



2017-07-01

# Survivors' Perceptions of Support Following a Parent's Suicide

Suzanne Nicole Bennett  
*Brigham Young University*

Follow this and additional works at: <https://scholarsarchive.byu.edu/etd>

 Part of the [Counseling Psychology Commons](#)

---

## BYU ScholarsArchive Citation

Bennett, Suzanne Nicole, "Survivors' Perceptions of Support Following a Parent's Suicide" (2017). *All Theses and Dissertations*. 6910.  
<https://scholarsarchive.byu.edu/etd/6910>

This Thesis is brought to you for free and open access by BYU ScholarsArchive. It has been accepted for inclusion in All Theses and Dissertations by an authorized administrator of BYU ScholarsArchive. For more information, please contact [scholarsarchive@byu.edu](mailto:scholarsarchive@byu.edu), [ellen\\_amatangelo@byu.edu](mailto:ellen_amatangelo@byu.edu).

Survivors' Perceptions of Support Following a Parent's Suicide

Suzanne Nicole Wilson Bennett

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

Melissa A. Heath, Chair  
Sarah M. Coyne  
Aaron P. Jackson

Department of Counseling Psychology and Special Education  
Brigham Young University

Copyright © 2017 Suzanne Nicole Wilson Bennett

All Rights Reserved

## ABSTRACT

### Survivors' Perceptions of Support Following a Parent's Suicide

Suzanne Nicole Wilson Bennett

Department of Counseling Psychology and Special Education, BYU  
Educational Specialist

Children who experience a parent's death by suicide are a vulnerable population at risk for emotional and mental health issues as well as suicide attempts (Cerel, Fristad, Weller, & Weller, 1999; Kuramoto et al., 2010; Wilcox et al., 2010). Yet, in spite of the knowledge that effective postvention is in reality prevention (Cerel et al. 2008), relatively little is known about these children and adolescents, particularly regarding their experiences following the suicide. The current research study investigated which resources, assistance, and actions of those around the child were perceived as most helpful and unhelpful following the parental suicide.

Through semi-structured qualitative interviews using the hermeneutic approach, the researcher interviewed 17 adults who, as children or adolescents, were bereaved by parent suicide. Helpful experiences and support included assistance processing the suicide and an openness in the face of stigma. Unhelpful experiences included judgment and blame, silence regarding the suicide and deceased parent, and a heightened awareness of the surviving parent's challenges. Individuals who were perceived as helpful generally had pre-existing relationships with the children and helped meet their practical and emotional needs.

It is recommended that customized and varied support be offered, along with the message that it is important to talk about suicide and memorialize the deceased parent. Additional research is needed to further explore the complex experiences of children of parent suicide; this will aid in the development of evidence-based interventions to better support them.

Keywords: parent suicide, child survivor, grief, bereavement, coping strategies, qualitative interview, retrospective

## ACKNOWLEDGMENTS

Just as it takes a village to raise a child, it took many supportive individuals over the course of years for me to be able to successfully complete this thesis. Looking back throughout my youth, I thank my dad who taught me around the dinner table to love using new words, my mom who patiently sat up with me to complete late-night essays on *The Odyssey* and *A Tale of Two Cities*, and my public school English teachers who introduced me to thesis statements and set my feet on the writing path. Recently, my family has been extremely helpful throughout the long days (and nights!) of thesis work by offering their skills of proofreading, editing, and copyediting. At critical moments throughout this intense process, my sister Janel put her life on pause and helped propel me forward. My family has also provided other support in the form of prayers, texts and calls, chocolate, back scratches, and pep talks. I offer a heartfelt thanks to each of them.

I express deep gratitude to my incredible mentor, Dr. Melissa Heath, for her optimism and encouragement which she offered with astounding consistency. Her confidence in my abilities and potential to succeed helped me to see—and reach—what I initially failed to even glimpse in myself. My undergraduate research assistants, Brian Farstead and Holden Brimhall, who spent hours transcribing interviews and helping to analyze them, were a critical part of my success as well. I also thank all my friends who trusted me by referring their personal acquaintances to participate in my study. Finally, I express great appreciation and admiration for the individuals who chose to share their story with me. Each has a remarkable journey and demonstrated amazing resilience in the face of very difficult circumstances. Without their gracious participation, this entire project would have been impossible.

## TABLE OF CONTENTS

TITLE PAGE.....	i
ABSTRACT.....	ii
ACKNOWLEDGMENTS .....	iii
TABLE OF CONTENTS.....	iv
LIST OF TABLES.....	vi
CHAPTER 1: INTRODUCTION.....	1
CHAPTER 2: LITERATURE REVIEW .....	3
Suicide of a Loved One.....	4
Parent Suicide .....	7
Post-Suicide Challenges.....	11
Conclusion .....	20
Statement of Problem.....	21
Research Questions.....	21
CHAPTER 3: METHOD .....	22
Research Design.....	22
Participants.....	23
Procedure .....	24
Data Analysis .....	25
CHAPTER 4: RESULTS.....	29
Non-Supportive Practices .....	31
Supportive Practices.....	38
Influential People .....	48
CHAPTER 5: DISCUSSION.....	52
Implications for Practitioners.....	52
Implications for Surviving Parents .....	55
Implications for Other Supporting Adults .....	56
Implications for Government and State Organizations.....	57
Limitations .....	58

Implications for Future Research.....	59
Conclusions.....	61
REFERENCES .....	63
APPENDIX A: TELEPHONE SCREENING SURVEY .....	71
APPENDIX B: INFORMED CONSENT.....	72
APPENDIX C: DEMOGRAPHIC SHEET.....	74
APPENDIX D: INTERVIEW PROTOCOL.....	75
APPENDIX E: HANDOUT.....	77

## LIST OF TABLES

1. *Participant Demographics and Information Surrounding the Suicide* 30

## CHAPTER 1: INTRODUCTION

Suicide is an issue of concern, both for individuals who end their lives prematurely, as well as for the suicide survivors left behind to grapple with the death. One who completes suicide has been referred to as putting a “psychological skeleton in the survivor’s emotional closet” (Shneidman, 1969, p. 22). Naturally, much focus has been directed toward suicide prevention (U.S. Department of Health and Human Services [HHS] Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). However, since suicide has yet to be eliminated, there continue to be suicide survivors with significant needs that must not be overlooked (McMenamy, Jordan, & Mitchell, 2008; Sakinofsky, 2007).

The wrestle with suicide can be extremely difficult for any adult survivor, and many studies have investigated the effects of suicide on loved ones left behind (Jordan & McIntosh, 2011; Pfeffer, Jiang, Kakuma, Hwang, & Metsch, 2002). However, very few studies have addressed the specific needs of children and adolescents who have lost a parent to suicide (Brown, Sandler, Tein, Liu, & Haine, 2007; Hung & Rabin, 2009). What is our society doing to assist these *children of suicide*? When included in studies at all, these children are usually grouped with those who have lost other family members to suicide, including children, spouses, and siblings (Jordan, 2001; Sveen & Walby, 2008). Studies focusing specifically on the children themselves are quite rare (Cerel, Jordan, & Duberstein, 2008; Jordan, 2001; Wilcox et al., 2010). As a result, little is known about them, their experiences, and the support they receive from others. To the knowledge of the author, no existing studies examine how these children perceive and make meaning of the support offered them following the suicide.

Through semi-structured interviews of adults who were bereaved by their parent’s suicide as children (ages 18 years and younger), this study aimed to explore children’s perceptions of



support—including specific interventions—following the suicide death of their parent. The study was conducted in order to examine what constitutes helpful and unhelpful experiences following a parent’s suicide, in order to understand how best to comfort and encourage these children and to identify unsupportive practices that should be avoided. Due to the difficulty of locating children bereaved by parent suicide as well as potential ethical concerns with interviewing these children, adults were interviewed and asked to recall their childhood when the suicide occurred.

## CHAPTER 2: LITERATURE REVIEW

Suicide is a topic of concern internationally and across the United States. In 2015, the number of total number of deaths by suicide reported in the United States was 44,193, according to the Centers for Disease Control and Prevention (CDC, 2017). Worldwide, the World Health Organization (WHO) indicated that approximately 804,000 people were reported to have died by suicide in 2012 (WHO, 2014). However, the number of deaths by suicide is most likely underreported and may be as much as three times higher than is typically reported (Andriessen, 2014; Madge & Harvey, 1999). Reasons for this include the sensitive nature of suicide, the associated stigma surrounding it (Lasrado, Chantler, Jasani, & Young, 2016) and laws in some places punishing the act of suicide (Ali, 2015; Lasrado et al., 2016; WHO, 2014). From a global financial perspective, suicide costs \$51 billion each year (CDC, n.d.). Unfortunately, global suicide rates increase every year; suicide is such an area of concern that the WHO has made a goal to reduce the suicide rates by 10% by the year 2020 (WHO, 2014).

Along with the overarching global problem of suicide, one must consider the many individuals who are personally affected by suicide. Leading suicide researcher Cerel (2015), in her address to the American Association of Suicidology's Annual Conference, emphasized the importance of recalculating the number of individuals affected by suicide. Previous researchers have indicated that only six to seven individuals are directly and significantly affected by one suicide (Berman, 2011; Cerel, 2015; Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014; Shneidman, 1969). Countering the long-held rigid and restricted definition of *survivor*, Cerel (2015) indicated that, on average, approximately 140 individuals are *affected* by one individual's suicide. In her research, she continues to stress the importance of challenging the repeated fallacy in underestimating the significant and painful wake of suicide and the tremendous effect suicide

has on immediate family, extended family, and acquaintances. She emphasizes the importance of considering those who are less directly associated with the suicide, but who none-the-less suffer personal distress when learning about the suicide (Cerel, 2015; Cerel et al., 2014; Cerel et al., 2016; Drapeau & McIntosh, 2016). When considering the bigger picture, Cerel (2015) indicates that the annual count of those who are exposed to suicide approximates 6.5 million individuals. Furthermore, when famous individuals die by suicide, a ripple effect of copycat behavior results in a subsequent upward spike in suicide attempts and self-injury rates (Jeong et al., 2012).

Indeed, the act of suicide is rarely an isolated event. Some have referred to suicide as “the tip of the iceberg of suffering” (Eckersley & Dear, 2002), suggesting there are many issues underlying suicide deaths. Specifically, the suffering does not start and end in a single moment of suicidal behavior. Rather, personal and interpersonal struggles precede the suicide and, following the tragic event—especially for family members who are left behind—survivors experience painful immediate, ongoing, and persistent personal challenges.

### **Suicide of a Loved One**

Suicide not only affects society but also those individuals left behind to cope with the loss, most often close family members. The negative effects of suicide are far-reaching and affect individuals and families (Cain, 2006). It has been estimated that following each suicide, six people are seriously affected by the death and experience significant challenges coping with the death (Shneidman, 1969). When combined with current suicide data, this results in approximately 265,158 total loss survivors each year (Kochanek, Murphy, Xu, & Tejada-Vera, 2016). However, as discussed above, many more people may be affected per suicide. While the term “suicide survivor” could refer to a variety of different people and situations—including those who have attempted suicide and survived (Cerel, McIntosh, Neimeyer, Maple, & Marshall,

2014; Jordan & McIntosh, 2011)—in this document, the author will use the term “survivor” to refer to anyone seriously affected by a close friend or family member’s suicide.

A specific group of survivors affected by suicide are children and adolescents. One researcher estimated that each year 10,000 children in the U.S. are left behind after the suicide of a relative (Pfeffer et al., 2002). These children are certainly directly affected by their family member’s suicide death. Jordan and McIntosh (2011) examined feelings and thoughts after people experience different types of death and came up with a four-tier model.

In the first tier, general grief feelings and thoughts often include sorrow, pain, missing and yearning for loved ones. The next tier, unexpected deaths, yields all the first tier feelings along with feelings such as shock and disbelief. The third tier, sudden and violent deaths, can include (along with feelings from the first two levels) experiences of trauma and no longer feeling invulnerable. The final tier, suicide deaths, result in feelings of anger, abandonment, aggression, and rejection (Jordan & McIntosh, 2011). Jordan and McIntosh (2011) conclude that feelings after a death can be related to the type of death, and that suicide survivors may experience feelings from all four tiers due to the nature of suicide. This model helps us begin to understand the complexities of the emotions and feelings suicide survivors may experience.

Dyregrov (2009) studied adolescents who had lost a close family member or friend to suicide and examined their experiences. He found that adolescents’ reactions to a suicide of a loved one may be manifest as shock, sadness, anger, appetite disturbances, sleep disturbances, and social withdrawal. Other challenges may be manifest inwardly; the youth may worry about who will take care of them, feel guilt, think that the parent is just sleeping and will come back, or notice their surviving parent’s struggles and hesitate to voice their own needs (Mitchell et al., 2006). Suicide survivors may have difficulty making meaning of the death, higher levels of guilt

and responsibility surrounding the death, and increased feelings of abandonment (Jordan, 2001). Difficulties in focus and concentration were reported by 100% of 32 adolescent suicide survivors in one study (Dyregrov, 2009). This affected their school experience; the pressure to continue performing academically was difficult for these adolescents during a time of great difficulty.

Over the years, various studies have been conducted to examine the differences between suicide bereavement and non-suicide bereavement. Jordan (2001) reassessed the published studies on the topic of general suicide bereavement compared with non-suicide bereavement, finding that there are indeed legitimate differences between the two bereaved groups. Specifically, Jordan found that bereavement by suicide was different in the grief themes, the social support system surrounding the survivor, and the impact of the suicide on the family processes. However, it was concluded that methodologies vary widely between the published studies comparing bereavement experiences, resulting in semi-inconclusive results regarding the difference of suicide bereavement versus other bereavement. The author noted the need for additional, well-planned research to further examine the potential differences between the two groups (Jordan, 2001).

Researchers Sveen and Walby (2008) conducted a thorough, systematic review of 41 studies which compared those bereaved by suicide with those bereaved by other causes of death; four of these studies included children or adolescents. While Sveen and Walby did not identify a significant difference in mental health between the two groups as identified in the studies, they did identify other differences; namely, a uniquely intense grief process in suicide survivors as identified on suicide-specific assessments, including shame, blaming, stigma, rejection, and concealing the cause of death. This suggests there is a specific need of suicide survivors to receive situation-specific grief assistance following the suicide. While general treatment

techniques may be helpful for some individuals following a suicide, there is a need to develop further empirical interventions catered to suicide survivors (Jordan, 2001) and specifically child suicide survivors (Sveen & Walby, 2008). Interviews and suicide-specific assessments can assist in better identifying these differences (Sveen & Walby, 2008).

### **Parent Suicide**

The imprecise statistical recording of the number of parents who die each year by suicide make it difficult to also know how many children have experienced a parent suicide. Some potential reasons for these difficulties are the lack of a comprehensive nationwide data collection system (Colpe & Pringle, 2014), the sensitive nature of suicide, the desire of some families to cover up the suicide, and the ambiguity of potential suicides (not knowing if it was an accident or an intentional death). Of the more than 42,000 annual U.S. suicide deaths reported by the CDC for 2014, over half (22,063) were suicides of people ages 25-54, the age when most people will have children living at home with them (Kochanek et al., 2016). Leading researchers in the field of parent suicide, Cerel et al. (2008), estimate that between 7,000–12,000 children in the US each year have a parent die by suicide.

**Impact of a parent's death.** Children who experience a parent death struggle, whether the death is by suicide or any other reason. Yamamoto et al. (1996) found that a parent death is the most stressful life event a child can experience. A parent death has both immediate and long-lasting implications (Worden, 1996). When compared with non-bereaved youth over a three-year period, youth who have lost a parent show struggles in career planning, work, relationships with peers, and future career aspirations (Brent, Melhem, Masten, Porta, & Payne, 2012). Those who have lost a loved one to “violent, unexpected, or untimely deaths”—whether to suicide or another reason—are at a higher risk of experiencing complicated grief (Loy & Boelk, 2014, p.

153). After a parent death, regardless of the cause, children and youth have needs that should be addressed with sensitivity, including the need for support, nurturing, and continuity (Worden, 1996).

**Implications for the surviving child.** When the cause of parent death is suicide, the surviving child is especially vulnerable. Sensitivity and care must be used with this specific population of bereaved children. While much is still unknown about these survivors, a parent suicide has many ramifications for the surviving child, both short- and long-term. Some of these implications include mental health concerns and suicide risk, contextual issues surrounding the death, post suicide challenges, and long-term ramifications of the suicide.

***Mental health concerns and suicide risk.*** How does the suicide of a parent affect mental health and suicide risk in surviving children? Significant studies, summarized below, found increased risk for suicidal ideation, hospitalization for suicide attempts, mood disorders, and other mental health disorders.

In a large analysis of population data from Sweden over 30 years, Wilcox et al. (2010) examined outcomes for 503,229 parentally-bereaved youth and 3,807,867 non-parentally bereaved youth. This included 44,397 children and teens whose parents had completed suicide, which is 1000 times more participants than any previous longitudinal studies on children of parent suicide. Their compelling findings indicated that children and adolescents who lost a parent to suicide were three times more likely to complete suicide later in life than those individuals who had living parents. They also found that these children were more likely to be hospitalized for suicide attempts. Strengths of this study included an extremely large sample size, an extensive data collection system, and longevity over three decades. These strengths

allowed researchers to investigate long-term ramifications of parent suicide on surviving children and clearly identify some of the risks for children of parent suicide.

Kuramoto et al. (2010) also examined Swedish population data and examined data for 23,000 children and adolescents who had lost a parent to suicide. They found that those whose mother completed suicide were at greater risk for hospitalization for suicide attempts. Also using data from Sweden, Kuramoto, Runeson, Stuart, Lichtenstein, and Wilcox (2013) found that offspring of parent suicide are more likely to attempt suicide sooner than their parentally-bereaved peers. They also found that younger children struggled more long-term than adolescents who lost a parent to suicide. The need for long-term monitoring for children was recommended, and close monitoring of their adolescent counterparts for one to two years (Kuramoto et al., 2013).

Cerel, Fristad, Weller and Weller (1999) studied 26 parent-suicide-bereaved children over two years and found that initially, suicide-bereaved children show similarities to other children experiencing a parent death. However, differences in elevated symptoms in the suicide bereaved emerged within the first year. They found that child suicide survivors of parent suicide experience more anger, anxiety, and shame than other peers who experienced a parent death.

In a study by Pfeffer, Karus, Siegel, and Jiang (2000), children ages five to 12 years old bereaved by parent suicide were compared with children bereaved by parent cancer. Children who lost a parent to suicide exhibited more depressive symptoms in the 18 months following the death than the children bereaved by cancer. Symptoms included negative mood, ineffectiveness, and interpersonal problems; this may be related to the particular process of suicide bereavement involving the suddenness of the death or the way the suicide occurred (Pfeffer et al., 2000).



In 2010, Wilcox et al. found that parental suicide, relative to other forms of parental death, increased the risk of depressive, personality, and psychotic disorders. Wilcox et al. also noted that youth and teens are more affected by parent suicide than are young adults.

One longitudinal study in the United States followed children for up to three years (Melhem, Porta, Shamseddeen, Payne, & Brent, 2011), which included 42 children bereaved with parent suicide as a subset of the overall sample. The authors of this population-based longitudinal study claimed to have largest sample of children of suicide-bereaved offspring of any studies at that time which directly assessed children and their surviving parents. These children were not the major focus of the study and most results were combined with other children in the sample. However, the authors did note that by the end of the five years, seven of the 42 the suicide bereaved children were associated with increased risk of depression.

Not all studies have identified significant differences between children who have lost a parent to suicide compared with losing a parent to other reasons. Brown et al. (2007) suggest that the cause of parent death is not very influential in the grieving and coping process, and that children of parent suicide do not show significantly more depressive symptoms. The study did not follow individuals over a long time period, however. The effects of parent suicide may be far-reaching and perceptions of it may change as individuals move through different periods of life.

***Contextual issues.*** In order to better understand children of parent suicide, it is important to explore additional components of the “iceberg of suffering” referred to by Eckersley and Dear (2002). While there are many difficult, complex issues in a child’s life surrounding a parent suicide, some notable issues include pre-existing family dysfunction, how the child was told of the suicide, and developmental factors.

***Pre-existing family dysfunction.*** Suicide is rarely an isolated incident causing stress to the family unit; there are usually difficult circumstances prior to the death, as well as following the death. Ratnarajah and Schofield (2008) found that all 10 of the participants' families had severe dysfunction and unresolved trauma prior to the parental suicide. For those families whose loved one experienced extended mental health issues prior to the suicide, there may be a sense of relief following the death, the feeling that a heavy burden has been lifted (Jordan, 2001).

***Child developmental factors.*** The age and maturity of the child at time of suicide plays a significant role in how the child processes the death. This is true not just for parent suicide, but parental death in general (Worden, 1996). Grieving children greatly benefit from stable adults who encourage healthy grieving processes and ensure their needs, both practical and emotional, are being met (Worden, 1996). Yet, as mentioned above, a particular challenge for the surviving parent in a parent suicide is that they invariably are thrust into the mourning process themselves, and may not be able to provide the support for the child that he so vitally needs. Families also may assume the child is too young to understand what is going on and may not be told about the suicide (Cain, 2002). At this difficult time, the child is sometimes largely left unsupported (Ratnarajah & Schofield, 2008).

### **Post-Suicide Challenges**

***Learning of the suicide.*** An immediate issue confronting the surviving parent is if or how they should tell the child about the parent's suicide. Some children who are not initially told the death was a suicide, but find out later by accident, experience increased feelings of vulnerability, shame, and lack of trust in the surviving parent (Ratnarajah & Schofield, 2008). While it is generally not helpful to withhold the information from children, for some surviving parents, there are some limited instances where waiting to tell may actually be the best option

(Cain, 2002). Informing a child about their parent's suicide on one occasion only does not provide enough support or allow the child to fully understand the complexities of suicide; the incident will need to be "told and retold" (Cain, 2002) as children mature. Effective healing and effective coping begin with clear communication about the suicide, and in a manner that is sensitive and age-appropriate (Mitchell et al., 2006).

**Additional stressors.** Within the first two years after the parent death, children bereaved by parental suicide display more behavior problems and anxiety than children who lose a parent due to other reasons (Cerel et al., 1999). Children may experience feelings of isolation, abandonment, and guilt (Schriebner, Sands, & Jordan, 2015). This is in part due to the "tremendous stigma" that suicide brings (Schriebner et al., 2015).

A parent suicide also results in changes in the surviving family, which affects all family members. In a study including 42 children of parent suicide, Melhem et al. (2011) found that the caregiver's functioning following a parent death significantly predicts wellbeing in children and adolescents. Children may also have to navigate changing family roles and expectations when a suicide in the family occurs. Following a suicide in the family, some youth experience role reversal, where they, as children, take over parenting roles in caring for other siblings or for the parent while the parent is unable to care for himself or for the children (Dyregrov, 2009). This adds additional stress to the child or youth. Other potential stressors often include financial difficulties, housing changes, schedule changes, decreased trusted adult supervision, the need for downsizing, and increased extended family involvement.

**Long-term ramifications of parent suicide.** Many of the specific long-term ramifications of parent suicide are currently unknown. The seminal 30 year study on over 40,000 suicide bereaved children and adolescents by Wilcox et al. (2010) informed the literature

on increased risk for parental suicide on mental health and suicide risk outcomes, as did the studies by Kuramoto et al. (2010, 2013). There is a need for large-scale future research on this topic in the United States and elsewhere to confirm these findings and explore other effects, especially since prior research is somewhat conflicting (Cerel et al., 1999). Additional longitudinal empirically-based studies with large sample sizes are needed to determine potential long-term effects of parental suicide bereavement during childhood or adolescence.

As children youth bereaved by parent suicide grow and mature, understandings of suicide change throughout the lifetime (Cain, 2002). As a result, children of parent suicides have a need for ongoing support, as they continue to feel and deal with the effects of the suicide long after the death occurred (Loy & Boelk, 2014).

While many specifics of long-term challenges may be unknown at present, research does show that the negative ramifications of parental suicide may persist throughout a child's life and even into the third generation (Cain, 2006). One of these potential effects of parental suicide is suicide by their offspring—the second generation—which could effectively ensure there is no third generation born (Cain, 2006; Kuramoto et al., 2010; Wilcox et al., 2010). Another effect of parental suicide that affects family lines is the fear that the third generation will follow the pattern of suicide set by the deceased grandparent (Cain, 2006). Research in this area is very sparse but needed (Cain, 2006).

**Intervention, support and resources.** There are many existing resources and interventions for children experiencing grief, but fewer exist for a child coping with a suicide loss. Interventions specifically for a parent-suicide survivors are even sparser (Ratnarajah & Schofield, 2008). While some interventions intended to address general grief or suicide of a loved one may be helpful for children after a parent suicide, children of parent suicide also need

support catered directly to them (Andriessen, 2014). In addition, it is important for resources to seek out suicide survivors who may otherwise be unaware of them (Campbell, 1997).

The lack of practical resources (printed and online) and interventions for this population has been described as an area of *significant need* for suicide-bereaved children (Andriessen, 2014) and an *urgent need* for children bereaved specifically by parent suicide (Ratnarajah & Schofield, 2008). Instead of supporting and developing resources for children after a suicide, efforts are often primarily focused on preventing suicide (Loy & Boelk, 2014). While prevention is certainly important, postvention efforts are no less valuable and are, in actuality, prevention efforts (Cerel et al., 2008). For this reason, the development of evidence-based resources for these children should be a high priority (Andriessen, 2014), including empirically-evaluated school-based interventions, which are scarce (Loy & Boelk, 2014).

***Contact with other suicide survivors.*** For adult suicide survivors, contact with other suicide survivors is extremely helpful; this contact allows the adult to understand his reactions to the suicide (Begley & Quayle, 2007). One pilot study of 63 suicide-bereaved adults found that suicide-specific support groups were much more helpful than general-grief support groups (McMenamy et al., 2008). The same study also found that every single individual who had one-on-one contact with another suicide survivor found the interaction was moderately to highly helpful (McMenamy et al., 2008). For suicide survivors, both adults and children, contact with other suicide survivors, which could be in the form of support groups or group therapy, is extremely important and helpful (Begley & Quayle, 2007; Pfeffer et al., 2002).

Support groups may be no less valuable to children and youth. In a promising study by Pfeffer et al. (2002), children and adolescents who had a family member die by suicide participated in group bereavement intervention that focused on coping skills, reaction to death

and suicide; these children showed lessening of depressive and anxious symptoms. One longitudinal study of five children who had lost a family member to suicide found that group interactions over four years helped participants with camaraderie and normalization (Veale, 2012).

**Formal therapy.** Supporting the child as part of a family system, an important area which remains largely undeveloped, is another very effective way to help the children of suicide (McMenamy et al., 2008; Ratnarajah & Schofield, 2008). Therapy can help the family create a new system that is functional, communicative, and healthy (Dyregrov, Plyhn, & Dieserud, 2011; Ratnarajah & Schofield, 2008). In addition to family therapy, individual counseling may be appropriate for some children; this can include play therapy, art therapy, bibliotherapy (which uses picture books to facilitate the therapeutic process), and other forms of therapy appropriate to the child's age and development.

**Children's lived experiences and perceptions of support.** One area that has not been explored in depth is how children of parent suicide perceive the support offered to them. In a study on suicide survivors (not specific to children), Wilson and Marshall (2010) found that survivors perceive the support offered them as not accessible and, for those who did receive professional support, as not very helpful. In fact, 94% of these suicide-bereaved individuals actually perceived a need from outside sources to help manage their grief, but only 44% received that help (Wilson & Marshall, 2010). Additionally, of those who received professional services, only 40% felt satisfied with the care they received (Wilson & Marshall, 2010). There is great disparity between the perceived need and the actual support being offered to these individuals.

Schreiber, Sands, and Jordan (2015) investigated the perceptions of two practitioners working with children of parent suicide for at least 15 years. They found that these children

were perceived by practitioners as particularly at risk for challenges, and that stigma played a large role in affecting the children. However, these are perceptions about the children, not from them.

Some studies have examined the experiences of suicide survivors through interviews. Gall, Henneberry, and Eyre (2014) interviewed 11 people who had lost a loved one to suicide about their experiences surrounding the suicide. Three of the 11 participants lost a parent to suicide, but the study did not indicate their age at the time of their parent's death. Researchers examined the suicide's impact on the individual, the types of coping strategies they used, and how they understood the suicide. They found that shock and guilt were common emotions in these suicide-bereaved individuals.

A study by Ratnarajah and Schofield (2008) is especially important for the research of parent suicide, in that they interviewed ten adults who, as children, had a parent die by suicide. Through their narratives of the suicide survivors' experiences, the authors gained insight into some of the circumstances surrounding a parent suicide, and various short- and long-term effects of a parent suicide that affect the family unit.

**Difficulties with suicide survivor research.** Suicide survivor research is an emerging field of study, and the subset of children who have experienced a parent suicide death presents a unique combination of challenges to the researcher. While there have been a number of studies completed on survivors of suicide, relatively few exist specifically focusing on children of parent suicide, and even those yield mixed results (Kuramoto, Brent, & Wilcox, 2009). Various difficulties with researching this bereaved population include challenges with data collection, sample sizes, recruitment, within-population differences, lack of qualitative studies, and perceived vulnerability.

**Data collection.** Finding existing data for new research on children of parent suicide is challenging. Sometimes the data simply hasn't been compiled. For example, many coroners don't regularly collect information on surviving children (Melhem et al., 2011) of parent suicides. The lack of data and longitudinal studies on this population in the United States has resulted in researchers joining with others internationally to examine extensive and in-depth Swedish data that is available (Kuramoto et al., 2010; Kuramoto et al., 2013; Wilcox et al., 2010). These studies contributed greatly to the field; however, there is a lack of this type of data available in the United States (Colpe & Pringle, 2014). The absence of this data is exposed when attempting something as relatively basic as identifying the number of children left behind after parent suicides in the United States. Leading suicide researcher, Julie Cerel, cited the number of children annually that experience a parent suicide is between 7,000 to 12,000 in publications from 1999, 2000, and 2008. Upon closer inspection, this number was actually derived from a 1984 publication by Small and Small (as cited in Cerel et al., 1999). However, this 30-year-old estimate, while frequently used and referenced within the last decade, may be inaccurate.

**Sample sizes.** Small sample sizes contribute to the lack of empirical research in this area (Hung & Rabin, 2009). With the exception of the studies relying on Swedish data (Kuramoto et al., 2010; Kuramoto et al., 2013; Wilcox et al., 2010), virtually all of the existing studies on children of parent suicide have relatively restricted sample sizes (Cerel et al., 1999; Melham et al., 2011; Pfeffer et al., 2000). This results in limited generalizability and applicability of most research findings.

**Participant recruitment.** Recruitment for new studies of children of parent suicide is another challenge, due to stigma regarding the subject of suicide, as well as a lack of comprehensive nationwide data collection system that follows the suicide bereaved over time,



and access to a population of minors. As a result, many samples use self-selecting recruitment strategies (Hung & Rabin, 2009). Cerel, Fristad, Weller, and Weller (2000) found that suicide-bereaved children resisted participation in studies three times as much as children who had lost a parent to a cause other than suicide.

***Differentiations within the population.*** As further research is conducted, terminology will need to be refined and standardized. This more precise vocabulary will help facilitate more accurate research and the development of targeted interventions to each group of survivors (Cerel et al., 2014). Another term that could be better defined is *children of parent suicide*. In this phrase, *children* could refer to either the individual's chronological age or simply the relationship with the deceased. Children of parent suicide may also be referred to as suicide survivors, which should not be confused with those who survive their own suicide attempt. Another subgroup of survivors of parent suicide for which there currently is no terminology include those whose parents separate, divorce, remarry, or move away from the child prior to the parent suicide; these individuals may present very different symptoms than children who were living at home with both parents when the suicide occurred. As research in this field advances, it will be important to develop more precise vocabulary to describe those affected by suicide (Cerel et al., 2014; Jordan & McIntosh, 2011).

***Lack of qualitative studies.*** Existing research on suicide survivors is based primarily on quantitative data (Sveen & Walby, 2008; Wilcox et al., 2010). Unfortunately, there is a lack of qualitative studies that explore the experiences and perceptions of children of parent suicide. However, exploring the lived experiences of suicide-bereaved individuals through qualitative research can provide important general understanding of this population (Begley & Quayle, 2007). Qualitative studies, including interviews, can provide rich insight and meaning into the

lives of those affected by a parent suicide (Ratnarajah & Schofield, 2008; Sveen & Walby, 2008), and can ultimately drive evidence-based supports and interventions.

***Perceived vulnerability.*** Researchers must be careful and sensitive when conducting research on suicide-bereaved individuals. However, it appears that participation in bereavement research, including interviews, may be personally helpful and therapeutic to suicide survivors (Omerov, Steineck, Dyregrov, Runeson, & Nyberg, 2013). In an extensive study done by Omerov et al. (2013) with 666 parents bereaved by suicide, only one participant indicated that study participation had created a negative effect that might last. This very small percentage ( $1/666 = .0015\%$ ) of participants suggests that asking questions of suicide survivors may not have the deleterious effect that many assume. Moore, Maple, Mitchell, and Cerel (2013) found no evidence that bereaved participants “are hurt by asking them to participate in research and by allowing them to make informed consent to participate.” In spite of the literature indicating otherwise, ethical review boards may reject proposed research on suicide bereaved on the basis of this population's perceived vulnerability. The science behind research on suicide-bereaved individuals should drive the research on this under-studied group, not the ethical review boards themselves (Moore et al., 2013).

In addition to not appearing harmful, many suicide bereaved actually have positive experiences with bereavement research. They may feel they are assisting others, as well as having a psychologically helpful experience themselves (Moore et al., 2013). In the Omerov et al. (2013) study, 50% of the participants indicated they experienced a positive effect as a result of their participation; reasons for the positive effect included gratitude to be able to share experiences, hope that their experiences could benefit others, and the feeling that answering the questions helped them work through their own memories. Additionally, 95% of suicide-

bereaved parents indicated they thought the study was valuable, and even if the participants did not have a positive experience, almost all acknowledged the study was important to society.

Other studies also indicate positive benefit from participation. In an interview study of individuals bereaved by suicide (Dyregrov et al., 2011), the participants' experiences were grouped into the following three categories: *overall positive* (62%), *unproblematic* (10%), and both *positive and painful* (28%). Even those who considered their interview experience painful still felt positive about their participation in the suicide bereavement research. When 64 bereaved parents who had lost their children to a sudden death, including by suicide, were interviewed multiple times by researchers, 64 out of 64 participants (100%) rated their overall participation in the study as *positive* or *very positive* (Dyregrov, 2004).

There is no significant evidence to suggest that sharing one's experiences surrounding the suicide of a loved one in a research setting creates a lasting harmful effect; research participation can even be positive or helpful to the bereaved (Moore et al., 2013; Omerov et al., 2013).

## **Conclusion**

In the study of suicide, a postvention focus should be an integral component (Andriessen, 2014), and the best postvention efforts are actually prevention efforts (Cerel et al., 2008). Recently, in the field of suicidology, there is a growing focus on children bereaved by parent suicide (Cerel et al., 1999; Kuramoto et al., 2010; Kuramoto et al., 2013; Ratnarajah et al., 2008; Sveen & Walby, 2008; Wilcox et al., 2010). This vulnerable population experiences difficulties following the suicide and are at higher risk for poor outcomes over a lifetime (Kuramoto et al., 2010; Wilcox et al., 2010). However, the research has not adequately explored the perceptions of these children.

### **Statement of Problem**

A great need exists to better understand the experiences of individuals bereaved by parent suicide as reported by themselves, but there is a paucity of existing knowledge of these children's experiences and perceptions of support. A better understanding of these survivors will play a critical role in providing more effective and timely support to them, which could help decrease immediate distress and lessen or even eliminate long-term challenges associated with parent suicide bereavement.

### **Research Questions**

1. From child survivors' perspectives, what are the perceptions of support offered to children who survived a parent suicide?
2. What experiences do adults who were bereaved by parent suicide when they were children or adolescents perceive to have been helpful following the suicide?
3. What experiences do they consider to have been unhelpful or harmful?
4. Which people do they perceive to have been helpful following the parent suicide?

## CHAPTER 3: METHOD

This section describes the current study's research design, participants, and procedure. The process of data analysis, using the hermeneutic approach, is outlined. This is followed by information on researcher bias.

### **Research Design**

The aim of the study was to explore what was helpful and not helpful in the parental suicide bereavement process. A qualitative inquiry method was selected for this study. John McLeod (2001) observed that qualitative research does not follow the strict cause-and-effect theory based on laws of science that is often found in quantitative research, but that qualitative studies provide a much more humanistic perspective; they support the concept that individuals and communities create and shape the world each lives in. As the study at hand seeks to explore how the world of a child is constructed and shaped following a parent suicide, the researcher felt that a qualitative study would offer much insight into this topic.

The hermeneutic approach was used in the study. Hermeneutics is known as the interpretation of texts, with the term "text" including discourse and even action (Kvale & Brinkmann, 2009). Thus, the hermeneutic approach can be used with interviews. It is informed and influenced by culture and history, the use of empathy, and movement back and forth from the whole and the part; in this way meaning and interpretation is obtained (McLeod, 2001). A goal of hermeneutics is to fuse various horizons by immersing oneself in the "text" being studied, allowing the world expressed to speak to the outsider's culture and world (McLeod, 2001). The researcher felt this approach would fit best for this type of research question due to the sensitive nature of learning from survivors of suicide and the knowledge that suicide and its aftermath is truly a complex experience—one difficult to comprehend without great empathy,

intent, and context. As a result of the study's sensitive topic, a convenience sample was necessary; purposive sampling and snowball sampling were used in order to find eligible participants.

### **Participants**

Of the adults who volunteered to be participants in the study, 17 met all delineated qualifications and were included in the research. The participants ranged in age from 19 to 53 years old ( $M = 26.88$  years,  $SD = 8.35$  years). The deceased loved ones were fathers ( $n=14$ , 82%) and mothers ( $n=3$ , 18%). The study's rates of deceased parents by gender were comparable with 2015 national averages for suicide by gender (men: 77%, women: 23%; Kochanek et al., 2016).

All participants were screened to ensure they met inclusion criteria, and informed consent was obtained from all participants prior to study participation. Inclusion criteria included a current age of 18 or older, the loss of a biological or stepparent parent suicide death when they were a child (18 years of age or younger). Additionally, the suicide was required to have occurred at least 1 year prior to the interview so as to avoid the risk of re-traumatization or exposure of feelings and experiences that were extremely recent and likely unprocessed by the participant.

**Sample size.** The sample size for this study was 17. A generally accepted sample size for qualitative interviews is 15, plus or minus 10; this is enough participants to allow for a variety of responses and yet not oversaturate the responses (Kvale & Brinkmann, 2009). Other similar qualitative studies conducted on suicide-bereaved individuals have similar sample sizes. A 2008 study by Ratnarajah and Schofield explored the short-term and lifelong impact of parent suicide on 10 adults. Begley and Quayle (2007) explored the lived experiences of eight adults bereaved

by suicide of either a child or sibling. Oulanova, Moodley, and Séguin (2014) interviewed 15 suicide survivors who were also peer counselors at suicide support groups.

**Recruitment.** Information about the study was shared with local suicide bereavement groups, local grief support groups, professional and personal contacts, social media forums, and local community centers, public libraries, and college campuses. Individuals were encouraged to contact the researcher if interested in participating in an in-person interview. Snowball sampling was also used by asking participants if they were aware of any other individuals who might be interested in participating. In this way, siblings of participants were recruited to the study.

### **Procedure**

Semi-structured, qualitative interviews were conducted in order to identify which interventions, interactions, strategies, and conversations were perceived as most helpful or harmful to the survivor. The interview questions were developed after examining similar studies (Begley & Quayle, 2007; Gall et al., 2014; McMenamy et al., 2008; Ratnarajah & Schofield, 2008). Each volunteer was screened prior to the interview to ensure research criteria were met (Appendix A). If considered eligible, an interview was arranged. Interviews were conducted in private study rooms of libraries in Utah, Salt Lake, and Davis counties within Utah.

The interviews, which were audio recorded, ranged from 36 minutes to 1 hour 29 minutes. During the pre-interview portion, the researcher explained the purpose of the study. Each participant was informed of the potential risks of the study (heightened awareness of difficult or traumatic feelings experienced surrounding the death of the parent or flashbacks or other intense, unwanted memories as a result of the interview questions) and given the opportunity to withdraw without penalty at any time. The participant completed hard copies of the Informed Consent form (Appendix B) and the Demographic Sheet (Appendix C).

During the interview portion, in accordance with the hermeneutic approach, the researcher sought to feel and display empathy during the entire interview process. She explained why she wanted to learn more about the experiences of the participant, and expressed appreciation for the participant's willingness to share experiences and thoughts with her. She sought to display empathy throughout the interview through phrases like, "I realize this probably isn't an easy thing to talk about." To assist her in the interview, she used a semi-structured interview protocol list of questions that had been designed for the purpose of this study (Appendix D). She paired these questions with counseling and listening skills to facilitate a safe place for discussion, telling, and even meaning making and discovery. The guiding questions were intended to be a flexible guide rather than a rigid step-by-step procedure.

Throughout the interview, the researcher sought to use encouragers minimally but used probes such as "Can you tell me more about that?" and "Can you give me an example of that?" to encourage the dialogue on deeper levels. This enabled her to understand the context more fully and displayed active listening to the participant. It was the hope of the researcher that these techniques encouraged the participant to engage, think, pause, and reflect within the interview conversation and thereby glean additional layers of content and meaning.

During the post-interview portion, each subject was thanked for sharing their experiences. Participants received a \$20 Amazon gift card for study participation. Participants were also asked if they knew of other individuals who might be interested in participating as well.

### **Data Analysis**

The research team for the study was comprised of the primary researcher, a university professor, and two trained undergraduate students. All 17 interviews were conducted by the



primary researcher. The undergraduate students transcribed the majority of the interviews, with each transcript confirmed by the other student and any subsequent transcription-related questions brought to the primary researcher.

In the hermeneutic approach, the process of analysis begins during, not after, the interviews. When conducting the interviews, the researcher was engaged in interpretation throughout. She also recorded notes and impressions immediately after the interviews ended. Following the interviews, the same philosophical and theoretical assumptions were used while transcribing the interviews and while interpreting the transcriptions. The interpretative process is indicated below.

The researcher read through each of the interview transcripts in an unfocused overview of the text (Jackson & Patton, 1992). This provided an important basis for analysis, for in viewing the text without—to the extent possible—any prior explanations or expectations, the researcher can start understanding the meaning from the participant's perspective (Jackson & Patton, 1992). In spite of having conducted the interviews, this is an important step for the researcher to take as she immerses herself in the text, in order to understand the deeper meanings contained therein.

Next, interpretations were articulated in successive readings of the text (Jackson & Patton, 1992). During these repetitions, each member of the research team followed the hermeneutic circle, a back-and-forth process going from a vague understanding of the whole, to interpretation of different individual parts, to relating these interpretations back to the whole. This circular process permitted the researcher to move to deeper levels of meaning (Kvale & Brinkman, 2009) and identify potential themes. Each team member engaged in this process individually; making notes of commonalities that appeared in the transcripts in an attempt to connect any common themes or statements. Components in each transcript that could be unique

or represent an unusual or contradictory theme were also noted. The researchers then circled back and re-examined the text in context for statements or meanings that could disprove the theme, or disconfirm it. After examining the transcripts individually, the research team met together to discuss findings and share possible themes. As potential themes were identified, the researchers continued to follow the hermeneutic circle by returning to the text for confirming or disconfirming evidence. Confirmed themes were kept, while unsubstantiated themes or ones that were not broadly represented were discarded.

The researcher also sought to select language that accurately expressed the meanings of the experiences described in the interviews (Jackson & Patton, 1992). Once valid interpretations of the text were obtained, through the hermeneutic process, then the researcher tried to accurately communicate the meanings and themes of the study through precisely chosen words and phrases to represent them. Through this multi-step and circular process, the transcripts of the interviews were analyzed thematically.

Participants were assigned a pseudonym to protect anonymity. A copy of the interview transcript was made available to each willing participant to allow them to review the interpretation and description of their experience, and make modifications or corrections to the transcript. Of the 17 participants, 16 agreed to review the transcript, and three responded with modifications which were then considered in the analysis. This use of member checking provided a validity check for the written interpretation of the audio interview.

The primary researcher is currently a graduate student at Brigham Young University. She is studying to become a school psychologist and has an interest in helping children affected by a parent suicide death. She was born and raised in Utah, and lived in Utah and Salt Lake counties during the course of the study. Her first involvement with suicide prevention was in

high school. She is an active member of The Church of Jesus Christ of Latter-day Saints (LDS). While none of her immediate family members have died by suicide, she has been affected by suicides of extended family members and friends. Throughout the course of this study, she has had the opportunity to travel and interact with many others involved in the field of suicidology. All of these factors contribute to researcher bias and the position from which she approached this research.

## CHAPTER 4: RESULTS

Seventeen adults were individually interviewed and asked about their experiences following their parent's suicide. While all participants experienced a parent suicide death, each set of circumstances surrounding the suicide was unique (see Table 1). Some participants were living in the same residence with the parent who died by suicide; others' parents had separated or divorced and the participant was not living with the parent at the time the parent completed suicide. Some were told it was a suicide immediately or shortly after the death; others knew their parent died but did not learn about the actual cause (suicide) until several years later. In fact, one participant reported that she learned that her father's death was a suicide less than 1 year prior to the interview.

Participants also differed in respect to other details. Some participants clearly remembered their deceased parent while others were young enough that they did not have any specific memories of the parent. No participant discovered their parent's body, but some parents completed suicide in the child's place of residence. One suicide was completed in the child's bedroom. Most participants lived in Utah when the suicide occurred, however a few lived outside of Utah. While information on religious affiliation was not specifically collected (Appendix C), most participants made comments throughout the interview that suggested they were currently or previously active members of the LDS Church, the predominant religion in Utah.

All participants experienced a biological parent's death. The age of the child at the time of the suicide ranged from 4 months to 18 years ( $M = 8.08$  years,  $SD = 5.32$ ). The elapsed time from the death to the interview ranged from 8 to 41 years ( $M = 18.8$  years,  $SD = 9.01$ ).

At the time of the interview, participants lived in three different counties in central and northern Utah. Additionally, two sets of siblings volunteered to participate. The first set was a brother and sister (Sibling Set A), the next set was two sisters and a brother (Sibling Set B).

Table 1

*Participant Demographics and Information Surrounding the Suicide*

Pseudonym	Age at suicide	Age at interview	Ethnicity	Gender	Parent who completed suicide	Method	Location of suicide	Siblings
Jesse	4 months	25	Caucasian	M	Father	Gunshot	Home	N/A
Bethany	1	22	Caucasian	F	Father	Hanging	Farm in rural community	Sibling Set B
Malcolm	3	36	Caucasian	M	Father	Carbon monoxide poisoning	Vehicle away from house	N/A
Tiana	4	20	Caucasian	F	Mother	Hanging	Home	N/A
Melinda	4	21	Caucasian	F	Father	Poisoning	Hotel room	N/A
Cory	5	23	Caucasian	M	Father	Gunshot	Grandparents' house	N/A
Gavin	5	26	Caucasian	M	Father	Hanging	Farm in rural community	Sibling Set B
Danica	5	27	Caucasian	F	Father	Pill overdose	Don't know	N/A
Kristine	7	32	Caucasian	F	Father	Gunshot	Deserted neighborhood	N/A
Sonya	9	19	Asian	F	Father	Hanging	Home; her bedroom	Sibling Set A
Candace	10	32	Caucasian	F	Father	Hanging	Farm in rural community	Sibling Set B
Janay	11	19	Caucasian	F	Father	Shooting	A lake	N/A
Byron	12	21	Asian	M	Father	Hanging	Home	Sibling Set A
Winnie	12	53	Caucasian	F	Mother	Rifle	Home	N/A
Chase	15	25	Caucasian	M	Mother	Pill overdose	Rural road	N/A
Sally	16	26	Caucasian	F	Father	Hanging	Garage	N/A
Hallie	18	30	Caucasian	F	Father	Gunshot	Police station	N/A

*Note.* N=17; Siblings from the same family are identified by their respective sibling sets.

The research team conducted and analyzed the typed transcripts of the interviews using the hermeneutic method to identify common themes. While each individual's experience was unique, even amongst siblings, some common themes emerged. These themes are grouped according to non-supportive practices, supportive practices, and influential people.

### **Non-Supportive Practices**

Almost all participants recalled experiences and interactions following their parent's suicide that they perceived as unhelpful or particularly difficult. Some participants were very adamant, expressing strong opinions about what was not helpful. Others felt like they adequately managed their situation, but wished certain aspects of their experience could have been different. All of these types of responses were grouped into the *non-supportive* category.

**Silence, avoidance, and half-truths.** An extremely common theme that emerged during many interviews was the silence and stigma surrounding parent suicide. This reluctance to address the suicide resulted in children having difficulty processing the death. Some surviving parents created—intentionally or unintentionally—a culture of not talking about the suicide or the deceased parent's life. Some adults told half-truths or lies about the suicide. In addition to not talking about the suicide, parents often would not talk with the child about how he or she was handling everything. Surviving parents commonly did not provide an opportunity to ask questions. The stigma surrounding suicide likely compounded these children's experience of silence and secrecy. Although parents may have perceived the need to shield the children from the facts surrounding the suicide, child survivors perceived this lack of accurate dialogue—or dialogue at all, in some cases—as unhelpful and even detrimental.

Winnie, age 10 when her mother completed suicide, said, “Other than with my [church youth group] leader, there was not an adult who talked with me heart-to-heart about my mom's

death.” Even upon her return to school following her mother’s passing, no one acknowledged her mother’s death. “Nobody said anything,” she recalls. When the parent’s suicide was not acknowledged or discussed, this often led to a lack of discussion about the parent’s life as well. Winnie’s father remarried shortly after her mother’s death, and all photos of her mother were taken down; this further reinforced the message of shame and avoidance regarding her deceased mother.

Tiana shared an especially poignant example regarding half-truths and silence surrounding parent suicide. Tiana was four years old when her mother died. She was informed that her mom was “gone.” She kept wondering when her mom was going to come back. Adults told her it was going to be okay, but she remembers knowing they were lying because their words didn’t match their emotions. As a preschooler, she sensed this conflict and felt a lot of fear as a result.

At age 11, Tiana’s father took her to the cemetery and shared the information that her mother died by suicide. He then told her, “Don’t talk about it. Don’t bring it up with people.” When she couldn’t talk about her mother’s suicide, she stated that she felt shame about the secret. Additionally, without anyone to discuss it with, she felt like she had to handle it on her own. She described her situation:

I just thought...“I guess I had to figure this out on my own...I have to deal with it by myself”... and so I didn’t ... even talk to my dad about it. I didn’t talk to my siblings about it...I just thought about it.

Years later, when Tiana finally learned more about her mother’s suicide, her fear and anxiety were reduced. She summarized, “The more you understand something, the less reason you have to be afraid of it.”

In some instances, the silence surrounding parent suicide resulted in the child experiencing feelings of resentment and abandonment. Bethany, a one-year-old when her father died, offered this explanation:

I think the lack of conversation about him, kind of this secretive vibe that he has ... it didn't help me.... It made me more frustrated ... So talking about it... it's proven it just soothes, it really does, so I think my curiosity and kind of the resentment I have for him ... the abandonment feeling, I think, would've been filled if I had known more about him.

For others, the lack of dialogue about the death and suicide impacted their ability to address emotions and thoughts surrounding the suicide. Cory recalled that since his dad died, he didn't talk about it for a "long, long time," and none of his family did either. They kept the topic on the "back burner," adhering to unspoken rules of silence. In the meantime, he felt like everything stopped in his life, including his ability to progress and be happy. He observed some of the effects that come from a lack of dialogue:

If you bottle it up for so long, eventually things will explode. It's like putting a can of beans on a campfire and just letting it go without opening the top, it's going to explode eventually... So with all that pain and suffering that is felt with the loss of a loved one, those things need to be addressed.

Interestingly, Cory wasn't the only participant who used the phrase "bottle it up" in reference to dealing with issues and feelings surrounding the suicide. Three other participants also mentioned bottling things up. One even joked metaphorically about how she had some significant "food storage" going on because she was so good at bottling up her emotions and keeping them inside.

When there is no culture of openness and the ability to talk about the suicide and the deceased parent is stifled, children often internalize their struggles and questions in maladaptive



ways and fail to learn adaptive coping methods. Lacking opportunities to talk about his father's suicide, Cory ultimately turned to self-medication and other harmful maladaptive coping methods. In his late teens he finally went to see a counselor to work through issues related to his father's suicide. Similarly, Danica, who as a child was told her father died in a car accident—when he actually overdosed on pain medication—also turned to self-medication and risky behaviors.

**Feeling judged or blamed by others.** Youth were sensitive to others judging them, their deceased parent, or their surviving parent because of the suicide. Others were more concerned about how their deceased parent was being perceived. Kristine said, “My biggest thing with suicide was I didn't want people to judge [my dad] because they didn't know him.” She described one of her fears was that people would only remember her father's death and not his life. She suggested that others experiencing the death of a loved one by suicide should “focus on their life more because their death was just a moment of desperation.” So often the deceased parent was remembered primarily by the way he or she died, instead of by their life. This was perceived negatively by their children and sometimes interpreted as others passing judgment on their deceased parent and family.

Other participants experienced or feared judgments from others. Some didn't want others to know about the suicide because they feared being treated differently by others. Participants described these fears, such as peers being afraid that the child survivor might be crazy too or that the child survivor might attempt suicide. Others actually experienced harsh judgments from extended family members. Candace, age 10 at her father's death, explained that her extended family on her father's side judged and blamed her mom for her father's death. Her brother, Gavin, age five at his father's death, remembered hearing his father's brother accuse his mother

of being a “husband killer.” Some extended families withdrew their support, either all at once or gradually. This was particularly painful because relationships with the deceased parent’s side of the family most frequently were strained or severed.

One of the ways participants coped with their feelings or fears of being blamed or judged by others was to disguise the cause of their parent’s death. When people asked how their parent died, some left it vague and said their parent “was sick.” Candace told people a truck fell on her dad.

Some participants felt judged by the way people responded after learning of the suicide. Many people changed the subject or ended the conversation abruptly. One youth did not like it when people said, “I’m sorry.” He felt like others did not need to show pity or be sorry since he had not done anything wrong. He instead preferred that people say something acknowledging the magnitude of the situation such as, “Oh, that’s the worst.” Some participants remembered peers or others saying blunt phrases such as, “Your dad killed himself,” “Oh, your dad’s in hell,” and “Oh, why didn’t he want to be with you?” Other responses like “I know how you feel” were also not helpful since they were perceived as inaccurate and off the mark. Instead, one participant recommended using non-blaming and non-judgmental phrases such as, “It’s hard, huh?” and “I can’t even imagine” to convey support.

**Self-blame.** Some children and youth blamed themselves for their parent’s suicide. Bethany was born a year before her father completed suicide and was an extremely fussy baby. She remembers thinking, “Oh my gosh, I must have been a part of the reason, if not the whole reason...” Other children blamed themselves for not being more aware, feeling they could have prevented the suicide. Sonya recalled,

I ended up getting really angry at ... myself because I was thinking to myself, why didn't I notice this? And the day that he died...I was rushing to school and I was thinking to myself, 'Oh, I usually just crawl into bed with my dad and give him a hug and say goodbye,' but that day I didn't because I was so late for school and I was rushing to get out the door... And so when [the suicide] happened I thought, I kept thinking to myself, 'What if I just told him—my father—I loved him? Would he have changed his mind, maybe?'

Other children also blamed themselves and the suicide shaped their concept of self-worth. Danica, age 5 at her father's death, concluded, "I just knew that I wasn't good enough for him to stick around." However, she also noted that learning about his mental illness struggles (including depression, bipolar disorder, and anxiety) helped her not blame herself as much.

**Awareness of the surviving parent's difficulties.** An awareness of the surviving parent's difficulties following the suicide often complicated the child's coping process. Multiple participants mentioned the challenge of observing their surviving parent struggle following the suicide. Janay described this as "the hardest thing" about her whole experience. She was aware of some of the financial difficulties her mother faced, including needing to pay off business debts incurred by her deceased father. Children and youth were frequently aware of at least some of their surviving parent's needs.

While difficult, this stressor was eased somewhat when the child was aware of other adults assisting their parent. However, some children who were aware of their surviving parent's needs felt reassured when those needs were being met. When some saw adults supporting their parent, they also felt indirectly supported themselves. Melinda, age four at the time of her father's death, remembered her mom looking devastated immediately after the suicide, but also

remembered that “the people who supported my mom also... supported me.” Some participants preferred that others support their parent over themselves, due to their awareness of their surviving parent’s challenges. Byron, age 12 at the time of his father’s death, clearly remembered his father’s coworkers, his godfather, and extended family members reaching out to his mom. He said that their offers of support to his mom were “a lot more important than... for them coming to me, ‘cause I know it affected her a lot more than it did me.” Byron perceived that his mother was struggling more than he was, and was reassured by knowing she was being assisted.

One participant sensed her surviving parent’s needs and stepped in to fill as many of those as she could herself. She also allowed other adults to support her mother. Candace, age 10 at the time of her father’s death, recalled her mom spending lots of time talking on the phone to her friends, and knew that her mom was getting the help she needed during that difficult time. In the aftermath of the suicide, Candace continued to be sensitive to her mother’s needs and tried to fill some of those herself; she helped her mother by frequently tending her fussy baby sister, Bethany, even joking later that she raised her. She also would try to comfort her mom when she noticed her mom was sad or lonely; her mom would reciprocate the same for her.

**Feeling extreme emotions.** When others repeatedly showed extreme emotions regarding the suicide, the child often perceived this as negative. Tiana said, “I just always felt afraid to talk about my mom or to ask questions because every time I did, people would get really upset.” Hallie recalled dreading family gatherings because of the display of intense emotions. Speaking of seeing her deceased father’s three sisters, she said, “I remember every time we would see them they would just sit and bawl.” She found herself dreading these social events, which under

different circumstances might have been a very supportive environment for her. This display of strong emotions—which did not match the emotional expression of the child—was not helpful.

In contrast with the above instances, one mother's use of emotional expression provided great help to her daughter. Kristine remembered her mother crying with her and her siblings, but she noted that she matched the level of their emotions—and never exceeded them. She also did not see her mom crying at other times. Kristine recalled this in a positive light. Parent and child sharing in emotional expression together, with the parent matching the child's level and intensity of emotions, may be helpful for children's abilities to develop healthy coping skills and to facilitate processing the traumatic event.

### **Supportive Practices**

All participants were able to identify experiences and forms of support that they perceived as helpful following their parent's suicide. Some participants also shared things that they wish had occurred and that they feel would have been helpful. Both types of experiences are included in this section as helpful support.

**Assistance in processing the suicide.** Caring adults helped participants when they created an openness to talk about the deceased parent and events surrounding the suicide. Participants noted that this was very beneficial. By opening channels of communication, the adult was able to learn what the child was thinking and debunk thoughts such as "It's my fault," "If only I had..." and "He didn't love me or he wouldn't have left me on purpose."

Assistance in processing the suicide can begin the moment the child learns of the suicide. Sonya, age nine at her father's death, wished she could have had "the situation properly explained" from people she already trusted, and had them ask her how she was really doing. She said, "Rather than going through, 'Your dad's dead, you need to move out, here's the funeral..."

go to school'... I would've liked to have just sat down and have someone explain to me... 'Okay, this happened. Are you okay?'"

Sometimes children had experiences that facilitated the processing of the suicide when trusted adults just listened. In the Asian culture where Byron grew up, suicide was perceived as very shameful and taboo, and they didn't talk about it with others, even inside his own family. However, he did recall one visit with his father's friend where he was able to talk about his experience. He stated, "Just... by having someone to... really talk to who knew what I was going through, that helped a lot. Just... being able to vocalize it, tell my story... that was beneficial."

Adults who brought up the difficult topics and inquired how the child was doing in a meaningful way helped the children feel cared about and provided a space for them to begin processing. Sometimes this was the surviving parent; other times it was another adult. Sonya, who regretted not hugging her dad the morning of his suicide, struggled with unresolved issues for years until she saw a counselor as a teenager, issues that might have been resolved sooner with adult assistance.

Sometimes participants indicated they didn't have assistance processing the suicide, such as when Sonya indicated that the morning her dad completed suicide, she hadn't hugged him goodbye as she left for school. She commented she always wondered if that was the reason why he completed suicide. It wasn't until she was a teenager that she began to really struggle and she went to see a counselor, where they traced her struggles back to unresolved issues with her father's death.

**Counseling.** Participants were varied in their experiences with and opinions regarding counseling support. Some never received any formal counseling, which they were fine with because they felt they never needed it. Others were never offered the option and yet they wished

they could have had that support; they felt they could have benefited from it. Sonya, age 9 at her father's death, mentioned that her mother and her brother, age 12, got to talk to their ecclesiastical leader following the suicide, but that option wasn't offered to her because she was considered too young to need it. She commented that she might have been young, but she wasn't stupid, and wished she could have talked to him as well. She did eventually benefit from formal counseling as a teenager. Interestingly, in his interview, her brother Byron never mentioned speaking with that leader, and indicated that he had never received professional counseling services which did not help him and he instead turned to escaping through playing video games.

In some cases, participants received counseling—individual or family—but perceived it as not beneficial or even harmful, particularly when they were forced to go. Lastly, some individuals received counseling and acknowledged how helpful it was for them. Those individuals who had positive reviews of counseling often went individually as teenagers or adults, and not as children. A few participants who received counseling as adults specifically mentioned how helpful receiving Eye Movement Desensitization and Reprocessing (EMDR) therapy was for them; this was considered worth mentioning because no other therapeutic approaches were specifically mentioned by participants.

**Developmentally-appropriate support.** Participants perceived offered support as helpful when it matched their developmental level. This support included being allowed and expected to behave like kids, given accurate and understandable explanations of mental illness, and not given more information about the suicide than needed.

Multiple children were allowed flexibility according to their age and development, both immediately after the death and in the following weeks and months was helpful. Winnie was allowed to leave the Friday night viewing early to go to a friend's birthday sleepover.

After the funeral the next day, her friend invited her to participate in an activity. Her relief in escaping the post-funeral activities was obvious when she stated, “They took me motorcycle riding and we got out of there...” This need for reprieve from the mourning process was not uncommon; Gavin recalled after the funeral wanting to do something else or go play video games or something, but feeling the expectation that he had to be sad—and stay sad.

Another way children were supported developmentally was through appropriate explanations of suicide and mental illness. Fifteen of the 17 study participants disclosed that their parent who completed suicide had some form of mental illness, either diagnosed or highly suspected. Being told about mental illness and explaining the connection to suicide did not often happen for participants when learning of the suicide, but when it did, participants felt that was helpful. Candace, age 10 at her father’s suicide, said, “they told me that my dad had a chemical imbalance, and I remember thinking that that was really helpful, because then I didn’t feel like he didn’t love me and that’s why he did this...” Winnie, age 12 at her mother’s suicide, now wishes that mental illness were described as having a “broken brain.”

Another way these children were supported developmentally was when they were not given more information than needed. Graphic details about the suicide method were avoided, if possible. None of the participants discovered their parent’s body, which appeared to help the experience be less traumatizing. Those participants who were privy to more intense scenes and details, including being on scene when the police officers arrived at the house, seeing their surviving parent faint when upon learning of the suicide, and noticing gruesome details at the location of the suicide, indicated this firsthand exposure to the trauma significantly complicated their coping experience.



**Religious values, spiritual experiences, and dreams.** Religious beliefs, spiritual experiences, and dreams were mentioned and indicated as helpful in over half of the interviews. This may be in part because the interviews were primarily conducted in Utah County, which is predominantly LDS; this religious affiliation likely influenced some participants' religious experiences and perspectives. Some participants, however, indicated uncertainty regarding discussing spiritual experiences and related topics in the research setting. With assurance they could share whatever they felt comfortable with, most of these participants proceeded to elaborate. As the researcher was from Brigham Young University, a private LDS church school, these individuals may have felt more comfortable broaching these particular subjects than with a researcher from another university.

The belief that they would see their parent again, that he or she was "okay," or that the child would be okay were particularly common themes. Religious beliefs were described as "crucial" or paramount in importance for many participants. Multiple individuals had inspiring dreams or felt strong connections with their deceased parent. Candace recalled special dreams in the month following her father's death where he hugged her and told her repeatedly that he loved her. Kristine remembers hearing her dad's voice after he was deceased assuring her that he loved her. These types of experiences are not unique to the LDS population or to religious groups, however. Experiencing contact with a deceased loved one is considered a typical experience for many grieving individuals and is not considered abnormal; between 39 to 90 percent of the bereaved report experiencing some sort of contact with a deceased loved one (Klugman, 2006).

Other study participants found an inspired purpose in their experience with a parent suicide. Chase, whose interview was full of faith-related experiences, described feeling the

conviction that this experience had a purpose and would help him become better and stronger somehow; it made him more empathic towards others who were struggling.

There were a few instances where religiosity was mentioned as not helpful, such as a religious doctrinal pamphlet on suicide, feeling like a “project” of neighbors and church congregation members, an overdramatic clergy at the funeral who also provided unwanted counseling to the family, or where members of the religious congregation were gossiping and judgmental. However, these were not the major focus of the interview discussions. Overall, spiritual experiences, beliefs, and dreams were considered a major help to over half of the participants.

**Normalizing.** Finding companionship in the loss of a parent helped ease the burden of suicide; this allowed the participant’s loss or tragedy to feel more normal. Losing a loved one to suicide can feel very isolating, particularly to most of the participants who didn’t know anyone else who had been affected by suicide. However, when individuals were able to connect with others who had also experienced a parent death, this brought comfort and helped normalize the experience of a parent death. Typically, the other peer’s parent had not also died by suicide, but simply having that contact with another who had lost a parent was perceived as helpful.

Normalizing helped existing friendships to deepen. Sally’s best friend’s father had died two years previously to cancer, and Sally recalled how their friendship deepened and strengthened as a result of her friend reaching out to Sally and asking how she was doing following her father’s suicide.

Normalizing with peers also allowed participants to feel less isolated. Kristine, a seven-year-old when her father died, told how through the years she came in contact with quite a few other friends whose fathers had also died, and she formed the informal “Dead Dads Club.” She

knew it sounded morbid and crude, and while they never held a meeting or “did” anything, she said “that was nice to have somebody there that, even though it was different circumstances, it was nice to be like, ‘Oh yeah, your dad died too, we’re friends.’” Hallie described how a peer who had also lost a parent reached out to her. Following her father’s suicide, this student left Hallie an anonymous note and small gift. Even though she never found out who the girl was and doesn’t remember the situation of how the girl’s parent died, Hallie described that gesture as a significant support to her at that time.

Whenever participants mentioned interactions with another peer whose parent had died, they indicated this was a positive experience. The one exception to this was Danica, who attended a grief group in middle school. She thought it was pointless and did not like it. All others indicated contact with peers who had experienced a parent death was helpful.

**Family routines and activities.** Spending time together as a family, whether immediate or extended, was often seen as helpful. Family routines included routines the family participated in prior to the suicide, or new ones. One participant tenderly recalled sitting on her mom’s bed with her siblings and mom each night in the aftermath of the suicide as she read them all a book. Her extended family rallied around them and created a “Family Fun Friday” where they regularly went out into the community and did fun activities with cousins.

Spending time together and doing things together were perceived as helpful. Chase, speaking of his aunts and uncles and other extended family members, spoke of the support gained from spending time with them when he said, “I knew they loved me and that I knew that they shared my burden.” He remembered doing fun things together, not just sitting around being sad. “We just spent time as a family just having good family time, and that was really helpful to know that you don’t have to just be sad all the time from then on out.” Others continued to go on

family vacations; Disneyland was a frequently-mentioned vacation spot. In fact, one family took went to Disneyland on the anniversary of the suicide every year so they would have something positive to do on what otherwise could be a very difficult, emotional day. Engaging in family activities outside of the house provided a needed reprieve from the intensity of the grief process. This also sent the message to children that it's fine to not feel sad all the time following a parent suicide. In some cases, spending time together engaged in activities provided a model of coping for the surviving children. Engaging in activities together also allowed for the creation of new family memories, which also appeared to be helpful.

**Creative expression.** Some participants found ways to participate in or express themselves creatively. For three participants, this was through writing. Participants wrote poems, stories, letters to friends, and their thoughts and questions related to the suicide. For Hallie, writing helped her start to process the suicide, indicating it was “a good way for me to get things out at first that was [sic] maybe still too fresh to verbalize.”

Some found comfort in listening to or creating music. Sally listened to Oldies music that her father loved because it helped her remember him positively. Hallie sang the Josh Groban song “You’re Still You” at her father’s funeral, which provided her with important closure and creative expression. Winnie wrote music “just to feel better.” Creative expression appeared to help children memorialize and process the suicide in different modalities than simply talking. These activities typically didn’t need a lot of adult supervision and tapped into participants’ existing interests and abilities; this may have increased the likelihood of them happening and their power in the coping process.

**Chances to memorialize.** Having the option of participating in memorializing activities and having tangible objects to remember the deceased were important and helpful.

Memorializing activities mentioned included the wake or funeral, visits to the cemetery, and sharing stories and memories. The formal funeral process was helpful for some participants' grief processes. Some youth even spoke or sang at the funeral. One mother encouraged her children to engage in the memorializing process at the viewing. She told her children their father would be in the casket and look different, and she advised them to spend a lot of time with him since it was the very last time they would see him. Candace, age 10, sat by her father's casket for a long time during the viewing; she noted that this provided her with very important and helpful closure. Her younger brother, Gavin, listened to an audio recording of the funeral many years later and indicated that was "probably the most grieving that I've done."

Some participants memorialized at the cemetery. Winnie, age 12 at her mother's death, recalled frequently riding her bike to the cemetery and spending time at her mother's grave. One participant's family went to the cemetery every Memorial Day and told stories of their deceased family members, including her father. Her family didn't treat her dad's grave any differently than the others, which she noted with gratitude. Other participants never mentioned the cemetery, or had only been to their parent's grave a handful of times.

Sharing memories and stories of the deceased parent was another way participants memorialized their parent. For children of parent suicide this was especially important, and some participants yearned for more information and stories. In the interview process, many participants shared their own memories of their deceased parent prior to the death, or stories they had been told of them by others. Even stories that did not portray the deceased parent in a flattering light were treasured and retold. One participant found important closure when she went on a religious mission and found ways to share her mother's story with others. At the

conclusion of the interviews, many participants indicated that while the interview process was difficult at times, they “felt better” after sharing their experiences.

Others found memorializing their parent through tangible items to be helpful. One participant had objects from her father that really helped her, including her father’s glasses, rocks he painted, and a photo of him. Another participant treasured her only physical items from her father—a T-shirt and a watch—because her stepmother had thrown out all his possessions following the suicide. Photos were another item frequently brought up in the interviews. One participant was given a book of photos and memories from friends and neighbors who knew her father. Unfortunately, multiple participants only had one photo of their deceased parent; they wished they had more. Winnie’s experience of all photos of her mother being removed, referenced earlier, was particularly difficult for her. Overall, tangible objects provided a way to memorialize the deceased parent, and participants greatly missed them when they were not available to them.

**Meaningful gifts.** Receiving personalized gifts following the parent suicide was perceived as a helpful and memorable experience by participants. Some of the mentioned gifts included notes from classmates or friends, handwritten letters from previous and current teachers, a book from a church congregation with pictures and memories of the deceased parent, a new dress to wear for the funeral, a sand dollar, and a doll. Winnie, whose mom had helped her start a Madame Alexander doll collection, was given a doll from her church group. That gift was so meaningful to her that, 41 years later, she still has that doll on display in her home. In each of these cases, the gifts were customized and personal to the child, suggesting a true connection and concern for their wellbeing.

## **Influential People**

This section examines common themes and qualities in the influential people mentioned by participants. The positive influence they were able to have on these children and youth is also explored.

**Pre-existing relationships.** People who knew the child well prior to the death were most suited to provide helpful assistance. In some cases, the surviving parent was the person who helped the child the most. Cory, age five at his father's death, recalled, "Without [my mom] ... I wouldn't be here today. Most definitely." He noted that something that helped with the healing process was her ability to relate to how difficult it was for all of them. She also assured him of her love for him. Other participants also had similar experiences where they felt very close to and relied heavily on the surviving parent.

Even when there was a close relationship with the surviving parent, other adults who knew the child played important roles. Kristine remembers feeling grateful she learned of her father's death from her bishop (her ecclesiastical leader), with whom she already had a relationship, instead of the police. Byron felt relief when he was finally able to share his story with someone who was a friend of his father's, a family friend, and someone he already trusted.

Some participants did not have a close relationship with their surviving parent before the suicide. For these individuals, the most influential people were adults other than their surviving parent. Sally, who did not have a close relationship with her mother prior to her father's death, described the most influential person in her grief journey as her high school counselor with whom she already had a relationship. When she learned of her father's suicide while at school, her high school counselor accompanied her to the house. Her counselor also advocated for flexibility with school assignments in the following weeks and months, helping her to graduate

from high school. In addition, Sally's basketball coach and basketball team were extremely supportive and influential as well—writing cards, calling her, and even going so far as to dedicate a basketball playoff game to her and her father.

**Met practical needs.** As with any death, many practical needs arose immediately following the suicide deaths. Throughout the interviews there were numerous mentions of family members, communities, religious groups, neighbors, and friends addressing the family's practical needs. These needs included meals, childcare, housework, yard work, funeral arrangements, financial needs, and housing arrangements.

Changes in housing arrangements were common amongst participants. Byron and Sonya (Sibling Set A) moved the same day of their father's death due to cultural perceptions surrounding suicide in the Asian country in which they lived. Kristine's family moved to a different state less than two weeks after her father's death. While not all participants changed housing immediately, some participants ended up living with their grandparents (their surviving parent's parents) for a period of time. Others had family members or close friends come to live with them for a time or come daily to help household tasks, chores, and the basics of keeping a family going.

Chase's aunt moved in with them for at least a month following his mother's suicide. He described the valuable help she provided when he said "we just played together a lot and she cleaned our house and made us food and... our house was... cleaner than it... ever was... Just being there with us made a big difference to me."

Financial gifts were perceived as especially helpful in some instances. Janay described how finding anonymous jars of money on their porch was very helpful since her surviving parent didn't have a job. Other participants recalled neighbors bringing in meals for weeks. One



participant remembered an older neighbor lady coming and reading books to her and her siblings once a week. Providing support for practical needs was one important form of support that for some children supported them emotionally as well.

**Spoke positively of the deceased.** People who knew and spoke kindly, yet accurately, of the deceased parent were helpful; they provided a place for the child to talk about and memorialize their parent. For Winnie, her father answered her questions but she described him as mostly “off limits;” the person she turned to instead was her youth group leader. Kristine remembered that her mother always spoke positively of her father, and actively mentioned him. Her extended family did so as well. She said,

I’ve always liked that my family has never judged that my dad died a certain way. They treat him with just as much respect as everybody else ... And they don’t have any contempt; they only talk about the good. They talk about how much they loved him.

Individuals who spoke of the deceased parent, particularly focusing on positive aspects of their life, encouraged healthy memorializing and an openness to talk about the deceased parent.

**Educators.** Other adults were able to be influential in the lives of these children because of the setting in which they worked: schools. While not all participants mentioned their school experience following the suicide (some were not even school age at the time of the death), school professionals who were mentioned as helpful included principal, teacher, former teacher, and school counselor. These professionals displayed compassion and assured the family and child of their support. They wrote notes, made home visits, allowed the family and child to determine when they were ready to return to school, provided flexibility with deadlines, and in general advocated for the child following the suicide. A few participants even found out about their parent’s suicide while they were physically at school; these individuals received on-site crisis

response support from school educators. Other participants recalled peers who gave them kind notes or spoke kindly—actions certainly facilitated, if not initiated, by observant and caring educators. These varied forms of support were recalled as helpful by participants and were all related to professionals working within the school system.

Overall, study participants came from various backgrounds and situations, yet even with these differences, common themes regarding their perceptions of support emerged throughout the interview and analysis process. Aspects that were commonly perceived as unhelpful or harmful included silence, avoidance and half-truths; feeling judged or blamed by others; blaming themselves; an awareness of the surviving parent's difficulties; and an extreme display of emotions. Common helpful support and experiences included assistance processing the suicide, counseling, developmentally-appropriate support; religious values, spiritual experiences, and dreams; normalizing and connecting with others who had lost a parent; family routines and activities; creative expression; chances to memorialize; and meaningful gifts. People who had a positive influence on these children included those who had a pre-existing relationship with the child, met practical needs, spoke positively of the deceased, and were employed in the school system. Participants in the study were placed in a vulnerable position following to their parent's suicide, yet their opinions regarding the support offered by those around them provides important information on their experience as well as how to best support them.

## CHAPTER 5: DISCUSSION

This study examined the perceptions of support received by individuals who—when they were 18-years-old or younger—experienced their parent’s suicide. Previous research and prevention efforts have not focused specifically on this group of bereaved children (Cerel et al., 1999; Sveen & Walby, 2008). This study examined retrospective reports of children’s experiences following their parent’s suicide. This study’s research questions concerned the following issues: children’s perceptions of their experiences following a parent suicide; which type of experiences and supports were considered beneficial; which experiences and interactions were considered unhelpful or harmful; which individuals were particularly helpful in the aftermath of the suicide, and why these individuals and experiences were perceived as helpful or harmful. Previous research has not honed in on the survivors’ perceptions of support offered, particularly in cases of parent suicide. To better understand the experiences of these children, a qualitative approach was considered to be the most appropriate way to gather data.

### **Implications for Practitioners**

There is much room for improvement in how practitioners support these individuals. Important takeaways from this study are succinctly described in the following sections and are summarized in Appendix E.

**Talking about suicide is not only okay, but it is an important part of healing.** Caring adults need to send the clear message—it’s okay to talk about suicide. Talking about suicide helps children process the trauma and helps break down social stigma surrounding suicide. Hallie shared how she currently handles addressing her father’s suicide with her step sons, ages 7 and 10. “It happens quite often that they see a picture of him and be like [sic] ‘Who’s that?’, ‘That’s my dad.’ ‘Oh yeah, how did he die?’ ‘Suicide.’ ... Even though they’re young... it’s

nothing they need to be protected from.” Children should not be expected to talk about the suicide all the time or only in one particular setting, but rather they need to be provided with a safe person with whom they can share concerns, ask questions, and discuss feelings. When adults do not address the suicide, children may internalize their confusion and it can lead to future difficulties.

**Each situation is unique.** Professionals must customize their support based on the individual’s situation. Considerations include the child’s maturity level, prior relationship with both parents, subsequent relationship with surviving parent, proximity to the death, spiritual convictions and experiences, personality and life perspective, and existing support network of caring adults and friends.

**Schools provide a natural support network.** Schools are uniquely positioned to provide support to school-age children and adolescents following a parent’s suicide. A caring environment is facilitated by educators offering flexibility with attendance policies and assignments; making home visits; and providing classroom activities, such as making cards for the child or family and role playing compassionate interactions. Additionally, educators can teach and model compassionate ways for students to respond to the grieving classmate. Caring gestures facilitate the classmate’s return to school after a parent’s suicide. Empathic phrases may include, “I’m sorry to hear about your father’s death,” “I can’t imagine what that would be like,” and “Wow, that must really affect the way you see the world.” To make it easier for children and youth to break the stigma and barrier of silence associated with suicide, teachers and other school staff can provide examples of compassionate responses and role play interactions. Educators and staff should also closely monitor children to make sure that joking, teasing, and inappropriate or spiteful comments are not permitted.

**To normalize the trauma, foster connections with others.** Help children to connect with others who have been through similar challenging experiences. These connections help to normalize the trauma. This association does not need to be with another child or youth who have lost a parent to suicide; in fact, with the exception of siblings, participants in this study did not have experiences with other suicide survivors. Merely connecting with others who had experienced a parent death (regardless of the cause of death) was meaningful.

**Offer a variety of support options for children and family.** Participants in this study offered mixed perceptions regarding the helpfulness of professional counseling services. According to participants' responses, formal counseling may or may not be helpful. Mental health professionals are in a tenuous, yet potentially very helpful, position to support families following a parent suicide. Some challenges include the stigma surrounding counseling, talking to an unfamiliar adult, issues with other family members, and differing belief and value systems between the family and the mental health professional. Mental health professionals need to carefully consider the family's value system and need to be extremely sensitive to the surviving parent's wishes regarding the amount of information conveyed to children.

Although mental health services should not be forced on children, a variety of support options should be offered, including school-based counseling, individual counseling, family counseling, informal peer groups, and bereavement support groups. In some cases, family counseling could be beneficial in facilitating family members' discussion about the suicide, validating feelings, and answering questions. In addition, young children should not be automatically ruled out of the need for formal counseling services; they may also benefit from professional assistance to cope with what they know and how they feel about the death.

Cain (2002) suggests that the child's understanding of the suicide will be ongoing and fluid as the child matures, has life experiences, and learns more about the suicide. For this reason, ongoing or as-needed counseling services could be a very helpful way to continue supporting these children across the life span. Additionally, Eye Movement Desensitization and Reprocessing (EMDR) therapy in particular may help survivors to process the trauma associated with a parent's suicide (World Health Organization and United Nations High Commissioner for Refugees, 2013).

**Provide opportunities for children to memorialize their deceased parent.** Though adults may want to forget the suicide and avoid talking about it, youth need opportunities to memorialize their deceased parent. This may include talking about memories, looking at pictures and keepsakes, visiting the cemetery, journaling, and creating memory books or boxes. Over time, they become more curious about their deceased parent's life and may request additional stories and information. Providing avenues for them to access this information facilitates their journey through grief.

### **Implications for Surviving Parents**

The adage, "You can't draw water from an empty well" applies to the surviving parent following their spouse's suicide. This is particularly true for parents who are caring for children in the home. There will inevitably be a period of intense emotions following the suicide; during the mourning period it may be extremely difficult or even impossible for the surviving parent to meet their own needs in addition to their children's needs. Surviving parents must understand and be reminded of the importance of self-care, and that it is okay to accept and even ask for help with childcare. Self-care is not selfish, it is self-preserving. One participant in this study advised parents to "Take care of you so you can take care of your kids."

Surviving parents should communicate that they are also grieving, letting children know that they are not alone in their grief. However, extreme displays of parents' emotion could overwhelm children, who lack mature coping skills. Children, especially adolescents, are likely to be concerned about their surviving parent. Children benefit from knowing that their parent is getting personal help and taking proactive steps to manage stress and grief. Parents can also model good coping strategies and reassure their children about how they are working through tough times.

Discussing a parent's suicide with a child or youth, including sharing initial information and deciding the extent and type of details to share, can be extremely difficult for surviving parents. This is a personal decision and should be decided on a case-by-case basis. An excellent resource to assist caring adults in this difficult process is *Supporting Children After a Suicide Loss: A Guide for Parents and Caregivers* by Sarah S. Montgomery and Susan M. Coale. This short (28 pages), succinct book, gives compassionate, practical suggestions for supporting children. The information is in an easily-accessible format and includes "Dos and Don'ts" and other helpful ideas.

Regardless of how much information the parent decides to share with the child, it is important to remember the following advice: "Telling the truth does not mean sharing all the details at once" (Montgomery & Coale, 2015, p. 10). It is acceptable to tell children and youth, "I don't have the words for this yet, but when I do, we will talk more about this."

### **Implications for Other Supporting Adults**

A grieving family's extended family, friends, neighbors, communities, religious affiliations, and other connections form part of a natural support network already in place. It is important to remember that family members can be a great source of help as well as a great

source of difficulty (McMenamy et al., 2008). Extended family members who are interested in helping the grieving family should offer support sensitively, without expressing judgment or blame. All family members should be supported, especially the surviving parent. When children are involved, supportive adults should remember that all situations are unique, and even siblings' reactions can be very different; so support needs to be customized. The grief process ebbs and flows, and children need time and space to grieve as well as to behave like typical kids.

**Support the surviving parent.** The family healing process is expedited by a well-functioning parent. Unfortunately, the surviving parent might receive less support from friends and families due to the nature of the suicide. Providing immediate and appropriate practical and emotional support to the surviving parent may facilitate healthy grief and coping mechanisms in the parent. When the surviving parent feels supported and is managing grief appropriately, they may be able to better address the needs of their own grieving children.

**Practical support lifts family burdens.** Practical support includes providing meals, yard work, child care, financial support, housing arrangements, funeral arrangements, and covering additional costs. Other support can include cards or notes, hugs, phone calls, play dates, and fun activities. This is one way to support the entire family, surviving parent and children alike. A family's natural support network of supportive adults from a variety of places are uniquely positioned to provide important support to the grieving parent and children.

### **Implications for Government and State Organizations**

Government and state organizations can support bereaved children and families by creating national and state registries to identify these vulnerable children and collect information including age at time of parent suicide, other siblings living in the home, and siblings living out of the home. This information will assist agencies and mental health professionals in better



understanding these children and in supporting families in addressing their needs. Additionally, registries will help in locating the surviving parent to provide long-term follow up and ongoing access to resources.

Local and state governments could consider initiatives to develop resources to address difficult mental health topics such as suicide. For example, the United Kingdom has produced a number of children's books specifically addressing highly sensitive topics, including suicide bereavement. Websites created with videos, pictures, and stories of other parent-bereaved children or youth, along with digitized copies of available books, handouts, and other resources, could play an important role in facilitating healthy coping skills. Additionally, counseling services and bereavement groups could be provided through online platforms. These options could be especially beneficial for children living in rural areas where limited resources are available.

### **Limitations**

This study had several limitations. One limitation was the nature of the sample. Participants were part of a convenience sample, out of ethical necessity. It was unknown if recruitment methods would reach individuals who were eligible to participate, and if those individuals would indicate interest in participating. Another unknown was regarding recruitment. Recruitment for study participation was difficult at times, and the researchers were unsure if the parameters to participate were too narrow to complete the study.

Geographic and age constraints were another limitation. Participants lived in three different counties in central and northern Utah, and most happened to be adults in their twenties when interviewed. However, while the geographic location was relatively small, and the inclusion criteria quite limited, the participants still came from varied situations. For example,

the age of the participant at the time of the parent death ranged from 4 months to 18 years old. This resulted in drastically different interviews and results. Other individuals were young when the suicide occurred, but they did not learn definitively of the suicide until they were older. The most significant example was a participant who was 20 when she found out it was suicide; she was interviewed just under one year following her “finding.” Another important difference was that most children lived with the parent who completed suicide, but some did not, as their parents were separated or even divorced. The small geographic area is one limitation of the study that may prevent generalizability to other locations. However, this study nonetheless informs the literature on this specific group of individuals.

The retrospective aspect of this study is another limitation. People’s memories of a time many years prior to the interview may not be completely accurate. In addition, there was no way to verify if these memories were accurate, even amongst siblings sharing perceptions of similar events. Although this retrospective aspect may be considered a limitation, the author also simultaneously considers it a strength. Tragedies are memories which sometimes are very distinctly remembered, particularly feelings of loss and sadness. Reviewing past events allowed participants to look back in their past using critical thinking. Adult participants were able to look back and consider how helpful specific interventions were and how interventions might be adapted to be more helpful in supporting children following a parent’s suicide. This length of time between the death and the interview allowed individuals to ponder on their experience from a metacognitive point of view. Thus, all data collected were used without exclusion criteria.

### **Implications for Future Research**

One aspect of parent suicide this study did not investigate was how the gender of the parent affected the child’s experience, though other studies have looked into this (Kuramoto et

al., 2010). Future qualitative research could separate groups according to which parent completed suicide, in the hopes of answering questions such as, “Does a mother’s suicide effect children differently than a father’s suicide?” and “Are there certain ways to provide support that are more helpful with a father’s suicide death, as opposed to a mother’s suicide death, and vice versa?” and “Are the negative effects of parent-suicide more severe if the child and parent are the same gender?”

The current study also did not distinguish among a variety of factors regarding relationship with the parent, i.e. if they were living with their parent at the time of the suicide death, how frequently they saw the parent prior to the death, the effects of non-traditional (foster, adopted, or step) parent suicide on the child, the age they were at the time of the death, and the relationship with the deceased parent before the death and the surviving parent before and after the death. Additional research is needed to more closely examine these relationships.

An unexpected factor in the study was individuals who learned the death was a suicide at a different time than learning of the death. These participants fit all research criteria, but because they occurred at different times, it may be helpful in future studies to separate out these perceptions of support and to examine their responses to support offered after the death versus after the suicide. However, even with those who did not learn of the suicide earlier, the adults still knew it was suicide and often they did not openly discuss the deceased or the death so often the death was dealt with differently than if it were death by another means. The death itself was still shrouded in the effects of suicide, even if the child was not consciously aware of it. And, some of the participants who were told later indicated that they “kind of already knew” it was suicide.

Additionally, when the child was extremely young at the time of parent suicide, various interview questions had to be modified as some were not directly applicable. Much of the information these individuals shared was based on the surviving parent's accounts and recollections. Future research could separate ages of parent suicide and examine the relationship between the child's age and their perceptions of support.

Other factors to examine in future research could be a same-sex parent (Cheng et al., 2014), the effect of siblings on child coping, and other extended family support. Additional research could be done for children who have experienced a parent's attempted (but not completed) suicide. Resources for these children of attempted parent suicide are essentially non-existent (Williams, 2014).

## **Conclusions**

Survivors of parent suicide are often silent, struggling survivors. When children of parent suicide are still minors, they are even more vulnerable and typically unable to advocate for themselves. For this reason, society must take an active role in advocating for them in the most helpful way possible. In order to effectively do this, we must take their perspectives into consideration.

This study's research findings inform society on this understudied aspect of parent suicide and may provide important information to the field of suicide postvention. The best postvention efforts are actually suicide prevention efforts (Cerel et al., 2008). Thus, effective postvention actually includes a preventative measure in helping to keep survivors alive. Additionally, the information and understanding gained from this study may help mental health practitioners enhance the quality of support services for children following a parent's suicide.

In closing, a recent study of 166 suicide survivors revealed that only 40% of individuals who received professional services considered those services to be helpful (Wilson & Marshall, 2010). Clearly, professionals must do a better job in supporting suicide survivors, especially child survivors of parent suicide. There is great need to better inform professionals on how to best support children of parent suicide; this increased quality of service can in turn, increase the child's quality of life immediately following the suicide and in the ensuing years.

## REFERENCES

- Ali, F. (2015). Exploring the complexities of suicide bereavement research. *Procedia - Social and Behavioral Sciences*, *165*, 30–39. doi:10.1016/j.sbspro.2014.12.601
- Andriessen, K. (2014). Suicide bereavement and postvention in major suicidology journals: Lessons learned for the future of postvention. *Crisis*, *35*(5), 338–348. doi:10.1027/0227-5910/a000269
- Begley, M., & Quayle, E. (2007). The lived experience of adults bereaved by suicide: A phenomenological study. *Crisis*, *28*(1), 26–34. doi:10.1027/0227-5910.28.1.26
- Berman, A. L. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life-Threatening Behavior*, *41*(1), 110–116. doi:10.1111/j.1943-278X.2010.00009.x
- Brent, D. A., Melhem, N. M., Masten, A. S., Porta, G., & Payne, M. W. (2012). Longitudinal effects of parental bereavement on adolescent developmental competence. *Journal of Clinical Child and Adolescent Psychology*, *41*(6), 778–791. doi:10.1080/15374416.2012.717871
- Brown, A. C., Sandler, I. N., Tein, J-Y, Liu, X., & Haine, R. A. (2007). Implications of parental suicide and violent death for promotion of resilience of parentally-bereaved children. *Death Studies*, *31*(4), 301–335. doi:10.1080/07481180601187092
- Cain, A. C. (2002). Children of suicide: The telling and the knowing. *Psychiatry*, *65*(2), 124–136. doi:10.1521/psyc.65.2.124.19937
- Cain, A. C. (2006). Parent suicide: pathways of effects into the third generation. *Psychiatry*, *69*(3), 204–227. doi:10.1521/psyc.2006.69.3.204

- Campbell, F. R. (1997). Changing the legacy of suicide. *Suicide and Life-Threatening Behavior*, 27(4), 329–338.
- Centers for Disease Control and Prevention. (2017). Web-Based Injury Statistics Query and Reporting System (WISQARS): *Fatal Injury Reports, National, Regional and State, 1981 – 2015*. Retrieved from <https://webappa.cdc.gov/sasweb/ncipc/mortrate.html>
- Centers for Disease Control and Prevention. (n.d.). *Suicide Facts at a Glance 2015*. Retrieved from <https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf>
- Cerel, J. (2015, April). *We are all connected in suicidology: The continuum of "survivorship."* Plenary presentation at the 48th annual conference of the American Association of Suicidology, Atlanta, GA.
- Cerel, J., Fristad, M. A., Weller, E. B., & Weller, R. A. (1999). Suicide-bereaved children and adolescents: A controlled longitudinal examination. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(6), 672–679. doi:10.1097/00004583-199906000-00013
- Cerel, J., Fristad, M. A., Weller, E. B., & Weller, R. A. (2000). Suicide-bereaved children and adolescents: II. Parental and family functioning. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(4), 437–444. doi:10.1097/00004583-200004000-00012
- Cerel, J., Jordan, J. R., & Duberstein, P. R. (2008). The impact of suicide on the family. *Crisis*, 29(1), 38–44. doi:10.1027/0227-5910.29.1.38
- Cerel, J., Maple, M., van de Venne, J., Moore, M., Flaherty, C., & Brown, M. (2016). Exposure to suicide in the community: Prevalence and correlates in one U.S. state. *Public Health Report*, 131(1), 100–107. doi:10.1177/003335491613100116

- Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The continuum of “survivorship:” Definitional issues in the aftermath of suicide. *Suicide and Life-Threatening Behavior, 44*(6), 591–600. doi:10.1111/sltb.12093
- Cheng, C.-C. J., Yen, W.-J., Chang, W.-T., Wu, K. C.-C., Ko, M.-C., & Li, C.-Y. (2014). Risk of adolescent offspring’s completed suicide increases with prior history of their same-sex parents’ death by suicide. *Psychological Medicine, 44*(9), 1845–1854. doi:10.1017/S0033291713002298
- Colpe, L. J., & Pringle, B. A. (2014). Data for building a national suicide prevention strategy: What we have and what we need. *American Journal of Preventive Medicine, 47*(3S2), S130–S136. doi:10.1016/j.amepre.2014.05.024
- Drapeau, C. W., & McIntosh, J. L. (2016). *U.S.A. suicide: 2015 official final data*. Retrieved from <http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2015/2015datapgsv1.pdf?ver=2017-01-02-220151-870>
- Dyregrov, K. (2004). Bereaved parents’ experience of research participation. *Social Science & Medicine, 58*(2), 391–400. doi:10.1016/S0277-9536(03)00205-3
- Dyregrov, K. (2009). The important role of the school following suicide in Norway: What support do young people wish that school could provide? *Omega – Journal of Death and Dying, 59*(2), 147–161. doi:doi.10.2190/OM.59.2.d
- Dyregrov, K. M., Dieserud, G., Hjelmeland, H. M., Straiton, M., Rasmussen, M. L., Knizek, B. L., & Leenaars, A. A. (2011). Meaning-making through psychological autopsy interviews: The value of participating in qualitative research for those bereaved by suicide. *Death Studies, 35*(8), 685–710. doi:10.1080/07481187.2011.553310



- Dyregrov, K., Plyhn, E., & Dieserud, G. (2011). *After the suicide: Helping the bereaved to find a path from grief to recovery*. Retrieved from <https://ebookcentral.proquest.com>
- Eckersley, R., & Dear, K. (2002). Cultural correlates of youth suicide. *Social Science & Medicine*, 55(11), 1891–1904. doi:10.1016/S0277-9536(01)00319-7
- Gall, T. L., Henneberry, J., & Eyre, M. (2014). Two perspectives on the needs of individuals bereaved by suicide. *Death Studies*, 38(7), 430–437. doi:10.1080/07481187.2013.772928
- Hung, N. C., & Rabin, L. A. (2009). Comprehending childhood bereavement by parental suicide: A critical review of research on outcomes, grief processes, and interventions. *Death Studies*, 33(9), 781–814. doi:10.1080/07481180903142357
- Jackson, A. P., & Patton, M. J. (1992). A hermeneutic approach to the study of values in counseling. *Counseling & Values*, 36(3), 201–209. doi:10.1002/j.2161-007X.1992.tb00788.x
- Jeong, J., Shin, S. Do, Kim, H., Hong, Y. C., Hwang, S. S., & Lee, E. J. (2012). The effects of celebrity suicide on copycat suicide attempt: A multi-center observational study. *Social Psychiatry and Psychiatric Epidemiology*, 47(6), 957–965. doi:10.1007/s00127-011-0403-7
- Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior*, 31(1), 91–102. doi:10.1521/suli.31.1.91.21310
- Jordan, J. R., & McIntosh, J. L. (2011). *Grief after suicide: Understanding the consequences and caring for the survivors*. New York, NY: Routledge.
- Klugman, C. M. (2006). Dead men talking: Evidence of post death contact and continuing bonds. *Omega – Journal of Death and Dying*, 53(3), 249–262. doi:10.2190/40UP-PKC5-D4RV-E1QV

Kochanek, K. D., Murphy, S. L., Xu, J., & Tejada-Vera, B. (2016). Deaths: Final data for 2014.

*National Vital Statistics Reports*, 65(4). Retrieved from

[https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65\\_04.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf)

Kuramoto, S. J., Brent, D. A., & Wilcox, H. C. (2009). The impact of parental suicide on child and adolescent offspring. *Suicide and Life-Threatening Behavior*, 39(2), 137–151.

doi:10.1521/suli.2009.39.2.137

Kuramoto, S. J., Runeson, B., Stuart, E. A., Lichtenstein, P., & Wilcox, H. C. (2013). Time to hospitalization for suicide attempt by the timing of parental suicide during offspring early development. *JAMA Psychiatry*, 70(2), 149–57. doi:10.1001/jamapsychiatry.2013.274

Kuramoto, S. J., Stuart, E. A., Runeson, B., Lichtenstein, P., Långström, N., & Wilcox, H. C. (2010). Maternal or paternal suicide and offspring's psychiatric and suicide-attempt hospitalization risk. *Pediatrics*, 126(5), e1026–e1032. doi:10.1542/peds.2010-0974

Kvale, S., & Brinkmann, S. (2009). *InterViews: Learning the craft of qualitative research interviewing* (2nd ed.). Thousand Oaks, CA: SAGE.

Lasrado, R. A., Chantler, K., Jasani, R., & Young, A. (2016). Structuring roles and gender identities within families explaining suicidal behavior in South India. *Crisis*, 37(3), 205–211. doi:10.1027/0227-5910/a000379

Loy, M., & Boelk, A. (2014). *Losing a parent to suicide*. New York, NY: Routledge.

Madge, N., & Harvey, J. G. (1999). Suicide among the young—the size of the problem.

*Journal of Adolescence*, 22(1), 145–155. doi:10.1006/jado.1998.0207

McLeod, J. (2001). *Qualitative Research in Counselling and Psychotherapy*. London, UK: SAGE.

- McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008). What do suicide survivors tell us they need? Results of a pilot study. *Suicide and Life-Threatening Behavior, 38*(4), 375–389. doi:10.1521/suli.2008.38.4.375
- Melhem, N. M., Porta, G., Shamseddeen, W., Payne, M. W., & Brent, D. A. (2011). Grief in children and adolescents bereaved by sudden parental death. *Archives of General Psychiatry, 68*(9), 911–919.
- Mitchell, A. M., Wesner, S., Brownson, L., Gale, D., Garand, L., & Havill, A. (2006). Effective communication with bereaved child survivors of suicide. *Journal of Child and Adolescent Psychiatric Nursing, 19*(3), 130–136. doi:10.1111/j.1744-6171.2006.00060.x
- Montgomery, S. S., & Coale, S. M. (2015). *Supporting children after a suicide loss: A guide for parents and caregivers*. Pasadena, MD: Chesapeake Life Center.
- Moore, M., Maple, M., Mitchell, A. M., & Cerel, J. (2013). Challenges and opportunities for suicide bereavement research: The experience of ethical board review. *Crisis, 34*(5), 297–304. doi:10.1027/0227-5910/a000191
- Omerov, P., Steineck, G., Dyregrov, K., Runeson, B., & Nyberg, U. (2013). The ethics of doing nothing: Suicide-bereavement and research: Ethical and methodological considerations. *Psychological Medicine, 44*(16), 3409–3420. doi:10.1017/S0033291713001670
- Oulanova, O., Moodley, R., & Séguin, M. (2014). From suicide survivor to peer counselor: Breaking the silence of suicide bereavement. *Omega, 69*(2), 151–168. doi:10.2190/OM.69.2.d
- Pfeffer, C. R., Jiang, H., Kakuma, T., Hwang, J., & Metsch, M. (2002). Group intervention for children bereaved by the suicide of a relative. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(5), 505–13. doi:10.1097/00004583-200205000-00007

- Pfeffer, C. R., Karus, D., Siegel, K., & Jiang, H. (2000). Child survivors of parental death from cancer or suicide: Depressive and behavioral outcomes. *Psycho-Oncology*, *9*(1), 1–10. doi:10.1002/(SICI)1099-1611(200001/02)9:1<1::AID-PON430>3.0.CO;2-5
- Ratnarajah, D., & Schofield, M. J. (2008). Survivors' narratives of the impact of parental suicide. *Suicide and Life-Threatening Behavior*, *38*(5), 618–630. doi:10.1521/suli.2008.38.5.618
- Sakinofsky, I. (2007). The aftermath of suicide: Managing survivors' bereavement. *Canadian Journal of Psychiatry*, *52*(6, Suppl. 1), 129S–136S.
- Schreiber, J. K., Sands, D. C., & Jordan, J. R. (2015). The perceived experience of children bereaved by parental suicide. *Omega - Journal of Death and Dying*, *0*(0), 1–23. doi:10.1177/0030222815612297
- Shneidman, E. S. (Ed.). (1969). *On the nature of suicide* (1st ed.). San Francisco, CA: Jossey-Bass.
- Sveen, C. A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: a systematic review of controlled studies. *Suicide and Life-Threatening Behavior*, *38*(1), 13–29. doi:10.1521/suli.2008.38.1.13
- U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012, September). *2012 national strategy for suicide prevention: Goals and objectives for action*. Washington, DC: Author.
- Veale, A. (2012, November). *Children bereaved by suicide: Evaluation of a group intervention*. Retrieved from <http://hdl.handle.net/10147/275954>
- Wilcox, H. C., Kuramoto, S. J., Lichtenstein, P., Långström, N., Brent, D. A., & Runeson, B. (2010). Psychiatric morbidity, violent crime, and suicide among children and adolescents

- exposed to parental death. *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(5), 514–523. doi:10.1016/j.jaac.2010.01.020
- Wilson, A., & Marshall, A. (2010). The support needs and experiences of suicidally bereaved family and friends. *Death Studies*, 34(7), 625–640. doi:10.1080/07481181003761567
- Worden, J. W. (1996). *Children and grief: When a parent dies*. New York, NY: Guilford Press.
- World Health Organization. (2014). *Preventing suicide: A global imperative*. Geneva, Switzerland: Author.
- World Health Organization and United Nations High Commissioner for Refugees. (2013). *Assessment and management of conditions specifically related to stress: mhGAP intervention guide module* (version 1.0). Retrieved from file:///C:/Users/Reled/Downloads/EMDR%20(1).pdf
- Yamamoto, K., Davis, O. L., Jr., Dylak, S., Whittaker, J., Marsh, C., & van der Westhuizen, P. C. (1996). Across six nations: Stressful events in the lives of children. *Child Psychiatry and Human Development*, 26(3), 139–150.

## APPENDIX A: 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.**

## APPENDIX B: INFORMED CONSENT

### **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 Prospective 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 one hour about your experiences surrounding and after your parent's suicide
- 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.

#### **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 a parent suicide death and be able to distribute this information to help inform those who support children with a parent who dies by suicide.

#### **Confidentiality**

The research data will be kept in a secure location on a password protected computer and only the researcher will have access to the data. Unique pseudonyms will be assigned to each participant to preserve anonymity in any publications or presentations resulting from this research. At the conclusion of the study, all identifying information will be removed and the data will be kept in the researcher's locked cabinet for 3 years following the study after which time it will be destroyed.

#### **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](mailto:suzannebennett@byu.net) or Melissa Allen Heath at (801) 422-1235 or [melissa\\_allen@byu.edu](mailto:melissa_allen@byu.edu) for further information.

**Questions about Your Rights as Research Participants**

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](mailto: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)**



## APPENDIX C: DEMOGRAPHIC SHEET

Please answer the following questions.

What is your age?

What is your ethnicity?

What is your gender?

What county do you currently reside in?

Which parent completed suicide?

Were they your biological or adopted parent?

How old were you (and siblings) at the time of the death?

How long ago did the death occur?

Where (home, work, etc.) was the suicide completed?

What was the method of the suicide?

How did you learn of the death?

## APPENDIX D: INTERVIEW PROTOCOL

## Guided Interview Questions

**Pre-Interview**

Establish rapport  
 Review research study  
 Explain Consent Form  
 Demographic sheet  
 Answer any questions

Signed consent form from participant \_\_\_\_\_  
 (1 copy of Consent Form remains with participant)

Demographic sheet from participant \_\_\_\_\_  
 (check for complete answers and legible handwriting)

**Part A: Guiding interview questions**

Start audio recording  
 Show empathy  
 Express appreciation

*(1) Thank you so much for participating. I realize this probably isn't an easy thing to talk about. If at any time you need to take break, redirect questions that might be uncomfortable, or end the interview, please let me know. We can stop at any time, if needed.*

*Let's start with a general question—Having a parent who died by suicide – what was that like for you? Tell me about your experience.*

- (2) In the immediate aftermath of the suicide,*
- (a) What did you perceive as most helpful?*
  - (b) What did you perceive as least helpful?*
  - (c) Who was helpful and who was not helpful?*
- (3) In the year following the suicide,*
- (a) What did you perceive as most helpful?*
  - (b) What did you perceive as least helpful?*
  - (c) Who was helpful and who was not helpful?*

*(4) Since the death, have you received professional counseling services to help you cope with the suicide? If so, what type of counseling and for approximately how long?*

**Part B: Reviewing books**

Invite the participant to review 3-5 children's books on loss, death, suicide, or related topics.

Present hard copies of the picture books with give the participant a chance to review them.

Ask the participant to indicate which books they would recommend to children bereaved by suicide (and those supporting them) and why.

Ask the participant if there are any additional books or resources they would recommend.

**Wrap up**

Check-in: *How are you doing?*

Regardless of how they answer, remind the participant of what resources are available (Professor Melissa Heath, survivor groups, providers in Utah County such as Wasatch Mental Health, websites that offer support including Hope4Utah.com, afsp.org, sprc.org, and the 24/7 suicide hotline 1-800-273-8255) if they should feel the need at any time.

Ask the participant if they would be willing to review a transcript of the interview to ensure accuracy and make any corrections or modifications; if so, direct the participant to include their email address on the Informed Consent document.

Thank the participant for their cooperation and give them gift card.

## APPENDIX E: HANDOUT

### **After a Parent's Suicide: Effectively Supporting Children and Youth**

For a child, the death of a parent has both immediate and long-lasting implications (Worden, 1996) and brings with it intense sadness, loss of nurturing support, and multiple life changes (Pfeffer et al., 2000; Smith et al., 2014). Parent death by suicide is a particularly difficult challenge experienced by 7,000 to 12,000 children in the U.S. each year (Cerel et al., 2008). These children are especially vulnerable; child survivors of parent suicide are at risk for internalizing behaviors, lower self-esteem, higher levels of anger and shame, and depressive symptoms (Cerel et al., 1999; Pfeffer et al., 2000). Additionally, these children have an increased risk for self-harm and suicide attempts (Kuramoto et al., 2010; Wilcox et al., 2010).

Although the negative ramifications of a parent's suicide are significant and enduring, even extending into the third generation (Cain, 2006), few empirical studies have focused on this specific group of suicide survivors (Kuramoto et al., 2009). While there are abundant resources for children experiencing grief, minimal practical resources (printed or online) exist specifically for children who grieve their parent's suicide—despite the significant need (Andriessen, 2014).

Through semi-structured qualitative interviews using the hermeneutic approach, researchers interviewed 17 adults who, as children or adolescents, were bereaved by parent suicide. Helpful experiences and support included assistance processing the suicide and an openness in the face of stigma. Unhelpful experiences included judgment and blame, silence regarding the suicide and deceased parent, and a heightened awareness of the surviving parent's challenges. Individuals who were perceived as helpful generally had pre-existing relationships with the children and helped meet their practical and emotional needs.

#### **Conclusions and Recommendations:**

It is recommended that customized and varied support be offered, along with the message that it is important to talk about suicide and memorialize the deceased parent. Additional research is needed to further explore the complex experiences of children of parent suicide; this will aid in the development of evidence-based interventions to better support them.

- **Caring adults need to send the clear message: “It’s okay to talk about suicide.”** Talking helps children process the trauma.
- **Every situation is different.** Professionals must customize their support based on the individual's situation. Considerations include the child's maturity level, relationship with both parents, proximity to the death, spiritual convictions and experiences, personality and life perspective, and support network of caring adults and friends.
- **Schools are a natural support network.** A caring environment is facilitated by educators offering flexibility with attendance policies and assignments; making home visits; and providing classroom activities, such as making cards for the child/family and role playing compassionate interactions.
- **Support the surviving parent.** The family healing process is expedited by a well-functioning parent.
- **Practical support lifts family burdens.** This includes providing meals, yard work, child care, financial support, fun activities, etc.

- **Connecting with others who have been through a similar experience helps normalize the trauma.** Formal counseling may or may not be helpful. Although services should not be forced, a variety of support options should be offered, including school-based counseling, individual and/or family counseling, informal peer groups, and bereavement support groups.
- **Youth need opportunities to memorialize:** talking about memories, looking at pictures and keepsakes, visiting the cemetery, journaling, and creating memory books or boxes.