

Original Research

Suicide in post agreement Northern Ireland: A Study of the Role of Paramilitary Intimidation 2007-2009**Sharon Mallon¹, Karen Galway², Janeet Rondon-Sulbaran³, Lynette Hughes⁴, Gerry Leavey⁴**¹Open University, Faculty of Wellbeing, Education and Language Studies.²Queen's University Belfast, School of Nursing.³University of Ulster Business School, Newtownabbey, UK.⁴University of Ulster, Bamford Centre for Mental Health.Submitted to SOL: March 5th, 2018; accepted: January 06th, 2019; published: April 08th, 2019

Abstract: Since the end of the 'Troubles' in Northern Ireland, there has been a rise in the number of acts of intimidation and Paramilitary Punishment Attacks (PPA). Anecdotally, some suicides have been linked to such incidents. To date, there has been a lack of research examining this association. This article details a case series study exploring how individual deaths by suicide in Northern Ireland were connected to intimidation. Data from Coroners, GP records and interviews with family members were examined to identify experiences of intimidation among a two-year cohort who died by suicide. Further case based analysis was conducted using a modified version of the psychological autopsy method. Our results indicate that in 19 male suicides there were incidents of intimidation in the twelve months prior to death. The suicides of these men are discussed in relation to the suicide model of entrapment. Our findings highlight the continuing problem of intimidation in Northern Ireland and suggest further research into the connection between these incidents and suicide is warranted.

Keywords: *Northern Ireland, Victims, Political violence, Trauma, Entrapment, Suicide, Intimidation*

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Introduction***Imperfect peace***

The conflict in Northern Ireland, colloquially known as the 'Troubles', came to an end in 1998 with the signing of The Good Friday agreement. However, the transition between violence and peace was not straightforward. It was widely accepted that while

there was a dramatic fall in the number of violent murders after the peace agreement, there was a rise in the incidence of acts of intimidation, including threats of violence and paramilitary punishment attacks 'PPA' (Healey, 2006; Hill, 2007).

Throughout the 30 years of the troubles, intimidation in the form of actualized and threatened violence had been a consistent feature of Northern Irish society (Kennedy, 1995). It was claimed intimidation came about because in

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contrast to the police (bound by the law and security restrictions), paramilitary groups could directly deal with antisocial behavior, by threatening or inflicting PPA on individuals (Bishop & Mallie, 1988). During the early days of the ceasefire such was the level of this type of behaviour that the term 'imperfect peace' was coined to acknowledge that certain forms of violence were tolerable in the interest of reform and transition (Jarman, 2004).

Recording and Defining Intimidation

Levels of intimidation have tended to fluctuate with political developments (Silke and Taylor, 2000). Between 1994 and 1995, it was reported that the number of PPA by the IRA increased fourfold, from 32 to 141, but it was suggested that by 2006 these had dropped to 72 (Eriksson, 2009). A recent freedom of information request suggested that almost 20 years after the ceasefire, incidents of PPA are on the rise again (Black, 2017). However, a reluctance to report such behaviour means the validity of police statistics has been questioned (Eriksson, 2009). For example, one report from the Office of First Minister and Deputy First Minister estimated that in 2009-2010 there were as many as 774 cases recorded cases of intimidation by paramilitaries in Northern Ireland (Matthews, 2012). In addition, reported figures are described as 'the tip of the iceberg', because they exclude injuries that do not result in hospitalization (Hamill, 2011 p.3).

Any discussion of the issue is further hampered by the localized nature of the phenomenon and ambiguity surrounding the terminology used to describe it. The term 'PPA' is broadly used to refer to an actual physical beating or shooting that is inflicted upon an individual by members of their own community (O'Neill et al, 2002). However, Darby (1986) critiqued the use of the term PPA because it limits the discussion of this phenomenon by excluding other forms of terror closely associated with this type of behaviour. He favoured the use of the term 'intimidation' as it refers not only to the exercise of violence but incorporates other acts such as the threat of violence, exile orders, curfews and acts of aggression. In our research for this paper we found considerable overlap between these phenomenon both in the records we examined and in the literature. For clarity, here we broadly use the definition of the intimidation as set out by Darby (1986), to explore the association between death by suicide and the range of events that are covered by his use of this term. Where we use the term PPA, we are referring to the exercise of violence.

Overview of Intimidation

Intimidation is predominantly a male experience, carried out by male gangs on 'miscreant' male subjects (Porter, 2004). By contrast, the intimidation of women is rare but not unknown (Eriksson, 2009). The Good Friday agreement meant it was politically unacceptable to use firearms in such attacks. As a result, the 'punishment' changed from shootings to beatings with baseball bats or iron bars (Eriksson, 2009). Although they rarely result in death, the physical injuries that result from PPA are extensive and debilitating, they show typical characteristics including fractured limbs, sometimes compounded by puncture wounds if nails have been used (Monaghan, 2002).

The lack of knowledge on the psychological impact of intimidation has been highlighted elsewhere (Price, 1998). One qualitative study on the subject suggested many of the young people displayed symptoms of PTSD and powerlessness affected many of those caught up in these incidents (Hamill, 2011). The high levels of stress experienced by these men is further supported by an earlier paper that suggested young people and adults were being admitted to psychiatric hospitals in order to flee from paramilitary threats (Campbell and Healey, 1999).

Acts of Suicide and Intimidation

The relationship between suicide and terrorist activity, in the form of intimidation, is poorly reported in the literature. Hamill's (2011) study reported that just over one third who had been intimidated had experienced suicidal thoughts, while 22% admitted having attempted suicide (Hamill, 2011). Anecdotal accounts have been more conclusive in making a connection between individual death by suicide and intimidation. In 1996, Mo Mowlam, then Secretary of State for Northern Ireland, publicly acknowledged a link between intimidation and suicide in the Houses of Commons, reporting that 167 PPA had taken place in 1995 and naming two individuals who had died by suicide following this form of beating (HC Deb, 1996). A further example listed in the CAIN Chronology of the conflict records that in "July 1997 a young man...hung himself on the railings of a motorway in Belfast. He had previously suffered a paramilitary 'punishment' attack..." (CAIN, 1997). In the same year, a newspaper article argued that the growth of suicide among young men in North Belfast could be attributed directly to punishment beatings (Sunday Life, 2004, quoted in Tomlinson, 2007). The subject was again raised in the House of Commons in 2004 when it was suggested that PPA

were creating a “pressure towards suicide among young people” (HC Deb, 2004).

The publication of powerful individual accounts has continued in the media (Black, 2017). However, to date there has been no empirical research directly examining either the psychological consequences of intimidation, or any connection between such acts and death by suicide. The aim of this paper is therefore to address this gap in the literature by exploring the issue of intimidation in deaths by suicide using Williams’ (1997) entrapment model to examine how suicidal behaviour may be seen to be a behavioural response to a stress incurred as a result of intimidation.

Methodology

The data collected for this paper was part of a broader study of suicide in Northern Ireland, extended details of which have been reported elsewhere (Leavey et al, 2016). Suicide is a complex issue with multifarious causes (Scourfield and Evans, 2015). The literature tends to focus on mental illness, but life events and social circumstances are increasingly considered to be of central importance (Cavanagh, et al, 2003). As a result, in order to capture a broad range of relevant data the original study was a mixed methods design that combined data from official sources, with family informant interview data. In our approach to data collection and analysis we used a modified version of the psychological autopsy approach (Beskow et al., 1990, Stanley et al, 2010). This approach allowed us to build a picture that took account of the individuals’ social contexts, life events and clinical information, in addition to possible psychological factors associated with their suicide. The analysis presented here focuses only on those individuals who died by suicide who had been affected by issues of intimidation prior to their death. As such, it represents a case series study, a design which uses data only on those individuals who have experienced a particular event of interest (King et al. 2017).

Comprehensive details of the data collection process can be found in our main report (Leavey et al, 2016). In brief, a self-designed proforma was used to collect data from files at the Coroner’s office for 402 deaths recorded as suicides that occurred between 2007-2009. Data collection was focused on the social and psychological context of these deaths, including significant life events such as intimidation. The General Practice (GP) medical records for the majority of these deaths (n=363) were then

accessed and the same process of data collection was followed. Details recorded from both sources included the date of the event as well as detailed qualitative data about the circumstances surrounding it. As part of the main study we had also undertaken in-depth interviews with bereaved family members and close friends (n=78). The process of data collection for interview data followed the approach of Owens et al. (2008) in that an emphasis was placed on encouraging the informant to talk freely about the person who died and to ‘tell the story’ of the suicide as they perceived it. During two of these interviews intimidation was mentioned to the interviewer as a factor related to the suicide, as a result data relating to intimidation events from these two cases were included in our analysis.

For this paper, we integrated information from all data sources to identify and report on those individuals who had experienced incidents that fitted with Darby’s (1986) definition of intimidation. As previously highlighted this classification includes both the threat and enforcement of violence in the form of PPA, while also incorporating issues such as exile orders. Relevant data from each data source were combined to create a case summary for each individual who had been affected by intimidation. As per the modified psychological autopsy approach demonstrated by Stanley et al (2010), all three forms of data were treated as both quantitative and qualitative sources, summaries were then analysed thematically across the case studies using an approach that relied on key themes generated by the data. In this paper, we report only on those individuals who experienced intimidation related events during the twelve months preceding their death. This allows us to distinguish between historical events and events that directly preceded the suicide. All cases have been anonymised and any identifying features have been removed. In addition, given the sensitive nature of this topic we have limited the amount of detail provided on any individual case. Ethical approval for this study was obtained from the NI branch of the UK Office for Research Ethics Committee (ORECNI). Access to personal confidential data in both the Coroners’ records and the General Practitioners’ records was granted via the ‘research exemption’ within Section 33 of the Data Protection Act.

Findings

Our overall aims and methodological approach have influenced the way we present our findings. In Figure 1 we present a quantitative

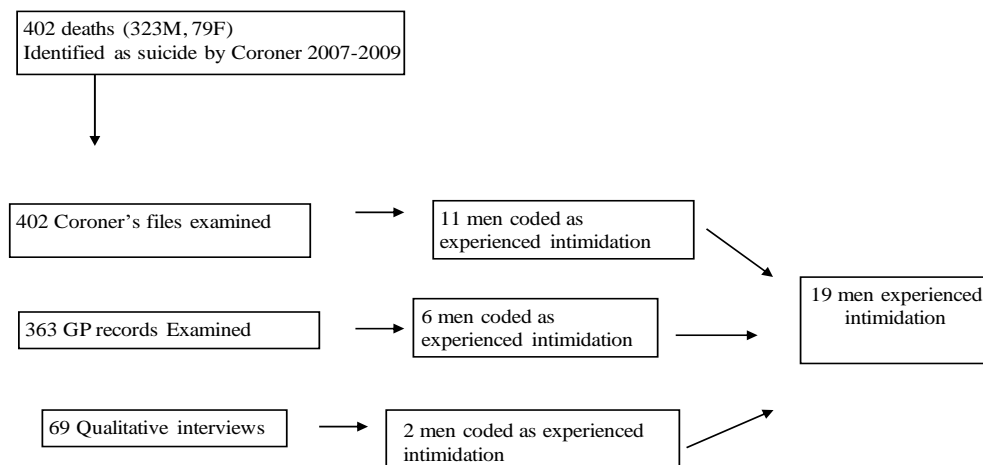
overview of the individuals coded as having experienced intimidation in the last twelve months of their lives. In our main findings section we provide a descriptive overview of the two groups of the men that emerged from the thematic case based analysis. This overview focuses on the general characteristics of the men in these groups as well as information based on their response to the intimidation. Brief qualitative data from all sources is used to illustrate our key themes in relation to these areas.

Broad Overview: We identified 19 individuals who experienced intimidation in the year preceding their deaths (Figure 1). All 19 were male, they were aged between 18-63, with an average age of 34. Most were aged between 15 and 44 (Table 1). The vast majority, (n=15) were listed as unemployed with only four men noted as being in employment at the time of their death. They were also

predominantly single (n=13); three men were listed as separated/divorced, three were listed as married or cohabiting.

The period of time between the intimidation and the suicide varied across the twelve-month period, with the vast majority taking place within six months of the death. In some cases, the individual died within a few hours of the incident. In most cases it was possible to deduce from the records the reasons for the intimidation. Some could be connected to anti-social behaviour linked to alleged criminal activity. However, some of these men were initially intimidated after an episode of perceived anti-social behaviour linked to a break down in family relationships or to an incident related to alcohol or drug consumption. For example, it appeared one man was intimidated because he repeatedly held loud house parties.

Figure 1: Experiences of Intimidation in the Twelve Months Prior to Suicide¹



¹An additional 7 individuals who experienced intimidation after the 1998 ceasefire but longer than twelve months prior to their death were excluded from this analysis because of the historical nature of the events.

Table 1. Age Range of Men Affected by Intimidation

<i>Age Range</i>	<i>Males in this age range</i>	<i>Recent intimidation (n)</i>
15-24	65	5
25-44	144	10
45-64	89	4
>65	25	0
Total	323	19

Case Based Analysis Following case based analysis individuals fell into two distinct groups based on

their previous vulnerabilities and help seeking behaviour.

Group 1

General characteristics: The lives of the ten men placed in Group 1 were characterized by enduring mental health problems experienced over a number of years. These issues were associated with consistent attendance at GP and Psychiatric Services over many years and in most cases (n=7) up to the time of their death. Typically, the intimidation we identified as having occurred in the year prior to the suicide was part of more extended abuse, with at least seven of the men having been subject either to an additional period of intimidation in the form of a PPA or period of exile that took place outside the twelve month time period.

Reaction to intimidation: All ten men had repeatedly sought help for emotional problems related to the intimidation. For example, one entry in GP records noted that a consultation had taken place in response to the delivery of a "death threat" for which the man was suffering from "panic attacks". Some of the men engaged well with the services offered to them, however the help offered appeared to be of limited assistance and professionals struggled to assess their mental health status. The following statement refers to a consultation in which a healthcare professional attempted to assess the mental health of the man: *"(it is) difficult to tell how much is paranoid personality exacerbated by alcohol use, and how much is reasonable responses to threats"*.

While another psychiatrist noted that: *"(his) difficulties with the law and paramilitaries have created much of the stress"*. While pre-existing mental illness was a feature of all Group 1 cases, the psychological consequences of the intimidation were also clear. Medical notes frequently recorded the men were so scared by the threat that they experienced difficulty sleeping and were unwilling to leave the house to attend appointments.

Group 2

General characteristics: In contrast to Group 1, the nine men categorised into Group 2 had no history of help seeking for mental health issues. None had previously been diagnosed with a mental health problem, although some had been noted by the GP to have alcohol and drug issues.

Reaction to intimidation: This group of men fell into two groups based on their reaction to the threat. Four men sought help from their GP in relation to the threat, the remaining five did not seek help but data recorded in Coroner's records and family interviews indicated a threat had been received and was potentially a factor in the suicide. Further details of these cases are described below.

The medical records of the four men who attended their GP to discuss their experience of intimidation contained consistent references to feelings noted as "anxiety". Unlike the men in Group 1, these men had no previous consultations for mental health issues, and the emergence of these problems came about in direct relation to issues associated with the intimidation. Across all the cases, the challenges medical professionals experienced when diagnosing their cases were evident as they struggled to assess the men for mental illness, in particular around their feelings of anxiety. For example, in the notes of one of the men it was clear the psychiatrist initially assessed the man as suffering from symptoms of paranoia and refused his request for diazepam. Two weeks later the man was subjected to a PPA and at a subsequent GP appointment was noted to be in an agitated state, at which point he was prescribed diazepam. In another case, the man attended CMHT on a number of occasions. He was also initially thought to be experiencing paranoia but at later consultations the recorded comments shifted, so that shortly before his death the patient's notes contained the following statement:

"it is the assessment of this doctor that there is no psychiatric diagnosis and the response is appropriate given the threat he is under... overall, his main problem was difficulty adjusting to ongoing threats".

The medical notes of three of the four men in this sub-category indicated a clear link between intimidation and suicidal thoughts. For example, the notes of one man indicated his first consultation for emotional problems came four months before his death, when the following was noted in his GP records:

"...a friend has told him that the paramilitaries are after him and he would rather die than let them injure him".

In one case a man attempted suicide on the day he first learnt about the threat and died at a second attempt two months later.

In the final five cases, evidence from GP records indicated they had never sought help for mental health and no help was sought in relation to the psychological consequences of the intimidation. Evidence linking the intimidation to the suicide came in three cases from Coroner's records and in two cases from an interview with the family of the deceased. One typical entry from the Coroner's notes recorded that an assault had taken place one month prior to the death and a further threat was received shortly before the death. It was also noted that the deceased had mentioned fear of further assault to a friend.

In the two cases in which relatives identified intimidation in relation to the suicide, interviewees described learning about the issues only after the suicide had taken place. For example, in one interview a mother commented on a rising sense of panic in her son's behaviour in the days preceding his death. As this quote shows, she suspected there was something wrong but her son was reluctant to share his worries:

"...he had a black eye. He went "mum, I was coming up from my mate's last night and I got jumped."...I knew something was badly, badly wrong and I said to him "(name removed) are you in trouble?" "No, ma! No!" ...he wouldn't give; he wouldn't give".

While another man's family reported finding out afterwards that:

"...there were things (that) happened that we didn't know about until after my brother died{...}We know he was getting bullied because we've talked to people that seen him but they didn't know what it was about....the police didn't know nothing about it. When we found out what was going on we didn't want to involve the police..."

In this final quote, we can see that even after the death the family was reluctant to involve the police service.

Discussion

We have presented an examination of those individuals who died by suicide between 2007-2009 who were identified as having experienced intimidation in the twelve months preceding their deaths. Our study provides a unique contribution to the literature in a number of ways. Firstly, as we have previously stated, the examination of issues relating to intimidation in relation to suicide is valuable given the hitherto absence of work in this area. Secondly, taking a case series approach to multiple data sources has provided a unique opportunity to explore the impact of these incidents and the support that was sought in connection with them. We were able to use rich qualitative detail from all sources to provide a contextual analysis of these types of events in relation to their eventual suicides.

Our analysis indicated that 19 of the 323 men (none of the women) who died by suicide over a two-year period in Northern Ireland had been subject to intimidation in the year preceding their death. This gendered pattern of victimization is consistent with overall patterns of exposure to troubles related events, in that it is disproportionately associated with the male gender (Smyth and Hamilton, 2003). Barring gender, there appeared to be no exception to who

could become a target for intimidation; although the majority of victims were young or in mid-life, four men aged 45- 65 were also affected by these issues. In most cases, the intimidation occurred within a few months of the suicide, in some cases taking place on the day of the death itself.

In all of these cases, the suicide could at some level be connected to the experience of intimidation. For the purposes of understanding other underlying vulnerabilities we have categorized them according to their previous mental health status. The first group of ten men we identified had been under the care of mental health professionals for some years prior to their death, engaging with multiple services. A second group of men had no prior history of mental health problems. We discuss each of these groups in turn before presenting a broader discussion on the issue of intimidation and suicide.

Association between Suicide and Intimidation

The connection between intimidation and suicide in our first group of ten men is difficult to assess as there are a number of potentially compounding factors to consider when assessing their situations. These men had been subject to intimidation over a continued period time and may have experienced trauma associated with these historical incidents. By comparison, the impact of intimidation and its connection to suicide among the second group of nine men is arguably more easily assessed. In these cases medical records indicated that prior to their intimidation they had never sought help for mental health problems. The cases of the four men who sought medical help in relation to the intimidation clearly illustrated both the emotional distress caused by the threat and the limited responses available to medical professionals. Qualitative data from the Coroner's office and family members of the remaining five men who died without seeking help from medical professionals, suggested the men were experiencing rising levels of panic and hopelessness with a desire to conceal the cause of their distress.

Overall, we believe our case series analysis demonstrates that intimidation may play a role in some male suicides in Northern Ireland. However, any association between the two issues is undoubtedly a complicated one. Suicide research has repeatedly demonstrated that it is a complex phenomenon with many risk factors (Scourfield and Evans, 2015). These include a long-established association between suicide and unemployment, which featured heavily among these men (Lester, 1970). Symptoms of PTSD, such as those experienced by victims of intimidation in Hamill's

(2011) study, have been associated with suicidal ideation and attempts (Ursano et al, 2010). Furthermore, existing research into individuals who were being bullied at the time of their death has demonstrated how complex the issue is likely to be among this group, with a range of factors including emotional regulation problems, impulsivity and connectedness also contributing towards suicide (O'Brennan et al, 2009).

We acknowledge that it is impossible in a study of the kind presented here to assess to what extent pre-existing or unrelated issues may have also contributed towards these suicides. Nevertheless, our results echo others in suggesting there is an important link between bullying and social forms of intimidation, and suicide ideation (Kaminski & Fang, 2009). In the next section, we apply a well-established theory from the suicide literature to our findings to further explore how the men's response to the intimidation may be linked to their eventual suicide.

Entrapment

The issue of mental illness is a prominent feature both in the suicide literature and within these cases. However, our findings highlight the struggle medical professionals had in diagnosing and responding to the distress exhibited by these men. Williams' (1997) entrapment model views suicidal behaviour as a behavioural response to a stressful situation; it relies on the psychological concept of entrapment which it defines as a state in which a person feels they cannot get away from something they wish to flee. In the model Williams states that "*suicide is not unique to any particular diagnosis ... (but) is linked to symptoms of inner turmoil that seems inescapable and uncontrollable*". Thus the particular benefit of the entrapment model in this analysis is that it accommodates the presence of an underlying mental illness but allows the focus of the analysis of suicidal behaviour to be on the impact of external sources of stress.

The model focuses on three interrelated elements: defeat, lack of escape and blocked defensive mechanisms. Each of these is linked to suicidal behaviour and can be applied to the cases here. Defeat is a psychological construct that can be used to link depression to the outcome of direct social conflict or attacks (Taylor et al, 2011). Men experiencing defeat are likely to become submissive in an effort to avoid further injury. They may also become demobilized and unable to remove themselves from the stressful situation (Taylor et al, 2011). The concept of defeat in this context may help to explain why some of these men lacked the motivation to seek help. Defeat is

closely linked to the second element of the model, lack of escape, in that these men seemed to be unable or unwilling to evade the threat. It is the third element of entrapment, blocked defensive mechanisms, that is particularly relevant to our discussion because the nature of our data focused on help seeking among fourteen of these men. Next, we consider the ways in which each of the three defensive mechanisms Williams (1997) identifies as usually being open to an individual, (informal support, formal support and community support) may have been blocked in these cases, thus contributing to these suicides.

Blocked Defensive Mechanisms: Informal support

The entrapment model suggests when considering suicide that "*the most important preventative factor when uncontrollable stress threatens to overwhelm the individual, is the availability of social support from friends and family*" (Williams, 1997. p.63). We have limited evidence as to whether these men accessed informal support. However, we know that the majority were unmarried or divorced, and from GP records ascertained that some men had complex family dynamics, thus these important avenues of support were blocked. In addition, for those men who did have social support, qualitative interview data from family members was striking in demonstrating how reluctant these men were to reveal the events to their families, thus meaning this avenue of support was also blocked.

Blocked Defensive Mechanisms: Formal support

In fourteen cases, the men sought help from medical professionals in relation to the intimidation. As we have demonstrated, the particular nature of these threats meant medical professionals were challenged in their assessment and limited in the help they could offer, their focus being limited to the assessment of issues associated with mental health. It is thus possible that the sense of entrapment experienced by these men may have escalated following their attempts to seek help, as their fears were heard but could not be adequately responded to. In Hamill's (2011) study there was evidence of the damaging impact of a failed attempt at seeking help, when the young men reported having revealed intimidation but receiving no help.

The criminal nature of acts of intimidation means we also need to examine the role of formal sources of support from organisations such as the Police, who would be considered by many to be a first line of defense in these cases. A detailed discussion of the role of the Police Service of Northern Ireland (PSNI) is hampered in these cases by our lack of

access to police records. However, we can report that few of the records we examined contained references to the PSNI and family members reported a reluctance to report the issues. This, in combination with the history of these events in Northern Ireland lead us to conclude it is unlikely these men sought help from this formal source. This may have further contributed to their sense of entrapment. Hamill (2011) suggested the reasons intimidated men do not appear to have sought, or been encouraged by others to seek help from the police may be explained through the application of Miers (2000) theory of help seeking among victims of crime. This model suggests that in order to seek help, these men would have to consider themselves to be victims, be able to identify and contact relevant help seeking agencies, and then be accepted as deserving of victim status by those agencies. In the cases presented here, it is likely that each of these norms of victimhood have been broken thus preventing them from seeking formal support.

Blocked Defensive Mechanisms: Community support

This leads to our discussion of the final defensive mechanism offered in Williams' theory; the wider community. In some communities in Northern Ireland, intimidation is viewed as part of the informal management of anti-social behaviour, threats and beatings are thus considered to be an appropriate response to persistent offending by these individuals (Hamill, 2011). Collective, community identities are particularly important for individuals in politically conflicted areas such as Northern Ireland, where it has been suggested that increased social cohesion and social binding among groups has acted as a psychologically useful defensive device (Curran, 1998). Sociological models provide a clear link between suicide and the act of being ostracized from one's community (Durkheim, 2002; Fullagar, 2003). The continued toleration of intimidation among some communities in Northern Ireland may thus feed into the individual's view that their lives are not valued within their own communities.

Limitations

There are a number of limitations to the findings presented here that require emphasis. It has been suggested that medical records are likely to be the best source of information on intimidation because they record the physical details of such attacks (Eriksson, 2009). However, in this sense these records are also limited as they capture only the most serious assaults where the individual required hospital treatment because of

their injuries. Our methods offset this limitation by supplementing GP data with that contained within Coroner's files. These have their own drawbacks and broader issues about the limitations and benefits of Coroner's data in suicide research have been discussed elsewhere (Mallon et al, 2016). In brief, such records are collected on behalf of the Coroner whose purpose in these cases was to determine if the death of an individual was likely to be a suicide. As a result, Coroner's officers and members of the PSNI make critical judgments about which pieces of information should be recorded. Overall, it is thus likely that the representation and frequency of cases in this analysis may have been affected by the politically sensitive nature of the topic. However, the use of evidence from a range of data sources minimised the limitations associated with any one particular data source.

Another limitation of our data is the limited time period over which deaths were examined. By focusing exclusively on those who died we are unable to predict the suicide risk that intimidation brings to the general population. However, by providing qualitative data about the lives of these men, we have built up a detailed picture of those who died after being targeted and their help-seeking responses to the threat. We further acknowledge that the characteristics of an individual's personality, as well as broader social matrices, and historical and cultural factors (Slaby and Pflum, 2015) influence the impact of intimidation. In addition the deaths analysed here occurred between 2007-2009. Despite the age of the data, recent reports show that the number of assaults has risen since this period (Black, 2017) therefore these issues remain pertinent and if anything the size of the problem is likely to have increased.

In relation to the overarching matters of reliability and validity, our findings can be judged by examining the evidence provided here in support of these claims (Hammersley, 1992). The third-party nature of the data collected means it is not possible for us to be absolutely certain that the intimidation described here was related to specific paramilitary groups. Nevertheless, we have to the best of our ability limited our analysis to those individuals where the balance of probabilities would suggest that the violence was linked to organized groups within the community, either because the source of the threat was overtly recorded in the data sources, or the nature of the attack indicated it was a PPA (Monaghan, 2002). In addition, in order to protect the confidentiality of individuals we have deliberately limited the amount of descriptive detail presented in this

article that may have supported our claims. In particular, the examples provided from each individual case are necessarily brief. We have opted to obscure the details of the threat because of our desire to protect the families of the individuals concerned.

Finally, it is impossible for us to be entirely sure that the accounts of intimidation were true or accurate. In some cases, it is possible that the fears of some of these men were creations of already paranoid and troubled minds. However, the nature of our data sources mean we are as confident as we can be that these threats had a basis in reality. For example, in a number of instances the threats recorded had been delivered via text message or word of mouth and were thus verifiable by an individual other than the deceased.

Conclusion

Our aim in this paper was to provide an empirical analysis of the association between suicide and intimidation, an area that has hitherto been anecdotal in nature. Our data demonstrates that intimidation was a feature in the lives of 19 men who died by suicide over a two year period. We believe this is the first time these issues have been directly connected in the literature. Nevertheless, we remain cautious and do not wish to simplify the association between suicide and intimidation, as some media reports may tend towards. Our intention here was to initiate a discussion of the connection between suicide and intimidation so that we may have a better understanding of the way in which these phenomena interact.

By using a case-based analysis, focused on help seeking behaviour, we illustrated how death by suicide could be connected to incidences of intimidation. We used the suicide model of entrapment and Mier's (2000) theory of victimization to theorize on a potential mode of action for this connection. Power differentials between the victim and the perpetrator are a key aspect of any experience of intimidation. It is our sense that the absence of an effective and robust criminal justice system may have forced some of these men to turn to the medical profession for help, while others sought no official support, before ending their life. It is not within the power or remit of medical professionals to prevent such events; however, where appropriate it may be prudent for them to work with relevant agencies to help these men develop techniques that manage the sense of entrapment that may be a consequence of intimidation.

Recent reports suggest that despite repeated condemnations and pleas from desperate family members, worrying levels of paramilitary style attacks continue to take place in Northern Ireland (NIHRC, 2013). At the center of Williams' (1987) entrapment model of suicide is the suggestion that the predominant motivation in suicidal behaviour is the need to escape. We conclude by stating that as long as intimidation continues, and as long as we fail to protect these victims from the perpetrators, it seems likely, that some men will choose suicide as their only escape from intimidation. It is therefore imperative to have clear evidence that can develop and influence policy responses to these problems.

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