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ABSTRACT

Although it has been stated that the majority of suicidal people give definite warnings of their suicidal intention, a percentage of suicidal people may dissemble (or mask), possibly 20%. The aim of this psychological autopsy (PA) study was to explore the mask of suicide, examining age and sex of the decedent, and survivors' relationship to the deceased. A PA study in Norway, with 120 survivors/informants, was undertaken. Overall, 80% of informants reported manifest and/or latent content of deception (dissembling); well above the 20% suggested. Three main themes emerged from the interviews of the 95 survivors that were related to the mask. In the opinion of the bereaved, reasons for the mask were due to: 1) Inability to adjust/impairment; 2) Relational problems; and 3) Weakened resilience. Differences in masking or (self) deception were found in the age of the decedent, but not in sex, nor in the survivors' closeness of the relationship. Older deceased people were perceived to exhibit more dissembling, associated to the suicide. Limitations are noted in this beginning study into the mask of suicide, and it is concluded that much greater research is needed to unmask the dangerous dissembling, maybe in some, self-deception.

KEYWORDS

Mask; psychological autopsy; (self) deception; suicide; survivors' narratives

"Suicide happens without warning" is a myth according to Shneidman and Mandelkorn (1967) (Leenaars, 1999, p. 349). However, another fact, according to Shneidman, was of 10 persons who died by suicide, eight have given definite warnings of their suicidal intentions (Leenaars, 1999). Therefore, he believed that 20% may mask their suicidal intention (Leenaars, 2010). In the 1990s, Shneidman (1994) had reconsidered his perspective on clues to suicide and he asked, "How it is that some people who are on the verge of suicide….can hide or mask their secretly held intentions?" (p. 395). Shneidman suggested that many clues are veiled, clouded, distorted and guarded, some even misleading. The communications, such as in a suicide note, may have a manifest content (e.g., "Happy Father's Day") and/or a deeper latent content (e.g., "I hope you are happy now"). There are (cognitive) distortions (e.g., All or nothing thinking) in what suicidal people communicate to a mother, relative, friend, doctor, and so on. Shneidman argues that these individuals live secret lives; they do not want other people to know about the unbearable pain (*psychache*) or mental disorder, for examples. Indeed, suicidal people (at least 20% or more) themselves may be unaware (unconscious), bewildered, and confused. Often they keep secrets, reflecting a basic coping style, with conscious and unconscious elements in the process (Bowers &

Meichenbaum, 1984; Leenaars & Lester, 1996). Shneidman calls the masks or walls, *dissembling*. To dissemble means to conceal one's motives. It is to disguise or camouflage one's feelings, intention, or even suicide risk. There may be self-deception.

Of course, secrets are universal; people keep secrets. This may be very true in suicide (and homicide). There are several types of secrets that have varying effects on wellness. Berg-Cross (2000) offered the following list of types: supportive, protective, manipulative and avoidant. It is probably true that supportive and protective secrets are often positive, and may even have healing value (Everson & Camp, 2011). Yet, the manipulative and avoidant secrets are never helpful in the wellness sense and are a source of anxiety, PTSD, depression, suicide risk, and homicide risk (Everson & Camp, 2011; Imber-Black, 1993). Dissembling may be one of the most lethal—if not the most lethal—aspects of the suicidal scenario. It is masking (or camouflaging) that kills so many. However, despite Shneidman offering arm-chair speculations, he did not undertake any research on dissembling and suicide risk (Leenaars, 1999). Goldblatt (1992) and Litman (1995) have separately observed that a small but a noteworthy percentage of patients who die by suicide are seen as having left no clues (maybe as low as 2%). For psychologists, psychiatrists and other mental health providers, the 20% is a great concern (Litman, 1995; Leenaars, 2004). Therefore, research is needed (D'Agata & Holden, 2018; Leenaars, 1996a, 1996b, 2017).

Studies on the Mask of Suicide

Many researchers from around the world have used different methods to study suicide. Shneidman and Farberow (1957), Maris (1981), and others have suggested the following avenues: national mortality statistics, third-party interviews (often called psychological autopsies [PA]), the study of non-fatal suicide attempts, and the analysis of documents (such as suicide notes). All of these avenues have their limitations. Mortality statistics by themselves reflect only numbers and are, at best, only a representation of the true figures. A third-party interview, such as in a PA, can only provide a point of view, which is not necessarily the suicide's view. Non-fatal attempters may be different than fatal suicide deaths. Documents may provide, to use Maris' words (1981), only a snapshot of an event that requires a full-length movie. Yet, each of these methods has been shown to also have benefits and to extend our understanding of suicide and suicidal behavior (Hawton & van Heeringen, 2000; Leenaars et al., 1997).

To the best of our knowledge, there are no studies on masking and mortality statistics, suicides and non-fatal suicide attempts. Suicide ideation is a poor proxy (D'Agata & Holden, 2018) for suicide attempts and deaths; however, low suicide risk populations are easy to recruit for study. There are two studies in the literature. Friedlander, Nazem, Fiske, Nadorff, and Smith (2012) found in a sample of undergraduates, who completed on-line questionnaires, that there may be an association between dissembling and suicide ideation. D'Agata & Holden (2018) also, using an on-line post (Amazon's Mechanical Turk), found in a sample of 295 people who completed questionnaires, associations between dissembling and psychache and dissembling and suicide ideation. However, as D'Agata and Holden note, the sample is a fallible proxy and studies of people who died by suicide are needed. Thus, from these two studies on people with

suicide ideation, at this time, no causal link can be made. To answer the question in this study, we need to look at the other sources of data: suicide notes and the PA.

Historically (Frederich, 1969), the following methods of suicide note analyses have been used: descriptive/content, classification (such as male/female), and theoretical-conceptual. Shneidman and Farberow (1957) have argued that the theoretical-conceptual approach offered the most promise. Leenaars developed a theoretical-conceptual analysis, which uses a theory (construct, schema) approach to understand the event, grounding the data in a foundation of science (Ayer, 1959; Carnap, 1959; Cronbach & Meehl, 1955; Hempel, 1966; Kuhn, 1962; Millon, 2010). The method utilizes a thematic-conceptual analysis of samples of suicide notes (see, for example, Leenaars, 1988, 1989, 1996a, 2017; and see Leenaars & Balance, 1984, for the methodology.) From the research, Leenaars (1988, 1996a, 2007, 2017) developed a multidimensional model of suicide.

Briefly, suicide is *intrapsychic* (mind). However, suicide is not only intrapsychic, it is *relational,* often interpersonal. (We have attempted to update terms and language, based on research and more current terms; e.g., "weakened ego" is now "weakened resilience.") Here are five main clues (evidence) of the suicidal mind that we have learned:

I. *Unbearable Psychological Pain*
The common stimulus in suicide is *unbearable* (unendurable) psychological pain, psychache (Shneidman, 1985, 1993). The suicidal person is in a heightened state of perturbation, an intense mental anguish. It is especially the feeling of hopelessness-helplessness that is so painful for many suicidal people. The suicide is functional because it abolishes the pain and provides what the person perceives as "the best solution."

II. *Cognitive Constriction*
The common cognitive state in suicide is mental constriction. Constriction, i.e., rigidity in thinking, narrowing of focus, tunnel vision, concreteness, etc., is the major component of the cognitive state in suicide. The suicidal person is figuratively wearing horse blinders, and is intoxicated by the blindness. Although there are more cognitive distortions (beliefs) in the suicidal mind, something is almost *always* either A or not A (i.e., black and white thinking).

III. *Indirect Expressions and (Self)Deception*
Ambivalence is the common internal attitude to suicide. There are indirect expressions, i.e., there are concomitant contradictory feelings, attitudes, and/or thrusts, often even toward life. Indeed, the suicidal person may be least aware of, or perplexed by the reasons *why* death is chosen (self-deception). It may be unconscious. There are likely more reasons to the suicide than the person is consciously aware of and/or communicates.

IV. *Inability to Adjust/Psychopathology*
People with all types of pains, problems, psychopathology, etc., are at risk for suicide. Many people who died by suicide appear to suffer from mental disorders (e.g., depressive disorders, bipolar disorders [manic-depressive disorders], anxiety disorder, borderline personality). Yet, a relatively large number of cases

may be most consistent with a disorder not otherwise specified. They are basically totally paralyzed by pain and have no reason for living.

V. *Weakened Resilience(Ego)*
Resilience (or ego-strength) is defined as the capacity to adapt successfully in the presence of risk and adversity (Meichenbaum, 2012). It is the ability to adjust to challenging life experiences and even suicide risk. The suicidal mind lacks resilience or ego strength. Ego strength is a protective factor against suicide. Suicidal people, however, frequently exhibit a relative weakness in their capacity to develop constructive tendencies and to overcome their personal or system adversities (Zilboorg, 1936).

There are three main clues (evidence) of the suicidal relational (often relationship[s]) context that we have learned:

VI. *Interpersonal Relations*
The suicidal person has problems in establishing or maintaining attachments (with a person[s] or with another ideal[s]/relation[s], such as employment, health). Most frequently, there was/is a current and/or longstanding disturbed, unbearable interpersonal problem. The person's psychological needs were frustrated (Murray, 1938). Suicide appears to be related to an unsatisfied or frustrated attachment need (to a person and/or another relation/ideal), although other needs, often more intrapsychic, may be equally evident.

VII. *Rejection-Aggression*
Wilhelm Stekel first documented the rejection-aggression hypothesis in suicide (Leenaars, 1988). Loss is central to suicide; it is, in fact, often an interpersonal rejection or abandonment, although the loss can be another relational ideal (health, for example). It is an unbearable narcissistic (defined as excessive self-centered, all-encompassing, overwhelming, *unbearable*) injury. This injury/traumatic event(s) leads to unimaginable pain (psychache) and in some, maybe many, masking and (self-directed) aggression. Aggression is, indeed, a common emotional state in suicide.

VIII. *Identification-Egression*
Freud (1917/1974) hypothesized that intense identification with a lost or rejecting person or, as Zilboorg (1936) showed, with any lost relation/ideal (e.g., health, youth, employment, and freedom) is crucial in understanding the suicidal person, and especially the suicidal relationship(s). Identification is defined as an attachment (bond), based upon an important emotional tie (relation) with another person (object) or any ideal. If this emotional need is not met, the suicidal person experiences a deep pain (discomfort). There is an intense desperation and the person wants only to egress. Suicide is *escape*.

In concluding, from decades of study, we have shown (Leenaars, 1989, 1996a, 2007, 2017) that the theory proposed is useful and may allow us to understand the event and dissembling better.

Independent research on suicide notes (Niveau et al., 2019; O'Connor, Sheeby, & O'Connor, 1999), investigations of suicidal Internet writings (Barak & Miran, 2005) and

biographical studies of suicides (Lester, 1994) have supported the utility of Leenaars' approach to suicide notes, or any narrative analysis (e.g., survivors' narratives, Twitter posts). Independent studies of inter-judge reliability (e.g., O'Connor, Sheeby, & O'Connor, 1999; Barak & Miran, 2005) and four decades of study by Leenaars and international collaborators show that the percentage of inter-judge agreement has been satisfactory (>85%; see Shaughnessy, Zechmeister, & Zechmeister, 2000; Siegel, 1956). Cross-cultural validation has also been established among different countries (i.e., Australia, Canada, Germany, Hungary, India, Lithuania, Mexico, Russia, the United Kingdom, the United States, and Turkey).

A specific series of studies (Leenaars, 1987; Leenaars, Balance, Wenckstern, & Rudzinski, 1985) on Shneidman's formulations (1980, 1981, 1985) of suicide revealed that an important aspect of suicide was unconscious (unreported) processes; i.e., there are likely more reasons to the suicide than the person is consciously aware of and/or communicated. (Of course, it is possible that the person intentionally [consciously] dissembled in his/her note.) Distorted, clouded, guarded, and even misleading statements were observed in over half (75%) of all genuine suicide notes studied, regardless of age or sex. It was also found that unconscious processes were significantly more often found in genuine suicide notes than, matched for age and sex, simulated (control) suicide notes (Leenaars, 1986). Of course, theorists tend to disagree generally about what lies behind deception, faking, and even (unconscious) self-deception. It is, hence, understandable that individuals may agree that the suicidal person was dissembling but would conceptualize these exceedingly complex issues differently, and perhaps so would survivors in PA studies. However, we do know for a roadmap ahead, from Leenaars' study (1987), that the masking processes are most likely associated with *interpersonal* aspects in the suicidal scenario.

The largest challenge in studying the mask may well be: How do you verify not conscious communication (even if self-deception)? One latent thematic approach was suggested by Foulkes (1978). Foulkes Scoring System for Latent Structure (FSSLS) (1978) is an objective rule-following (linguistic/cognitive) system to describe the types of distortions that commonly occur in manifest narratives (such as notes, on-line posts and dreams). McLister and Leenaars (1988) and Leenaars and McLister (1989) examined genuine and simulated suicide notes, utilizing FSSLS. The studies showed that, indeed, more masking (distortions) was identified in genuine notes according to pre-established operational definitions. Of the 33 genuine notes, 21 contained distortions, almost 2/3 (64%) of the notes. Of the 33 simulated notes, 12 contained distortions, about 1/3 (36%) of the notes. Therefore, the FSSLS study appears to corroborate the observational studies of suicide notes, using Leenaars' theoretical-conceptual analysis.

We believe something latent is often present in suicide (Leenaars,1996b; Leenaars & Lester, 1996); yet, the question remains: what are these processes? To answer that question, our current study must examine both the manifest and latent levels (Braun & Clarke, 2006). Can we find corroborative evidence for the role of dissembling with other sources of data than suicide notes, clinical observation, and the study of suicide ideation in low-risk groups? Our study will be to examine the thematic content in the survivors' stories, by way of the psychological autopsy. What do survivors know about the hidden? Verification is, of course, a basic in science (Ayer, 1959; Millon, 2010).

The Psychological Autopsy

The psychological autopsy (PA) is the work of Shneidman (Leenaars, 1999). The psychological autopsy (PA) is a method for collecting data on psychological and contextual circumstances related to suicide (Curphey, 1961; Leenaars, 1999, 2017; Litman, Curphey, Shneidman, Farberow, & Tabachnick, 1963; Shneidman, 1977, 1993, 1994). A psychological autopsy is an objective procedure that seeks to make a reasonable determination of what was in the mind of the decedent vis-à-vis his or her own death. It does this by looking at the history of the decedent, the lifestyle, the intrapsychic and interpersonal characteristics, the cognitive style, the psychopathology, and so on. The psychological autopsy is primarily performed by talking to some key persons – spouse, lover, parent, grown child, friend, colleague, physician, supervisor, and coworker – who knew the decedent. Of course, a major limitation is that the story learned in a PA is the survivor's beliefs, not the deceased's beliefs (Leenaars, 2017; Maris, 1981), something the study of suicide notes attempted to address (Shneidman & Farberow, 1957).

The PA is a generally accepted way of studying suicide. Conner et al. (2011); Hjelmeland, Dieserud, Dyregrov, Knizek, and Leenaars (2012); and Pouliot and De Leo (2006) have concluded that the PA remains the largest validated approach to understand the psychological and contextual circumstances in suicide. This does not mean that the PA is not without controversy (Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012; Leenaars, 2017; Pouliot & De Leo, 2006). In their review paper, Pouliot and De Leo (2006) noted the following: ill-defined informants and other structural weaknesses highly reduce the material from where one can infer significant elements of the suicidal process.

There is only one PA study that comments on the association of secrecy and suicide (Rudestam, 1977). Rudestam, using a structured interview with 39 surviving family members examined the impact of suicide on survivors. Although the main focus was on the "severe" and "enduring" physical and psychological effects, he noted that 50% of survivors reported that they were completely unaware of the suicide risk before the death. Only 25% reported that there were manifest clues to the suicide. Therefore, it was established that 75% of suicidal people may have been masking or dissembling before the deaths. The present study is part of a PA study of suicides at the Norwegian Institute of Public Health, Oslo, Norway. The deceased had no previous history of suicide attempts or treatment in mental health care. Through the lens of thematic-conceptual analyses, the focus on the mask of suicide given by five to nine informants, related to each of 20 suicides, is presented.

Suicide notes, like any narrative, are available to thematic interpretation, similar to the protocols of survivors. A decision in a thematic analysis revolves around the 'level' at which themes or constructs are to be identified, whether at an explicit manifest level or at a latent level (Boyatzis, 1988; Braun & Clarke, 2006). At the manifest level, the observation and interpretation are explicit and at the surface. One does not look for anything beyond what the person said or wrote. One may theorize to broader meanings or theory (Braun & Clarke, 2006; Patton, 1990); yet, every interpretation must be obvious to everyone at the manifest level. This is not common in the practice of psychology; even concepts like "depression" or "suicidal" are constructs that are not simple but call for construction (Leenaars, 2017; Millon, 2010; Zachar & Kendler, 2010). In contrast to

manifest analysis, a thematic analysis at the latent level goes beyond the simple and obvious explicit content, examining the underlying ideas, assumptions, and conceptualizations (Braun & Clarke, 2006), such as even determining lethal suicide risk. The primary difficulty in conducting research on latent concepts (and constructs, such as distorted thinking or masking) is that observation and interpretation may be subjective (Kerlinger, 1964). The latent thematic analysis involves interpretative work; it is analysis at a deeper level, more like developing constructs (Burr, 1995; Millon, 2010: Zachar & Kendler, 2010). It is constructionism (Burr, 1995; Leenaars, 2017). One looks at not simply the conscious processes, but also at more complex ones, such as found in feigning, deception, and even self-deception. Of course, if one wants to uncover the mask, one must look deeper, beyond what is intentionally presented. It is often more than what is said or written at a manifest level.

As discussed, from over decades of studies of suicide notes, Leenaars (1988, 1996a, 2017) developed a multidimensional model of suicide. Leenaars et al. (2018) undertook a PA study to corroborate Leenaars' theory, examining age and sex of the decedent, and survivors' relationship to the deceased. A PA study in Norway, with 120 survivors/informants, was undertaken (see Landis & Koch, 1977; Leenaars, 1988, 1996a, 2017). Overall, there was considerable confirmatory evidence of Leenaars' intrapsychic and relational (interpersonal) factors in suicide survivors' narratives. In the Leenaars et al. 2018 study, in-depth thematic analysis of the protocol sentences or categories was not undertaken. The thematic examination of (conscious and/or unconscious) dissembling and suicide will be the purpose in this paper. The specific protocol examined pertains to the presence (communication) in the survivors' narratives for conscious (deception) and/or unconscious (deception and/or self-deception) processes or dynamics. We investigate whether there are likely more reasons to the suicide than the person (*deceased and/or survivor*) is consciously aware of and/or reported. The two independent judges objectively reconciled scores for informants' protocols for conscious and/or unconscious processes (dynamics) in the Leenaars et al. (2018) study will be examined. In that study, the judges' agreed upon observation for conscious and/or unconscious processes of deception was 95 (out of 120) informants; thus, 79.2%. The thematic examination of dissembling in the 95 informants' protocols was the purpose in this paper. Sixty-five per cent of the informants (78 out of 120, 65.0%) actually reported manifest dissembling (deception) of some type in the decedent (e.g., "He was very closed"; "He was very concerned about his façade"; "Faking it".) Thus, the judges in that study inferred in only an additional 17 survivors some type of *unconscious* (more latent) processes in the protocols, only 14.2% (e.g., clinical judgment, presence of cognitive distortion, contradictions among informants within a case (["We never had any problem, as he grew up. We were always happy", versus "He was, as a child, horribly abused; that pain killed him. He was always unhappy"], patterns/meaning units across the survivors of a decedent [e.g., family dynamics]). Therefore, given the manifest statements of the mask, we can be more definitive about our findings; furthermore, we believe, for obvious reasons of clinical risk, it is essential that such latent content cases are included in any study of the mask in suicide.

Not only may the memory of informants in PAs be unreliable, but also as close survivors may actively be denying any role in the suicidal process (Lester, 2004); thus, it is

important to secure information from many informants, and to include informants who position themselves in different ways to the deceased. This may be crucial in getting the kind of information we need to be able to understand the masks behind suicides. Based on the assumption that suicide is an act of communication, the informants' narratives are expected to reflect the stories behind the deaths, and to give as rich a picture possible of the dissembling. For the closest relatives, for example, the narratives may be so influenced by shameful feelings that they look outside of the family to find explanations (blaming work, colleagues, lovers, spouses). This may be particularly true for parents of deceased youngsters. Parents' narratives may be influenced by a need to restore their own and their child's moral reputation (Owens, Lambert, Lloyd, & Donovan, 2008). Therefore, survivors too may consciously and/or unconsciously dissemble. In particular, the closest informants may downplay information that reveal family conflicts and put themselves in a shameful position regarding the mental pain of the deceased. Our conceptualization of suicide, thus, may be highly enriched by interviewing several informants around each case. As in forensic science (Leenaars 2017), by exposing divergent views that may come to fore when interviewing several individuals who knew the deceased well, it is our aim to demonstrate the difference between relying on one or two close informants in juxtaposition to gathering information from multiple informants.

The purpose of this research, thus, is to present the findings of this corroborative PA study with what is known from the suicide notes and other studies (D'Agata & Holden, 2018; Friedlander et al., 2012; Rudestam, 1977; Leenaars, 2004, 2017), a step in examining the mask of suicide (Cronbach & Meehl, 1955: Millon, 2010). We will also look at the age and sex of the deceased. The final purpose is to examine the communications about not presenting consciously the real psychological and contextual circumstances related to the suicide, of spouses/(ex)partners, (step)parents and grown children ($n = 47$) vs. other informants (e.g., doctor, friend, boss) ($n = 65$). The PA will be the method employed here to further test the presence or absence of dissembling in suicide; basically, the question asked, as observed by Rudestam (1977), does the observation of masking in suicide have convergent data in a PA study? Thus, the aims of this study are: 1) Exploring the phenomenon of dissembling and suicide in survivors' narratives; 2) examining the suicides' age and gender differences; and 3) examining the differences among informants; that is, close vs. more distant relationships.

METHOD

Procedure

Based on death certificates and forensic reports, chief municipal medical officers in all municipalities of the seven counties with the highest suicide rates in Norway in 2003, were asked to identify suitable cases of suicide. Data were collected from 2007−2009. The chief municipal medical officers provided the name of the general practitioner (GP) of the deceased, and asked the GPs to ensure the exclusion of cases with a history of suicide attempts and/or treatment in mental health services and to identify the name and address of next of kin. Based on this information, the chief municipal medical officer sent a letter to the next of kin. The letter provided information pertaining to the

project and requested the return of a consent form to the project leader (second author). After written consent was received, the interviewer contacted the next of kin by telephone and arranged a time and place for the interview. After the interviews were completed, the informants were asked to provide names and addresses of other knowledgeable informants (the snow-ball method). The project leader sent a letter requesting them to participate, and the interviewer called them after a written consent was received. The procedure of recruitment was repeated until at least five informants (in one case four) had been included in each case. When the researchers used the snow-ball method, they used key informants (mostly parents or partners of the deceased) to recruit other informants who had known the deceased in various contexts and in different epochs of life. These would be central persons high in the "grief hierarchy", persons who had been close to the deceased. Recruitment was stopped when no new information seemed to be presented, or the informants did not have suggestions for further relevant informants.

Sample

The sample consisted of five (four in one case) to nine (in one case) key informants from each of 20 suicide decedents. Altogether, 120 individuals were interviewed. In most cases there were five informants (40%), followed by six (25%), seven (15%) and eight (10%), whereas two of the deceased (10%) were represented by four or nine informants. The informants included spouses/(ex-)partners ($n = 15$); (step)parents ($n = 25$), grown-up children ($n = 7$), siblings ($n = 19$), in-laws ($n = 5$), aunts/uncles ($n = 2$), cousins ($n = 2$), near friends ($n = 37$), (ex)girl/boyfriends ($n = 2$). In addition, one neighbor and 5 work colleagues were interviewed. Fifty-five (46%) of the informants were women; and 65 (54%) were men, ranging between 18 and 82 years of age (M = 36).The mean of the number of close (e.g., a parent) informants was 2.4 (SD = 1.0: range 0–4). The mean of "other" (e.g., a friend) was 3.6 (SD = 1.1; range 2–6). The total mean of the informants was 6.0 (SD = 1.3; range 4–9). The age of the deceased ranged from 19 to 61 years (M = 35.8; SD = 15.1). If we take the mean as the cutoff point, there were 9 older suicide decedents and 11 younger suicide decedents. (This was our definition of old and young in this study.) The female/male ratio was 4:16. There were only four females and 16 males, warranting *a priori* caution about subsequent comparisons. The methods of the suicides were hanging/strangling (12), shooting (6), CO-poisoning (1), and drowning (1). Regarding employment, 11 were employees (two on sick leave), four were students, two were company owners, one had quit the job voluntarily, one was unemployed but planning studies, and one was on disability pension. Nine of the deceased were married/cohabitating, three were living by themselves after having experienced a recent break-up of love relationships, one was divorced several years before the suicide, five were single without a girlfriend/boyfriend and two were living by themselves but were in love relationships.

Interviews

All interviews (i.e., narratives and in-depth interviews combined) were conducted by three researchers/clinicians with extensive experience and knowledge in the field of suicidology as well as in-depth interviewing of suicide bereaved individuals (Drs. Gudrun Dieserud, Kari Dyregrov, and Mette Lyberg Rasmussen). All the suicides took place in the time period 2007−2009, and in all except one case, the interviews were conducted between 6 and 18 months after the suicide (M = 8.7). In one case, the interviews took place 24–27 months after the death. Each interview lasted approximately 2.5 h (range 1.5–3 h). Most of the interviews were conducted in the homes of the bereaved, and some in the researchers' offices or hotels, depending on the preferences of the informants. The interviews were audiotaped and transcribed verbatim. Brief notes about immediate impressions were written by the researchers after each interview. In order to strengthen the inter-rater reliability of the transcriptions, a coding system for paralinguistic expressions (e.g., pauses, laughter, crying) was used by two trained transcribers. All transcripts were overseen by the interviewers.

The interview consisted of a combination of a narrative part and follow-up questions. The narrative started with the opening question: "What are your thoughts on the circumstances that led to the suicide of X?" The informants were asked to talk freely about their own perceptions. Thus, this initial part of the interview was primarily governed by the informants, where the informants told about their own experiences of the deceased in their own words. After the narrative part of the interview, the interviewer asked pertinent follow-up questions, based on a standardized theme guide developed by Shneidman (and his co-investigators, Norman Farberow and Robert Litman [Leenaars, 1999, 2017]). Toward the end of the interviews, the informants were asked whether there was anything further that they wanted to tell the interviewer.

After the interviews, a debrief session was held, to ensure that no informant was left in distress. Arrangement for follow-up was made when needed (one informant asked for professional assistance related to family conflicts and in two other cases, names of professsionals were given in case some other persons in the families would want to see someone).

Data Analysis

In the Leenaars et al. (2018) study, in-depth thematic analysis of the protocol sentence on unconscious (dissembling) processes was not analyzed; there were 95 survivors who identified that the person who died by suicide was perhaps dissembling or masking. The thematic examination of dissembling in the 95 informants' protocols will be the purpose in this paper.

Thematic analysis was conducted by the senior author of all scores associated to having a defensive intent, conscious and unconscious, including meaning condensation and categorization and concluding with themes of dissembling (Kvale, 1996). We follow an evidence-based qualitative and quantitative approach (Ayer, 1959; Boyatzis, 1988; Braun & Clarke, 2006; Burr, 1995; Cronbach & Meehl, 1955; Smith, Flowers, & Larkin, 2009). Like in the suicide notes, we are mindful that our themes must be verifiable in the actual protocols (Carnap, 1959; Leenaars, 2017). The analysis followed the five-step

phenomenological based procedure suggested by Giorgi (1975) and later by Kvale (1996). A detailed examination of the transcriptions of the interviews, that searched for the informants' awareness of the deceased's dissembling, was performed. The first step required that, after the interviews had been conducted, tape-recorded, transcribed, and translated (Leenaars et al., 2018), the interview was read through to get a sense of the whole. Then, phrases or sentences ("meaning units") that directly pertained to the conscious and unconscious mask of suicide were marked in the transcriptions. Third, the categories that dominated the meaning units were stated as simply as possible, as these were understood by the researcher (the first author). The fourth step consisted of integrating the meaning units and categories in terms of the specific purpose of the study. After having analyzed the expressions of masking of the informants around each deceased ("cluster"), we compared all 20 groups with each other, looking for common themes. Since the present study is concerned with the identification of potential differences/similarities in the informants' understanding of the mask of suicide, the analyses were carried out with an awareness of the relationship between the informant and the deceased. This involved comparing observations from informants who shared the same position to the deceased, as well as across all of the interviews related to each suicide. In this way, by letting the relationship between the informant and the deceased be included in our analyses of their narratives, the researchers interpreted the informants' interpretations of the deceased through the informant-deceased relationship (Smith et al., 2009). Repeated evidence of similar experiences across the interviews resulted in the identification of conscious and unconscious dissembling themes. In the final step, the mask themes from all the interviews were linked together into descriptive statements of the core components of the phenomenon (Kvale, 1996). Perhaps the process for some quantitative researchers may be seen as too heuristic; yet, from the first author's examination, it is quite consistent with the accepted method of systematic literature review (Mann et al., 2005); they are both bottom-up methods.

Critical questions about the interpretations were continually asked during the data analysis. The validity of the analyses was based on consideration on three levels (Yardley, 2008). First, by interviewing 5–9 individuals who were close to the deceased, it is assumed that we are exposed to a variety of explanations as to the suicide mask, dependent on the relationship to the deceased. Second, through a critical examination of the verified protocol sentence (Leenaars et al., 2018) attempts were made to reduce researcher/interviewer bias. Third, by presenting the total selection of meaning units related to the core question to the first author, the validity and credibility of the data set were sought to be strengthened. Of course, like in a systematic literature review, it is possible for the researcher to be unaware (unconscious) of alternative constructions.

Importantly, in applying a manifest and latent thematic mode of analyses, the researchers were not only looking at pieces of text (as in content analyses), but the analysis was carried out in a process of examination, not a single read, going back and forth in each interview text as well as back and forth between cases (i.e., the informants around each deceased). In order to make sense of the informants' personal world, we acknowledged the influence of the researchers' own conceptions and pre-knowledge. The connectedness to the interpretative tradition was important and included both an

TABLE 1. Frequency and percentage of agreed upon endorsement for the three main themes of the suicide mask.

	Inability to Adjust/Impairment	Interpersonal	Weakened Resilience
Total (out of 95)	60 (63.2%)	90 (94.7%)	92 (96.8%)
Young (out of 45)	32 (71.1%)	45 (100%)	45 (100%)
Vs.			
Old (out of 50)	28 (56%)	45 (90%)	47 (94%)
Male (out of 78)	49 (62.8%)	74 (94.9%)	77 (98.7%)
Vs.			
Female (out of 17)	11 (64.7%)	16 (94.1%)	15 (88.2%)
Close (out of 35)	21 (60%)	30 (85.7%)	32 (91.4%)
Vs.			
Other (out of 60)	39 (65%)	60 (100%)	60 (100%)

effort to understand the participants' point of view (being empathic) and the asking of critical questions to the data. Thus, in the thematic analysis, researchers are encouraged to remain close to their informants, but also to move beyond the text to a more interpretative and psychological level (Smith et al., 2009). These are perhaps the deeper latent constructions. In these efforts, the possibility of coming closer to understanding suicidal phenomena would be greater on the basis of information from many informants, rather than from one or two survivors.

Ethical issues

The project was conducted in accordance with the The Declaration of Helsinki (The World Medical Association 2008), as well as research experiences with vulnerable individuals (Dyregrov, 2004). The project was approved by the Data Inspectorate and the Norwegian Regional Committee for Medical Research Ethics South. Informants had the right to withdraw at any time from the study. Identifying information about the deceased and the informants have been altered in the publication process in order to protect anonymity. A clear direction in the ethical approval given multiple informants for each suicide, was that no identifying data, including relationship, age, sex, etc., were allowed to be published in any study. This specific ethical demand may limit some important observations; however, we respect the decision in this study. The purpose, the procedure and issues of confidentiality of the study were repeated to informants when they were contacted by telephone and prior to commencing the interview.

RESULTS

The thematic analyses of the 95 informants, who exhibited manifest and/or latent content about the decedent's mask, revealed three superordinate themes associated to the mask. In the opinion of the bereaved, reasons for the dissembling, conscious and/or unconscious, were due to: 1) Inability to adjust/impairment; 2) Relational problems; and 3) Weakened resilience. From the survivors, we learn that the common stimulus in suicide is *unbearable* (unendurable) pain, psychache (see Shneidman, 1985, 1993). The suicidal person was seen as in a heightened state of perturbation, an intense *anguish*. The decedent was primarily seen as wanting to flee from a painful trauma, impairment, interpersonal problem, etc.—a wide array of intrapsychic and relational specters. The

informants reported any number of painful emotions; they included despair, anguish, anxiety, boxed in, rejected, depressed, deprived, forlorn, shame,disgrace, distressed, and especially, hopeless and helpless. Yet, the person masked. Table 1 presents the frequency and percentage of observed main themes of the suicide mask, total, young vs. old, male vs. female, and close vs. other (see Table 1).

Three themes from the survivors' protocols emerged as central to the question: Why do people dissemble (mask) problems, pain, self, suicide-risk, and more?

Inability to Adjust/Impairment

People with all types of pains, impairments, problems, etc., are at risk for suicide; impairments, however, are common. Impairment may be any loss or abnormality of psychological or physiological or anatomical structure or function (WHO definition). Informants reported mental problems, physical impairment/disability, anxiety, depression, alcoholism, ADHD, dyslexia, sleep disturbance, chronic pain, gambling addiction, and more. From the survivors, we learn that suicidal people see themselves as in unendurable pain, paralyzed, and unable to adjust. Therefore, according to the bereaved, the decedents wore a mask. Furthermore, the informants believe that the decedents were too weakened to overcome difficulties, even with the dissembling, or maybe because of it, and did not survive life's adversities (e.g., "He could not take it any longer.").

Relational Problems

The suicidal person has problems in establishing or maintaining attachments (with a person[s] or with another ideal[s], such as employment). Most frequently, there was/is a current and/or longstanding disturbed, unbearable interpersonal problem, although other relational (attachment) problems were evident. A calamity prevailed; some of the reported problems were: relational (marital) break-up, abuse in childhood, death of a parent, parental divorce, family secrets, parental conflict, bullied at school, loss of job, work-related problems, business failure, unaccepted by a person (e.g., lover, father, mother), divorce from partner, separated from lover, and more. A positive development in those same disturbed relational aspects may have been seen as the only possible way to go on living, but such a development was seen as not forthcoming. Loss, rejection, abandonment, etc., most often in the interpersonal realm was seen as an unbearable narcissistic injury (although the injury may, for example, be at the workplace or school). The person's psychological needs were frustrated. Based on Henry Murray's outline of needs (Leenaars, 2017; Murray, 1938), the following list was most evident in the informants' narratives: autonomy, counteraction, dominance, harmavoidance, infavoidance, inviolacy, and rejection (see Table 2 for definitions). The injury and frustrated needs led to *unbearable* pain and in some, maybe many, masking, and finally death.

Weakened Resilience

Resilience (or ego-strength) is the ability to adjust to challenging life experiences (such as impairment or relational problems) and even suicide risk. It is a

TABLE 2. A partial list of Murray's Psychological Needs evident in the survivors' narratives.

Autonomy. To get free, shake off restraint; break out of social confinement; avoid or quit activities of domineering authorities; be independent and free
Counteraction. To make up for failure by restriving; overcome weakness or repress fear; to maintain self-respect and pride on a high level; overcome
Dominance. To control other humans; influence or direct others by command, suggestion or persuasion; or to dissuade, restrain or prohibit others
Harmavoidance. To avoid pain, physical injury, illness and death; escape from a dangerous situation; to take precautionary measures
Infavoidance. To avoid humiliation; avoid or quit conditions that lead to scorn, derision, indifference or embarrassment
Inviolacy. To protect the self; remain separate; maintain distance; to resist others' intrusion on one's own psychological space; remain isolated
Rejection. To exclude, abandon, expel, separate oneself or remain indifferent to a negatively seen person; to snub or jilt another

distinct concept from psychopathology (Leenaars, 1989, 1996a; Meichenbaum, 2012). The ego with its enormous complexity is an essential factor in the suicidal scenario. The OED defines ego as "the part of the mind that reacts to reality and has a sense of individuality." Ego strength or resilience is a protective factor against suicide. The person's ego had likely been weakened by a steady toll of reported traumatic life events (e.g., loss, rejection, bullied, sickness, parental death, parental divorce, loss of job). Here is a partial list of descriptors, provided by the survivors: perfectionist, stubborn, kept secrets, very proud, overwhelmed, burdened, high expectations, weak, impulsive, anxious, depressed, low self-esteem, distorted thinking, jumped to conclusions, negativism, unaccepting, inability to accept changes, and more. There is, to put it in one simple word, vulnerability. A weakened resilience correlates positively with suicide-risk. This was likely a common reason for the dissembling, and the final egression, death.

Variations in Demography

There were 120 people interviewed as informants for the 20 suicides. When we only examined the informants who reported conscious and/or unconscious dissembling in the decedent, 95 (79.2%) informants were identified. Out of this group, 78 (65%) reported manifest content and 17 (14.2%) exhibited latent content. In the complete sample of 120 survivors, there were 66 informants of suicide who were younger than the mean of 35.8 years and 54 informants of suicide who were older than the mean. In the current masking sample of 95 survivors, there were 45 (68.2%) informants for the young suicides, and 50 (92.6%) informants for the older group. In the full sample, there were 22 survivors of the suicides who were female and 98 survivors of the suicides who were male. In the current deception sample, there were 17 (77.3%) informants for the female suicides and 78 (79.6%) informants for the male suicides. Finally, in the complete sample, there were 48 close informants (e.g., spouses, (ex)partners, (step)parents, and grown children) vs. 72 other informants (e.g., sibling, friends, boss). From this larger group, 35 (72.9%) "close" bereaved noted a mask and 60 (83.3%) "other" survivors noted a mask. One demographic observation stands out, informants of older suicides were much more likely to identify conscious and/or unconscious deception than the survivors of young suicides [X^2 ($N = 120$) = 10.73, $p < .001$]. Otherwise, there

appear in the current study to be little differences in being aware of the mask of suicide.

Res ipsa Loquitur: Some Actual Protocols of the Survivors

Of course, a basic in phenomonology (Husserl, 1907/1973) is that there is only one's observations of reality. Thus, it may assist the reader to illustrate our observations based on the principle, *Res ipsa loquitur* ("The facts speak for themselves"). We offer some actual protocols (statements) made by the survivors. To avoid issues of confidentiality, we only offer some excerpts of the informants on the themes that emerged; Dissembling, Inability to Adjust/Impairment, Relational Problem(s), and Weakened Resilience.

Dissembling: *He kept everything inside. One had to try to interpret, but it was difficult, because he was just laughing. Everything was just "a piece of cake".*

It is a façade.

He kept everything to himself, both physical and mental pain.

She kept her feelings to herself.

She has always been hiding behind a façade; it was very important for her to keep up appearance.

He kept his feelings to himself.but he was always a very happy guy, he was always an entertainer.

The family must keep the façade.

Something inside bothered him, and he told no one whatever. He was a shy person. He had a few friends to talk to, but he never talked about his feelings.

I saw no sign, nothing indicated the he had problems … nothing.

Inability to Adjust/Impairment: *He was very closed, I really did not know him. He never confided in anyone, not even about his physical pain, even though he was very much in pain at the end.*

Q. Personality and life style? *She was occupied with keeping the façade. You would not think that she was that ill if you saw her, a lovely woman, she had her beliefs, could discuss many things. Sweet and smiling.*

It is almost incomprehensible . but on hindsight I have been thinking that he put too much pressure on himself . everything should be perfect. scared of making mistakes . feared the consequences from making mistakes … he was depressed. But he would not tell us.

Relational Problem(s): *Bill was very successful, he had to be. They expected so much of him, it was insane. It was out of the question to tell your mother that you had problems … and that you thought of killing yourself. . And he told me, near the end, that he was really fed up with his mother.*

In our family, the facade should always be perfect. Behind the façade things are far from perfect, but we never talk about it.

His father died when he was 14. When his father died, at home, he was carried out of the house while Bill was asleep in the next room. They never talked about his father's death. It was hard to lose his father at such a young age. Q. Interpersonal? *Could never talk about problems with his mother, or any other. Family codex is not to talk about difficulties.*

What was wrong in our relationship was that we never talked about our feelings, and that has ruined a lot. And, after the break up, I talked to him; it must have been a few months afterwards. He suggested that we could give it a new try. And if we managed better to talk and all… But I felt, when we did not manage to talk during those 5 years it did not stand a chance, nothing would change.

Weakened Resilience: *I have a husband who was a perfectionist . and more and more so. It really bothered him when things were not properly done.*

He was absolutely devastated, it was unacceptable, it meant a lot to him that things always should be right, he was very "A+". Bill was socially insecure when there were new people around. He could pretend, put on a social facade that many people do when they meet new people. But I think he was much more inner insecure … and that he has been that way for a long time … it would take a licensed psychologist to be able to see the nuances in what was about to develop. And you should have pressed him really hard and say that even if he said that nothing was wrong, and nothing seemed to be wrong, you had to go on pressing him to talk about all the feelings he must have had.

So in a way when things started to get difficult, I think it was an unknown phenomenon for Bill to ask for help. To lean on to someone, admit that I need help now, to accept help.

But I am thinking that he did not manage to accept, as he always needed to be the strong one. He has been the top one, always. And the falling height must have been enormous for him.

I think he was very concerned about his facade, that he was able to fix everything, and we believed that he was one who fixed everything… . But Bill could say "I have never discussed things like that with my father, I have never had anyone to discuss things like that with, I have just done things like that myself." He has been so outstanding, right. So maybe he was very unfamiliar with his adversity … He appeared to have a sky-high self-esteem, as he was so competent in all areas. He was sociable, he was good in sports, he was smart, he was a pedlar, he was good with the kids, he was a coach, you see… he was practical, in a way he was everything. He felt very guilty, he really was very embarrassed

DISCUSSION

The survivors knew the mask. Ninety-five (79.2%) informants (out of 120) reported some manifest and/or lantent awarness of dissembling; actually, we inferred the existence of possible unconscious processes in their protocols of only 17 cases (14.2%). We found in 78 cases, a large majority (65.0%) were well aware (conscious) of the decedent's mask. Rudestam (1977) had actually reported 75%, more in keeping if we look at manifest and more latent levels. Maybe, dissembling in suicide is much higher than often reported. Indeed, we believe that masking may well be a very significant dangerous aspect of the suicidal process. The percentage of the dissembling or masking phenomenon is much higher than the small percentage (about 2%) observed in patients by Goldblatt (1992) and Litman (1995), and even much higher than the 20% figure that Shneidman and Mandelkorn (1967) made up (Leenaars, 2010). It is highly consistent with Rudestam's (1977) study of 75%. Are we underestimating deception in suicidal people? It is of further interest that classic volumes on deception offer very little insight; for example, Rodgers and Bender's *Clinical Assessment of Malingering and Deception* (2018) makes a two-word note of deception and suicide; however, once we explored its source, there were no further facts. Yet, our suicide note studies, and now convergent

PA study, would suggest it is a quantitatively very significant influential factor of suicide. Although our sample may be skewed (i.e., not diagnosed and/or treated for psychopathology), our study suggests it may be 65–80%. Perhaps, the most dangerous are the manipulative and/or avoidant secrets (Berg-Cross, 2000); further study of the types of masking is needed.

Relational factors are most frequent, as suggested by Leenaars (1987), regardless of age and sex of the decedent, or closeness of the bereaved. Almost 95 percent of informants associated the mask to the relational stage. The suicidal person was seen as experiencing a traumatic event or hurt or injury (e.g., unmet love, a failing marriage, disgust with one's work, being a burden in a relation). The person's psychological needs were frustrated. Suicide was associated to thwarted or unfulfilled needs; needs that are most often frustrated interpersonally. It is most likely that the unbearable pain (psychache) and frustration of needs allowed the person to choose (consciously and/or unconsciously) deception (D'Agata & Holden, 2018), and in the end, even seek to escape from life and accept death. It is clear that much greater study of the interpersonal aspects of deception and suicide is needed.

About a third less survivors reported a wide array of impairments, not only mental illness (whether about male or female suicides, young or old suicides, and close informants vs. other). In the current PA study, over 60% of informants reported an inability to adjust (or cope); whether one uses the word/concept of impairment, imbalance, problem, distress, disorder, illness, psychopathology, or the like, is a matter of personal/ecological preference. Consistent with the suicide notes findings, in the PA study, about 60% of the suicides were judged to be highly correlated with inability to adjust, whatever the impairment was (e.g., drinking too much, mental illness, chronic pain, physical disability). Hjelmeland, Dieserud, Dyregrov, et al. (2012) have discussed the whole issue of proxy in PA studies; our study is the survivors' views, not the decedents'. Yet, suicide notes and survivors' narratives tell a convergent story.

Most evident of the three themes, some 96.8% of the informants saw the decedent as having a weakened resilience or vulnerable ego. Resilience (or ego-strength) is the ability to adapt to even suicide risk (Meichenbaum, 2012). The bereaved associated this vulnerability to current and/or historical traumas; in order of observation, they were relational problems and impairment. There was a relative weakness in the decedent's capacity of developing constructive abilities (e.g., love, attachment, wellness). There were, we believe, unresolved problems, whether one calls it a "complex" or weakened resilience or vulnerable ego (e.g., distorted thinking; symptoms or ideas that were discordant, unassimilated, and/or antagonistic). The suicidal mind lacks resilience. Ego strength is a protective factor against deception, keeping deadly secrets, lying, and suicide. Masking, however, is vulnerability and, like suicide, an egression.

As discussed, and since the very early discussions (Leenaars, 2017), PA studies were known to have a number of problems (Leenaars, 1999; Maris, 1981; Pouliot & De Leo, 2006; Shneidman, 1993). One of the most serious errors—if not the most serious—is the use of only one or two informants. This is contrary to the very beginning of efforts of gaining deeper insight into the complexity of the suicidal process (Shneidman, 1993). Our studies in Norway, we believe, clearly show this flaw and we hope to begin to attempt to correct the error.

Although Dieserud, Leenaars and Dyregrov (2015) showed that proximity of the relationship to the deceased governs the search for a reason of suicide, our findings did not demonstrate differences in awareness of the mask. Although our sample is very small, the sex of the suicide victim also did not make a difference in awareness of dissembling; however, the age of the decedent did make a difference. Survivors of older suicides seemed to be very significantly ($p < .001$) more aware of and/or reported more deception than the bereaved of younger deaths (92.6% vs. 68.2%).

Strengths, Limitations, and Future Directions

There are multiple strengths of our study; there was support for Leenaars' observation of high rates of dissembling in suicide notes, using a PA method; there were improvements in our PA design (e.g., multiple informants); there were extensive and thorough data about each deceased; and others discussed earlier. Yet, there are, of course, limitations to the current study, many common to PA studies. Specifically, the sample in this study may be unique, and findings, thus, may not be generalizable to other suicide decedents. Indeed, our sample likely skewed the results in favor of our search for the hidden. The sample was identified as a group not diagnosed and/or treated for mental illness; maybe a masking group. Further, although multiple survivors ($n = 120$), were interviewed, the number of decedents was 20. The number of informants may be a strength in this study; yet, the sample size of suicide decedents can be seen as limited. Yet, it is above some frequently cited studies in the literature (e.g., Kelly & Mann, 1996, $n = 6$), although others have larger samples (e.g., Zhang, Conwell, Zhou, & Jiang, 2004). Like other problems in PA studies, greater consensus may be needed on the number of decedents that is best. The caution about the few female cases has already been cited; furthermore, our age division was based on a simple demographic split and there are better alternative age models (Leenaars, 2017). Our study is only a beginning of studying the mask; it is a bottom-up study. More research is needed. For many (Tugwell & Knottnerus, 2015), the "evidence-pyramid" model with randomized control studies as the only acceptable evidence is seen as too limited. We need a matrix of studies, supported by the World Health Organization (WHO) (Tugwell & Knottnerus, 2015): Surveillance studies, observation/phenomenology studies, cross-sectional studies, longitudinal designs, etc. Finally, although masking may be figural in suicide, alternative interpretations are, of course, possible. Perhaps, we can start top-down research (theory testing) next. Besides study of Leenaars' multidimensional theory, there is also a need to examine the concept of dissembling and other important variables, such as Maltsberger's concept of worthlessness (Malsberger, 1986) or O'Connor's concept of entrapment (O'Connor & Portsky, 2018). We need to reach through the mask; we need diverse concepts/theories and methodologies to understand dissembling and suicide better, and thus, we hope to prevent it. Despite these limitations and probably other ones, we strongly believe that much greater research is needed, with diverse quantitative and qualitative methods, on the mask of suicide.

Concluding Thoughts

The effect of the personal equation begins in the act of the observation—not merely in explanations. "One sees what one can best see oneself" (Jung, 1971, p. 9). Like Husserl

(1907/1973), Jung (1971), and many more, we mistrust the fact of "pure observation" or "objective observation"—a key problem in many PAs, especially if one uses one or two (close) informants. By the very nature of our humanity, we (including researchers) share a number of commonalities and that includes the unquestionable facts of the personal equation in explanation, such as in why suicidal people dissemble. In our study we looked at the informants' point of view, not the suicide decedents'. Yet, our finding is corroboratively similar to the suicide note studies; in the same vein, the two methods of studies converge on the fact that suicidal dissembling is most correlated with the relational stage. One third more informants (94.7% vs. 63.2%) saw the relational stage as more critical than personal impairment. Future research must take up the challenge to define, predict, and control the interpersonal mask to suicide.

AUTHOR NOTES

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