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Very Young Child Survivors of Parent Suicide: Perspectives on
Children's Literature for Bibliotherapy

Cortland L. Watson

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of
Educational Specialist

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ABSTRACT

Very Young Child Survivors of Parent Suicide: Perspectives on Children's Literature for Bibliotherapy

Cortland L. Watson

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The death of a parent by suicide is especially traumatic. Researchers estimate the number of children in the United States annually who experience their parent's suicide ranges from 7,000 to 30,000. These child survivors experience more complicated grief as compared to children bereaved by a parent's non-suicidal death. In particular, very young children have difficulty understanding that their parent completed suicide. Across time they struggle with confusion and intense emotions associated with their parent's suicide. Due to the stigma associated with suicide, feelings of guilt, and intense grief, surviving family members avoid talking about the suicide. Young children are often confused and suffer in silence with limited understanding about who the deceased parent was and why the parent completed suicide.

Individual semi-structured interviews were conducted with seven adults, who as young children experienced the death of their father by suicide. All participants reported being five years old or younger at the time of the suicide. Participants explained how they found out about the suicide; how they developed an understanding of their deceased father across the years; and how they developed memories of their father, largely dependent on others' stories and reported details.

At the conclusion of the interviews, participants were offered nine children's picture books. Participants self-selected books from these nine books and offered their impressions about how these books may or may not be helpful for young child survivors of parent suicide. Their reactions to the books are discussed in relationship to their personal stories and lived experiences. Their reactions have implications for how potential books must be carefully selected, making considerations in light of the child's unique experiences.

Participants' responses highlighted the importance of attachment issues, the challenges of forming a connection to the deceased loved one with limited memories of their parent. Ultimately, survivors' perceptions and experiences are tied to the challenges of navigating Worden's (1996) *tasks of grief*. Implications for applied practice include considering how to use children's literature to open and encourage communication, allowing children to ask questions about the suicide; supporting young children in accepting the reality of their parent's death; facing the grief and pain with the support of loved ones; adapting to changes in their life's trajectory due to their father's suicide and adapting to altered family relationships; and building memories of the deceased loved one, and when possible, ensuring healthy attachment to the deceased parent.

Keywords: father's suicide, child survivor, grief, bibliotherapy, communication, tasks of grief

ACKNOWLEDGMENTS

There are many situations in the history of the world that have made lasting impacts. These huge events are often summed up to a singular event, but are rarely so. The invention of the printing press took years to develop, the first flights in the air and space are marred by tragedies, but the celebration of the singular event is usually the narrative being told. The story behind this thesis is like that of an iceberg. The tip of the iceberg is being seen, while a much larger portion of the structure lies beneath human view. The work put behind this thesis is astounding, it intersects with years of research and provides great implications for field work, and it could not have been done without the expertise of everyone involved.

My family is the first to be appreciated. My wife has been kind and loving as I have spent many hours working through school so that I might be able to meet deadlines. My children have been loving as they sit on the couch and watch me work on continuous edits. My parents have been supportive, exemplary in work ethic, and have shared their love for me throughout the process.

Elizabeth Cutrer-Pàrraga's expertise and diligence in working with me is immeasurable. The time and effort that she put into this thesis can only be described as a miracle. Melissa Heath has been like a loving mother to me. She took me in under her wing, brought my children books and provided me with compassion and confidence that only a mother can provide. Terrell Young has been kind and patient as I have been working through this process. In all, being a father, husband, student, and full-time employee has only been possible because of these dedicated and compassionate people.

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DESCRIPTION OF THESIS STRUCTURE AND CONTENT

This thesis, *Very Young Child Survivors of Parent Suicide: Perspectives on Children's Literature for Bibliotherapy*, is written in a hybrid format. This format combines the traditional thesis requirement with journal publication formats.

The preliminary pages of the thesis reflect requirements for submission to the university. The body of the thesis is presented in journal article format and conforms to length and style requirements for submitting research manuscripts to psychology and education journals.

The extended literature review is included in Appendix A. This thesis document contains two reference lists. The first reference list contains references included in the journal-ready article. The second reference list includes all citations that are referenced in Appendix A, "Review of the Literature." Appendix B and Appendix C contain Brigham Young University's Institutional Review Board's approval to conduct this research.

Introduction

The World Health Organization (WHO) identifies *suicide* as a public health priority and *suicide prevention* as a “global imperative” (WHO, 2019, p. 7). They estimate that worldwide, approximately 800,000 individuals die from suicide each year (WHO, 2019). Placing this number in context with other types of death, WHO reports that more individuals die from suicide each year than from homicide and war, breast cancer, or malaria.

On a national level, information posted on the U.S. Centers for Disease Control website (CDC, 2021) emphasizes, “Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities.” In the United States, suicide is the tenth leading cause of death, accounting for approximately 48,000 deaths each year (Centers for Disease Control and Prevention [CDC] & National Center for Health Statistics, 2020).

However, numbers do not fully communicate the anguish and suffering associated with suicide. Each incident of suicide is accompanied by untold stories of those left behind—the survivors. For survivors, the stigma surrounding suicide amplifies and complicates their grieving process, in particular, impeding opportunities to talk about the death (Cain & Fast, 1966; Mitchell et al., 2006; Regher et al., in press; Wilson et al., 2019). This intensifies survivors’ isolation and alienation (Ross et al., 2021). Tragically, many survivors suffer in silence and with limited emotional support (Baxter, 2019; Hanschmidt et al., 2016; Pitman et al., 2017; Ross et al., 2021).

Child Survivors of Parent Suicide

Of all childhood traumatic events, the death of a parent is considered to be one of the most stressful (Hiyoshi et al., 2021; Worden, 1996; Yamamoto et al., 1996). For surviving children, a parent’s death triggers both short- and long-term physical, emotional, and mental

health challenges (Brent et al., 2012; Hiyoshi et al., 2021; Worden, 1996). In addition to the loss of the parent, the associated cause of the parent's death has implications for surviving children (Kuramoto et al., 2009; Kuramoto et al., 2010). In particular, the death of a parent by suicide is especially traumatic (Ratnarajah & Schofield, 2008; Schreiber et al., 2017).

Researchers estimate the number of children in the United States annually who experience their parent's suicide ranges from 7,000 (Cerel et al., 2008) to as high as 30,000 (Hung & Rabin, 2009). These child survivors experience more complicated grief as compared to children bereaved by a parent's non-suicidal death (Cohen & Mannarino, 2018; Romanowicz et al., 2018; Schreiber et al., 2017).

When compared to typically developing peers, child survivors of a parent's suicide (CSoPS) experience higher levels of depression, anxiety, and anger (Hua et al., 2020; McMenamy et al., 2008). They often struggle with peer-relationships, academic achievement, and across the years struggle with interpersonal relationships and have difficulties sustaining employment and job satisfaction (Brent et al., 2012; Loy & Boelk, 2014). Additionally, one of the most worrisome outcomes for CSoPS is that they are three times as likely to attempt and ultimately complete suicide as compared to children from families with two living parents (Burrell et al., 2017; Kuramoto et al., 2013; Serafini et al., 2015).

As such, CSoPS are identified as a highly vulnerable population (Hung & Rabin, 2009; Ratnarajah & Schofield, 2008; Schreiber et al., 2017). Even though there is a great need to support these children in their immediate and ongoing needs, research examining how to assist this population is very limited (Eckersley & Dear, 2002; Ratnarajah & Schofield, 2008; Schreiber et al., 2017).

In particular, immediate and ongoing needs of CSoPS include supporting and encouraging children to ask questions, to talk about the parent's death, and helping children understand why the parent chose to die by suicide (Cain, 2002; Hagström, 2019; Hung & Rabin, 2009; Wilson et al., 2019). However, research indicates that this communication is often very limited and that formal and informal support are difficult for survivors to access (Baxter, 2019; Cerel et al., 2008; Hung & Rabin, 2009; Leichtentritt et al., 2018; Schreiber et al., 2017). For CSoPS, this unmet need complicates their grieving process (Cerel et al., 2008; Hung & Rabin, 2009; Leichtentritt et al., 2018; Wilson et al., 2019).

To help children adaptively cope with and manage the strong emotions associated with a parent's suicide, Schreiber et al. (2017) and Montgomery and Coale (2015) emphasize the need to present information about death and suicide on a level that is developmentally appropriate for the child. Ultimately, the choice should not be whether or not to talk about the parent's suicide, but how to talk about it and how to encourage honest conversation (Cain, 2002; Hagström, 2019; Montgomery & Coale, 2015).

Young Children's Adjustment Following a Parent's Suicide

Kuramoto et al. (2013) note that adolescents are especially vulnerable to suicidal ideation and completion of suicide in the first two years following their parent's suicide, with risk declining after that point in time. Although minimal research has been conducted with children who are very young (under the age of 6) following a parent's suicide, Kuramoto et al. (2013) noted that very young CSoPS, not adolescents or young adults, have the highest rates of suicide across the life span.

When investigating children's behavior and social emotional development following a parent's suicide, researchers' findings offer mixed results. Kuramoto et al. (2013) noted that

children who experienced their mother's suicide were at a higher risk for suicide attempts resulting in hospitalization than were survivors of a mother's death from unintentional injury. However, Tsuchiya et al. (2005) and Geulayov et al. (2012) noted that in comparison to adolescents and young adults, younger children exposed to maternal suicide appeared to suffer greater ill effects across time. Although Kurmato et al. (2013) suggest that the child's grief stemming from a mother's suicide may differ from child survivors of a father's suicide, this difference did not significantly alter the risk trajectory for CSoPS attempting and completing suicide.

Although the importance of the mother's mental health has continuously been identified as a critical factor in children's development, the importance of the father's influence on children's mental health and behavior cannot be ignored (Azaine & Singh, 2019; Cabrera et al., 2018). Emphasizing the important role fathers play in their children's physical and mental well-being, Azaine and Singh (2019) note, that actively involving fathers in their children's lives "may provide a potential opportunity to reduce mental and emotional health problems among children" (p. 495).

Bibliotherapy to Support Young CSoPS

Bibliotherapy, a term first used by Crothers in 1916, relies on the power of stories to help individuals cope with and process difficult experiences (Arruda-Colli et al., 2017; Heath et al., 2005). Many practitioners support the use of bibliotherapy as a developmentally appropriate counseling intervention to open communication about death and to support children who struggle coping with their grief following the death of a loved one (Arruda-Colli et al., 2017; Berns, 2003-2004; De Vries et al., 2017; Heath et al., 2008).

The type of books used for bibliotherapy may include fiction, non-fiction, poetry, and children's literature. Stories are selected that will best support children in coping with their loss (Arruda-Colli et al., 2017; Berns, 2003–2004; Corr, 2004). Stories provide different perspectives; support children's social emotional growth; and normalize experiences, helping children know that they are not alone and that others have experienced similar situations (Heath et al., 2005; Heath et al., 2017; Rubin, 1979). Berns (2003–2004) indicated that children may more freely share feelings when addressing challenging situations through the safety of characters in a storybook.

Although a few Internet websites, such as the Canadian site *ParentBooks* [https://www.parentbooks.ca/Crisis_Intervention_&_Counseling.html] and the Dougy Center [<https://www.dougy.org/resources/audience/kids?how=&who=&type=&age=0-6>], list young children's books about suicide, minimal research has been conducted with this type of support for very young children (Regher et al., in press). We also note that several websites focused on supporting survivors of suicide provide suggestions for very young children's grief- and suicide-themed books (e.g., [<https://www.sosmadison.com/books/helping-children-and-teens-cope-with-a-suicide>] and [<https://www.soslsd.org/bookstore/children/>]).

Focus of This Study

Additional research is needed to inform mental health practitioners, teachers, and parents about providing support to young CSoPS (<6 years old). Caring adults need specific strategies to open and maintain communication about the parent's suicide and strong emotions associated with such a loss, in particular anger, anxiety, depression, guilt, and complicated grief (Bennett, 2017; Brown et al., 2007; Cerel et al., 1999, 2000; Cohen et al., 2017; Wolfelt, 2002).

Noting these needs, the primary purpose of this study was to explore how adults, who as young children lost a father to suicide, perceived the potential therapeutic benefits of children's literature (picture books). More specifically, the goal of this study was to gather information that would inform selection of books for bibliotherapy-based interventions to support young CSoPS.

Method

Prior to conducting this research, the proposed study was approved by Brigham Young University's Institutional Review Board. The correspondence emails documenting this approval are included in Appendices B and C.

Research Design and Recruitment

A case study research design was utilized for this study (Merriam, 2009). Case studies have been appropriately used across the social sciences to examine the context of real life phenomena (Smith, 2018) ranging from community based health programs (Killingback et al., 2017) to Covid-19 mental health challenges (Bhuiyan et al., 2020). Creswell (2007) suggested that case study design is typically chosen when researchers want to understand phenomena that are unusual, uncommon, or unique (e.g., adults who, as young children, experienced their father's suicide).

The current study was especially well suited for this design in that the researcher sought to understand how each participant made sense of surviving a parent's death by suicide as well as which children's literacy books might be helpful in supporting CSoPS. As is common with case study research (Ridder, 2017), this study incorporates data from multiple participants including one-on-one interviews, field observations taken as the participants shared their experiences, and observations of participants' interaction with children's literature considered as potentially therapeutic with CSoPS.

Participants

Purposeful sampling was utilized to select participants for this study. Participants were selected from a pre-existing data set that explored the experiences of adults who as children, under the age of 18, experienced the death of a parent by suicide (Bennett, 2017; Wilson et al., 2019). Criteria used to select the participants included in the current study included the following: (a) the participant must be a child survivor of parent suicide; (b) the participant's parent who completed suicide was the participant's father; (c) the participant's parent completed suicide when the participant was younger than 6 years old; and (d) at the time of the interview the participant was older than 18. Seven participants from the larger data set met these criteria. The participants' demographic information is listed in Table 1. Three participants were female and four were male. At the time of their father's death, three of the participants were 5 years old; one participant was 4 years old; one was 3 years old; one was 1 year old; and one participant was 3 months old.

Participants in this study were recruited through invitations sent to bereavement groups, social media platforms, and suicide prevention groups. Additionally, information and invitations were posted on public and college library bulletin boards (within 50 miles of the sponsoring university). Interested participants were invited to contact the initial primary researcher through email. Following email contact, appointments were made for face-to-face individual interviews.

Data Collection and Analysis

Interviews

Data collection took place through individual interviews and observation notes taken during the interviews. Before beginning the interview, the participants filled out a brief

demographic questionnaire. The initial interviews with the seven participants lasted 30–90 minutes and took place in a conveniently located local library’s private meeting room.

Table 1

Participants’ Demographics

Name (all names are pseudonyms)	Participant’s Gender	Participant’s age at the time of father’s suicide	Mode of father’s suicide
Danica	F	5 years old	Overdose
Malcolm	M	3 years old	Poisoning in vehicle
Jesse	M	3 months	Gunshot wound
Delani	F	1 year old	Hanging
Melinda	F	4 years old	Poisoning in hotel room
Justin	M	5 years old	Hanging
Cory	M	5 years old	Gunshot wound

Observations of Interactions With the Books

Observations took place directly following the interviews as the participants were interacting with nine children’s picture books. Each of the participants (as adults) were presented children’s books that counselors may share with children following a death or suicide. Table 2 provides a summary and description of the pre-selected children’s books. All books are children’s picture books, with minimal text. Eight of the books were specific to grief following the death of a loved one. Of these, four of the books were specific to suicide (one book about a mother’s suicide, two books about a father’s suicide, and one book about an uncle’s suicide). One book, *The Invisible String* (by Patricia Karst) is commonly recommended for therapeutic bibliotherapy for a variety of issues, including grief.

Table 2*Description of Children's Books Shared With Participants*

Book title	Author	Book description
<i>After a Suicide: A Workbook for Grieving Kids</i>	The Dougy Center <i>The National Center for Grieving Children & Families</i>	This is a book of activities and prompts for conversations to help a child cope with a parent's suicide. Includes quotes from children. Has few illustrations and those illustrations look as if a child drew them.
<i>The Little Flower Bulb</i>	Eleanor Gormally	The main character is a little boy whose father has died by suicide. The family learns to cope with the pain of their father's death. In his memory they plant a flower bulb and care for it, awaiting its bloom after winter ends. The illustration style may be perceived as eerie.
<i>The Invisible String</i>	Patrice Karst	This book does not specifically address parent suicide. The three main characters are a mother, her young daughter, and her son. The children are afraid, and the mother describes the love between her and them as an invisible string. The invisible string of love between those you love and yourself stays connected no matter the situation. Illustrations are simple line drawings without a lot of detail.
<i>Luna's Red Hat</i>	Emma Smid	Luna, the main character, talks to her dad about why her mother died by suicide. The two talk about the circumstances of Luna's mother's death and also share their happy memories of her.
<i>When Someone Very Special Dies: Children Can Learn to Cope with Grief</i>	Marge Heegoard	This is a workbook style book that leads children through different drawing exercises to help them deal with grief because of death (not suicide specific).
<i>Not the End: A Child's Journey Through Grief</i>	Mar Dombkowski	This is based on a true story. The little girl, who is the main character, tells the reader all about how her family has grown and how life continued after her father died. The exact cause of death is not specified. This book is not suicide specific.
<i>Samantha Jane's Missing Smile</i>	Julie Kaplow and Donna Pincus	The story centers on a conversation between Samantha Jane and her neighbor, Mrs. Cooper. Samantha Jane used to be happy before her father died. Samantha Jane starts to feel better as she talks to her neighbor. This book is not suicide specific.
<i>My Uncle Keith</i>	Carol Ann Loehr	This book is framed around a conversation between a young boy, Cody, and his mother. They are talking about Uncle Keith's suicide. They talk about Uncle Keith's mental health and the need to seek help for mental health issues, including depression.
<i>Tear Soup: A Recipe for Healing After Loss</i>	Pat Schwiebert and Chuck DeKlyen	The main character is an older woman, Grandy. Her husband is deceased. She cooks a "tear soup" to express her grief. This book considers the nature of grief and how people deal with grief in different ways. This book is not suicide specific.

Participants' interviews and observations were audio-recorded then transcribed verbatim. Each participant was asked to review and select books that they believed would benefit a child who experienced a parent's suicide. The aim of this activity (reviewing the books) was to help provide feedback in selecting books that would specifically help a bereaved child understand suicide and process their emotions following such a tragic event. Each participant was observed as they looked through and read the books. Participants were also observed as they provided explanations as to why they chose specific books and whether or not they felt the books would be helpful in supporting CSoPS.

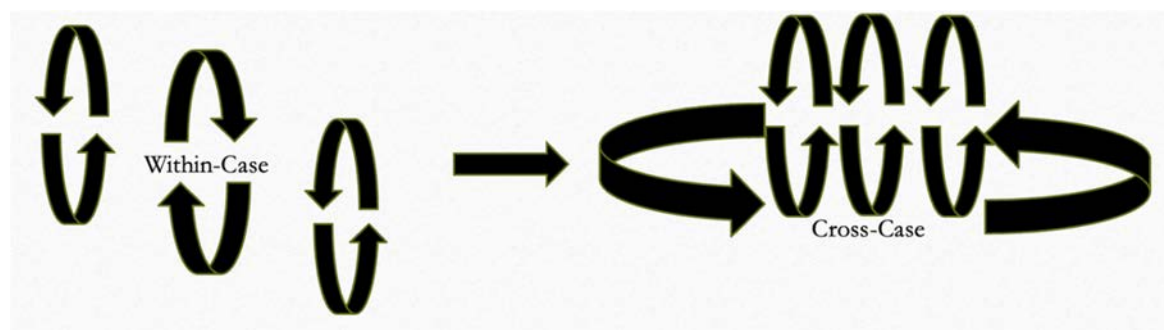
After the interviews and observations were completed, audiotaped interviews were transcribed. Each transcript was provided to the associated participant for their review. Participants were offered the opportunity to clarify points in the transcript, or to revise their comments, if needed. Following approval from the participants, the transcripts were de-identified and then uploaded to a secure password protected server. For this current study, a second approval from the university Institutional Review Board was granted to analyze deidentified data specific to this study's seven participants previously described (see Appendices B and C).

Coding and Analyses

Transcriptions of each interview and observation were downloaded into a word document which served as a tool to read, code, and analyze the data. The analysis was completed through a manual process of *within-case* and *cross-case* analysis. This analysis is represented in Figure 1 and more fully described in the following sections.

Figure 1

Pictorial Description of Within-Case and Cross-Case Analysis



Within-Case Analyses

The goal of this study was to understand the perspectives of young child survivors of parent suicide on what children’s literature would be beneficial to this population in the future. *A priori* codes were used during first cycle within-case analyses. There were three major *a priori* codes used during first cycle coding in order to organize the data. These three *a priori* codes include the following: (a) how the participant found out about the suicide, (b) how the participant reacted to the suicide, and (c) how the participant reacted to the books. Organizing the data according to these three *a priori* codes allowed the researcher to form a foundation to set the stage for a deeper understanding of the data across time and for each individual.

Next *emotive-coding* was used during the *within-case* analysis to explore other important aspects of the individual experiences of each participant. *Emotive-coding* is a process used to examine evidence of organizing and revealing interpretive and personal meaning of the data, such as what a participant might be experiencing in their mind (Prus, 1996; Saldaña, 2016). This type of coding has been deemed appropriate when exploring intrapersonal and interpersonal experiences that lead individuals to decision-making and judgement. This type of coding has also been found helpful to explore mood and tone of books (Prus, 1996; Saldaña, 2016).

During this stage of the analysis, process-coding was also used. Process codes are often referred to as action codes that include gerunds, or “-ing” words, are used to help the researcher understand change or shifts in thinking or behaviors over a period of time (Saldaña, 2016). This type of coding was particularly helpful in exploring how participants reacted to the suicide. Comparing and contrasting of the portraits from each participant and their perspectives on the books. Each portrait is representative of a participant. This allowed for the researcher to notice differences and similarities between each participant. See Table 3 for a sample participant portrait during phase one of *emotive-coding and process coding*.

Cross-Case Analysis

The second phase of data analysis includes the researchers creating a table to organize the data across all participant portraits. See Table 4 for a complete list of codes across all participant portraits.

The next step of the analysis process included the research team engaging in multiple data review rounds to make meaning of and reduce the codes from across the participants. The purpose was to condense the code lists into overarching themes that would robustly describe the experiences of the participants. The resulting six overarching themes included:

- Theme 1: How the participants found out about the suicide from others
- Theme 2: How the participants found out about the suicide themselves
- Theme 3: Elements that activated the healing process
- Theme 4: Elements that prolonged the healing process
- Theme 5: Books participants found helpful
- Theme 6: Books participants found unhelpful

Table 3*Sample Participant Portrait: How Participant Found out About Father's Suicide*

Emotion codes (Cody, age 5)	Process codes (Cody, age 5)
<u>Confusion</u> – [participant] Um... so I was five years old, it was November...when was it? It was a while back. So anyway, so my dad hadn't come home for a little, for a couple days or a day or two, I can't remember for how long it was.	<u>Others Missing</u> – [Dad]So anyway, so my dad hadn't come home for a little, for a couple days or a day or two, I can't remember for how long it was.
<u>Confusion</u> – [participant] They just came to our house [grandparents and uncles suddenly show up] and I thought that was kind of weird.	<u>Others Showing up</u> – [unexpected family members] But my grandparents suddenly showed up and a couple of my uncles showed up as well.
<u>Distraught</u> [uncle] And he was visibly distraught.	<u>Playing</u> – [participant] I was young, I was playing in the gutter with some toys or whatever.
<u>Confusion</u> –[participant] I didn't know what was going on.	<u>Others Talking</u> – [uncle to participant] And... my uncle Josh, he came up to me and he talked... he started talking to me
<u>Confusion</u> [participant]And so later on, I don't know what age or how old I was when I found out what really happened.	<u>Others Dysregulating</u> – [uncle's emotional dysregulation] and he was visibly distraught
Confusion [participant] but... I found out that he committed suicide... Well, I didn't find out the method. I just know he committed suicide.	<u>Asking</u> – [participant to uncle] – I asked him, I said, 'What's wrong?'
Confusion [participant] I didn't find out the method until a while later. I don't member how old I was... The way I found out that he shot himself was through his death certificate.	<u>Hearing</u> – [participant] –And then, in the background, I heard my mom just collapse and she was screaming.
	<u>Others Collapsing</u> – [mother] I heard my mom just collapse and she was screaming.
	<u>Others Screaming</u> – [mother] I heard my mom just collapse and she was screaming.
	<u>Others talking</u> – [grandparents] Grandparents had informed her what had happened.
	<u>Others talking</u> – [uncle] And then my uncle told me, like, 'Hey, your dad passed away.'
	<u>Others showing up</u> – [uncle] Like I said, my uncle, he came and... He showed up.
	<u>Separating</u> – [participant] My uncle came to me separately.
	<u>Others Talking</u> – [uncle to participant] One of my uncles, and he started talking to me about it, and he said, 'Hey, your father passed away.'
	<u>Others Withholding</u> –They didn't say how it happened, what happened, anything like that.

Table 4

Codes Across All Participant Portraits: Sample of Cycle 1 Codes for A Priori Codes 1 and 2

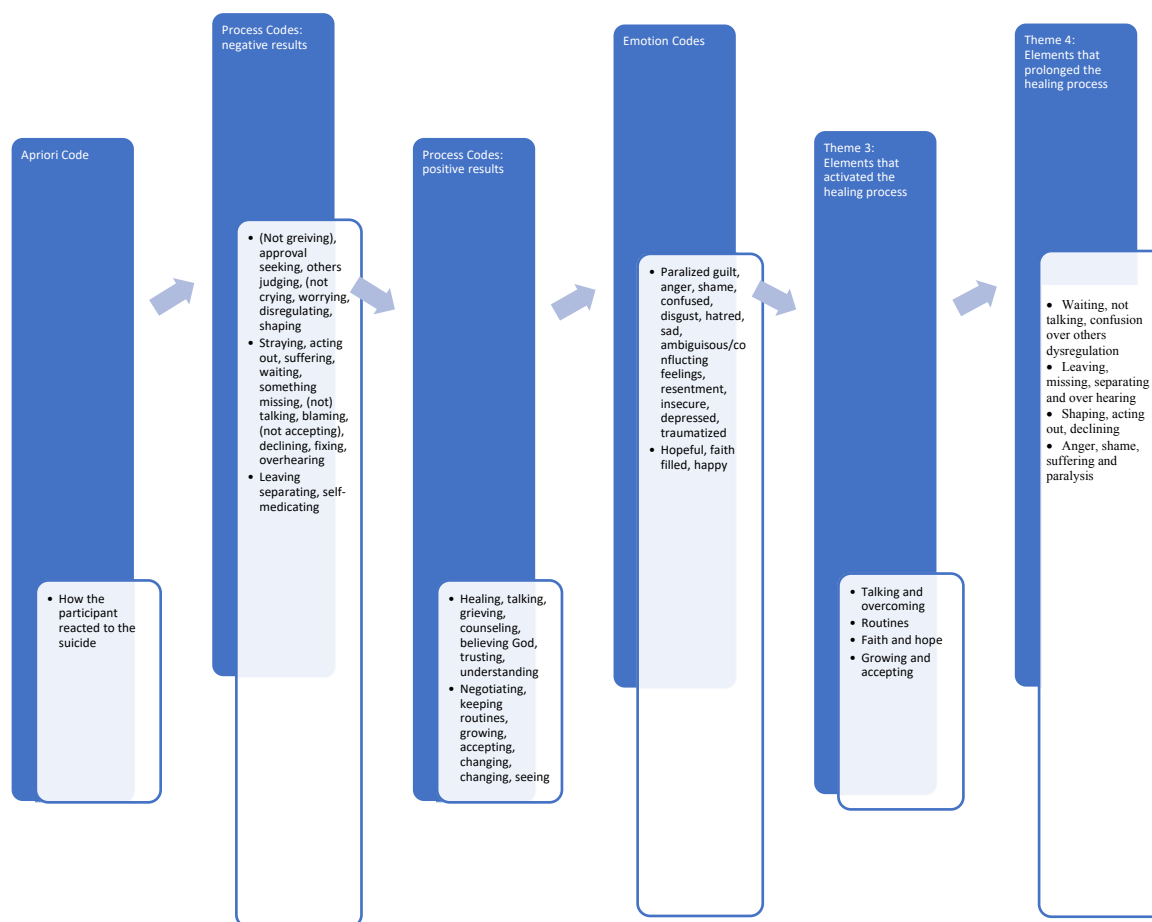
A priori codes	Process codes	Emotive codes
1: How participant found out about the suicide	Others showing up suddenly Others talking Others dysregulating Others collapsing Others screaming/yelling Others crying Others withholding/not talking Asking Playing Hearing Huddling Forgetting Running Leaving Noticing missing Connecting	Confused Fear
2: How participant reacted to suicide	Prolonging healing process Straying Acting out Suffering Waiting Something missing (Not) talking Blaming (Not) accepting (Not) grieving Approval seeking Others' judging (Not) crying Worrying Declining Shaping Dysregulating Fixing Overhearing Leaving Separating Self-medicating Overcoming Healing Talking Grieving Negotiating Keeping routines Growing up Accepting Changing Seeing Counseling Believing God Understanding	Paralyzed Guilt Traumatized Anger Shame Confused Disgust Hatred Sad Ambiguous/conflicting feelings Resentment Insecure Depression Hopeful Faith filled Happy

See Figure 2 for an example of how the team reduced the second set of code lists into themes about how the participant found out about the suicide. This process was conducted with each participant's data.

The use of in-depth fusion of coding from *within* and then *across* coding strategies resulted in a more in-depth understanding of each participant's experiences. This process was necessary in order to fully explore and understand how adults, who as young children lost a father to suicide, perceived the potential therapeutic benefits of children's literature (picture books). This process also helped us gather and make sense of participants' lived experiences and their perceptions and insights regarding the selection of books for bibliotherapy-based interventions to support young CSoPS.

Trustworthiness

To ensure trustworthiness in this study, triangulation, peer debriefing, member checking, thick description, external auditing, and researcher positionality were included (Brantlinger et al., 2005). The sample size of seven participants provided differing views of the phenomena of a father dying by suicide, which helps in triangulating and strengthening the results. The researchers included peer debriefing by meeting with their thesis committee chair to discuss emerging data and the analyses. Member checking was utilized during the original data collection by returning the transcripts to the participants and ensuring that participants approved their transcripts. A thick description of the context was provided through the mining worksheets, thus providing a better understanding of the context (Tracy, 2020). Last, reflexivity was used to consider ways in which the researchers' perspectives may have influenced the analyses.

Figure 2*Coding of Themes***Primary Researcher's Perspective**

Since adolescence I have been interested in the support of CSoPS. In high school a close friend's mother died by suicide. As I interacted with my friend, I was aware of this challenging situation and I frequently observed his sadness and noted the pain in his facial expression. However, I never knew how to support him. I felt like it would be inappropriate and uncomfortable to talk with him about the suicide, so I never did. When my friends and I were around him, we would act as if nothing happened, as if everything was normal. I knew that by ignoring the suicide we were not helping him, but at the same time I did not know how to help.

As time went on, it seemed like everything just faded away, people did not talk about the situation and it appeared to me that my friend was doing well enough to continue on with his life. Since that time, and as I have developed professional interests in suicide prevention, this experience has increased my desire to search for and support those individuals who are impacted by suicide and who suffer in silence. The experience of not knowing how to help my friend has fueled my desire to learn more about supporting suicide survivors, specifically minors that are impacted by the suicide of a loved one. For me, learning how to assist this population is a professional and personal goal. In particular, my hope is that this research study will inform effective interventions to better support CSoPS.

Results

Data from the in-depth interviews and observations revealed six overarching themes: (a) how the participants found out about the suicide from others; (b) how the participants found out about the suicide themselves; (c) elements that activated the healing process; (d) elements that prolonged the healing process; (e) books participants found helpful; and (f) books participants found unhelpful. In the following sections participants' illustrative quotes are included to provide thick descriptions of each theme.

How Participants Found Out About the Suicide From Others

Because participants were so young at the time of the suicide, most had only vague memories of finding out about the suicide. Their first memories of finding out about the suicide was from others. As a whole, they described finding out from others as a “traumatizing” and “confusing” experience. Participants shared how “others” would unexpectedly show up. Cody shared that his grandparents and uncles just showed up: “*But my grandparents just showed up*

and a couple of my uncles showed up as well.” Similarly, Malinda said, “The police just showed up at our house and my mom just, like, knew.” Similarly, Justin shared his experience,

My uncles just showed up and then we started hunting for [my dad]. And then we went out to the barn, walked in, and I remember I was behind my uncle who was in front leading.... And I remember, feeling a kind of tension there. I think my uncle knew something was wrong.

After family members showed up, the participants describe the accompanying traumatic emotional reactions of nearby adults and family members. These emotional reactions included yelling, screaming, collapsing, and crying. For example, Malinda remembered,

I just have a distinct memory of, like, being at my grandparents’ house in the morning and seeing my mom, so very upset and, I just remember, like, that there were days when it was so hard, you know, where she didn’t want to, like, you know, keep living.

Justin related his uncle’s reaction when the uncle first spotted his father after the suicide. *“He got to the top of the stairs. I was just about to the top of the stairs myself and I remember him going ‘Oh shit!’ and yelling at me to run home now!”* Cody described his mother’s reaction: *“I heard my mom just collapse and she was screaming.”*

Next, the participants described their reactions to the emotions of the adults as they found out about the suicide. Justin describes how frightened he was as he reacted to his uncle’s shouts to run home:

I remember running home and I kept thinking there must have been a monster in the barn. I had no idea. Then my mom left and the rest of us stayed home and I remember we were just kind of sitting there, uh, in the living room, huddled up close together just scared, I had no idea what was going on.

Another participant, Danica, described how she reacted to her mother's reaction after hearing the news of the father's suicide.

Um, so she took me and my little sister into the shower and just started crying. She said it was so we could all cry and be wet at the same time. I didn't really know what was going on and I was crying because she was crying.

The majority of participants also described the continued confusion as they observed the extreme emotional reactions of the adults. They reported not understanding what had happened.

Cody said, *"One of my uncles, and he started talking to me about it, and he said, 'Hey, your father passed away, but they didn't say how it happened, what happened, anything like that.'"*

Malinda (four years old at the time of her father's suicide) indicated that she was never told about the suicide until 14 years after the suicide. At this time, she was 18 years old. She reported,

I wasn't really told the details of, like, how my father passed away, until very recently. I didn't know it was actually this past summer where we, like, sat down, me and my [mom and stepdad] and my brother and I, and just, like, talked about it, what happened and [how he committed suicide].

On Their Own: How Participants Found out About the Suicide

The participants each shared how they did not understand what had happened to their father or the specifics of how their father died. They describe acting as typical children prior to the suicide. For example, both Cody and Justin share how they were playing when others unexpectedly showed up and interrupted the playing. Cody remembered when adults showed up to tell him about his father's death, *"I was young. I was playing in the gutter with some toys or whatever."* Justin laughed as he reported, *"I remember going to their basement. I found a cookie*

monster toy that I loved and I was like 'sweet!' At the time, that's all I cared about was that cookie monster toy."

Some of the participants talked about how they had a vague sense that something was wrong or missing. Cody shared, *"So my dad hadn't come home for a little, for a couple days or a day or two, I can't remember for how long it was."* Malinda reported a similar experience:

Kind of just out of the blue, um, he just, like disappeared, um, just, like, didn't come home from work, I think one day, and I do remember he was missing for a couple days.

It seemed it took some time, but each of the participants started asking questions about the father's absence and about the death. For example, even though Justin's mother had initially told him about his father's death, he describes a process of wondering and trying to make sense of what happened to his father. At first, he did not know that his father died by suicide. Justin continued to ask his mother about his father's death. He stated, *"Later on, a few years later, all I remember at first was asking, 'Mom, who killed Daddy?'"* Danica described a similar experience:

So later, in like first grade I remember hearing...so I was like 6 or 7, so the next year...I remember hearing my mom and my grandma talking about Larry dying. And it was the first time that I remember hearing about his death and really connecting with it. I asked, 'He's dead, right?'

Elements That Activated the Healing Process

As participants disclosed ways in which they reacted to the news of their father's suicide, they shared elements that helped to activate and as well as prolong the healing process. These elements included talking and overcoming, maintaining routines, accepting, and being faith filled. These elements are described in the following sections.

Talking and Overcoming

All of the participants described the healing effects of openly talking about the suicide, most often talking with a trusted family member or counselor. Cody related that he never talked about the suicide with anyone for 14 years. He went on to explain the healing effect of talking with a trusted counselor. He stated,

And as soon as I talked about it, like I said, I overcame it. It took a little while but eventually it happened, you know. I never went to counseling until [I was 19 years old]. And that's when the healing process started to take place when I started going, going to counseling... I was 19, I think, roughly.

Malinda also commented on the helpfulness of talking to a counselor. She stated, *“I remember, like, going into, like, the counseling center and I always really liked going, like, I really, like, looked forward to it.”*

Maintaining Routines

Participants also related how helpful it was for them to keep regular routines as they moved forward in the healing process. Justin remembered going back to school:

It was a preschool. It was at this lady's house up the street in her basement. She had a classroom. Going back to school must've helped to just normalize things because I felt pretty normal then.

Accepting

Participants shared experiences that helped them to accept the death of their father. Justin talked about developing the ability to share about his father's death. He commented,

I remember I would anticipate it because every time you would meet new people, a friend's parents or anything like that, you know, they're inevitably going to start asking

about family and all that so you kind of start to anticipate that question coming up and try to measure your response. But I got to where I would just say, 'He killed himself.' And that was it.

Malcolm shared how he came to accept his family life as his “new normal” after the suicide:

I had a mom and that's my life. I had my sisters and yeah. It wasn't abnormal to me even though I could probably step back and compare someone else's family to mine and see that there's differences, but, you know, at the time, and still to this day, I just feel like everything's normal. It was just, that was life.”

Being Faith Filled

Another idea that helped participants in activating the healing process was the idea of faith. Cody shared his personal his insight:

The man upstairs changed me, God. And... I think having also, like, a belief in a higher power, belief in Jesus, or whoever those people may be to certain individuals, as they develop those beliefs in them they can seek healing through them, which I think is the ultimate goal. At least that's how I healed completely, was through them.

Similar to Cody, Malinda, shared her beliefs:

I believe that we have, this living God who cares about us, and He's not going to let us, be unhappy and the people who had to deal with those horrible things during their life, like, won't have to feel the guilt for, like, their actions they took because, like, He understands perfectly. So, I think that's a huge factor in healing.

Elements That Prolonged the Healing Process

Participants also shared elements related to the suicide that prolonged the grieving and healing process. These elements included waiting to talk about the suicide; leaving, missing, and

separating; acting out; and feeling paralyzed, conflicting feelings, and needing to fix it. These elements are further described in the following sections.

Waiting to Talk About the Suicide

All of the participants discussed the difficulty of not being told about the suicide in ways they could understand. Cody succinctly described the critical need to talk about the suicide.

I mean there's these like un, unspoken rules that people follow. They are just like 'Wait till they're older to talk about it.' So none of us [siblings] talked about it. We just kinda kept it on the back burner. [Looking back on it], I don't think that's wise. Yeah, so just not talking about it prolonged the healing process for each of us.

Danica added. *"I was so traumatized and so angry that I wasn't told directly. That I had heard about it through eavesdropping. So like, there's that whole thing!"*

Leaving, Missing, and Separating

The participants described how they felt left by their fathers. Cody said, *"We're like, what the heck we're a family, why did you leave us?"* Jesse shared similar thoughts:

I am missing something and I can't help but be reminded of it. So, I know it's up to me to get over it but it's just, I haven't been able to. It is more his absence more than his death.

Malcolm reiterated the impact and subsequent feelings he experienced through the absence of his father. He commented,

So basically, I just grew up in a fatherless home. I didn't have a father and my sisters didn't really want to, um, hang out with the little boy. So, it shaped me. I mean, it would've been nice to have a father and to do this and that as a boy. So, I think it [the experience of growing up in a fatherless home] was extremely pivotal for me.

Danica also described what it was like to not have a father as she grew. Yet, in her description, she seemed to indicate she was somehow to blame for her father leaving the family; *“Not only did he leave me and my sister when he divorced my mom, but now it’s like I wasn’t even good enough for him to stay around.”* This idea seemed to prolong the healing process.

Danica continued,

As a kid I just knew that I wasn’t good enough for him to stick around. My little sister wasn’t good enough, my mom, my other siblings, you know. So that’s kind of what middle school was like.

In addition to the tragedy of the suicide and feeling left by their fathers, the participants also related how they were separated from family members from their father’s side of the family. Malcolm talked about how he is only in contact with his mother’s side of the family currently; *“My mom and my sisters, my maternal grandparents –that’s the constant is the maternal side.”* Justin reported similar experiences after the death of his father: *“I know there is a lot of anger and resentment in my family from both sides. Neither side of the family really gets along and I don’t see any of my father’s siblings anymore.”* At the time of the interview Justin had not interacted with his father’s family in many years. Cody added that he too had experienced a separation from his father’s family. He reported not seeing or interacting with his uncles and grandparents on my father’s side. Cody said that over time, they *“separate[ed] themselves from us, it kind of grew apart.”*

Acting Out

Several of the participants disclosed how their grief and pain from their father’s death served as a catalyst for maladaptive behaviors. Cody described a time of straying away from

family values in order to find short-term relief from the pain, described as “self-medicating.” He shared his perspective:

I wasn't a good boy for a long time, I strayed and that was primarily because of the pain that I had. I mean, it's a lame excuse but it's, it's, it's really true. Like, if, if you have all that pain, that's the core problem if you don't solve it. You can see all these other actions are made manifest because of that problem And so, I think a lot of people that have had, had parents or loved ones commit suicide, they primarily start doing drugs, they do all these other things, it's because they're trying to self-medicate to cover up that pain. I did. For a long, long time and it was difficult to get out of.

Jesse talked at length about his ongoing battle with anger, depression, self-hatred, and seeking approval. He shared these perceptions:

I get my anger from him, I get my depression from him. I dislike myself and my life. I would be willing to sacrifice myself for a new me. I have that constant need of, at least, self-approval, not really approval from others, but, at least, I seek it from others. Does that make sense?... I constantly want to build myself up, but I don't take anything from others. I'll take their negatives but not the positives.

Delani described about her self-blame for her father's death:

Mom says that I was her 'Mother's Day present from hell.' She says it jokingly, but apparently, I was the worst baby ever and I was born [the week of] Mother's Day. I was extremely fussy. I cried all the time. I was just a terrible child. Mom says I was just, a huge stress, basically.

As Delani repeatedly heard this as a child, she worried that she caused her father to complete suicide. She worried that she was, in fact, the absolute cause of her father's death. She continued,

It makes me feel like maybe he did that [completed suicide] because of me because I was born. It took me so long to get over and my mom did not help with this part. Me hearing how difficult I was as a baby and then my dad committing suicide when I was so young, I was like, 'Oh my gosh, I must have been a part of the reason, if not the whole reason,' you know?

Feeling Paralyzed, Conflicting Feelings, and Needing to Fix It

Several participants described feeling paralyzed after the suicide. Cody relates,

I remember that [cough] that since that day, for a long, long time, it felt like everything just stopped. Everything in my life, just... My progression, my happiness, like everything was just kind of off whack. Because there was that huge part of my life that was taken away in an instant.

Other participants shared how they felt stuck in their complex feelings they had for their fathers. For example, Jesse described how he could not yet come to terms with the word *Dad*. He stated,

I can't even call him Dad, because there's no such thing. So, I don't know what that means but... You know what I mean? The fact that everyone has a dad except me. I had a father, you know. That's just biological, there's nothing intimate whatsoever. Dad is more casual and whatnot. Father is just a clerical word. I want to say Dad, but I can't. So even to this day I still have that mind war.

Danica also shared her complex, sometimes conflicting emotions towards her father:

People who commit suicide are so selfish and I thought that all the way up until adulthood. Which is a shame because there's a lot more to suicide than that, but as a kid I just knew that I wasn't good enough for him to stick around. I also hated being compared to my dad. Forever, I hated it. Being averse to him has made it much easier because I don't like him as a person. I'm happy that he's not my father. I'm happy that I wasn't raised with him. But I hate that it's like I wasn't even good enough for him to stay around.

Justin shared how a Sunday school teacher's impulsive and unthinking remark caused conflict in his feelings for his father. Justin related, *"As a little kid I worried that I would never see my dad again. So, one day in church I asked the Sunday School teacher, 'If someone kills themselves can they go to heaven?'"* Without a second's hesitation, the Sunday School teacher looked at Justin and replied. *"No."* Justin explained, *He gave me a pretty frank answer and was like 'well, it's technically like a form of murder and so you can't really go to [heaven], or whatever.*

Cody also explained an ongoing conflict in his feelings about his father's death. He related, *"They keep inviting me to speak in church on Father's Day. To this day, I keep declining. I can't do it."*

In addition to feeling paralyzed, and dealing with conflicting feelings about their fathers, almost all of the participants talked about needing to fix something related to their fathers. For example, although Malinda did not seem to blame herself for her father leaving, she did seem to indicate that it was her responsibility to learn about him and to get to know him. Malinda said,

It kind of makes me sad that I feel like I don't know a lot about his life, like, I feel, like, I don't, like, know him very well um, but, the thing is, is, like, I can still, like, make that happen now, you know.

Even when the participants attended therapy sessions, they gave the impression that each individual is responsible for “fixing it.” Danica discussed how even though counseling sessions were very confusing for her, she still felt she needed to “fix it.” She further explained:

Like, I couldn't understand a metaphor to save my life. I just couldn't connect those pieces, so when I was with the counselor and they're trying to, you know, tell me the grass isn't greener on the other side, like that made no sense to me at all. They were trying to teach me through proverbs. I had no idea what was going on because I was, just my brain didn't function like that. So, I was never told, straight up, like how, you know, this is what's going on, this is what you need to do to fix it.

Jesse also seemed to indicate that all of his years in counseling taught him he could fix things by “sucking it up.” He commented, “*I've always had some kind of counselor. And um, basically all you do is you can vent and then suck it up. That's what I've basically learned in life.*”

Participants' Perceptions of Books

Participants reacted to the books in various ways by describing which books they felt would have been helpful or unhelpful to a child survivor of a parent suicide. It struck the researchers how closely participant's reactions to the books seem to mirror their experiences of finding out about the suicide and how they reacted to the suicide.

Characteristics of Books Participants Found Helpful

Table 5 describes participants' descriptions of helpful and unhelpful aspects of the books. Participants described books as helpful that seemed to be gentle; positive; contained bright, colorful images and illustrations; helped them to feel connected to a loved one; addressed fears; and acknowledged the challenges of losing a parent to suicide.

Gentle. Cody delighted in the book *Are You Like Me?* because of its gentle way of easing children into the difficult subject or memory of a loved one's suicide. He said, "*It's like guiding them through. It is a good analogy. It is helpful. It eases into it very gently.*"

Positive. Malcolm also labeled *Are You Like Me?* as a "wonderful book." He explained; "*It's a positive book and helps make you think about things you weren't thinking about.*" Jesse agreed. He expanded, "*So the pictures, are obviously big and colorful, kids like that. Good imagery. Yep, this book is perfect.*"

Connecting and Attaching. As a whole, *The Invisible String* stood out as a favorite for the participants. Several commented that the book helped them remember they were connected to loved ones always. Cody commented, "*This is a really good book. I liked it because my mom always said, 'No matter where you are, no matter what you do, I will always love you.'*"

Delani also described how *The Invisible String* addressed the need to feel connected. She said, "*I like how the book talks about how kids would take the invisible string with them wherever they go to feel connected.*" Delani seemed deeply impacted by the mother in *The Invisible String* when she told the children that no matter how she feels, whether angry or not, their connection would not be broken. Delani continued, "*This book [tapping on *The Invisible String*] is something that kids will always remember. Yes, 'The Invisible String.' Kids would connect to it.*"

Table 5*Participants' Description of Helpful and Unhelpful Books*

Helpful books	Process codes	Emotion codes
<ul style="list-style-type: none"> • Are You Like Me? • The Invisible String • Not the End • Samantha Jane's Missing Smile 	Approving, guiding, easing, Helping, Gentling, Relating, Attaching, Liking, Understanding, Applying, Connecting, Addressing, Encouraging, Appreciating, Representing, Acknowledging	Happy Nice Love Positive Hopeful
Unhelpful books	Process codes	Emotion codes
<ul style="list-style-type: none"> • <i>My Uncle Keith</i> • <i>After a Suicide: An Activity Book for Grieving Kids.</i> • <i>Are You Like Me?</i> • <i>Luna's Red Hat</i> • <i>Little Flower Bulb</i> 	Leaving Triggering Increasing Fear Confusing Missing parts	Fear Insensitive Confused Sad Ambivalent Unclear Unhelpful Cold Negative

Note. See Table 2 for a complete description of the books, and participant reactions.

Addressed Fears. Participants also seemed drawn to *The Invisible String* because the book addressed fears attached to their father's suicide. Delani explained,

The book says, 'Can a string reach all the way to Uncle Brian in heaven?' That's good. I would've enjoyed this book as a kid. When the book says, 'does the string go away when

you're mad at us? The mother responds, 'Never.' I like that. Because that was my greatest fear with what happened to me as a little girl.

Delani was so taken with the idea that about suicide should address fears, that even though she found the book, *After a Suicide: An Activity Book for Grieving Kids* unhelpful, she responded positively to the one line in the book that addressed a fear she had related to the suicide. She commented, *"This page is okay."* She referred directly to one statement in *After a Suicide: An Activity Book for Grieving Kids*: "You may think you did something to cause this to happen, this is not true."

Delani also responded positively to the idea of the invisible string applying to separations caused by death and other traumatic situations. She expanded,

I felt like [The Invisible String] addressed a lot of things. Like it addressed death, it addressed the simple fears of a child....Like their mother or father being angry at them, the string is still there even if the parents are angry at the child. That gets at a child's main fear of someone not liking them or someone being mad at them.

Malcolm agreed, *"This [The Invisible String] is a nice book with a very happy, helpful message. It is applicable in all scenarios."*

Acknowledging. Participants also felt that books were helpful that acknowledged the challenges of living with losing a loved one to suicide. Malinda explained,

I liked that it [Not The End] showed, like, that there is, like, dark time, you know. And I really liked that they showed the family, like, engaging in, like, positive, uplifting, happy activities, like, after the death.

Malinda was also drawn to another book that acknowledged the pain associated with suicide.

She said,

I think that's important to acknowledge, like, yeah, it's painful, and I think just, like, shoving that away and, like, not acknowledging the pain, like, is not beneficial. Um, I really like this book, this part [Samantha Janes Missing Smile] where she says, 'But sometimes I worry that if I talk to you about dad, you'll start to feel sad.' So I like that this book acknowledges that and says that it's okay and that, like, the parent figure, like, wants the child, um, to talk to them.

Characteristics of Books Participants Found Unhelpful

Participants seemed to be specifically sensitive to books that seemed confusing. They reported that these types of books would not be helpful to children. Participants also described books as unhelpful if the book seemed to be rough or insensitive, had perceived missing parts, were cold, were triggering, were negative in nature, or if the book seemed to increase fear.

Confusing. Danica described the book, *Luna's Red Hat* as unhelpful because she found it to be confusing. She said, *"I don't think I would've understood this book as a kid. I would've been like, okay what's going on? I don't understand. I don't even know if I would get it."*

Melinda discussed how she found the book, *Not The End* as confusing. She stated, *"I don't know if I got the analogy of, like... like, your life is a book and, like, turning the pages just because I think the process is more of a continuum rather than, like, chapters and segments."*

Delani also shared how children would find the book, *After a Suicide: An Activity Book for Grieving Kids*, confusing. She said, *"It would be hard for a kid to relate to this. I don't get this."*

Although some participants found the book, *Are You Like Me?* to be helpful, Jesse had a strong negative reaction to the book, which he found confusing. He stated,

The book is too nuanced. You need to say 'to stop them from living' or something like that because like, if you're just like 'stop working' it's confusing. It's like, no, you need to be more straightforward. I just don't like that phrasing. There's got to be a better way of saying that. I would put that first, 'be sure to talk to grownups about your fears because this one kind of seems backward. It needs to be near the beginning.

Insensitive. Cody found the book, *My Uncle Keith* unhelpful. He explained, “*I don't think it's helpful because it's not, uh, explained with a sensitivity.*”

Missing Parts. Participants also reacted negatively and found books unhelpful that seemed to be obvious omissions, “*missing parts:*” *I'm basically just seeing friends and family [in Are You Like Me?]. Is there 'hey, you can also refer to someone at school'? I'm not seeing that.*

Cold. Books that appeared cold received negative reviews and were rated unhelpful by the participants. For example, Delani believed the cold language appearing in the book, *After a Suicide: An Activity Book for Grieving Kids*, would hinder a young child's understanding and connecting with the book's information. She said, “*I don't really like this book. It's just, cold, not creative. I shouldn't be so critical, but it is just cold. It's not a story.*”

Triggering. As soon as Justin saw the cover of the book, *Little Flower Bulb*, he immediately reacted negatively, “*I don't like the art style, right away.*” Participants' overall feeling based off of the illustrations was quite negative. Justin (whose father died by hanging) commented, “*See his head is kinked. And now, we've been talking about my dad so much, it makes it look like he's hanging.*” The cover illustration of the *Little Flower Bulb* includes a little boy whose head is tilted to one side. This was particularly off-putting and triggering for Justin, who commented, “*He kind of looks dead right there, to be honest, like, that hollow look in his eyes.*”

Jesse described a book that seemed to be triggering for him as well. He commented, “*The thing is, this kid’s kind of screwed [in the book Are You Like Me?]. It makes my brain feel like bullshit!*” Dana also described a triggering moment after reading the book, *Luna’s Red Hat*. Wistfully, she commented, “*And [this book] just made me feel so sad.*”

Increases Fear. In addition to being triggering, books that seemed to induce fear were rated as unhelpful. Justin related his negative impression of the *Little Flower Bulb*, “*Maybe it’s intended that way to, like, you know, let kids know that life can be scary and dark and rough and stuff like that. But this is not a book for children.*”

Discussion

This study was based on individual semi-structured interviews conducted with seven adults who, prior to age of six years old, experienced the death of their father by suicide. These data are a subset from 17 full individual interviews that were collected and initially analyzed by Wilson et al. (2019). Although the current study draws from seven of the interviews conducted by Wilson et al. (2019), we analyzed data previously gathered, but not reported in the prior study. We investigated survivors’ perceptions of the potential for bibliotherapy to support very young CSoPS. At the conclusion of each interview, participants offered feedback on nine children’s picture books (described in Table 2). This offered participants the opportunity to share their impressions of how the stories may or may not be helpful in supporting very young CSoPS. This placed the participant in a position of strength and served as a transition to exit the interview. Participants were told that their recommendations would help adults select books to share with young children who experienced their parent’s suicide.

Communication About the Father's Suicide

One of the biggest challenges that participants reported was the lack of opportunity to talk about their father and their father's death. Participants reported that as young children, they were confused about *how* and *why* the father decided to complete suicide. Because the children were so young at the time of the father's suicide, many adults assumed the children could not understand. However, participants reported being confused and fearful, sensing the adults' intensity of emotions but not being able to connect the emotions with what was happening. Even over time some of the children never talked about their father's suicide. Participants remembered feeling guilty about possibly being the cause of why the father died by suicide. As the children reviewed the nine books, the fears and confusion discussed in the interviews were reflected in the comments made during their review of the books.

Our major takeaways from the participants' interviews: books shared with CSoPS should include reassurance that they are loved, that the suicide was not their fault, and that they are not alone. Selected stories should assist children in helping to clarify the swirling confusion in their young lives.

Aligning Bibliotherapy Intervention With Worden's Tasks of Grief

As we reviewed the interviews and the comments made while participants reviewed the children's books, we thought about Worden's (1996, 2008) four tasks of grief. We note the difficulty young CSoPS will experience when facing challenges associated with a parent's suicide. First of all, because the facts about the parent's death are often not shared with the young child, the child will have difficulty understanding that the parent's death is real. Some children may not attend the funeral or see their deceased parent. Due to circumstances related to the suicide, the parent's body may be cremated, or the family may request a closed-casket

funeral rather than having an open viewing. The reality of death is difficult for a child to understand, particularly in the case of suicide (Montgomery & Coale, 2015).

There is a heavy stigma associated with suicide (Hanschmidt et al., 2016; Hung & Rabin, 2009; Loy & Bolk, 2014; Pitman et al., 2016), contributing to others tending to avoid talking about suicide because they may not know what to say or how to offer support (Montgomery & Coale, 2015). Sharing books with children about grief and loss may help them understand the reality of death and lessen their feelings of isolation, guilt, and shame (Berns, 2003–2004; Corr, 2004; De Vries et al., 2017).

Based on feedback from the participants in our study, we recommend matching the books with aspects of the child's specific situation. We recommend offering the child a few books and letting the child select one that they prefer. Initially books may not be specifically about a father's death, but about expressing emotions, about grief and loss in general. Then, as the child feels comfortable asking questions and specifically talking about the suicide, adults could offer suicide-themed books and talk directly about the suicide.

Based on Worden's second task of grief, children must face the emotional pain associated with their father's death, not alone but with the loving support of others. This task of grief requires supportive adults to gently guide children through the sadness and painful emotions associated with grief (Wolfelt, 2002). We may want to shield children from emotional pain, but we all must learn to live with our grief (Montgomery & Coale, 2015). Reading books about emotional expression and helping children identify what they are feeling is helpful in addressing this task of grief (Regher et al., in press).

Third, children will have a difficult time facing the changes in their life after the father's suicide. As mentioned by several participants, family dynamics changed overnight with the

father's side of the family often ceasing to have contact with the children or surviving parent. Financial hardships may necessitate the mother working or remarrying someone who can support her and the children. These changes are substantial. The surviving parent is often emotionally unavailable to the children due to the trauma and personal crisis she is facing (Loy & Boelk, 2014; Montgomery & Coale, 2015). CSoPS need to be reassured that they are loved and that family members, caring adults, teachers, and counselors will support them and their mother during this difficult time. Children also need to know that their surviving mother will get the help and support she needs (Bennett, 2017; Wilson et al., 2019).

Fourth, and possibly the most challenging for CSoPS, children need to memorialize their deceased father, build connections that they will carry with them over time. Cerel and Sanford (2018, p. 76) indicate that "It's not who you know, it's how you think you know them." They indicated that for CSoPS, the actual facts and the formally identified relationship do not drive how children respond and cope with the reality of the suicide. They indicate that children's memories and grief are grounded in the "nature and perceptions of the relationship" (Cerel & Sanford, 2018, p. 76). Older children will have a more established relationship with the deceased parent, but for very young children this is often missing. The memories participants reported were often molded by those around them. Over time other's stories become the child's memories. In some cases, these stories were painful and may need to be reframed and retold. Surviving parents must be careful in how they portray the child in a negative way. For example, Delani reiterated that she was frequently described by her mother and family members as "the Mother's Day gift from hell." She felt the guilt associated with her belief that she was possibly the cause of the father's suicide. These memories were very painful for her to bear and she had a difficult time having fond memories of her father because of her guilt. Delani and other

participants in this study were especially impressed with *The Invisible String*. This book assured children that their interpersonal connections with loved ones cannot break and that are always present regardless of what we do or where we go. This book addressed a critical need for our participants. In order to address this fourth task of grief, children need reassurance that they are connected to their deceased father and that even death does not break this connection.

Limitations

In this study we only included seven young child survivors who experienced their father's suicide. This may seem like a narrow selection of participants. Indeed, appropriate sample sizes must be determined in both quantitative and qualitative studies. However, while sample size in quantitative work concerns itself with statistical power, sample size in qualitative work is concerned with *sufficient* information power (Malterud et al., 2016).

Sufficient information power depends upon sample specificity, quality of dialogue, and analysis strategy. Typically, the closer the match between the study phenomena and the life of the participant, the greater the information power. Also, carefully planned, in-depth interviewing accompanied by attentive member checking and rich, thick (Tracy, 2020), multidimensional (Smith, 2018) descriptions of data episodes used for analyses (Malterud et al., 2016) creates higher quality dialogue. Sample specificity, quality of dialogue, and intentional use of analysis strategy correspond with lower sample sizes that offer sufficient information power (Malterud et al., 2016). The methodology and analyses implemented for this study were particularly suitable and allowed the researchers to drill down and explore in depth the nuances of seven children's experiences as CSoPS (Smith, 2018).

Another potential limitation, our findings may not generalize to child survivors of a mother's suicide. Additionally, our findings may not generalize to older children. Another

limitation, we did not investigate the differences in responses between female and male survivors. Furthermore, this study only investigated participants' perceptions of children's books and did not investigate the actual effectiveness of children's books in addressing the needs of CSoPS.

We acknowledged at the outset the inherent complications, uncertainties, and advantages of working with the retrospective stories of members of a vulnerable population (e.g., CSoPS). This study's data are retrospective in nature and participants reported on memories of their experiences following their parent's suicide. We rejected the criticism that retrospective memory work is too subjective a source for social science research (McLeod & Thompson, 2009). We ascribed to the idea that retrospective interviews by adults have been found to include more depth and emotional poignancy than memory work with children (McCammon et al., 2012), and can forge a missing voice for vulnerable or silenced populations such as CSoPS (McLeod & Thompson, 2009). As such, we attended to recognized principles of rigor for retrospective work by developing research questions that focused on a specific situation (parent suicide) rather than a life in its entirety; and compared present thoughts (which books may be beneficial) about past events (to child survivors of parent suicide). As a team, (through rounds of reflexivity described below), we realized that regarding treatment, child survivors' perceptions across time, whether consistent or inconsistent, provided targets for supportive intervention to address (Supiano et al., 2017).

Recommendations for Future Research

Suggestions for future research may include gathering information from those who work with very young CSoPS, identifying their perceptions of interventions that they consider most effective in opening communication about the parent's suicide. Additionally, gathering

information from the surviving parent and the child's teachers would also assist in clarifying which interventions may be more helpful. Longitudinal studies, though more challenging to conduct, would provide insights into developmental changes across time and the effects of postvention intervention to support young CSoPS (Brent et al., 2012; Cerel et al., 1999).

The importance of continuing to investigate how to best support young CSoPS should not be underestimated. These children face incredible challenges. They need support as they navigate the tasks of grief. Those who assist must acknowledge that these tasks are more difficult for CSoPS. As such, children need to be supported in asking questions and communicating about their parent's suicide. We propose that sharing carefully selected children's books with CSoPS will open and strengthen this communication.

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APPENDIX A

Review of the Literature

The United States of America reports about 48,000 deaths by suicide each year (Centers for Disease Control and Prevention [CDC] & National Center for Health Statistics, 2020), however these numbers are believed to be underreported (Andriessen, 2014; Madge & Harvey, 1999). The stigma surrounding suicide complicates many things, from reporting to coping with the loss of an individual (Ali, 2015; Lasrado et al., 2016; The World Health Organization [WHO], 2019). Organizations and groups are beginning to come together to help combat the prevalence of suicide (WHO, 2019). Historically, researchers have claimed that six to seven people are profoundly impacted by each suicide (Berman, 2011; Cerel, 2015; Cerel et al., 2014; Shneidman, 1969), however, Cerel (2015) indicated that this number was closer to 140 persons. Further research suggests that family, friends, and acquaintances are all impacted by suicide (Cerel, 2015; Cerel et al., 2014; Cerel et al., 2016; Drapeau & McIntosh, 2016).

The actual act of suicide is not a singular event, but the culmination of many events (Eckersley & Dear, 2002; Jeong et al., 2012). The suffering associated with the act of suicide is felt long before by the individual's suicide—the suffering precedes and follows the suicide, not dissipating immediately after the death (Jeong et al., 2012). The strained preexisting interpersonal relationships between the victim and those around them highly influences family members and friends and these issues are exacerbated by the suicide and continue to be a source of emotional strain following the suicide (Jeong et al., 2012)

Suicide of a Loved One

Jordan and McIntosh (2011) created a four-category model of emotional and intellectual experiences of people after the death of a loved one, while comparing the different types of

death. Category one is the expected deaths. These types of death are followed by general grief accompanied by pain, sadness, and the desire to have the loved one back. Category two includes unexpected deaths. Survivors experience symptoms along with those of category one, but also feel disbelief and/or shock. Category three is sudden and violent death. Survivors of this type of death often experience the symptoms of the first two categories, along with trauma and a feeling of vulnerability regarding their own death or tragedy. Category four is death by suicide. Survivors feel all of the previous symptoms, but suicide deaths amplify feelings of rejection, abandonment, and anger (Jordan & McIntosh, 2011).

Many researchers have questioned the similarities and differences between suicide specific grieving compared to non-suicide bereaving. Jordan (2001) conducted a meta-analysis of the research on this comparison. Generally, the social support network, the effect on the family unit, and themes of grief were different for suicide survivors. The meta-analysis concluded that the research was too varied in methodology to make conclusions, but indicated a need to further the research.

Sveen and Walby (2008) also did a review of 41 studies comparing people bereaved by death and those bereaved by suicide, including four studies with children and adolescents. Assessments showed a more intense grieving process in suicide survivors. This process includes feelings of blame, rejection, shame, and concealing the cause of death.

Suicide impacts many areas of life, including large and small scale (Cain, 2006). When talking about suicide, the term “survivor” may apply to different individuals, including those who have attempted suicide and those impacted by a suicide (Cerel et al., 2014; Jordan & McIntosh, 2011). When *survivor* is used in this case study, it will refer to the individuals deeply impacted by the suicide of a loved one. With the previously discussed number of people

impacted by the suicide of one individual, it is estimated that there are 6.5 million survivors of suicide each year (Cerel, 2015; Cerel et al., 2016; Cerel et al., 2014; Drapeau & McIntosh, 2016).

Suicide of a Parent

Over half of the reported 42,000 United States suicides in 2014 were of individuals between the ages of 25–54, which are typical child rearing years (Kochanek et al., 2016). With this in mind, it is estimated that there are 7,000 to 10,000 CSoPS each year (Cerel et al., 2008; Pfeffer et al., 2002). The inconclusive statistics create a number of obstacles in understanding this population (Colpe & Pringle, 2014). Colpe and Pringle (2014) indicated that some of these obstacles include the tender, sensitive nature of suicides, families wanting to keep the suicide private, and identifying certainty of suicide over accidental deaths.

Dyregrov (2009) considered the experiences of 32 adolescent survivors of parent suicide and concluded that symptoms include sleep and appetite disturbances as well as social withdrawal (Jordan & McIntosh, 2011). Adolescents internalize thoughts and feelings like guilt, denial of death, concerns about caregivers, and denial of their own needs due to the grieving of other family members (Mitchell et al., 2006). These survivors also feel abandonment, guilt, responsibility for the suicide along with challenges in making meaning of the death (Jordan, 2001). Dyregrov (2009) found that every single adolescent reported issues with concentration, impacting their schoolwork.

Pre-Existing Issues in the Family

In most cases, suicide is not an isolated event. Unresolved trauma and a high level of dysfunction has been found to exist in families prior to the suicide of a parent (Ratnarajah &

Schofield, 2008). In some situations, a sense of relief may be experienced if that individual had been suffering through extended mental health issues (Jordan, 2001).

Aftermath of a Parent's Suicide

Yamamoto et al. (1996) found that the death of a parent is one of the ultimate stressors in a child's life. These children suffer short-term and long-term consequences (Worden, 1996). These include hardships with social life, careers and life planning (Brent et al., 2012). Children and young adults that experience the death of a parent need nurturing, and continuity of support that includes compassion and thoughtfulness (Worden, 1996). When the death of a parent is unexpected, sudden, or violent, the grieving process is complicated (Loy & Boelk, 2014).

Mental Health After the Suicide of a Parent

Initial research suggested that child suicide survivors bore resemblance to other children that lost a parent under different circumstances (Cerel et al., 1999). However, as noted by Cerel et al. (1999), during the second year after the suicide, suicide survivors had more intense grief symptoms, anger, shame and anxiety. Researchers continue to find that CSoPS are at a higher risk of psychotic, depressive and personality disorders (Wilcox et al., 2010). The age of the child also has implications, with younger children having a more difficult time after the suicide (Wilcox et al., 2010).

A study compared CSoPS, between the age of five to twelve, to similarly aged children who lost a parent to cancer (Pfeffer et al., 2000). Eighteen months after the death of their parents, the CSoPS demonstrated higher levels of depression. Maladaptive and more extreme forms of grieving were observed in the CSoPS, which included ineffectiveness, interpersonal issues, and depression (Pfeffer et al., 2000). A three-year study followed the lives of children that

experienced the sudden loss of a parent, finding that CSoPS had an increased risk of depression as compared to children whose parent died by another cause (Melhem et al., 2011).

There have been several published articles that support these findings, but there have been other articles suggesting that CSoPS are no different from other children that experience the death of a parent. For example, Brown et al. (2007) indicate that the type of death of a parent does not significantly affect the grief and coping of a child. The study by Brown et al. (2007) suggested that CSoPS are not at higher risk of depression.

Increased Risk of Suicide

The age of CSoPS at the time of a parent's death significantly impacts how the child grieves and processes the loss of the parent (Worden, 1996). These children benefit greatly from having reliable adults that ensure emotional and physical needs are met, while encouraging proper grieving. In the context of a suicide, both the child and the surviving parent are suddenly put into grieving, which can make it hard for the surviving parent to meet the child's needs (Cain, 2002). This often results in the child not being properly supported (Ratnarajah & Schofield, 2008). Some parents feel that CSoPS are too young to understand the situation, therefore they do not tell the child about the suicide (Cain, 2002).

A 30-year longitudinal study from Sweden considered the outcomes of bereavement (Wilcox et al., 2010). This study included 3,807,867 children that did not experience the death of a parent as a child; 503,229 children that experienced the death of a parent; and 44,397 who were CSoPS. In the Wilcox et al. (2010) study, across time, CSoPS were three times as likely to die of suicide, and at a higher risk of being hospitalized for suicide attempts as compared to children with living parents.

Challenges After the Suicide: Learning About the Suicide

Ratnarajah and Schofield (2008) found that the communication within a home, following the suicide of a parent, is often dysfunctional. Some CSoPS are not even told about the cause of their parent's death. Some of these children find out when they are older, leading to increased feelings of shame, a decrease in the trust towards the surviving parent, and an increased sense of vulnerability (Ratnarajah & Schofield, 2008). Although withholding information about the death can have negative outcomes, the choice to wait or not tell the child may be perceived by the surviving parent as the preferred option (Cain, 2002). Further research indicates that one discussion about the suicide is not sufficient. Children need to be told about the nature of the suicide as they continue to grow and mature (Cain, 2002). This communication should be clear, age-appropriate, and sensitive. This kind of communication fosters effective coping and healing (Mitchell et al., 2006).

Other Stressors After the Suicide

CSoPS engage in more problematic behaviors in the first two years following the death, when compared to other children that have experienced the death of a parent (Cerel et al., 1999). These behaviors have been linked to many different feelings and experiences. Schreiber et al. (2017) found that CSoPS feel isolation, guilt, and abandonment, which is associated with the stigma surrounding suicide.

The well-being of CSoPS is significantly predicted by how the child's caregiver is functioning (Melhem et al., 2011). After the suicide of a parent, family roles and expectations change. The surviving parent is dealing with their own grief, which adds a lot of stress to the child's load. Role-reversals often occur following the suicide of a parent, expecting the child to fill parenting or nurturing positions (Dyregrov, 2009). Some CSoPS end up taking care of their

surviving parent or siblings. CSoPS are then left to deal with other stressors including a change in housing/schedule, financial issues, decreased supervision, but an increase in extended family involvement (Dyregrov, 2009).

Long-Term Effects of Parent Suicide

CSoPS continue to grow in their understanding of the suicide as they age, develop, and enter into different stages of adult life (Cain, 2002). This long-standing adaptation of understanding means that support of CSoPS extends for years as they process and cope with the suicide (Loy & Boelk, 2014). Although many of the long-term consequences that CSoPS face are still unknown, the current research indicates that the consequences are felt throughout the entirety of life and that effects extend to the next generation (Cain, 2006). One example is accompanied by the higher rates of suicide within the population, meaning that the next generation will not even be born (Cain, 2006; Kuramoto et al., 2010; Wilcox et al., 2010). Additionally, CSoPS have also been identified as a group that fears that their own children will follow their grandparent's example of suicide, extending the pain of suicide across generations (Cain, 2006).

Research on this specific population is very difficult and lacking due to the context of suicide and the incompleteness of data (Cain, 2006; Wilcox et al., 2010). The most influential longitudinal research is the Wilcox et al. (2010) 30-year study of over 40,000 CSoPS. This article asserts that CSoPS are at an increased risk of mental health disorders and suicide. Their findings are also supported by other researchers (Kuramoto et al., 2010; Kuramoto et al., 2013). Researchers have called for similar studies to take place in the United States and other countries so that we can better understand this vulnerable population (Cerel et al., 1999). This research

would enable professionals to identify and understand the potential long-term effects on CSoPS, which would clarify some of the conflicting results in prior research (Cerel et al., 1999).

Supporting CSoPS

Although supports exist for children that are grieving, few interventions exist that are specific to CSoPS (Ratnarajah & Schofield, 2008). Generalized interventions for children that are dealing with grief can be helpful, but research has shown that specific interventions are needed for this at-risk population (Andriessen, 2014). Once these interventions are available, they need to be disseminated to those who are seeking interventions and supports for this vulnerable population (Campbell, 1997; Dyregrov et al., 2011).

The supportive materials for CSoPS are limited, but they are considered to be a “significant” or “urgent need” (Andriessen, 2014; Ratnarajah & Schofield, 2008). Many of the existing resources are focused on suicide prevention, rather than postvention (Loy & Boelk, 2014). Cerel et al. (2008) noted that postvention for CSoPS is just as important as prevention and that a postvention treatment is actually a form of prevention. The capacity of postvention strategies to serve as prevention strategies means that the development of evidence-based interventions for CSoPS should be prioritized (Andriessen, 2014). Loy and Boelk (2014) identified the need and encouraged the development and implementation of evidence-based interventions specifically for school settings.

Generally, those affected by suicide find contacts within their own population and suicide-specific support groups to be helpful (Begley & Quayle, 2007; McMenemy et al., 2008). This contact has also been identified as very beneficial for CSoPS (Begley & Quayle, 2007; Pfeffer et al., 2002). CSoPS who participate in group grieving interventions focusing on the reaction to suicide and the development of coping skills have decreased survivors’ anxiety and

depression symptoms (Pfeffer et al., 2002). These groups also help children to normalize their experience, increasing feelings of camaraderie with other participants (Veale, 2012).

Formal therapy includes direct services provided to an individual by a mental health professional. Family therapy has shown promise in helping CSoPS to feel supported (McMenamy et al., 2008; Ratnarajah & Schofield, 2008). This therapy focuses on helping the family to create a healthier environment (Ratnarajah & Schofield, 2008). It also fosters the development of more functional and appropriate communication (Dyregrov et al., 2011; Ratnarajah & Schofield, 2008). Although typical grief support may help CSoPS, there is a need for researchers to develop evidence-based techniques specifically for this population (Jordan, 2001; Sveen & Walby, 2008).

Child Survivors' Perception of Support and Experiences

CSoPS have reported that supports are often inaccessible, and even when available, survivors often consider supports to be ineffective (Wilson & Marshall, 2010). In this same study, 94% of participants felt that formal, outside support was needed to help cope, while only 44% of the participants received that support. Of those who received support, only 40% indicated that they felt the support was adequate. While CSoPS are being affected by the support they receive, the perspective of the helpers also plays a factor. Over 15 years, practitioners observed that CSoPS are affected by the stigma of suicide, which increases the risk of challenges during postvention (Schreiber et al., 2017). Ratnarajah and Schofield (2008) interviewed CSoPS and found that survivors experienced and perceived short and long-term impacts on the family unit.

Research With Suicide Survivors

Research that is based on suicide survivors is a challenging area of study (Moore et al., 2013; Omerov et al., 2013). Research with CSoPS is even more challenging. Few studies exist

that specifically examine CSOPS and those studies that have been conducted have produced carrying results (Kuramoto et al., 2009). Challenges that exist with this population include small sample sizes, varied terminology, difficulty recruiting participants, varied methods of data collection, lack of qualitative studies, and ethical challenges because of the perceived vulnerability of suicide survivors (Moore et al., 2013; Omerov et al., 2013).

Sample Size

Empirical research with CSOPS is limited due to small sample sizes (Cerel et al., 1999; Hung & Rabin, 2009; Melham et al., 2011; Pfeffer et al., 2000) with the exception of studies consisting of Swedish data (Kuramoto et al., 2010; Kuramoto et al., 2013; Wilcox et al., 2010). Limited sample sizes lead to limited applicability and generalizability of the findings.

Terminology

The standardization of precise terminology for this population could facilitate the creation of targeted interventions for groups, as well as facilitating more accurate research (Cerel et al., 2014). For example, *children of a parent suicide* is a phrase that is often found in the research that could be defined more accurately. *Children* can refer to age or relationship. This population is also referred to as *suicide survivors*, which is also a term for someone who did not die from a suicide attempt, rather than someone left behind after the suicide of a loved one. Children who were removed, due to divorce or separation, from a parent that completed suicide do not have a specific term to identify them in research. The proper identification of this group may lead to more specific needs and assist researchers in developing interventions for this particular group of survivors. As this body of research grows, more precise terminology will be required (Cerel et al., 2014; Jordan & McIntosh, 2011).

Recruitment

There is a lack of data collection on CSOPs in the United States and in other countries when we consider longitudinal data, the stigma around suicide, and other identifying demographic information (Wilcox et al., 2010; Wilson & Marshall, 2010). With the difficulty of accessing this population, most studies revert to self-recruitment strategies to engage participants in research (Hung & Rabin, 2009). CSOPs have been identified as a group that is three times less likely to participate in research than those who have a parent die by other means (Cerel et al., 2000).

Data Collection

Data on this population is difficult to find because the information is usually not gathered by coroners following the suicide of a parent (Melhem et al., 2011). The United States lacks sufficiently accurate data on suicide survivors, thus leading researchers to other countries (Colpe & Pringle, 2014; Kuramoto et al., 2010; Kuramoto et al., 2013; Wilcox et al., 2010). Sweden is a country that has collected extensive data on suicides and suicide survivors, which has helped the research move forward. This lack of data means that we are also unsure about how many CSOPs are in the United States. Cerel et al. (1999, 2000, 2008) have estimated that there are 7,000–12,000 new CSOPs each year.

Lack of Qualitative Research

The existing research on suicide and survivors of suicide has a higher concentration of quantitative research (Sveen & Walby, 2008; Wilcox et al., 2010). There are fewer studies considering the perception and experiences of CSOPs. Qualitative studies with this population would provide insight into the thoughts, feelings, and experiences of this vulnerable group

(Begley & Quayle, 2007; Ratnarajah & Schofield, 2008; Sveen & Walby, 2008). These insights would provide necessary data to assist in the creation of evidence-based interventions.

Perceived Vulnerability

Caution and sensitivity should ethically be considered with all populations that participate in research. Research with vulnerable populations should consider more extensive measures to protect these individuals. Suicide bereaved individuals have found participating in research to be cathartic or therapeutic (Omerov et al., 2013). In a study consisting of 666 parent survivors of suicide, only one participant identified potentially lasting negative consequences that might arise after participation (Omerov et al., 2013). This indicates that suicide bereaved individuals are not hurt through participation in research (Moore et al., 2013). Although research has shown little to no negative impacts on suicide bereaved individuals, ethical review boards have often rejected research proposals that include this population (Moore et al., 2013; Omerov et al., 2013).

Individuals that engage in research have found that such participation is a positive experience (Omerov et al., 2013). These individuals saw participation as a way to assist others in this experience, or that it is a personal benefit to participate (Moore et al., 2013). Fifty percent of participants identified positive experiences and effects of participating in research, such as helping others, working through their own grief, and gratitude for being able to share their story (Omerov et al., 2013). Dyregrov et al. (2011) had participants identify quantitatively their experience with participation. The responses included 62% *overall positive*, 10% *unproblematic*, and 28% *positive and painful*. Dyregrov (2004) also interviewed parents who lost children suddenly, including suicide, and all 64 participants identified the experience as *positive* or *very positive*. There is not significant evidence to suggest that this vulnerable population could

experience negative long-lasting effects from participating in research (Moore et al., 2013; Omerov et al., 2013). Omerov et al. (2013) also noted that 95% of participants perceived their participation as valuable and helpful to the larger society.

Tasks of Grief

Grief is unique to each person that is experiencing it, but there are generalities that reach across the board. In contrast to the linear grieving process of Kübler-Ross (1969), Worden (1996, 2008) identified “tasks” of grief. Worden (1996) detailed the tasks that those going through the grieving process face: (a) accepting the reality of the death; (b) facing the emotional pain associated with grief; (c) adjusting to the changes in one’s life after a loved one’s death; and (d) remembering/memorializing the death and life of the deceased person.

Worden (1996, 2008) stated that the tasks of grief are not sequential in nature, nor is there an endpoint for grief. Time will bring the grieving process to light throughout an individual’s lifetime, with challenges arising at different personal milestones and major events. Time then allows the individual to grieve in different ways as they develop and mature. With appropriate support, a child’s grief can become part of their daily life, meaning that the associated feelings will decrease in intensity (Worden, 1996, 2008). In addition to this statement, Wolfelt (2002) stated that if “...children are not compassionately companioned through their complicated mourning journeys, they are at risk for behavioral and emotional problems” (p. 655). Caring adults in all areas of a child’s life have opportunities to provide this support.

Bibliotherapy

Stories, including written and oral, have been used around the world as a way to understand and process the world around them and their experiences. Stories, in the classroom and in more traditional settings, have helped people to understand themselves, other people and

the world around them (Avraamidou & Osborne, 2009; Montgomery, 1996; Schank & Berman 2002). The term *bibliotherapy* was coined in 1916 by Crothers (Crothers, 1916). Bibliotherapy is described as the process of using books, of all genres, to facilitate healing, help with processing issues and also help understand experiences (Forgan, 2002; Rubin, 1979). Bibliotherapy has been utilized with children to facilitate development, emotional competency and to provide perspective on learned experiences (Heath et al., 2005).

Bibliotherapy can be used effectively with children to help them develop social and emotional skills. The use of bibliotherapy can strengthen a child's emotional learning, gain self-awareness, which is understanding the connection of emotions and actions, and create a positive outlook on the future by helping them understand their own strengths and weaknesses (Heath et al., 2017; Pehrsson & McMillen, 2005). This intervention also strengthens a child's ability of self-management, the ability to cope with stress, increase awareness of how behavior affects other people and increase self-control (Heath et al., 2017).

Those who receive bibliotherapy not only improve self-awareness and self-management, but they increase their empathetic understanding of others as well as themselves (Pehrsson & McMillen, 2005, 2007). Another benefit of bibliotherapy comes from the discussion and activity following the reading, where the child is able to discuss thoughts, feelings and behaviors which may help the child cope with and navigate their negative emotions (Pehrsson & McMillen, 2005, 2007).

Bibliotherapy also helps children to define their own cultural identity. This happens through the bibliotherapy process where children see new perspectives on problems, emotional points of view, and different perspectives on the world and other events. This development is key to a child's development of self and identity (Heath et al., 2017; Pehrsson & McMillen, 2007).

As an intervention strategy, bibliotherapy helps children find hope, feel empowered, and take action (Betzael & Schechtman, 2017). This process of effectively using bibliotherapy includes finding a text that fits a child's current situation and experience.

There are two types of bibliotherapy used to help children: developmental bibliotherapy, which are focused on typical developmental aspects of life (socialization, conflict, etc.) and clinical bibliotherapy, where books or stories are used to help with emotional issues such as mental illness, including trauma (Heath et al., 2005; Heath et al., 2017). Developmental bibliotherapy is more appropriate in the classroom setting led by teachers, after they have received appropriate training (Doll & Doll, 1997; Heath et al., 2005; Olsen, 1975).

Researchers have found and agreed upon several aspects of a successful bibliotherapy lesson plan; (a) pre-reading, (b) guided reading, (c) post-reading discussion, and (d) reinforcement activity (Forgan, 2002; Heath et al., 2005; Maich & Kean, 2004). Research has shown that using bibliotherapy a natural setting is optimal (Maich & Kean, 2004). An example of a natural setting is when teachers use this technique during Language Arts time in small groups or whole class instruction. School psychologists and school counselors are also good candidates for using bibliotherapy lessons in their work (Heath & Cole, 2012; Pehrsson & McMillen, 2005, 2010).

Regardless of the setting and type of bibliotherapy, it is of the utmost importance for practitioners to choose the correct text for the situation of the individual (Pardeck & Markward, 1995). The text needs to fit both the current circumstances and the context of the situation because children have the capacity to identify with the situation and characters (Pardeck & Markward, 1995). Practitioners should consider the age, developmental level, emotion of the text and special needs of the child when choosing the text for bibliotherapy, a picture book would be

appropriate for a young child with limited language skills (Britton & Fujiki, 2017; Forgan, 2002; Pardeck & Markward, 1995).

Once a book is chosen based on careful considerations, introduce the themes in the story and ask the client to identify with and carefully consider the characters, their actions and emotions (Sridhar & Vaughn, 2000). Then read the book with the child, and take the time to read it well by being expressive, asking questions and checking understanding throughout the text (Britton & Fujiki, 2017; Forgan 2002; Sridhar & Vaughn, 2000). Discussion of the text should immediately follow and touch upon the characters, emotions, themes and the plot, preferably in sequence (Forgan, 2002). The discussion should facilitate thoughts about the book, preferably making comparisons to the situation, and then verbalizing thoughts and emotions (Forgan, 2002; Pardeck & Markward, 1995). This communication enhances connections between the child and the practitioner and facilitates a better understanding on both sides (Tu, 1999).

Activities are great opportunities for practitioners to enrich and deepen the child's identification and experience with the text (Forgan, 2002; Heath et al., 2017; Pardeck & Markward, 1995). This part of bibliotherapy, the activities, can also include explicit instruction on specific skills, like emotion identification (Forgan, 2002). Some useful activities include art, drama, and writing because they are engaging and active (Pardeck & Markward, 1995).

With all of the benefits of bibliotherapy, researchers have identified the post-reading activities to account for much of the benefits (Pehrsson & McMillen, 2005, 2007; Pehrsson et al., 2007). Although bibliotherapy has been shown as an effective support, bibliotherapy should be used in tandem with psychotherapy on in-clinic patients (Fanner & Urquhart, 2008).

Beneficiaries of Bibliotherapy

Bibliotherapy is a useful therapy for many populations (Corr, 2004; Ford et al., 2000; Heath & Cole, 2012; Kohutek, 1983; Lenkowsky & Lenkowsky, 1978; Montgomery & Maudners, 2015). Gifted students, neurotypical students, students with disabilities (Ford et al., 2000; Lenkowsky & Lenkowsky, 1978), youth in correctional facilities (Kohutek, 1983; Montgomery & Maunders, 2015), children and teens with divorcing parents (Pehrsson et al., 2007), children of the LGBTQ+ community (Duimstra, 2003; Forgan, 2002; Nicholson & Pearson, 2003; Vare & Norton, 2004), and children that have language impairments benefit from the appropriate use of bibliotherapy (Britton & Fujiki, 2017). In addition, children that are bereaving the death of a family member have found bibliotherapy to be successful in their respective situations (Corr, 2004; Heath & Cole, 2012).

Emotional/Social Health and Bibliotherapy

Bibliotherapy supports the social/emotional health of clients because it uses stories as a means to synthesize and process difficult situations and emotions, while also providing instruction (Doll & Doll, 1997; Heath et al., 2017; Jackson & Heath, 2017). Bibliotherapy can teach skills of self-management, stress management and provide instruction on how to react to difficult situations (Davis, 2017; Jackson & Heath, 2017). Heath et al. (2017) found that bibliotherapy helps children become more aware of the connection between emotions and thoughts. This awareness improves optimism, builds confidence, and expands the capacity to realize and work through challenges (Heath et al., 2017; Pehrsson & McMillen, 2005). This improved ability of being aware of the connection between emotions, thoughts and behaviors improves an individual's ability to manage, cope, and have self-control in their given situations (Heath et al., 2017; Pehrsson & McMillen, 2005, 2007).

Bibliotherapy also enables clients to see problems differently, and develop emotional points of view (Heath et al., 2017; Pehrsson & McMillen, 2005, 2007). Cultural identity can also be shaped through bibliotherapy as clients are able to understand other cultures as well as identify and define their own culture (Heath et al., 2017; Pehrsson & McMillen, 2005, 2007). Effective bibliotherapy provides hope and encouragement to clients, which provides them the motivation to act (Betzael & Shechtman, 2010, 2017).

Theron et al. (2017) conducted a study with bibliotherapy and orphaned children in South Africa. They used African folktales as their text and saw positive results. The participants improved resilience, which was determined to be highly important for this vulnerable population. After the intervention, participants showed self-confidence in their problem-solving ability, ability to recognize their own strengths, responsibility taking, and peer engagement.

Another study by Betzael and Shechtman (2017) demonstrated positive results in terms of decreased levels of anxiety. This study used superhero stories with children who were being raised in a group home due to parent death or parental absence. When using both superhero and non-superhero texts, participants demonstrated positive outcomes for decreasing the levels of perceived anxiety. Children who were presented with only superhero text demonstrated decrease in anxiety, worry, sensitivity, physiological measures of anxiety, social anxiety and these decreases lasted through postvention.

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APPENDIX B

University Institutional Review Board Approval**Memorandum**

To: Melissa Heath
 Department: BYU - EDUC - Counseling, Psychology, & Special Education
 From: Sandee Aina, MPA, HRPP Manager
 Wayne Larsen, MAcc, IRB Administrator
 Date: December 04, 2019
 IRB#: IRB2019-365
 Title: bibliotherapy support for child survivors of parent suicide

Brigham Young University's IRB has approved the research study referenced in the subject heading as exempt level, Category 4: Secondary research for which consent is not required: Secondary research uses of identifiable private information or identifiable biospecimens, if at least one of the following criteria is met:

- i. The identifiable private information or identifiable biospecimens are publicly available;
- ii. Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects;

This category does not require an annual continuing review. Each year near the anniversary of the approval date, you will receive an email reminding you of your obligations as a researcher and to check on the status of the study. You will receive this email each year until you close the study.

The study is approved as of . Please reference your assigned IRB identification number in any correspondence with the IRB.

Continued approval is conditional upon your compliance with the following requirements:

1. A copy of the approved informed consent statement can be found in iRIS. No other consent statement should be used. Each research subject must be provided with a copy or a way to access the consent statement.
2. Any modifications to the approved protocol must be submitted, reviewed, and approved by the IRB before modifications are incorporated in the study.
3. All recruiting tools must be submitted and approved by the IRB prior to use.
4. Instructions to access approved documents, submit modifications, report adverse events, can be found on the IRB website, iRIS guide: http://orca.byu.edu/irb/iRIS/story_html5.html
5. All non-serious unanticipated problems should be reported to the IRB within 2 weeks of the first awareness of the problem by the PI. Prompt reporting is important, as unanticipated problems often require some modification of study procedures, protocols, and/or informed consent processes. Such modifications require the review and approval of the IRB. Please refer to the [IRB website](#) for more information.

APPENDIX C

Institutional Review Board Approval on Original Research Study

Consent to Be a Research Subject

The main purpose of this form is to provide you with information that may affect your decision about whether or not to participate in this study.

Introduction

This research study is being conducted by Suzanne Bennett (School Psychology Graduate Student) and Melissa Allen Heath (PhD, School Psychology Graduate Program Coordinator) at Brigham Young University to determine, through the lived experiences of others, how to best support children following a parent's suicide death. You were invited to participate because you are over 18 and one of your parents died by suicide while you were a child (before the age of 18) and at least 2 years ago.

Procedures

If you agree to participate in this research study, the following will occur:

- you will be interviewed for approximately 60-90 minutes about your experiences surrounding and after your parent's suicide
 - as part of the interview, you will be asked to review 3-5 children's books on suicide and/or death (estimated 20-30 minutes)
- the interview will be audio recorded to ensure accuracy in reporting your statements
- the interviewer will take notes to assist her with the interview process
- the interview will take place at a local public library in a private study room at a time convenient for you.
- Optional: you may review the typed version of your interview and make corrections (estimated 30 minutes)

Risks/Discomforts

Some interview questions may prompt memories that trigger sadness, grief, or emotional discomfort. You may skip any question or discontinue participation at any time without penalty. Melissa Allen Heath (licensed psychologist) is supervising this study and is available to discuss concerns and referrals for counseling if desired. Her contact information is below.

Benefits

We don't expect any direct benefits to you from participating in the study. It is hoped, however, that through your participation researchers may learn about how children are supported after and cope with a parent suicide death. Summaries of participants' information will be distributed to professionals who help support children following a parent's suicide.

Confidentiality

Unique pseudonyms will be assigned to each participant to preserve anonymity in the interview transcriptions and any related research data (e.g., demographic sheet). No identifying names or identifying information will be included in any publications or presentations resulting from this research. After the tapes have been transcribed, the audiotapes will be kept in the researcher's locked cabinet for 3 years following the study after which time, the data and transcripts (hard and electronic copies) will be



destroyed. The transcriptions (with pseudonyms) will be carefully reviewed by the primary researcher and her thesis committee. After the transcriptions have been carefully reviewed, these hard copies and electronic copies will be stored with the audiotapes for three years.

The electronic research data will be kept in a secure location on a password protected computer and only the researcher and supervisor (Melissa Heath) will have access to the raw data.

Compensation

You will receive a \$20 Amazon gift card for your participation in this study. Compensation will not be prorated. If you choose to withdraw from participation at any time during the interview, you will still receive the gift card.

Participation

Participation in this research study is voluntary. You have the right to withdraw at any time or refuse to participate entirely without jeopardy to yourself.

Questions about the Research

If you have questions regarding this study, you may contact Suzanne Bennett at (801) 473-4495 or suzannebennett@byu.net or Melissa Allen Heath at (801) 422-1235 or melissa_allen@byu.edu for further information.

Questions about Your Rights as a Research Participant

If you have questions regarding your rights as a research participant contact IRB Administrator at (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu.

Statement of Consent

I have read, understood, and received a copy of the above consent and desire of my own free will to participate in this study.

Name (Printed): _____

Signature: _____

Date: _____

I agree to be interviewed. _____ (initial)

I agree to be audio recorded. _____ (initial)



Telephone Screening Survey

Thank you for contacting me about this research. I am grateful for your interest. I am going to ask you a few questions to make sure that you are eligible to participate in this study.

1. What is your date of birth?
(Use the current date to determine the age of the individual.)
Qualifying response: 18 or older
Disqualifying response: Younger than 18. Skip to end.
2. Did one of your parents (either biological or adopted) die by suicide?
Qualifying response: Yes
Disqualifying response: No. Skip to end.
3. How old were you when the suicide death occurred?
Qualifying response: Age 0-17 years
Disqualifying response: 18 or older. Skip to end.

NOTE: *Researcher will subtract answer 3 from answer 1 to determine how many years ago the death occurred.*

- Qualifying answer: 2 or more years ago
Disqualifying answer: Less than 2 years ago. Skip to end.

If participant qualifies to participate according to all the questions above, proceed with details regarding the study.

Scheduling details: Determine which public library is most convenient for them and when they are available to meet; agree on a time. Ask if they would like a reminder text, phone call, or email prior to the interview. Obtain participant phone number and/or email.

Interview details: It is anticipated the actual interview will take about forty-five minutes to an hour and fifteen minutes. Also included, we will have you review a few children's books for your feedback. This will add an additional 20 to 30 minutes. After everything is done, you will also have the opportunity to review the typed transcript of your interview (optional for the participant). This may take approximately 30 minutes. In total, participating in this research may take up to 2 hours of your time. Before starting the interview, I will provide an explanation of the study in writing for you to review and to sign, indicating your consent to participate. You will have the opportunity to withdraw from the study at any time without repercussion. After our initial meeting, you will receive a \$20 Amazon gift card.



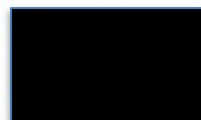
If participant does not qualify to participate according to the questions above, explain that they are not eligible (offer reasons why) to participate in this study and thank them for their interest and time.

Institutional Review Board
for Human Subjects



Brigham Young University
A-285 ASB Provo, Utah 84602
(801) 422-3841 / Fax: (801) 422-0620

October 26, 2015



Re: Helping Children Cope in the Aftermath of a Parent's Suicide

Dear 

This is to inform you that Brigham Young University's IRB has approved the above research study.

The approval period is from 10-26-2015 to 8-4-2016. Your study number is F15278. Please be sure to reference this number in any correspondence with the IRB.

Continued approval is conditional upon your compliance with the following requirements.

1. A copy of the 'Informed Consent Document' approved as of 10-26-2015 is enclosed. No other consent form should be used. It must be signed by each subject prior to initiation of any protocol procedures. In addition, each subject must be given a copy of the signed consent form.
2. All protocol amendments and changes to approved research must be submitted to the IRB and not be implemented until approved by the IRB.
3. The enclosed recruitment advertisement has been approved. Advertisements, letters, Internet postings and any other media for subject recruitment must be submitted to IRB and approved prior to use.
4. A few months before this date we will send out a continuing review form. There will only be two reminders. Please fill this form out in a timely manner to ensure that there is not a lapse in your approval.

If you have any questions, please do not hesitate to call me.

Sincerely,

A handwritten signature in black ink that reads "Robert Ridge".

Robert Ridge, PhD., Chair
Santee M.P. Munoz, Administrator
Institutional Review Board for Human Subjects