energy before other symptoms improve may facilitate suicidal tendencies, which have lain dormant, and allow them to become active once again.

However, whereas Cassells’s study examined inpatients, our study examined soldiers during active military duty who underwent selection procedures before they were drafted—clear signs of severe mental illness would have caused a rejection from the army. Furthermore, most of the soldiers exhibited a stable level of energy as evident by their high level of duty functioning. Thus, the dissociation between emotional states and army duty functioning could have been modulated by factors other than the regeneration of energy. Although individuals in our sample suffered from emotional distress that led to suicide, they were able to master internal resources sufficient to enable functioning under army demands. Thus, that emotional expression and efficient behavior may, in fact, be subject to the control of different mechanisms and processes. If so, it is possible that expression of emotions is regulated by the need to gain relief and the wish to be helped, whereas the highly structured environment regulates duty functioning. Alternatively, it may be argued that such a split between one’s emotional realm and observable functioning is inherent to many intense emotional experiences.

Most of the stressors that were reported as instigators of the suicides in the present sample can be characterized as related to difficulties in interpersonal relationships, in attaining achievements (e.g., separation, failure), or as problems in daily coping characteristic in closed system environments such as the army (i.e., administrative and legal problems; Borrill, 2002; Patterson, Jones, Marsh, & Drummond, 2001). In contrast to studies that included army personnel from Europe and the United States, neither our study nor Apter et al.’s study (1993), who investigated a sample similar to ours, reported substance abuse as a trigger. This discrepancy might reflect a cultural difference with regards to the prevalence of drug abuse or to differences in the types of triggers leading to suicide in different societies, and possibly also a difference in reporting.

Our analysis of the military’s response to the suicidal crisis yielded two additional major conclusions concerning help-seeking (by the suicidal individual) and help-provision (by others). With
respect to help seeking, most of our sample communicated either
direct (37%) or indirect (42%) suicidal intents, yet very few sought
help from available mental health services. These findings are con-
sistent with the findings of Robins (1981). Furthermore, very few of
the distressed young adults were willing to seek or accept pro-
fessional help when the suggestion was initiated by others. It seems
likely that suicidal individuals in our sample lacked confidence in
the usefulness of professional help. With respect to help provision,
army personnel and peers who received direct or indirect commu-
nications responded with an attempt to support the individuals
who communicated suicidal intents in various ways, but in the
great majority of cases did not refer them to professional help.

Why was no professional help suggested? First, the narratives
reveal that in many cases, peers and lower level army personnel
did respond positively to the distressed individuals by attempting
to provide social support, encouragement, and relief from difficult
duties. In many cases, this type of help indeed brought about a
temporary relief. At that point, the peers and army personnel
may have interpreted the temporary relief as a sign that the sup-
port provided was both proper and sufficient treatment, and thus
restrained from further action. Second, the review of the detailed
narratives reveals that individuals communicating their suicidal
intent may have appeared to be seeking a drastic and immediate
(and sometimes unrealistic) change in their life reality, such as
the ability and the power to prevent separation from a loved
one. This desire may have led their peers to assume the type of
help they were seeking was different from the type of help offered
by professionals. Finally, army personnel might have focused on
observable functioning and behavior, instead of on the emotional
distress. This is particularly true for the cases of the stable and tra-
gic narratives. This tendency may have contributed to a false nega-
tive assessment of the suicidal status and therefore to a withholding
from decisive intervention.

Our findings suggest that in an acute suicidal crisis it is neces-
sary that the suicidal individual receives concrete help specific to
his/her crisis. Sometimes help may entail immediate emotional
support (as in the case of the soldier who was in deep mourning
and was offered relief from duties instead of referral to therapy
for emotional support), and in other cases this crisis calls
for immediate action that has the possibility to be perceived as a
significant change in one’s life reality (e.g., being transferred to another unit), and may be more beneficial than empathy or emotional support. Such an approach may alleviate acute stress, and allow the individual to use better coping mechanisms. It is possible that had H (see Table 4) received concrete suggestions of specific strategies aimed at achieving some of her goals, rather than empathy, she might have deferred her lethal action. Army personnel may need to be educated not only to be alert to different forms of suicide trajectories, but also to serve as mediators for referrals to professional help even when there are signs of temporary relief in suffering and improved functioning.

Another implication of the present findings is that gauging evaluations on the level of overt functioning when other risk factors and hints of suicidal behavior are present may lead to false negatives in the assessment of the suicidal risk. Suicidal individuals can exhibit intact functioning despite the emotional distress and suicidal intentions. It is suggested that a high level of functioning does not preclude the risk of suicide and that emotional distress is a better indicator of future suicide. However, even emotional distress could be masked by a stable or tragic narrative. Suicidal individuals may present themselves with no overt distress or mood fluctuation, and may even exhibit positive affect. Thus, a stabilized or elated mood does not always mean that the suicidal risk is non-existent. Our findings suggest that once a person in crisis has hinted toward suicidal intentions directly or indirectly, he or she should be considered in danger until an in-depth evaluation has taken place. Not only absence of overt depression but even elated mood may coexist with a suicidal state of mind. Similar caution should be also adapted in the therapeutic process. Positive changes in mood or functioning should be carefully evaluated until a parallel stable change in behavior occurs, and cognitive and emotional coping is evident for a reasonable length of time. Moreover, the therapist may prepare the suicidal patients for fluctuations in his/her mood as a part of emotional state and help him/her cope with the temporary emotional fluctuations. Such a preparation in and of itself can help sustain the changes.

Our study suffers from several methodological weaknesses, the most central being the lack of a control group. Ideally, we would have liked to include a group of suicide attempters or of soldiers who accidentally died during training. Clearly, there are
almost insurmountable practical difficulties with the recruitment of relatives and commanders for such endeavors. Future research may attempt to resolve this problem. Second, a small sample size did not enable a comparison between men and women serving within the scope of this study. Third, our findings are affected by our specific subject population (young adults serving in the military) and needs to be extended to other age groups and settings. Finally, albeit the autopsy/narrative study can provide important insights into the suicidal state of mind, it should be borne in mind that much of the information was obtained after the suicide had already taken place. This inherent shortcoming could have caused a bias in the perception and interpretation given by the informants (although see Brent et al., 1988).

References


