University of Alberta

The Experience of Parents Bereaved by the Suicide of Their Youth

by

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Dedication

This dissertation is dedicated to my husband and best friend, Roman, my children, and my grandchildren. I am so privileged to have all of you in my life.

Abstract

This study employed a basic interpretive qualitative approach to investigate the experience of six mothers and two fathers, who had been bereaved between one and eight years by the suicide of their child, who was between the ages of 15 and 24 years old at the time of death. Youth suicide is a significant problem that affects a large segment of the Canadian population. Suicide is the second leading cause of death for Canadian youth between the ages of 10-24. For every young person that commits suicide, a subsequent number of mothers and fathers are left behind to grieve their child's loss. A review of the literature on youth suicide and bereavement reveals a lack of literature on the experience of parent suicide survivors. Research examining their pre-suicide stress is particularly scant.

In-depth interviews were conducted with each of the eight participants and the data were analyzed to uncover the essential aspects of this phenomenon. The following four themes emerged which capture the experience of the parents in this study: experiencing pre-suicide stress, experiencing their child's death, grieving the loss of their child, and experiencing personal growth. These themes provide us with a clearer understanding of the issues surrounding the bereavement of these parents, further our knowledge of this phenomenon, and provide mental health professionals with information that can help them work more effectively with these survivors.

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CHAPTER ONE

INTRODUCTION

Youth suicide is a significant social and human problem in Canada. Suicide is the second leading cause of death for Canadian youth between the ages of 10-24 (Langlois & Morrison, 2002). Statistics Canada (2004) reported that 605 Canadians aged 24 and under committed suicide in 1997, and educated estimates are that 50 to 100 times this number attempted suicide. Several researchers have estimated that about one million youth undergo suicidal crises each year in North America (Shagle & Barber, 1995).

The effects of youth suicide reverberate throughout the immediate family, friends, and the broader social community. Conservative estimates are that each suicide directly and immediately effects an average of six people (McIntosh, 1996; Shneidman, 1969). For every young person that commits suicide a subsequent number of mothers and fathers are left behind to suffer severe grief in the aftermath of their child's self-destruction. As Arnold Toynbee (as cited in Stillion, 1996) stated, "'There are always two parties to a death; the person who dies and the survivors who are bereaved . . . and in the apportionment of suffering, the survivor takes the brunt'" (p. 41). While parental grief is generally conceded to be the most severe type of bereavement, parental grief due to suicide is even more intense and profound than parental grief associated with other causes. Parents bereaved by suicide not only experience the loss of their child, but are also left struggling with the deliberateness of the act, the unending questioning of "why," exacerbated guilt, shame, and societal stigma (McIntosh, 1993; Nelson & Frantz, 1996; Trolley, 1993). Thus, the experience of losing a child to suicide may be one of the greatest burdens parents may ever have to endure.

Historically the focus of attention has been upon the person who engaged in suicidal behaviour and suicide investigators paid little attention to the psychological impact a suicide had on family members and significant others. However, beginning in the mid-seventies and continuing until the present, researchers have begun to develop a body of research that is shedding light on the experience of suicide survivors, as well as highlighting their need for support through the grieving process. Nevertheless, the data is still very limited and many areas remain in need of investigation (Clark, 2001; McIntosh, 1996; Murphy, 2000). Research investigating parent suicide survivors is particularly scanty. Furthermore, most of the studies that have been conducted are quantitative in nature and although they have broadened our knowledge of this phenomenon they have not increased our understanding of parents' experiences. As Osborne (1990b) pointed out, "natural science aims at objectivity through explanation, control and prediction, while phenomenological research aims at the elucidation of meaning and understanding of human existence from an individual's point of view" (p.16). Little is known about the adjustment of parents bereaved by the suicide of their youth (Murphy, 2000), or about the family dynamics that occur before and after a youth's suicide and how these dynamics effect parents' grief (Clark, 2001), areas that merit investigation as Shneidman (2001) noted:

> A benign community ought routinely to provide postventive health care for the survivor-victims of suicidal deaths. Postvention is prevention for the next decade and for the next generation. Of the three possible (temporal) approaches to mental health crises—prevention, intervention, and postvention—in the case of suicide at least, postvention probably represents the largest problem and thus represents the greatest area for potential aid. . . . A comprehensive understanding of "the suicidal problem" obviously ought to include postvention along with prevention and intervention in a tripartite approach (p. 154-155).

In order to provide parents bereaved by the suicide of their youth with effective support we need to gain a greater understanding of their experience.

The Purpose, Significance, and Scope of the Study

As noted above, more studies that examine the subjective experience of parent suicide survivors are needed to further our understanding of this phenomenon. Therefore, the purpose of this study was to gain an understanding of what parents whose youth committed suicide experience using a qualitative method. Parents who have experienced the loss of a child through suicide are the most valid source of information regarding their experience. The insight and depth of understanding we gain from them can add to our knowledge of this phenomenon, enable mental health professionals to provide them with more effective support, and guide suicide postvention programs and policies. The scope of this study encompasses parents bereaved by the suicide of their child between the ages of 10 and 24.

The Research Question

The question this study asked was: "What is the experience of parents bereaved by the suicide of their youth?" By asking this question I hoped to learn from the participants what they considered to be the most important aspects of their experience surrounding their child's suicide; that is, their deepest thoughts and feelings. Through in-depth interviews and careful analysis I extracted themes common to participants' experiences. The careful, comprehensive descriptions that were obtained should increase our understanding of the bereavement experience of these parents, provide a broader picture of the phenomenon as a whole, and aid those of us in the helping professions to act more thoughtfully and more tactfully with these survivor-victims of youth suicide.

Furthermore, the themes that were identified were compared to the current literature to determine whether or not they were consistent with our present knowledge. By using a qualitative approach I hoped to elucidate aspects of surviving suicide that other methodologies may have overlooked. Instead of attempting to fit the experience of survivors into predetermined categories, I listened to these survivors' stories, and then established the common themes among them.

Overview of Methodology

This study was conducted using a basic interpretive qualitative research method (Merriam, 2002b) that addressed the complexity of this phenomenon. A basic interpretive qualitative research method is appropriate for investigating the experience of parents bereaved by the suicide of their youth because it recognizes the value of studying human experiences that are not approachable through quantitative approaches, and focuses on the wholeness of experience rather than solely on its objects or parts. Moreover, it allows the researcher to obtain detailed descriptions of the phenomenon in the participants' own words in informal conversations and interviews, and regards the data of experience as imperative in understanding human behaviour and as evidence for scientific investigations. Furthermore, it permits researchers to formulate questions that reflect their interest, involvement, and personal commitment. Lastly, this methodology views experience and behaviour as an integrated and inseparable relationship of subject and object and of parts and whole (Moustakas, 1994). The methodology employed in this study is discussed in greater detail in Chapter Three.

Definition of Terms

Since differences in terminology exist among researchers, the following definitions of terms are provided to ensure a mutual understanding of the terminology used in this study:

Suicide: an act of deliberate self-harm resulting in death.

Suicide Survivor: any person who has been affected by a death through suicide. Survivors can include family members, friends, neighbours, colleagues, schoolmates, therapists, and communities. However, for the purpose of this proposal, survivors are generally regarded to be family members.

Pre-suicide: the time preceding the suicide.

Youth: For the purpose of this study, youth is defined as beginning at the age of 10 and ending at 24. This is in line with the way Statistics Canada and the Office of the Chief Medical Examiner group their statistical data (i.e., ages 10-14, 15-19, 20-24).

Bereavement, Grief, and Mourning: Although in practice bereavement, grief, and mourning are often used interchangeably, distinctions among the terms exist. Bereavement is "the loss of a loved one by death" (Merriam-Webster's Collegiate Dictionary, 2003, p. 115) and encompasses both grief and mourning. Grief is the poignant distress experienced in response to bereavement (Merriam-Webster's Collegiate Dictionary, 2003, p. 550) and is viewed "as a normal reaction to overwhelming loss, albeit a reaction in which normal functioning no longer holds" (Parkes & Weiss, 1983, p.6). Lastly, mourning is "an outward sign (as black clothes or an armband) of grief for a person's death" (Merriam-Webster's Collegiate Dictionary, 2003, p.812) that is usually influenced by social customs and cultural expectations. It is also used to signify the

active process bereaved individuals go through in adapting to the loss of their loved one (Worden, 2002).

Overview of the Research Text

Following this introductory chapter, Chapter Two consists of a review of the literature pertaining to this study. First the stress parents experienced before their child's suicide is examined followed by a review of the pertinent literature on bereavement. Chapter Three describes the research methodology by detailing my rationale for choosing a basic interpretive qualitative approach, my presuppositions, how I chose and obtained participants, the interview procedure, data analysis, trustworthiness, and ethical considerations. The Fourth Chapter presents brief narratives of the participants and their child. Chapter Five presents the four common themes along with the 23 sub-themes that capture the findings. Finally, in Chapter Six, the four key findings are integrated with the existing literature. In addition, I provide practical implications, make suggestions for future research and education, discuss considerations for this study, and present my personal reflections.

CHAPTER TWO

REVIEW OF THE LITERATURE

Youth suicide impacts parents, siblings, and other family members, as well as friends and the community at large. Although researchers have focussed their attention on the impact of suicidal behaviours in a variety of domains, they have just recently begun to explore the experience of suicide survivors, particularly parent suicide survivors. To contextualize this study this chapter first examines the stress parents experienced before their child committed suicide followed by a review of the pertinent literature on bereavement.

Pre-Suicide Stress

Although researchers concur that most completed suicides are preceded by months or even years of intense stress due to repeated crises, suicide threats, and/or previous suicide attempts, (Clark & Goldney, 2000; Cottle, 2000; Esposito-Smythers, Jobes, Lester, & Spirito, 2004; Seguin, Lesage, & Kiely, 1995; van Praag, 2004), research examining parents' pre-suicide stress is limited (Clark, 2001; Wagner, Aiken, Mullaley, & Tobin, 2000). To provide some understanding about parents' stress before their child's suicide, the following section examines the challenges of parenting an emotionally disturbed child, the problems attributed to parents of a suicidal child, and the limited research on parents' knowledge about suicide and support parenting a suicidal youth.

The Stress of Living With an Emotionally Disturbed and Self-Destructive Child

Most adolescents who commit suicide had at least one pre-existing psychiatric disorder such as depression (Gardener, 2002; Kelly, Cornelius, & Lynch, 2002; Wilcox,

2004), alcohol abuse (Gardener, 2002; Kelly, Cornelius, & Lynch, 2002; Wilcox, 2004), substance abuse (Gardener, 2002; Kelly, Cornelius, & Lynch, 2002; Renaud, Brent, Birmaher, Chiappetta, & Bridge, 1999; Wilcox, 2004), schizophrenia (Gardener, 2002; Pompili, Mancinelli, Girardi, & Tatarelli, 2003), bipolar disorder (Gardener, 2002; Kelly, Cornelius, & Lynch, 2002), borderline personality disorder (Gardener, 2002), or conduct disorder (Kelly, Cornelius, & Lynch, 2002). Children with these disorders commonly experience irritability and immense mood swings, and can become violent even in the absence of provocation, leading to conflictual relationships with their parents (Esposito-Smythers et al., 2004). They also frequently engage in aberrant behaviours, and threaten and/or attempt suicide (Clark and Goldney, 2000; Jordan, 2001). Thus, parenting them can be extremely stressful (Jordan, 2001; Mohr, 2003). Indeed, the stress of parenting an emotionally disturbed and/or self-destructive child can become so unbearable that many parents experience a sense of relief when their child dies that they no longer have to cope with the intolerable stress and their child's destructive behaviour (Clark & Goldney, 2000; Seguin et al., 1995), as one mother, whose adolescent son committed suicide, reported:

> This is going to sound absolutely horrible. Horrible as we all felt, much as we missed him and the terrific load of guilt that we were all under . . . it was almost a relief. For years, every time the phone rang or I heard a siren, I would lose my stomach. (Esposito-Smythers et al., 2004, p. 190)

However, few researchers have examined the stress parents experience parenting a suicidal youth in detail. Besides a case study on adolescent suicide by Esposito-Smythers and colleagues (2004), in which a mother bereaved by the suicide of her adolescent talked about her pre-suicide stress and sense of relief at the death, only one other study, which indirectly alluded to the stress parents experience parenting a suicidal

adolescent, was found. It examined how parents felt after their adolescent attempted suicide and found that they experienced increased feelings of caring, sadness, and anxiety following their child's suicide attempt, and that 50% of the mothers experienced hostile feelings before and after the suicide attempt—feelings they were reticent to verbalize. The authors surmised that the hostility mothers experienced may have been reflective of a conflictual parent-adolescent relationship (Wagner et al., 2000). However, the stress parents experienced parenting a suicidal adolescent was not examined in detail.

Problems Attributed to Parents of Suicidal Youth

At the same time parents are experiencing the stress of living with a suicidal adolescent, there is evidence that many of them are also struggling with their own problems. Research on youth suicide has consistently demonstrated that most suicidal youth come from dysfunctional family backgrounds characterized by such features as lack of parental involvement and support (Flouri & Buchanan, 2002; Hollenbeck, Dyl, & Spirito, 2003; Seguin et al., 1995); impaired parent-child relationships, characterized by ineffective communication, a great deal of conflict, and a lack of emotional attachment (Clark & Goldney, 2000; Wagner, M. A. Silverman, & C. E. Martin, 2003); high levels of conflict, with behaviours ranging from verbal disagreements to domestic violence (Cleiren, Grad, Zavasnik, & Diekstra, 1996; Hollenbeck et al., 2003; Seguin et al., 1995; Wagner et al., 2000; Walrath et al., 2001); family and residential instability, in most cases due to separation or divorce (Aydin & Oeztuetuencue, 2001; Cottle, 2000; Flouri & Buchanan, 2002; Wagner et al., 2003); physical and sexual abuse (Grosz, Zimmerman, & Asnis, 1995; Henry, Stephenson, Hanson, & Hargett, 1993; Lester, 1993); and a family history of mental illness, characterized by high incidences of alcohol or substance abuse,

depression, criminality, schizophrenia, abuse, and suicidal behavior (Fernquist, 2000; Hollenbeck et al., 2003; Seguin et al. 1995; Wagner et al., 2003; Walrath et al., 2001). Thus, as the data implies, many parents experience their own personal stresses while parenting their suicidal child.

Although the data makes it clear that family dysfunction is closely associated with youth suicide, it is important to note some of the methodological problems encountered in researching the link between youth suicide and family dysfunction before continuing on to the next section. First, most of the conclusions in the above studies were based on adolescents' perceptions of family functioning, and it is not clear to what extent adolescents' perceptions of family functioning reflect the actual functioning of the family. A more balanced view of family functioning could be achieved if the data was gathered from multiple sources. In addition, the data on youth suicide and family dysfunction does not determine causality. In most cases it was not clear if dysfunctional family behaviours preceded or followed the suicidal behaviours of youths.

Parents' Lack of Knowledge About Youth Suicide

Researchers have found that when parents are provided with knowledge about youth suicide, as well as professional support caring for their suicidal child, the benefits for both the child and parents are immediately observable (Hollenbeck et al., 2003; Rotheram-Borus, Piacentini, Cantwell, Belin, & Song, 2000). However, there are few indications in the literature that parents are receiving the knowledge and support they need. One study was found that appraised parents' knowledge of youth suicide. It assessed 112 parents of adolescents about their knowledge of suicidal signs, their responses to a young person showing suicidal signs, their attitude to suicide, and their

intentionality toward suicidal people, before and after they viewed an educational video on youth suicide. Results demonstrated that parents improved in all these areas after watching the video. In addition, their attitude was more rejecting of suicide after viewing the video (Maine, Shute, & G. Martin, 2001).

Several studies have also found that general physicians and teachers, who many parents turn to with their concerns about their suicidal child, may also be lacking critical information about adolescent suicide. One study investigated 1639 Australian general practitioners about their knowledge of adolescent suicide using a 39-item Adolescent Suicide Behaviour Questionnaire and found that, on average, physicians got about 71% of the survey items correct. However there was considerable variability in the accuracy of their beliefs, with scores ranging from 4 to 38 items correct (D. I. Smith & Scoullar, 2001). A second study, using the same 39-item questionnaire, examined 404 general practitioners and 481 secondary school teachers regarding their knowledge of adolescent suicide and found that physicians and teachers scored respectively, on average, 71% and 59% of the questionnaire items correctly. Once again there was a great deal of variability in their scores. General practitioners ranged from 4-38 items correct, while teachers ranged from 0-34 items correct (Scouller & D. I. Smith, 2002).

Parents' Lack of Support Parenting Their Suicidal Child

The available research seems to indicate that parents are not receiving the support they need to parent their suicidal child. Peterson, Luoma, and Dunne (2002) surveyed 71 suicide survivors (aged 21-82 yrs) about their perceptions of the clinicians who were treating their loved one at the time of death and found that although almost all the survivors knew their loved one was in treatment only 11% of them were contacted by the

clinician before the death. The lack of contact was deemed problematic. Finally, in a recent ethnographic study on parents of children with mental illnesses, Mohr (2003) found that instead of feeling supported by the mental health workers who were treating their child, parents often felt diminished or dismissed by them.

Bereavement

In contrast to the lack of research examining parent suicide survivors' pre-suicide stress, the general area of adult bereavement has received considerable attention from researchers. This section reviews the following five aspects of bereavement: dominant models of grief, common grief reactions, bereaved parents, suicide bereavement compared to other types of bereavement, grief reactions of suicide survivors, and qualitative studies of parent suicide survivors.

Dominant Models of Grief

Various researchers have proposed models as a theoretical framework for how individuals respond to death (e.g., Bowlby, 1979, 1980; Kubler-Ross, 1969; K. Martin & Elder, 1991; Parkes, 1972, Parkes & Weiss, 1983; Rando, 1992-93; M. S. Stroebe & Schut, 2001b; Worden, 1991/2002). In the following section an overview of the dominant models of grief developed by Kubler-Ross, Parkes and Bowlby, and Worden will be presented.

Stage Model of Grief

Kubler-Ross (1969), a pioneer in the area of bereavement, proposed a five-stage model of grief based on her work with dying patients. Stage one consists of denial and isolation. The bereaved individual's initial reactions of shock and denial act as a buffer to the unexpected shocking news. Denial is usually a temporary defense that is eventually

replaced by partial acceptance. Social isolation usually accompanies the denial and shock, as the mourner engages in self-protective actions to ward off others who may trigger overwhelming emotional states. Stage two is characterized by anger. As the denial diminishes, and the bereaved individual acknowledges the death, he or she may experience feelings of anger, rage, guilt, envy, and resentment. This anger is often random, and can be expressed toward medical personnel, the self, the deceased, or other family members. In stage three the survivor engages in bargaining. He or she has not yet come to terms with the finality of the death, and believes that he or she can enter into some kind of an agreement with God to reverse the death. These bargains with God are usually kept secret or confided to a spiritual mentor. Stage four is characterized by depression. When denial of the loss can no longer be maintained, attempts at bargaining have failed, and the mourner views the situation as hopeless, depression ensues. Depression, if it is not prolonged, is considered a normal reaction of bereavement. The fifth stage is acceptance. The bereaved individual comes to terms with the reality of the death and is able to talk about the loss and remember the deceased without experiencing severe emotional upheaval. He or she also begins to experience hope about the future and begins to get involved in new activities and relationships.

Although Kubler-Ross's model of grief is still the most recognized and widely used, it has come under criticism regarding its applicability. Cordell and Thomas (1997) believe that it is not reflective of parental experience and lacks provision for individual variability. They noted that grief is not a linear progression, as the "stages" model suggests, but, rather, a free-flowing process that tends to fall into separate but overlapping phases of shock, awareness of the loss, conversation/withdrawal, healing,

and renewal. K. Martin and Elder (1991) criticized Kubler-Ross's model for implying that there is only one way to grieve--a linear progression from one stage to the other--and for not making allowance for returning to a stage without feeling like it is a set-back. Attig (1991) criticized the "stages" model for viewing the bereaved as passive recipients of grief and not providing mourners with helpful suggestions. Finally, Worden (2002) noted that people do not pass through stages in a series. Rather, there is an overlap in stages, and they are seldom distinct. He also expressed concern that novices would take the stages too literally.

As Sprang and McNeil (1998) noted, Kubler-Ross never intended to generalize her findings beyond her study population, and did not conceptualize the stages as static, linear processes. Moreover, most grief researchers now agree that the stages are non-sequential, may overlap, and are repetitive. Even so, there is concern that clinicians may inappropriately interpret deviations from the stages as maladaptive in terms of intensity or duration of the grief response. In spite of these concerns, researchers concur that Kubler-Ross's work has provided us with a foundation for the study of grief, and has been the impetus for the development of further theoretical frameworks (Trolley, 1993-94).

Phases of Grief

An alternative approach to stages is the concept of phases proposed by Parkes (1972, 1986) and Bowlby (1979, 1980), who collaborated on many of their ideas and theories. In phases of grief, which are an extension of Bowlby's (1980) attachment theory, mourning is viewed in terms of the pain of separation and loss of a relationship of attachment. The stronger the bond between the bereaved and the deceased, the greater the

extent of grief when the bond is broken. Grief work is comprised of a succession of clinical pictures that blend into and replace one another, and prepare the bereaved individual for acceptance of the loss (Cordell & Thomas, 1997; M. S. Stroebe, 1992-93). Although Bowlby (1980) and Parkes (1986) acknowledged that the intensity of grief, as well as the length of each phase, varies considerably from individual to individual, and that individuals may oscillate back and forth between phases, they believed that the basic pattern in the following four phases is generally followed in grieving.

Phase one consists of the period of numbness that occurs close to the time of the loss, and usually lasts from a few hours to a week. The numbness, shock, and denial the bereaved individual experiences serves to partially or totally block the awareness of the loss. Numbness can be interrupted by outbursts of extremely intense distress, and/or anger. Some form of denial continues to permeate further stages. Phase two is characterized by yearning. The mourner experiences intense longing for and preoccupation with the deceased, which lasts from months to years. Preoccupation with thoughts of the deceased derives from the urge to search for that person (Parkes, 1972). The permanence, rather than the reality, of the loss is denied during this phase. There is no sharp end-point to yearning, and pangs of grief can be re-evoked even years after bereavement. Anger is commonly experienced during this phase. Phase three is characterized by disorganization and despair. During this phase the bereaved accepts both the permanence and reality of the loss. This stage begins gradually as the intensity of the yearning begins to diminish and depression, apathy, and aimlessness begin to take over. As a result, the bereaved person finds it difficult to function in the environment. Phase four consists of reorganization. The bereaved individual experiences full

expression and resolution of grief. Depression, apathy, and aimlessness greatly diminish. The bereaved person begins to experience a sense of direction, and resumes interest in the future and in relationships with others. Mourning is finished when the bereaved completes this final phase.

The phases of grief have been most often criticized for being linear and passive—something the mourner must pass through. However, most mourners do not experience their grief in the linear and orderly manner suggested by Bowlby (1980) and Parkes (1986). Rather, they sometimes stay in one phase for a long period, or find themselves returning to earlier phases long after subsequent phases have been entered (Dunne, 1992; Freeman, 1991; K. Martin & Elder, 1991; Worden, 2002). Parkes (2001) recently addressed the criticisms levelled against the phases and noted that the sequence of the phases was never intended to be more than a rough guide, and it was recognized from the start that people would move back and forth through the sequence rather than following a fixed passage. He also expressed concern that some therapists may be applying the model in a rigid way when working with bereaved people, causing them discomfort.

Tasks of Grief

Worden (1991/2002), who views mourning as an active process, and not a state, proposed "The Four Tasks of Mourning" as a less rigid, client-empowering alternative to previous models. His tasks of mourning imply that the mourner needs to take action, and that mourning can be influenced by outside intervention. Although the tasks do not necessarily follow a specific order, and can be revisited and reworked with various tasks worked on simultaneously, there is some ordering suggested in the definitions. Worden

believes that all four of the following major tasks of mourning must be accomplished for equilibrium to be re-established, and for the process of mourning to be completed.

The first task of grieving is to accept the reality of the loss and overcome the inevitable denial that most people experience upon hearing of the death of a loved one. Part of the acceptance of reality is to come to the belief that reunion is impossible, at least in this life. Acceptance of the reality of the loss takes time since it involves not only an intellectual acceptance but also an emotional one. Traditional rituals, such as funerals, help many bereaved people move toward acceptance. The second task is to work through to the pain of grief. Although it is common to experience intense pain when a loved one dies, the bereaved must acknowledge and work through the pain, or it will manifest itself through some symptoms, or other form of aberrant behaviour. Anything that continually allows the mourner to avoid or suppress this pain can prolong the course of mourning. Worden encourages mourners to allow themselves to indulge the pain, to feel it, and know that one day it will pass. He believes that if task two is not adequately completed the bereaved individual may need therapy later on to work through the pain he or she has been avoiding. The third task is to adjust to an environment without the deceased. The death of a loved one affects survivors externally, internally, and spiritually. Externally, they have to come to terms with how the death has affected their every day functioning. For example, grieving the loss of a husband may entail the loss of a sexual partner, confidant, companion, provider, and baby sitter, depending on the roles the husband normally performed. Internally, the survivor has to come to terms with how the death has affected his or her sense of self. Finally, spiritually, the bereaved has to come to terms with how the death has affected his or her beliefs, values, and assumptions about the

world. The fourth task is to emotionally relocate the deceased and move on with life. The survivor must loosen the ties to the deceased to an extent that allows for involvement with others. Worden noted that although many people find this task the most difficult to accomplish, it can be accomplished, and the long-term process of mourning has ended when it is, although the bereaved individual never returns to the pre-grief state. Some indications that bereaved individuals have ceased mourning are that they are able to think about the deceased without wrenching pain, intense crying, and some of the other manifestations of intense distress they formerly experienced, and they have reinvested their emotions into life and living.

When Worden originally proposed his tasks of mourning, he believed the function of mourning was to detach from the deceased. However, he has recently modified his theory (Worden 2002) to accommodate the current research on "continuing bonds," and now believes that a healthy connection, one that does not prevent the mourner from moving on with life, can be maintained.

Some researchers believe that Worden's model has the most implication for prevention because "tasks" imply that the grieving person has power over the progression of the grieving process, and the grieving process can be influenced by intervention thus providing hope to the mourner (Sprang & McNeil, 1995). Other researchers acknowledge that Worden's model is an important development in the understanding of the process of coping adaptively with bereavement because each task is clearly defined in an action-oriented manner. However, they also point out the following shortcomings in the model: not all bereaved individuals go through the tasks or in the sequence suggested; the task model does not account for additional tasks, such as acceptance of the changed world

that need to be performed; and, it does not acknowledge that grieving individuals need to take breaks from grieving, need to reconstruct their subjective environment, rather than just adjust to the environment, and need to work toward developing new roles, identities, and relationships (M. S. Stroebe & Schut, 2001b). Finally, van Dongen, (1990) found that suicide survivors had difficulty achieving the tasks of grieving, because their persistence in asking agonizing questions related to the suicide interfered with their accomplishment of grief work.

Two important phenomena, currently of great interest to bereavement researchers, that are not accounted for in the above models of grief involve healthy enduring bonds with the deceased and personal growth. The above models imply that a healthy resolution to grief entails detachment from the deceased (P. R. Silverman & Klass, 1996), and view ongoing attachments with the deceased as unhealthy, and in some cases even pathological (Shaver and Tancredy, 2001). However, researchers have found that, rather than severing bonds with the deceased, many survivors maintain healthy enduring relationships with their deceased loved ones, which provide them with solace, comfort, support, and help them to transition from the past to the future. Survivors maintain these bonds by talking to the deceased, believing that the deceased is watching them, keeping items that belonged to the deceased, visiting the deceased's grave, and frequently thinking about the deceased (Klass, 1996; Klass, P. R. Silverman, & Nickman, 1996; Rosenblatt, 1996, 2000b; P. R. Silverman & Klass, 1996). As noted previously, Worden (2002) recently revised his theory to accommodate the emerging data on continuing bonds. However, his last task seems to imply that mourners cannot develop other

relationships as long as they are emotionally invested in the deceased (P. R. Silverman & Klass, 1996).

Additionally, none of the above models mention personal growth. Yet, researchers have found that bereavement, like other life crises, can be an impetus for personal growth in mourners. Personal growth is reflected in bereaved individuals' greater sense of identity (Milo, 2001); a re-ordering of priorities (Frantz, Farrell, & Trolley, 2001; Milo, 2001; Murphy, Johnson, & Lohan, 2003b; Schaefer & Moos, 2001); strengthened relationships with family and friends (Frantz et al., 2001; Milo, 2001; Schaefer & Moos, 2001); a better outlook and appreciation of life (Frantz et al., 2001); an entirely different worldview (Milo, 2001); increased independence, self-reliance, and self-efficacy (Calhoun & Tedeschi, 2001; Frantz et al., 2001; Schaefer & Moos, 2001); more wisdom, maturity (Schaefer & Moos, 2001), compassion, and understanding of others (Frantz et al., 2001; Schaefer & Moos, 2001); strengthened religious beliefs (Calhoun & Tedeschi, 2001; Frantz et al., 2001; Milo, 2001; Schaefer & Moos, 2001); increased self-understanding (Attig, 2001), self-esteem (Attig, 2001; Wortman & Silver, 2001) and viewing self as stronger (Attig, 2001;Calhoun & Tedeschi, 2001; Frantz et al., 2001); development of new coping skills (Schaefer & Moos, 2001); less fear of death (Frantz et al., 2001); increased sensitivity and responsiveness to others (Calhoun & Tedeschi, 2001; Frantz et al., 2001); greater appreciation and love for others (Frantz et al., 2001; Murphy, Johnson, & Lohan, 2003b); and a greater desire to help others (Klass, 2001). Although personal growth occurs throughout the bereavement process, as bereaved individuals struggle with their loss and engage in processes such as

introspection and a search for meaning, it is usually most evident once the intense pain of grief has ended (Calhoun & Tedeschi, 2001; Schaefer & Moos, 2001).

Researchers have noted other shortcomings in the above models. They lack clear empirical support and do not differentiate between bereaved individuals' negative ruminations and positive reflections while working through grief (M. S. Stroebe & Schut, 2001b). In addition, none of them seem to adequately account for many of the phenomena observed in the grief of parents after the death of their child. Instead, they may further burden suffering parents by pathologizing their extended grief reactions (Cordell & Thomas, 1997). The models also assume that bereaved individuals have to confront their loss in order to come to terms with it and avoid pathological consequences. However researchers have found that some bereaved individuals experience very little depression and grief during bereavement, do not work through their loss, and adjust well to their loss. A small number even show improved mental health after the loss (Bonanno, Wortman, & Nesse, 2004). Furthermore, the models imply that there is a resolution or completion of grief. However, we now realize that there is no end point to grief. Bereaved individuals simply adapt to their loss (M. S. Stroebe, Hansson, W. Stroebe, & Schut, 2001b). Finally, the models are not applicable to all cultures in our society (Stroebe et al., 2001b).

In spite of all these shortcomings, the models are still viewed as powerful tools that help us understand how survivors adapt to bereavement, especially in North American and European cultures. Furthermore, most researchers no longer view them as following a fixed and prescriptive course (M. S. Stroebe, Hansson, W. Stroebe, & Schut,

2001a; M. S. Stroebe & Schut, 2001b). In the following section, the grief reactions mourners commonly experience are discussed.

Common Grief Reactions

While reactions to the loss of a loved one vary, many grief reactions (the deep distress survivors experience in response to the bereavement) appear to be common among survivors. Although in real life these variables often exist in clusters--a complex interaction of biological, psychological, and environmental factors—they have been separated in the following section to help clarify the multifactorial nature of this phenomenon.

Biological Grief Reactions

Grief often includes concomitant physical reactions typical of stress and it is not unusual for survivors to become physically ill after the death of a loved one (Dyregrov, Nordanger, & Dyregrov, 2003; Hall & Irwin, 2001; M. S. Stroebe et al., 2001b; Worden, 2002). van Dongen (1990) reported that 54% of the bereaved individuals in his study consulted a health professional after the death of a loved one. Some symptoms of physical distress that are commonly reported by grieving individuals include hollowness in the stomach, a sense of depersonalization, feeling short of breath, dry mouth, appetite and sleep disturbances (Worden, 2002), gastrointestinal difficulties, headaches, nausea, menstrual irregularities, tenseness (T. L. Martin & Doka, 2000), tiredness and exhaustion, sensitivity to noise, tightness in the chest and throat, and muscular aches (T. L. Martin & Doka, 2000; Worden, 2002). Some mourners also experience feelings of panic associated with overwhelming affect, leading them to believe they are going crazy. This panic state may be induced by the psychological disorientation and disorganization

of the grief response, or the fear that the emotions or their intensity is abnormal (Sprang & McNeil, 1995).

Psychological Grief Reactions

The first response to any sudden death is usually shock and denial which often manifests itself as numbness and disbelief (Parkes, 1986). Kubler-Ross (1969) suggested that the shock and denial mourners initially experience may protect them from becoming overwhelmed. Shock effects have been found to be greatest among recently bereaved parents (Reed & Greenwald, 1991) and survivors of sudden deaths (Worden, 2002).

Anger is a common response to death, and normally follows once the initial denial has diminished (Kubler-Ross, 1969). Bowlby (1980) viewed anger as a logical constituent of the urgent, albeit futile, effort bereaved individuals make to restore the bond that has been severed by death. He believed that as long as anger continues, the loss is not being accepted as permanent and hope is still lingering on. On the other hand, Worden (2002) suggested that anger is caused by the frustration survivors experience that they were unable to prevent the death, as well as their fear that they will be unable to live without the deceased. He believes that anger that is not acknowledged can lead to complications in grieving. Anger can be experienced as general irritability or bitterness, or be expressed towards others such as medical personnel, clergy, officials, the deceased, other family members, and the self.

Guilt is another common element of bereavement, and may be the most painful aspect of grief (Kubler-Ross, 1969). It is normal to experience some sense of guilt regarding the relationship with the decedent, about things said or unsaid, done or not done before the death occurred (Barrett & Scott, 1989; Hasui & Kitamura, 2004). The

closer the bereaved's relationship with the deceased, the greater the possibility for feelings of guilt to surface. Family members may assume culpability for the death, feeling that their actions may have in some way caused the death or failed to prevent it (Sprang & McNeil, 1995; Worden, 2002). Some people experience a sense of relief after the death of a loved one, particularly if the loved one suffered a lengthy or painful illness, or if they had a particularly difficult relationship with the deceased. However, although family members are relieved to resume a normal family life, they usually experience guilt for feeling this sense of relief. (Clark & Goldney, 2000; Frantz et al., 2001; T. L. Martin & Doka, 2000; Worden, 2002).

Although it is not uncommon for grieving survivors to experience a sense of rejection, or feel that they have been deserted by the deceased, this is typically a fleeting sensation. Usually, the realities surrounding the death help the survivor rationally understand that the deceased did not leave him or her behind intentionally (Barrett & Scott, 1989).

It is common for bereaved individuals to experience visual and auditory hallucinations, or to sense the presence of the deceased. These hallucinations usually occur shortly after the loss and are transient in nature (Worden, 2002).

Depression is a normal by-product of the hopelessness a mourner experiences when he or she faces the reality of the death (Kubler-Ross, 1969), and entails the following classic symptoms: sleep disturbance, appetite disturbance, and intense sadness. However, in contrast to most clinical depressions, the bereaved do not commonly experience the loss of self-esteem (i.e., regarding themselves as less because of the loss)

(Worden, 2002). Although depression is a common response to grief, it diminishes with time and the bereaved person should return to his or her normal state.

Various researchers have found that a survivor's life is actually in jeopardy for at least a year after a death, regardless of the type of bereavement. It is also common for the bereaved to entertain ideas of suicide, as a means of rejoining the deceased, or to end their suffering, especially during the early months of bereavement (Bowlby, 1980; Parkes, 1986, Worden, 2002). A severe case of retroflected anger can also cause a bereaved person to become severely depressed or suicidal (Worden, 2002).

Toward the end of the resolution of grief survivors commonly search for meaning in relation to their struggling and suffering (Kalischuk & Hayes, 2003; T. L. Martin & Doka, 2000). Some researchers have suggested that questioning occurs because the death is more easily accepted if the survivor can intellectually formulate a plausible reason for it (Barrett & Scott, 1989). Others believe that the search for meaning is an integral part of the healing process and that a positive aspect of the grieving experience occurs when questions early in the grief process such as "Why did this happen?" and "What does it mean to me?" change with time to "What now?" and "How will I go on?" By questioning the loss, survivors are able to define the loss as a challenge and a change that can be managed (K. Martin & Elder, 1991). Their search for credible answers to an incomprehensible situation can also challenge their tacit assumptions about who they are and can sometimes prompt dramatic changes in their lives (Neimeyer, 2001). Finding meaning and purpose in life can buffer the negative aspects of the bereavement experience (Murphy, Johnson, & Lohan, 2003b; Ulmer, Range, & P. C. Smith, 1991) and help survivors integrate the death into their lives (Wheeler, 2001). Some bereaved

parents have found meaning in their lives as a result of their activities, beliefs and values, personal growth, connections with people, connections with their deceased child (Wheeler, 2001), and attendance at a bereavement support group for parents (Murphy, Johnson, & Lohan, 2003b).

Religious beliefs can either help or hinder survivors in their search for meaning. Survivors who deem the death as senseless (i.e., the death of a child) may experience a crisis of faith as they re-examine the notion of good people being protected by God. On the other hand, for many religiously oriented individuals their relationship with God and the church serves as a source of social support, and they are often better able to accept and cope with the death than their non-religious counterparts (Murphy, Johnson, & Lohan, 2003b; Sprang and McNeil, 1998). Bohannon (1991) surveyed 143 mothers and 129 fathers, who had experienced the death of a child within the previous 18 months and found that bereaved mothers who attended church on a regular basis seemed to experience lower levels of grief related to anger, guilt, loss of control, rumination, depersonalization, somatization, and despair. Although church attendance appeared to have a less significant effect on fathers' grief levels, they also experienced less anger and guilt. On the other hand, P. C. Smith, Range, and Ulmer (1991-92) found that belief in an afterlife, where the loved one continued an existence, was associated with greater recovery from bereavement and the existential well-being of survivors, even if it was unrelated to a religion or to a belief in God.

Social/Environmental Grief Reactions

Real or perceived loss of support from family and friends is commonly considered concomitant with grief. Bereaved individuals often report that friends and

family do not seem to be supportive enough during their grief. This lack of support may take the form of avoidance, abandonment of friendship, an unwillingness to listen, lack of concern and understanding, or isolation (Barrett & Scott, 1989). Sometimes the intense grief bereaved individuals experience frightens people off; that is people may avoid being around them because they are afraid of being engulfed in their deep sorrow, rage, anxiety, or depression, or they may be worried that too much may be required of them (Rosenblatt, 2000a). Lack of support may also be a by-product of our modern times. Whereas historically bereavement was facilitated by supporting family members and friends, religious rituals, social traditions, and customs, families are generally more isolated now, living far apart, and unavailable for support. Furthermore, our modern society seems to shy away from the discussion of death; people may not know what to say or may choose to avoid the grieving individual. As a result, bereaved individuals may be left alone with their grief. On the other hand, sometimes the bereaved may purposely isolate themselves, despite the presence of family and friends, because of the inappropriate expectations put on them by others (i.e., being condemned for grieving too long, displaying behaviour or emotion that is deemed inappropriate) (Sprang & McNeil, 1998).

It is not uncommon for survivors to become detached from family relationships. Although family members may have had a close bond prior to the death of a loved one, after the loss they may experience family conflict, withdraw, and become emotionally distant from each other. Sometimes conflict results because couples and children blame one another for the decedent's unhappiness, or for contributing to his or her death. More often, however, family members find it difficult to share their grief. As family members

detach, they all experience more difficulty coping with the bereavement. In some cases the marital conflict parents experience after the death of their child causes them to separate or divorce (Reed, 1993).

In conclusion, a wide variety of grief reactions comprise typical manifestations of grief. However, although these grief reactions are common in bereavement, it is important to realize that not all of them are experienced by every survivor, and that reactions are experienced in varying degrees, sometimes simultaneously, even the seemingly contradictory ones (T. L. Martin & Doka, 2000). The meaning bereaved individuals assign to their loss influences their grieving (Nadeau, 2001; M. S. Stroebe & Schut, 2001a). Other important determinants of grief are who the deceased was and his or her relationship to the survivor; the nature of the attachment (i.e., strength of the attachment, security of the attachment, ambivalence in the relationship, conflict with the deceased, dependent relationship); cause of death; how previous losses were experienced; personality variables; social variables (degree of perceived emotional and social support from others); concurrent stresses (Worden, 2002); and cultural background (Rosenblatt, 2001). Two of these determinants of grief, relationship to the survivor and cause of death, are examined in more detail in the following two sections. Many researchers concur that kinship, in particular parental loss, may have an even greater impact on the bereavement experience of mourners than the cause of death, as described in the following section.

Bereaved Parents

The loss of a child is one of the most devastating bereavements that an individual can experience and may have an even greater impact on the bereavement experience of

mourners than the cause of death (Cordell & Thomas, 1997; Kamm & Vandenberg, 2001; Milo, 2001; Nelson & Frantz, 1996; W. Stroebe & Schut, 2001). Leahy (1992-93) found that bereaved mothers had significantly higher levels of depression than both widows and bereaved adult daughters, with over 60 percent of the mothers scoring in the moderate to severe range of depression.

Most bereaved parents experience an intense and long-lasting crisis of meaning as they search for credible answers to a seemingly incomprehensible situation (Wheeler, 1993-94). Not only do they lose their beloved child, and their dreams and hopes for the child's future (Nelson & Frantz, 1996), but they are also left grappling with questions related to the innocence of youth, the brevity of life (Reed & Greenwald, 1991), and their disbelief that their child has died before them (Murphy, Johnson, Wu, Fan, & Lohan, 2003).

In addition, bereaved parents commonly experience deterioration in their psychological and physical health, with mothers reporting more pathology than fathers. Znoj and Keller (2002) found that 46% of the bereaved mothers, compared to 28 % of the bereaved fathers reported experiencing physical deterioration following the death of their child. In addition, 37% of all the bereaved parents had clinically elevated depression scores, with bereaved mothers once again reporting higher scores than the fathers. Finally, Qin and Mortensen (2003) found that bereaved parents are at an increased risk for suicide, particularly if their child died during early childhood. This risk is especially high in their first month of bereavement.

Bereaved parents seem to experience a more enduring bereavement than other survivors. Murphy, Johnson, Wu et al. (2003) found that it took the majority of parents,

whose child died by accident, suicide, or homicide, 3 or 4 years to put their child's death into perspective and continue on with their lives. Similarly, Martinson, Davies, and McClowry (1991) and Rosenblatt (2000a) reported that parents experienced strong feelings about the loss of their child even decades after the death. Because most people are unaware of the enduring quality of parental grief, many bereaved parents experience pressure from others to stop grieving (Rosenblatt, 2000b).

Finally, the loss of a child often strains the marriage relationship. Because both partners are simultaneously overwhelmed by the loss, they sometimes become so deeply involved in their own grief that they are unable to provide each other with the needed comfort and support (Nelson & Frantz, 1996). Marital problems usually arise because couples blame each other, are unable to share their grief (Reed, 1993), are not aware that men and women generally differ in how they grieve, do not discuss their differences in grieving, and/or misconstrue a particular grieving style as a lack of love for the deceased child (T. L. Martin & Doka, 2000). However, in spite of the stress and conflict marriages experience, the divorce rates do not increase when a child dies (Murphy, Johnson, & Lohan, 2003a; Schwab, 1998). Some couples' relationships even become strengthened as a result of the strain their marriage experiences (Kamm & Vandenberg, 2001; Rosenblatt, 2000a). It appears that the quality of the marital relationship prior to the child's death in large part determines the outcome of a couple experiencing the loss of a child. Usually, strong marriages are strengthened by the loss, while weak marriages disintegrate (Milo, 2001; Nelson and Frantz, 1996; Schwab, 1998). Being weak marriages they may have disintegrated even without the death of the child. In the following section, the unique experience of suicide bereavement is compared to other types of bereavement.

Suicide Bereavement Compared to Other Types of Bereavement

Most of the literature in bereavement focuses on the grief of spouses and researchers have only recently begun investigating the experience of bereaved parents, especially parents bereaved by the suicide of their child. Therefore, the literature in this area is still quite limited. The majority of studies that have been conducted are quantitative in nature and compare parents bereaved by suicide with parents bereaved by other sudden, traumatic deaths. Many of these studies have found that parental grief due to suicide differs in intensity and type from parental grief associated with death from other causes (Jordan, 2001; Seguin et al., 1995; Thompson & Range, 1992-93). McIntosh (1993) compared parents bereaved by accidents with parents bereaved by suicide and found that the intensity for parents of accidents diminished over time, while the intensity for suicide surviving parents either remained constant or even increased over time. Wheeler (1993-94) found that parent suicide survivors experienced lower levels of purpose in life, compared to parents bereaved by other causes, which indicates that this type of death may be more difficult to place in a meaningful perspective. Reed and Greenwald (1991) found that although suicide survivors experienced significantly less emotional distress and shock, they experienced greater feelings of guilt, shame, and rejection than survivors of accidental death. Seguin and colleagues (1995) compared 30 parent survivors of suicide with parent survivors of car accidents and found that the suicide survivors were initially more depressed, experienced greater shame, more negative life events during bereavement, and a greater history of loss compared to the accident survivors. However, parent suicide survivors did not differ significantly on measures of depression, grief, or mental distress. Holinger, Offer, Barter, and Bell (1994)

concluded from their clinical experience that parent survivors of teen suicide experience greater difficulty with guilt, shame, and stigmatization; feel that they have failed in their parenting role; and, assume a degree of responsibility for the death that may be unrealistically self-punitive. Finally, Qin and Mortensen (2003) found that parents bereaved by the suicide of their child were at greater risk for suicide than parents bereaved by a nonsuicidal death, especially during their first month of bereavement.

Some researchers have also found that the impact on mothers may be even more profound and long-lasting than on fathers. Brent, Moritz, Bridge, Perper, and Canobbio, (1996) conducted a controlled follow-up study, up to 3 years after the suicide, of family members of adolescent suicide victims and found that mothers showed an increased rate of recurrence of depression over follow-up, whereas fathers did not show an increased incidence of disorder compared to fathers of controls. However, it is difficult to draw a definitive conclusion about the results of this study because mothers were the main informants both about themselves and about fathers, and this study used a relatively small sample size (14 mothers and 11 controls), which makes it difficult to generalize results. Another study, that examined the violent death bereavements of 173 parents, found that 27.7% of mothers compared to 12.5% of fathers met diagnostic criteria for PTSD five years after the death (Murphy, Johnson, Chung, & Beaton, 2003). Although the prevalence of depression among females over males is an almost universal trend, it is possible, as these studies suggest, that the loss of a child may be an even greater stressor on the mother than on the father, because as Bowlby (1979) noted, "the first and most persistent bond of all is usually that between mother and young" (p.68). However, since only a few studies have specifically compared the bereavement experiences of mothers

and fathers whose child committed suicide, conclusions regarding gender differences must remain tentative.

Some researchers have suggested that suicide survivors may experience a more difficult bereavement than other survivors because, in addition to their grief, they may also be struggling with pre-existing problems (Jordan, 2001; Seguin et al., 1995) such as psychiatric illness in their families, more disturbed family dynamics, higher rates of loss, more conflictual or dependent relationships with the deceased, and lack of support (Clark, 2001; Clark & Goldney, 2000).

In contrast to the above studies that have found parent suicide survivors' grief to be more intense, a number of researchers have found no appreciable differences between suicide survivors and other bereaved individuals. Murphy, Johnson, Wu et al. (2003) compared 173 parents bereaved by accident, suicide, and homicide and found that suicide survivors did not experience the highest levels of distress, nor the lowest levels of acceptance of the deaths, or marital satisfaction, compared to the other bereaved parents. Dyregrov and colleagues (2003) compared parents bereaved by young suicides, sudden infant death syndrome (SIDS), and child accidents and found that suicide survivors did not have more difficulty adapting to their loss compared to survivors of SIDS or accidents. Rather, although the results were not statistically significant, parents bereaved as a result of accidents scored slightly higher on all the health measures than the survivors did. Reed (1993) also found no differences in total grief reactions between suicide and accident survivors in his study. Finally, McIntosh (1993) reviewed the literature that compared suicide survivors with other groups of survivors, and concluded that there are many more similarities than differences between suicide survivors and

other bereaved groups, particularly other sudden death survivors such as by accidental death. However, he noted that these conclusions are generalizations and must remain tentative until a larger, more representative and extensive body of evidence is accumulated. In the following section we examine suicide survivors' unique grief reactions.

Grief Reactions of Suicide Survivors

Grief after suicide is both similar to and different from grief after death by other causes. It is similar in that it comprises many of the common grief responses and processes traced out in the models presented earlier. Yet it is different because the very nature of a suicide death results in profound effects on the survivors that extend beyond what is considered to be "normal bereavement." This section describes grief reactions suicide survivors commonly experience that are more intense, or unique to suicide.

Although the first response to any sudden death is usually shock, after a suicide the shock may be particularly intense and long-lasting, since the death is usually unexpected, and the deceased ended his or her own life (Clark & Goldney, 2000; Sprang & McNeil, 1995). Survivors experience horror when they consider the extreme emotional distress the deceased must have been in to take his or her own life, the suffering in the dying process, and the possibility that the deceased may have changed his or her mind but was unable to stop the act. Some survivors also experience the shock of discovering the body (Clark & Goldney, 2000). Whereas survivors of other causes of death may experience numbness for a few hours or a few days, suicide survivors may experience numbness for weeks or even months (Wertheimer, 2001). Some suicide survivors meet the criteria for a diagnosis of posttraumatic stress disorder (PTSD), with symptoms in

one or more of the following clusters: re-experiencing, avoidance, or hyper arousal (Dyregrov et al., 2003; Murphy, Johnson, Chung et al., 2003; Murphy, Johnson, Lohan, & Tapper, 2002). Denial usually accompanies the shock suicide survivors experience. The unexpectedness and violence of the death, the stigma of suicide, and feelings of shame evoked by the suicide all contribute to the denial the suicide survivor experiences (Alexander, 1991).

Feelings of rejection and abandonment are more intense in suicide survivors than in other bereaved individuals and can be a serious and enduring concern, perhaps even one of the most devastating results of the suicide (Bailley, Kral, & Dunham, 1999; Clark & Goldney, 2000; Moore & Freeman, 1995; E. Silverman, Range, & Overholser, 1994-95). As noted earlier, although most bereaved individuals initially experience feelings of rejection, these feelings are brief and quickly subside when they realize that the deceased did not deliberately leave them. On the other hand, suicide survivors are faced with the reality that their deceased loved one deliberately and voluntarily chose to die. The deliberate, self-inflicted death by the deceased implies a deliberate abandonment and rejection of life, the survivor, and the relationship the survivor had with the deceased. Intense feelings of anger, betrayal, powerlessness, negativity, and isolation often accompany the profound feelings of abandonment and rejection suicide survivors experience, and can lead to low self esteem and intense grief reactions (Worden, 2002).

Shame is another predominant feeling suicide survivors experience (Bailley et al., 1999; Clark & Goldney, 2000; E. Silverman et al., 1994-95). Although some of our attitudes about suicide have changed over the years, there is still a stigma and discomfort associated with mental illness and suicide in our society and suicide survivors are often

left to grieve in secrecy, silence, and shame. Seguin and colleagues (1995) found shame to be unique and central to the experience of parent suicide survivors. Shame affects parenting of other children in the family and hinders interactions with family, friends, and other people, often limiting their support and increasing their isolation. The tendency to blame themselves or others is often intertwined with this sense of shame, and can be influenced by the reactions of others (Alexander, 1991; Worden, 2002).

Along with their painful feelings of grief, many suicide survivors experience a sense of relief when the death occurs that the severe stress they have been living with has ended. The relief suicide survivors experience differs from the relief individuals bereaved by chronic illness experience. Whereas survivors mourning the death of a loved one who died due to a chronic illness may experience relief that the deceased's physical suffering has ended, suicide survivors experience relief that the emotional suffering has ended for them and the deceased. Furthermore, whereas the reaction of survivors of chronic illness is viewed as acceptable (Clark & Goldney, 2000), the reaction of suicide survivors is cloaked in guilt (Aurthur, 2002). Parent suicide survivors experience relief for some of the following reasons: their child's emotional suffering has ended; the suicide threats and/or attempts have ended; their constant, and in some cases lengthy, worrying, suffering, and struggles with their emotionally disturbed and/or substance abusing child have ended; and/or, that they can return to a calmer and more normal family life (Clark & Goldney, 2000; Esposito-Smythers et al., 2004; Jordan, 2001; Seguin et al., 1995). Although several researchers have described the relief suicide survivors experience, none of the studies have examined this reaction in detail, limiting our understanding of this complex reaction.

Researchers have found that in the case of death by suicide guilt feelings can be seriously exacerbated (Robinson, 2001; Seguin et al., 1995; Sprang & McNeil, 1995; Stillion, 1996). Severe guilt is one of the most commonly reported reactions among parent suicide survivors (Aurthur, 2002; Barrett & Scott, 1990). Miles and Demi (1991-92) compared the guilt experiences of 132 parents, whose child died by suicide (62), accident (32), and chronic disease (38), and found that 92 percent of parents bereaved by suicide reported experiencing guilt feelings, compared to 78 percent of accident bereaved parents, and 71 percent of chronic disease bereaved parents. Furthermore, 34 percent of the suicide bereaved parents reported that guilt was the most distressing aspect of their grief. Parents experience guilt for not having discerned their child's suicidal risk, for not preventing the suicide, for thinking they may have contributed to the suicide, for inadequate parenting, for the breakdown in their communication and relationship with the deceased, because of the content of the suicide note, for the sense of relief they experienced after the death (Clark & Goldney, 2000), and for beginning to enjoy life again (Robinson, 2001). Guilt is further intensified if the suicide happened in the context of some interpersonal conflict between the deceased and the survivor, and can sometimes be manifested as blame that is projected onto others (Worden, 2002).

Suicide survivors are more likely than survivors of other deaths to experience an overwhelming sense of responsibility for their loved one's death, believing they caused it or could have prevented it (Bailley et al., 1999; Barrett & Scott, 1990; E. Silverman et al., 1994-95). Since parents are responsible for raising and protecting their child, they are often left questioning their competency and credibility as parents when their child commits suicide (Seguin et al., 1995). Their sense of failure, accompanied by their fear

of another possible suicide in the family, can cause parents to feel incompetent to take care of their family and parent their surviving children.

Suicide survivors often feel blamed by others, blame themselves, and/or blame others for their contribution to the deceased's death. Society tends to blame parent suicide survivors for allowing their child to commit suicide (Nelson and Frantz, 1996). However, sometimes survivors' perception that society will blame them is expected, rather than a reality (Clark & Goldney, 2000; Robinson, 2001).

Suicide survivors are at increased risk for involvement in life-threatening behaviours (Jordan, 2001; Murphy, Tapper, Johnson, & Lohan, 2003; Seguin et al., 1995). Many fear their own self-destructive impulses and seem to carry with them a sense of fate or doom (Worden, 2002). E. Silverman and colleagues (1994-95) compared suicide bereavement to other forms of bereavement and found that suicide survivors scored significantly higher than all other bereavement groups in their tendencies to engage in self-destructive behaviour. However, although suicidal ideation was commonly experienced among them, serious suicide attempts and completed suicides were less common. Suicide survivors' suicidal thoughts may represent their desire to be reunited with the deceased, to complete unfinished business, or they may be linked to their depression or to their loss and meaning in life (Clark and Goldney, 2000).

Suicide survivors often engage in a more difficult and enduring search for an acceptable explanation of the suicidal death, than survivors of other types of death (Kalischuk & Hayes, 2003; E. Silverman et al., 1994-95; Worden, 2002). Trying to understand why their loved one chose to end his or her life can preoccupy survivors for months, and even years, and may entail going over and over all the details of the days,

weeks, and months leading up to the suicide, the deceased's state of mind before the suicide, external pressures the deceased may have been experiencing (Clark & Goldney, 2000), their relationship and communication with the deceased, their actions and the actions of others, the suicide note, if one was left, and books on suicide (Wertheimer, 2001). However, in spite of their enduring quest for answers, they are seldom able to pinpoint the reason/s the deceased took his/her own life. Even when a suicide note has been left, the deceased's thinking processes were usually too distorted to clearly explain the real cause for the death (Robinson, 2001). Several researchers have suggested that suicide survivors' enduring search for answers helps them cope with the impact of the suicide on their lives (Kalischuk & Hayes, 2003; van Dongen, 1990).

Some experiences, such as sensitivity to the mention of cause of death in medical or official reports, concealment of the circumstances surrounding the death, and lying about the cause of death are unique grief reactions common among suicide survivors and logically outside of the experience of most other survivors (Barrett & Scott, 1989). In addition, the bereavement experiences of suicide survivors and, more recently, families with a member dying of AIDS, are often regarded negatively, because of the assumption that the deaths were caused by the individual's disturbed or immoral behaviour (Shapiro, 1994). Furthermore, unlike bereavement due to other causes, where mourners follow established patterns of grief, most suicide survivors have had no experience with suicide, and are left confused, with no traditional social customs to draw upon (Robinson, 2001; Jaques, 2000). Finally, while grieving the loss of their loved one, some suicide survivors worry that others in their family will develop a mental illness or experience suicidal ideation (Robinson, 2001).

Although the real or perceived loss of support from family and friends is commonly considered concomitant with grief, a family grieving over a suicide is given less overt social support than is normal in other bereavements (Hollander, 2001; Moore & Freeman, 1995; Seguin et al., 1995; E. Silverman et al., 1994-95; Sprang & McNeil, 1995). Suicide survivors often report being unable to obtain adequate or satisfying social support, as well has having to face stigmatization and differential treatment by others in their communities (Moore & Freeman, 1995). As a result, many of them have begun turning to bereavement groups on the Internet, where they can communicate with other suicide survivors and give and receive understanding and support (Hollander, 2001).

However, the data does not make it clear whether the survivors actually are given less support, or whether they only perceive a lack of support. Some researchers have suggested that suicide survivors may be creating their own isolation, as a result of the shame and loss of trust they have incurred (Clark & Goldney, 2000; Jordan, 2001). Their tendency to bypass the usual rites of mourning, such as having a wake and public funeral, may also eliminate the social structure they need to help remind them of the important connections that remain in their lives (Alexander, 1991).

Whereas in most other deaths there is typically no stigma attached to the survivor, researchers have found that suicide not only stigmatizes the survivor, but often results in a more negative view of the deceased's family (Bailley et al., 1999; Clark & Goldney, 2000; Grad, Clark, Dyregrov, & Andriessen, 2004; Moore & Freeman, 1995) . The stigma suicide survivors experience may be one of the major reasons that a suicidal death is considered by many to be one of the most difficult losses to endure (Sprang & McNeil, 1995). Stigma sometimes manifests itself as shame in suicide survivors; that is, survivors

may feel tainted by the suicide and as a result experience lowered self esteem, changed relationships, and social isolation (Esposito-Smythers et al., 2004). Moore and Freeman (1995) compared the attitudes of the bereaved, social workers, and members of the community and found that community members were more willing than other participants to identify shame as an appropriate emotion for suicide survivors, and to consider their families to be strange.

Many survivors also feel stigmatized by their religious communities. Until quite recently, suicide survivors were not allowed to have funeral services performed for their deceased, or to bury their loved ones in church cemeteries. However, now, due to their increased understanding about the emotional pain and suffering most people who committed suicide experienced, most religious communities, while not condoning the suicide, empathize with the deceased, perform the funeral and burial service, and offer love and compassion to the survivors (Clark & Goldney, 2000; Rolheiser, 2000a, 2000b; Wertheimer, 2001). Nevertheless, because these discriminatory views were held for so long, many suicide survivors still experience the effects of the stigmatization (Grad, et al., 2004).

Qualitative Studies of Parent Suicide Survivors

Several researchers have recently used qualitative methodologies to investigate families and parents bereaved by the suicide of a youth. Kalischuk and Hayes (2003) conducted a grounded theory study with 11 families who had survived the suicide of a youth and found that family members felt rejected and isolated due to the pervasive silence that surrounds suicide in our society, and as a result experienced a great deal of pain and suffering. Their theory that emerged conceptualizes the grieving, mourning, and

healing of survivors of youth suicide as related, dynamic, and seamless processes that influence their journey towards wholeness. Hollander (2001) collected data from a parent suicide support group and from over 10,000 e-mails from a number of online support groups for suicide survivors and found that although suicide survivors desperately need support to survive their loss, they often feel excluded from the rest of society and perceive their grieving as unwelcome. Indeed, their most common complaints were that they felt pressure from others to stop talking about their loss, to get over their loss, and to return to their pre-loss state, even though they needed to talk about their loss to help them "work through" their loss and reconstruct an identity that included the loss. As a result, many of them turned to other suicide survivors, in many cases on the Internet, who could tolerate talk of grief and loss, where they received and gave support. Finally, K. Dyregrov (2002) investigated 128 parents who had lost a child to suicide by combining questionnaires with in-depth interviews and found that although social support was crucial, parents also needed professional help, such as immediate assistance from trained personnel, long-term follow up, information, and care for their surviving children to help them accommodate to their loss.

Summary

Although researchers concur that most completed suicides are preceded by months or even years of intense stress, research investigating the stress parents experienced before their child committed suicide is lacking. However, by examining two risk factors for youth suicide, mental illness and family dysfunction, we can surmise that most parents experience two concurrent stresses during the pre-suicide period; the stress of parenting an emotionally disturbed and/or self-destructive child as well as stress due to

their own personal problems. The stress implicit in parenting an emotionally disturbed and self-destructive child is further corroborated by the sense of relief most parent suicide survivors experience when their child dies that they no longer have to cope with the stress or their child's destructive behaviour. Studies investigating whether parents of suicidal youth are receiving knowledge of youth suicide and support parenting their suicidal child are also non-existent. However, three related studies (Maine, Shute, & G. Martin, 2001; Mohr, 2003; Peterson, Luoma, & Dunne, 2002) indicate that parents likely lack both.

In contrast to our lack of knowledge about parent suicide survivors' pre-suicide stress, we have learned a great deal about the general area of bereavement. The models of grief proposed by Kubler-Ross (1969), Bowlby (1979, 1980) and Parkes (1972, 1986), and Worden (1991/1992) have increased our understanding of the process of grief and have furthered our intellectual understanding of bereavement. Although they have been criticized for a variety of shortcomings, and fail to address the unique bereavement experience of parent suicide survivors, the models are still viewed as helpful tools. Trained professionals, who are aware that grieving the death of a loved one is a personal and unique experience for every mourner that is influenced by multiple factors, and who view these models as general prototypes rather than fixed and prescriptive formulas, can effectively employ these models in their work with *many* of their bereaved clients.

Researchers have identified a variety of biological, psychological, and environmental grief reactions that bereaved individuals commonly experience. Although researchers disagree about whether or not substantial differences exist between the grief of parent suicide survivors and parent survivors of other types of death, most of them

agree that suicide as a cause of death complicates the bereavement of survivors who are often left struggling with unique grief reactions such as exacerbated guilt, shame, and societal stigma, in addition to the other "common" grief reactions. Many researchers also concur that kinship, in particular parental loss, may have an even greater impact on the bereavement experience of mourners than the cause of death. Thus, a youth's suicide is clearly one of the most anguishing deaths parents must come to terms with.

Although these research findings have added significantly to our understanding of bereavement, researchers have only recently begun investigating the experience of parent suicide survivors. Therefore the literature in this area is quite sparse. Moreover, most of the investigations that have been conducted are quantitative in nature and generalize parent suicide survivors' bereavement experiences. However, the bereavement experiences of individual parent suicide survivors are diverse and cannot be quantified or generalized. Furthermore, when different bereavements are combined together into scales, grief reactions that are unique to parent suicide survivors may be cancelled out (Reed, 1993). Quantitative measures of grief can only assess general aspects of functioning, and cannot uncover some of the unique thematic or qualitative differences associated with suicide bereavement (Dyregrov et al., 2003; Ellenbogen & Gratton, 2001; Jordan, 2001; Reed, 1993). These differences are more likely to emerge in qualitative studies, where participants are free to describe their experience in their own words.

Recently a few qualitative studies have considered parent suicide survivors' perspectives of their loss. However, none of them examined what parents experienced during the pre-suicide period. Thus our understanding of what these parents experience is still very limited and more studies are needed to add to our knowledge of this complex

phenomenon. This current study was designed to address these deficits in the literature. It uses an interpretive qualitative approach to examine the experience of parents bereaved by the suicide of their youth. The specific question it seeks to answer is: "What is the experience of parents bereaved by the suicide of their youth?"

CHAPTER THREE

METHOD

As noted in the previous chapter, my review of the literature found a lack of research examining the experience of parents bereaved by the suicide of their child. Furthermore, most of the studies that have been conducted are quantitative in nature, and although they have expanded our knowledge of this phenomenon, they have not increased our understanding of these parent suicide survivors' experiences. Therefore, to address this gap in the literature, my research question asks: "What is the experience of parents bereaved by the suicide of their youth?" This chapter describes the research methodology and rationale for choosing it, my presuppositions, the participants, the interview procedure, the data analysis, trustworthiness, and ethical considerations.

Design and Rationale

Since my research goal is to gain an in-depth understanding of this phenomenon from my participants' perspectives, I used a qualitative approach to help me answer my research question. The goal of qualitative research is to understand and uncover meaning from the perspective of the person/s involved, and elucidate it through description and interpretation. Furthermore, in contrast to positivist, quantitative researchers, who believe that meaning is fixed, measurable, and can be agreed upon, qualitative researchers believe that meaning is socially constructed by individuals interacting with their world, has multiple constructions, and is always changing. Therefore, researchers seek to understand participants' meanings at a particular point in time and in a particular context (Churchill, 2000; Merriam, 2002b; Patton, 2002; Whittemore, Chase, & Mandle, 2001). This approach is appropriate for my study because my participants' experiences are

embedded in their everyday lives, cannot be separated from their contextual life-worlds, and are in constant flux. Therefore, to obtain an overall, in-depth understanding of their experiences, it was necessary to view them holistically, within their complex system of interdependencies, as they were experienced at the time of the interview (Churchill, 2000; Merriam, 2002b; Patton, 2002).

A qualitative approach is also particularly suited for this study because its designs are naturalistic, inductive, and flexible, without any predetermined constraints or outcomes (Denzin & Lincoln, 2000; Patton, 2002). Meaning is mediated through the researcher, who is the primary instrument for data collection and analysis, and the outcome is a wealth of detailed data (Merriam, 2002b). As a qualitative researcher, I was able to explore parent suicide survivors' experiences by interviewing bereaved parent suicide survivors and asking them open-ended questions, and adapting my inquiry as my understanding deepened and new data emerged. My direct contact with participants also allowed me to use my personal experiences and insights to gain a better understanding of the phenomenon. As a result, I was able to obtain detailed, thick descriptions that captured my participants' personal perspectives and experiences (Churchill, 2000; Creswell, 1998; Merriam, 2002b; Patton, 2002).

Qualitative research encompasses a variety of approaches with many different focuses (Denzin & Lincoln, 2000). Since my primary purpose was to understand the experience of parents whose child committed suicide, I selected a basic interpretive approach that values understanding as an end in itself to uncover commonalities and make this phenomenon visible by providing rich, accurate descriptions of parent suicide

survivors' experiences that contribute to general knowledge about this phenomenon (Creswell, 1998; Merriam, 2002b; Patton, 2002).

Presuppositions

Since researchers are the primary instruments for data collection and analysis, and since it is impossible for them to eliminate their biases, they must identify them and monitor them so that readers of the study can determine how they shaped the collection and interpretation of the data (Merriam, 2002b). While conducting my research, I continuously engaged in a process of self-reflection to ensure I was aware of my prejudices and assumptions about the phenomenon I was investigating. I also discussed my thoughts, feelings, reactions, and changing perspectives with my supervisors and colleagues, and wrote them in a journal in an attempt to make them explicit, and to help me stay neutral to the content that emerged during my data collection and analysis. Finally, I included a short reflection about my experience of engaging in this research as part of the discussion, in Chapter Six, to enable those who read my research to assess the validity of my interpretations in relation to my frame of reference (Angen, 2000; Churchill, 2000; Hein & Austin, 2001; Meadows & Morse, 2001; Mertens & McLaughlin, 2004; Moustakas, 1994; Patton, 2002; Ray, 1994; van Manen, 1997).

Like many other qualitative researchers, I investigated this phenomenon because of my deep interest in it both professionally and personally (van Manen, 1997). As a psychologist, I have worked with suicidal clients and their families, and have conducted a comprehensive review and analysis of the literature on youth suicide, which examined prevalence rates, methods, risk factors, prevention, intervention, and postvention to gain more insight into the phenomenon (Snihurowych, 1997). I have also worked as a part-

time suicide prevention worker for a community crisis line. Personally, I experienced the pain of suicide when several members of my extended family committed suicide. My experiences have acquainted me with the despair of suicide survivors, and have motivated me to try to understand this phenomenon.

I came into this study with certain preconceptions about how parents whose child committed suicide would experience bereavement. As a parent, I have often experienced feelings of guilt and inadequacies while raising my children. Therefore I expected parents whose child committed suicide to feel that their parenting had been inadequate and to experience exacerbated guilt. The literature reports that most suicide survivors experience stigmatization and that it is one of the most difficult aspects of their bereavement. Therefore, I expected the parents I interviewed to indicate this also. Finally, my feelings as a parent, and my contact with bereaved parents led me to believe it would take a long time to come to terms with your child's suicide, therefore I expected the bereavement of these parents to be protracted.

Participants

Since my research goal was to understand the meaning of this phenomenon from the perspective of the participants, I employed purposive sampling; that is, I chose participants from whom I could learn a great deal about this phenomenon. My participants were intentionally sought because they met essential criteria for inclusion in the study (Merriam, 2002b; Palys, 2003). These essential criteria were that the participant was a mother or father of a child between the ages of 10 and 24, who committed suicide at least one year ago and less than ten years ago; desired to understand the nature and meaning of this phenomenon; was able and willing to share details of his/her personal

experience with the researcher at length; and allowed the researcher to tape-record and publish the data in a dissertation and other publications (Moustakas, 1994; Osborne, 1990a). The criterion of one to ten years after the suicide was included to ensure parents were not in shock and had at least one year to work through their grief, or were not experiencing difficulty recalling details due to the passage of time. Beyond these criteria participants were also selected on the basis of their ease of accessibility and willingness to participate.

After I received ethical clearance from the Education and Extension Research Ethics Board (EE REB) at the University of Alberta, I contacted two directors of community support networks in two large western Canadian cities, informed them about my research, and asked them if they would be willing to pass on my information and my telephone number to bereaved parents who fit my criteria, and who might be interested in participating in my study. Both of the directors agreed to do this. One of the first parents to contact me told other parents about my study after I interviewed her. In total seven interested participants phoned me and expressed interest in participating in the study. An eighth participant expressed interest in participating in the study when I met him at his home, while interviewing his wife. I had not met any of the participants prior to our first contact.

The number of participants required in a qualitative investigation varies. The researcher needs as many participants as it takes to illuminate the phenomenon (Osborne, 1990b). The size of the sample is influenced by the scope of the study, the nature of the topic, and the quality of the data. Fewer participants are needed if the scope is narrow, the topic is clear, and data obtained from participants is rich and useable (Morse, 2000).

The final number of eight participants was deemed sufficient for this study because data saturation had occurred and variation was both accounted for and understood (Patton, 2002).

Participants were six mothers and two fathers ranging in age from 38 to 52 years old, who had been bereaved between one and eight years by the suicide of their child, who was between the ages of 15 and 24 years old at the time of death. At the time of the interview, five participants were married, two to each other, one was separated from her husband, one was divorced and recently engaged, and one was divorced and had ended her engagement. All the participants had other children, and three participants had grandchildren. Their level of education ranged from grade 11 to post-secondary education, and at the time of the interview five participants held full time jobs, two worked part time, and one participant was not working due to posttraumatic stress disorder.

Interview Procedure

When interested parents first contacted me by telephone, I informed them about the purpose and nature of the research, the voluntary nature of their participation, confidentiality, their right to withdraw at any time, and the time commitment involved. I also told them that if they had any concerns, as a result of the interviewing process, I would provide them with a list of reasonably priced counselling services. Then I conducted a short telephone interview with them to determine whether or not they fit the essential criteria for inclusion in the study (see Appendix A). Once it was determined that the parent was an appropriate candidate for the study, an interview was arranged. I asked parents where they would be most comfortable being interviewed, and encouraged them to select a place where they could talk freely, with a minimum of distractions. One

participant chose to be interviewed in her office, and all the rest decided to be interviewed in their homes. Before our interview, I sent participants a letter reiterating everything we discussed (see Appendix B).

Data were collected through audio-taped, in-depth, unstructured interviews with each participant. One couple, a husband and wife, were interviewed together. Hearing each others' responses appeared only to enhance the interview. The seven interviews ranged in length from one and a half to five hours, with the five hour interview taking place on two separate occasions. Before beginning the interviews, I again reiterated the nature of the research, and reminded participants that their participation was voluntary, and that they could opt out at any time. I also discussed confidentiality with them and informed them that all personal and identifying data would be removed to ensure their anonymity. After answering any questions they had, I asked them to sign the consent form (See Appendix C), and then turned on the tape recorder.

Prior to data collection, I spent some time developing rapport with participants to establish an atmosphere of authenticity, acceptance, and trust. I explained my interest in the topic both as a psychologist and parent, disclosed some of my personal experience with the phenomenon, and gave participants an opportunity to ask me questions if they wanted to. This created an environment where parents felt free to share their experiences, one in which I could capture the nuances and meaning of each parent's life from his or her point of view (Osborne, 1990b). Once rapport and trust had been established, I invited parents to tell their stories in response to open-ended questions with minimal structure, so that parents' experiences could present themselves as spontaneously as possible. At the same time, I was careful to be disciplined by the fundamental question that prompted the need for the interview in the first place (van Manen, 1997). I also tried not to "lead" parents and to bring as few presumptions and preconceived structure to the study as possible, to ensure the focus of attention was on the perceptions and experiences of the parents. However, I probed once in a while to encourage parents to elaborate or

clarify their experiences (i.e., asked about the specific instance, situation, person, or event they were talking about). In addition, I employed prompts related to specific aspects suggested from the review of the literature, when parents came to closure on specific points that they were describing (Patton, 2002).

I prepared a general interview guide for guidance and reference during the interview (see Appendix D), and asked these questions, if they had not been covered during the interview, when parents finished sharing their experiences with me. I watched parents carefully during the interviews for non-verbal cues and made note of them (Osborne, 1990b; Patton, 2002). At the end of the interview, I encouraged parents to write down anything important that they may have forgotten to mention during the interview, and to contact me if they had any new information. Some of my interviews lasted much longer than my participants or I had anticipated because most of my participants appreciated having an opportunity to talk about their experience, and seemed more relaxed and less inhibited as the interview progressed. Indeed, several times when I shut off my tape recorder, because I thought the interview had ended, I had to turn it back on again because participants continued to share important information. After my interviews, I audio-taped my description of the time and setting of the interview, as well as my feelings and reactions.

I transcribed the interviews from the tapes onto computer files. While transcribing one of the interviews I realized that I had accidentally taped over part of it, so I phoned the participant and she consented to redo that part of the interview over the phone. After carefully transcribing the interviews verbatim, I phoned my participants and asked them if I could send them copies of their transcripts to give them an opportunity to add information if they wanted to, and clarify any misunderstandings that might exist to ensure that the transcripts accurately represented their experiences (See Appendix E). All the parents agreed to do this. However, one parent found her transcript too painful to read, and returned it unread. All the other parents made some minor changes, updated me

on their current situations, and indicated that the transcripts accurately represented their experiences.

Data Analysis

My data analysis was influenced by Colaizzi (1978). First, I read the transcribed interviews several times to immerse myself in the data, and acquire an overall sense of parents' experiences. Then I identified and extracted significant statements; that is, phrases or sentences that revealed particular aspects of the participants' experiences of the phenomenon, and eliminated repetitions. Following this, I paraphrased each excerpt to clarify its underlying meaning, and then formulated a theme from each paraphrase that captured the participant's meaning. As Colaizzi (1978) noted, this step required me to draw on my creative insight and take a precarious leap from what the participants said to what they meant. However, although I had to go beyond what was given in the original data to discover and illuminate the hidden meanings of the investigated phenomenon, I made sure the meaning remained true to the original data. Following this, I clustered the identified themes together, according to meaningful relationships, under one heading, into higher order clusters, and wrote a descriptive paragraph for each cluster to capture the meanings included in that cluster. I also listed variations in the themes separately. Everything up to this portion of the analysis comprised the "within person analysis" for each participant (Churchill, 2000; Colaizzi, 1978; Creswell, 1998; Giorgi, 1975; Hein & Austin, 2001; Merriam, 2002b; Mertens & McLaughlin, 2004).

Following the within person analysis, I engaged in second order thematic clustering, or "across person analysis" to uncover the commonalities in participants' experiences. First order thematic clusters were gathered for all participants, and re-clustered based on meaningful similarities in experience. As a result of this analysis, four second-order themes emerged that reflected the common experiences of parents bereaved by the suicide of their child. To validate this second order cluster of themes, I referred back to the original protocols and asked myself if there was anything contained in them

that was not accounted for in the cluster of themes, and whether the cluster of themes proposed anything which is not implied in the original protocols (Churchill, 2000; Colaizzi, 1978; Creswell, 1998; Giorgi, 1975; Hein & Austin, 2001; Merriam, 2002b; Mertens & McLaughlin, 2004).

Trustworthiness of Data

The following strategies were employed in this study to ensure it was conducted in a rigorous and systematic manner: (a) member checks; (b) peer review; (c) reflexivity; (d) adequate engagement in data collection; (e) maximum variation; (f) audit trail; and (g) and rich, thick descriptions (Merriam, 2002a, p. 31).

As I noted earlier, after I transcribed the interviews verbatim, I sent them to my participants to give them an opportunity to read them over to ensure that they accurately represented their experiences. Then I incorporated all the changes and new information participants provided into the transcripts before analyzing the data.

As a graduate student, I have the peer review process built into my dissertation committee. I have worked closely with my dissertation committee throughout this study, and have discussed raw data, emerging findings, and tentative interpretations with them. In addition, I consulted with members of my dissertation study group, and with several of my colleagues.

Since the researcher is the instrument in qualitative research, the trustworthiness of the data depends to a great extent on his or her skill, sensitivity, competence and rigor (Patton, 2002). To ensure my findings authentically represent the phenomenon I investigated, prior to engaging in this investigation, I engaged in critical self-reflections to become aware of my assumptions, beliefs, and biases regarding this phenomenon, and recorded my experience with this phenomenon and my presuppositions about what I expected to find once the study was under way. While engaged in this study, I continued

to monitor myself and described my ongoing thoughts, feelings, and reflections in a journal, and discussed them with my supervisors and colleagues (Hutchinson & Wilson, 1994). Finally, to help the reader understand how this research impacted me, I included my reflections in the discussion chapter.

To ensure I obtained an in-depth understanding of the phenomenon under investigation, I interviewed participants until my findings felt saturated; that is, I began to hear the same things over and over again, and no new information surfaced.

To obtain maximum variation, I included both mothers and fathers, who were at different stages in their bereavement, and who differed in the amount of time they had been bereaved by the suicide of their child, who differed in age from the other deceased children. This allowed information that was rich in both scope and depth to emerge.

I carefully documented my audit trail and have provided the reader of the study with a detailed explanation of the methods, sample, procedures, and decisions I made in carrying out the study so that he or she could reconstruct the process by which I reached my conclusion, and to demonstrate that my results are dependable and consistent with the data collected.

In qualitative research findings are considered valid and inspire confidence when the argument in support of the findings has been persuasive (Churchill, 2000; Polkinghorne, 1989). I have provided the reader with rich, thick descriptions to support my interpretations and to persuade him or her that my findings are trustworthy (Creswell, 1998; Merriam, 2002a; Sparkes, 2001; Whittemore et al, 2001). After reading these rich, thick descriptions, my reader will gain a greater understanding of the experience of parents whose child committed suicide. As van Manen (1997) noted, "a good description

that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way" (p. 39). Finally, my rich, thick descriptions will allow the reader to determine if the findings in this study resonate with his or her own experience and if they can be transferred to his or her particular situation.

Ethical Considerations

A trustworthy study is one that has been conducted in an ethical manner (Merriam, 2002a; Whittemore et al., 2001). Due to the highly sensitive nature of the information participants were asked to share for this investigation, ethical precautions to protect participants were paramount. To ensure the well-being of participants in this study, I employed the following steps:

1. Ethical clearance to conduct the study was obtained from the Education and Extension Research Ethics Board (EE REB) at the University of Alberta.
2. Participants were ensured confidentiality, and their privacy and anonymity was protected by assigning them pseudonyms, and altering or removing all identifying information. Participants were informed that their names, addresses, and telephone numbers would only be known to the investigator. This information and the audio-tapes of their interviews will be carefully guarded until they are destroyed.
3. All participants were informed that participation in this research is completely voluntary and that they had a right to refuse to participate or to withdraw from the study at any time without suffering any withdrawal of services, or any other

repercussions. After a complete explanation of the research purpose, process, and reporting of the results by the investigator, participants were asked to sign an informed consent form (see Appendix C).

4. Due to the highly sensitive nature of my research, I obtained a list of low-cost counselling referrals that I could refer my participants to if the need arose.
5. It was my hope that participants would benefit from participating in this research, and most of them indicated that they found it helpful/beneficial to talk about their experience. They also had the satisfaction of contributing to research that has increased our understanding of this phenomenon. In addition, all participants will receive a copy of the dissertation.

CHAPTER FOUR

AN INTRODUCTION TO PARENTS AND THEIR CHILD

Eight parents, who were willing to share their experience of losing a child to suicide, were interviewed. Two of these participants, Kate and Bill, were married to each other, and were interviewed together. All the parents described their bereavement experiences within the context of their history as well as their current situation. This chapter presents brief narratives of parents and their child to provide the reader with a sense of what parents experienced before the suicide of their child. The details parents provided randomly throughout the interviews have been complied chronologically to ease the readability of these narratives. Names and identifying information have been altered to protect the anonymity of parents and their families. For the purpose of clarity, I have provided the following list of parents and their child before proceeding on with the narratives.

Parent/s	**Child**	**Child's Age at Time of Death**
Alice	Lynn	16
Ann	Jesse	19
Sally	Anthony	20
Kate and Bill	Scotty	24
Sharon	Benjamin	15
Andy	Kris	18
Terry	Dawn	16

Alice

Alice, who was 52 years old at the time of the interview, was the youngest of five children. She was born and raised in a small community in Western Canada, where her father worked seasonally as a carpenter, and was often unemployed, and her mother as a cook and chambermaid. Later, when an influx of workers came to their community, her

mother also took in laundry from 40 or 50 migrant workers to help make ends meet. As a result, Alice and her siblings were often left to fend for themselves.

Home was often a frightening place for Alice, where she never felt safe. Her parents argued a great deal, and her father physically assaulted her mother. Alice once even witnessed her uncle "slapping her mother around." In addition, Alice was sexually abused by her two older brothers for many years. When she turned 13 years old, she realized this was not normal behaviour, and was absolutely devastated. However, she could not get her brothers to stop. She began to experience shame, guilt, and fear of being found out--feelings so unbearable that she shut down emotionally so she would not have to deal with them.

She proceeded through life feeling distant from her family, and lacking any close relationships, other than the sexual one with her oldest brother, which, she now realizes, fulfilled her need at that time to be loved and cared for, since she did not believe that anybody in her family cared about her. As she grew older she also became a scapegoat for things that went wrong in her home, further eroding her feelings of self-worth.

When Alice was 20 years old she met her husband, the gentlest person she had ever met, and someone she really felt safe with. They got married right after she completed her Nursing Assistant training, and then she began working in a hospital.

After seven years of marriage, and several months on fertility drugs, Alice became pregnant with their first child. Although her pregnancy went well, her baby died soon after birth, due to a lack of oxygen. However, Alice was convinced that her difficulty conceiving and her baby's death were punishment for her sexual abuse. She went back on fertility drugs and became pregnant with her daughter, Lynn, who was born when

Alice was 28 years old. Although Alice was thrilled, she was convinced Lynn was going to die of crib death. Therefore, she was elated when Lynn made it through the first year. Still, her feeling that Lynn was not going to be with them long persisted. When Lynn was four years old, Alice gave birth to her second daughter, Pebbles.

Alice embarked on parenting feeling incompetent, inadequate, lacking confidence, and with a poor self-image. She stayed home to raise her children, and they became her "life." Although she was unaware of doing this, to ensure that her children grew up feeling competent, confident, and with good self-esteem, she involved them at an early age in numerous activities, such as swimming, gymnastics, dancing, music, skating, ballet, ringette, piano, Brownies, and Girl Guides. In hindsight, she realizes that they were too busy and stressed.

> I wanted my kids to have the opportunities to do things. To help them feel competent. I didn't know that's what I wanted for them, but that's what I really wanted for them, so that they would have some confidence, cause I had none. I had no self-esteem. And I really wanted my kids to feel that they were capable of doing things. So they started things really early. . . . [Although] Lynn was fairly keen to try new things she didn't want to skate. . . . When she was little I would drag her to the skating rink and she'd sit down on the ice, so I'd skate and leave her sit, and didn't realize that she was saying, "enough already, I've got enough on my plate." I didn't understand anything about stress at the time. I just thought that we were doing all this stuff because it was fun, and didn't realize that she was probably very stressed.

She also realizes now that she was very stressed chauffeuring her children to all their activates, serving as a Brownie and Guide leader, starting a Parent Advisory Committee in their school, in which she stayed involved, and helping out in her children's classrooms.

> I was just the superest mom, because I believed that I needed to be involved. My parents were not involved with us, and I felt so awful about myself. So if I'm involved with my kids maybe they'll feel better.

When Lynn was in grade 2, Alice attended a meeting at her school about how teachers should discuss sexual abuse with children. Her own feelings were triggered by a picture depicting a shadowy figure entering a child's room, and Alice went into a depression for a couple of years. During this time she twice lost control and raged at her children, screaming and lashing out. Once, when Lynn would not practice her piano, she hit her with a skipping rope, leaving welts on her body. Alice said she was so out of control that if there had been a hammer lying there she probably would have used it. She can still recall the terror in Lynn's eyes. She felt devastated by what she had done. As a youngster she had been punished with a razor strap or belt and had vowed never to do that to her own children. Later, when Lynn went to school, Alice felt suicidal, and hid in the basement all day waiting for child welfare to come and take her away. However, by the time her husband arrived home from work, she had calmed down and everything appeared to be back to normal. Alice now realizes that during her depression, although she still did things for her family, she felt resentful and victimized. She also believed that she was crazy, but was afraid to go for help, because she feared losing her children. So she kept her depression a secret from her husband and everyone else.

Alice's daughter, Lynn, was a "a really neat kid . . . a very, very empathetic person . . . very sensitive, [with a] wonderful sense of humour." She began French Immersion in grade 1, as part of a cohort group of 26 children, and continued on through junior high and high school with the same group of students, who became her good friends. She enjoyed elementary school, and did really well in it. She also loved learning a new language.

> My kids really loved the languages. That's one gift, I guess, that I did give them, the opportunity to do that. [They] were both very fluent in French. . . . When Lynn got in junior high it was German. She went into German as well.

However, once Lynn entered junior high she began experiencing a great deal of stress in school. As a student in the French Immersion program, she experienced the resentment some of the English teachers bore towards her program because of its smaller class size and "cream of the crop" students. In addition, she had two teachers, one in grade 7 and one in grade 8, who were cruel to her, humiliated her, and reduced her to tears. Furthermore, she often felt like the recipient of the anger teachers felt towards her mother, who was very involved in her school and made "big waves" about the lack of services, appropriation of grant money, and teacher hiring practices. Finally, as Alice noted, Lynn often felt victimized, helpless, and the recipient of her mother's anger.

> I taught her how to be a victim really well. But I didn't know that at the time. . . . I can only teach her what I know. And I taught her basically how to be helpless. . . . I think she felt very much like a victim. She would come to me and tell me, and I'm saying, "*Well, what can I do about it?*" You know I've done this, and I've done this, and I can't do anything more about it." So I think she believed I was angry with her.

Grade 9 was a much better year for Lynn. She was involved in the drama club, which she loved, and had a wonderful drama teacher. However, when she entered grade 10 her school stress increased significantly. Once again, she had a teacher that "was really detrimental to the kids," and she missed 16 out of the first 30 days of school, due to stomach aches, headaches, and stress related illnesses. Alice sought help and support from the school counsellor and the grade coordinator, but received no direction from them. Meanwhile, Lynn continued to struggle with her teacher.

> Lynn would come home with stories that would make your hair curl. She would say, "Mom . . . [my teacher] really changes." I said, "What do you mean she changes?" "Well, . . . she'll be talking to my friend, and she'll turn around to me

> and her face changes, her voice changes, everything changes, and she's just awful. And then she'll turn back and she's sweet as pie again." And I'm going, oh yeah, right. So I keep thinking, what is it about Lynn that evokes all this negativity? And so, I figure well it's all her problem." (After Lynn's death Alice witnessed this teacher's behaviour exactly as Lynn had described it.)

By the end of grade 10, Lynn and her classmates were getting failing grades from this teacher, so Alice asked Lynn to consider transferring into the English program, to avoid being taught by her for the next couple of years. However, Lynn refused because she wanted to take French in university. So even though Alice felt wearied by the situation, she agreed that Lynn could continue on.

In November of grade 11, Lynn attempted suicide at school. She brought all the pills she found at home to school and swallowed them there. Then she told a friend what she had done, so her friend arranged to have her taken to the hospital. Alice was shocked by Lynn's suicide attempt, and upset by the lack of help and support they received from the hospital staff.

> I was sure this was nonsense. I went to the hospital and I realized, no, this has happened. . . . My husband . . . met us there. We talked to the doctor, and all that the doctor said to Lynn was, "Now are you going to talk to your parents?" And I kind of went, what? There was nothing, no recommendation, who we could see, or what this was about. The nurse just told me, " Don't ever have Tylenol around, because if she takes Tylenol it won't kill her, it'll just kill her liver."

Lynn refused to discuss her suicide attempt with Alice and her husband. Alice informed Lynn's principal about the suicide attempt and asked him to tell the teachers, to ensure Lynn received the help and support she needed at school. Then she immediately arranged for Lynn to be seen by a psychiatrist. However, when she arrived at the psychiatrist's office with Lynn, she was disturbed by the unprofessional and unethical conduct she witnessed there. In addition, she found the psychiatrist unhelpful and

unsupportive, and her advice that "16-year-old Lynn should have more fun by going to bars" inappropriate.

Next, Alice arranged for Lynn to seen by a psychologist. After Lynn had six individual sessions with the psychologist, they began having family sessions. However, Lynn's condition continued to deteriorate and she talked about suicide. She also began wearing black clothes, instead of her usual blue jeans and t-shirts, which to Alice signified her internal distress. Alice tried hard to monitor Lynn after her suicide attempt. However, she felt frustrated because she was getting conflicting advice from her doctor and psychologist about Lynn's medication, and lacked the information she needed to make the best decision about Lynn's care. As Alice's fear that her daughter would commit suicide increased, she became overly protective, and Lynn reacted by becoming more distant and angry.

> So in the home at this point . . . I was just like the mother hen, very over-protective, very worried. Wanted to know every move Lynn and Pebbles were making. Where they were all the time. Just really over-protective. . . . [Lynn] just wanted space. Was really starting to become more and more distant. Wouldn't want me to touch her. Would not want hugs. Wouldn't want me to ask her anything. She would . . . react usually with anger. . . . I saw more and more fighting with Lynn and Pebbles. It was kind of escalating. You know little things would bother Lynn; she'd retaliate by hitting or whatever.

Even as Lynn's mental health deteriorated, her stress at school increased. Instead of support, she experienced negativity, lack of understanding, and lack of support from her teachers and school staff. As soon as Lynn began private therapy, the school counsellor informed Alice that she ethically had to back out, leaving Lynn without counselling support in school. When things became too stressful for Lynn, and she excused herself from the classroom, as Alice had advised her to do, her teacher construed this as disrespect, and became "*livid.*" Although Alice had informed the principal that

Lynn feared being alone when she was too stressed to stay in the classroom, she was often put in a room by herself. Even though Alice had immediately informed the principal about Lynn's suicide attempt and asked him to inform the teachers to ensure Lynn received nurturing, understanding, and support, he failed to inform the staff. Finally, although she really persevered during her emotional struggles and worked hard to get three assignments done, her teacher wouldn't accept them, because "they weren't up to her potential."

> Lynn really persevered and worked hard and she got three assignments done, and handed them in. The teacher wouldn't accept them, because they weren't up to her potential. *Chokes me to this day*. . . . [Lynn] was just devastated. . . . So I got a phone call from the school counsellor. . . . "Could you come to the school right away and get Lynn?" . . . So I ran over to the school, and Lynn had finally calmed down. But I guess she was hysterical, because this teacher wouldn't accept these assignments. So the school counsellor said, "Take Lynn home and don't bring her back. . . . The next few days, just before Christmas, we're not going to be doing anything. Take her home and just let her chill out, and come back . . . in January. . . . She just isn't in very good shape right now. . . . I think we're going to see if we can get her exempt from exams. . . . There's just too much pressure for her."

When Lynn returned to school, during her absence, to exchange Christmas gifts, she was confronted negatively by three or four teachers.

> I dropped her off at this kid's entrance, and then I drove around over to the front entrance and I went to the office to tell them that Lynn was there, was going to be there for the hour. I guess by the time I got to the office, she had already been confronted by three or four teachers, "Oh we thought you were sick. What are you doing here? We thought you were so stressed out you couldn't be here. What are you doing here now?" I mean that's the kind of treatment . . . this depressed kid was getting from adults. It just blew me away. No one was nurturing her at all.

Lynn's condition seemed to improve during the Christmas holidays, but deteriorated when she returned to school. Although Lynn and Alice had been informed before Christmas that Lynn would likely be exempt from writing exams, the week before

Lynn completed suicide Alice and her husband were asked to attend a meeting at the school where they were informed that Lynn would have to write them.

> [I said], "we were told she was going to be exempt from exams." [The principal] said, "Well no, that's never been discussed." I'm looking at the school counsellor, and she's kind of got a confused look on her face. . . . She's not speaking up. . . . So [I said], "So what's this all about?" "Well we need to talk about Lynn and her exams that are starting on Friday." *I felt defeated.* I looked at my husband. I was just about in tears.

During their last family counselling session, Lynn talked about being suicidal and her suicide plan. She also asked her mother to have her admitted into a hospital. So Alice phoned their doctor and asked for his help.

> Lynn had been to the doctor the day before, and he had upped her medication, because she wasn't sleeping well. . . . So we're in counselling on this Friday night. She's telling them she's very suicidal, wants to kill herself, and how she's going to do it. Well I'm a basket case. I phone the doctor the next day and I tell him Lynn has asked me to get her into a hospital and she's saying she's suicidal. He said, "I just saw her yesterday. She was fine. . . . I can't get her in." . . . I'm just a wreck all weekend. I don't know what to do.

The day before her suicide, Lynn attended school and talked to some of her teachers. After school she went to her part-time job at the swimming pool, and then stayed after work to visit with her friends.

> Tuesday she went to school dressed in her black, and . . . . when she [got] to school she changed clothes and . . . wore colours. . . . She went to the math teacher and said good-bye. . . . The teacher said, . . . "I want you to know Lynn came and said good-bye to me that day. . . . I thought it was a little unusual, but I didn't make anything of it." . . . I think she thanked her and said good-bye. But you see Lynn was that type of kid. I mean she was just a nice kid. So it wouldn't have been really out of character for her to go do that. . . . Then I believe she went and said something to her German teacher as well, and the German teacher commented to her how nice she looked that day. Then after school Lynn went to work at the pool, and she phoned home and said she was going to stay longer, because she wanted to see a bunch of the kids she hadn't seen for a while. And of course, my husband and I are quite happy about this.

That same day Alice, who had been confronted by her children about her anger during their family counselling session two weeks earlier, and as a result had engaged in some "soul searching," attended a private session with the psychologist and disclosed her sexual abuse.

> We went to counselling on the 8th of January, that's the anniversary of our first baby's death, and the kids are saying, "Look at how angry she is" to the counsellor. "Look at how angry she is.". . . I'm sitting there and I'm saying, "I'm not angry." "*Look at her. Look at how angry she is.*" I said, "I'm not angry.". . . So the counsellor [said], "Well, what are you angry about?". . . I said, "I'm not angry." "*She is too, look at her.*" . . . Then I started to get annoyed. I said, "I'm not angry . . . today is the 18th anniversary of our first baby's death and I'm feeling kind of sad today." . . . Anyway, we talked about that, and they said, "No, she's angry." So I went home, and for the next week that played on me, and I really had to do some soul searching. . . . I finally thought, I need to talk to him because if my kids are seeing me as angry and I'm really sad what's going on? Cause I was confused. So I phoned him and I said, "Remember when you talked about how we hide secrets, and how we stuff them inside and we take them out every once in a while, then we put the lid back on and stick them back in?. . . Well, I've taken the lid off, and I can't get the lid back on. Will you see me?" So he said, "Yeah." So the Tuesday, that would have been the 21st of January, I went and saw him alone, and I finally disclosed. . . . about the sexual abuse and [said],"Could this be why I'm angry? Could this affect me?" . . . It was so awful. I was so ashamed. . . . It was just horrendous to say this. I could hardly cough the words up. . . . I didn't tell him very much at all, but at least it opened the door.

Alice returned home after her session with the psychologist feeling "absolutely drained." Then, because her husband and children were not going to be home for a while, she accepted her friend's invitation to go out for coffee. When she returned home at about 8:30 that evening her husband was still not home, and Lynn and Pebbles had just finished having "*one ripper of a fight.*"

> Pebbles was crying and really upset, and Lynn was sitting downstairs in her chair listening to CDs. Pebbles said, "I wish she would have died when she took pills the last time." I put 12 year old Pebbles to bed, and lay down with her and cuddled her, until she calmed down. She just vented how much she hated her and wished she was dead, how mean she is and on, and on, and on. I tried to explain to Pebbles that Lynn's feeling so powerless that she's the only one that she has power over right now, and that's probably what she's doing is wielding her power

> over her. That's all I could say to her. I rubbed her back, and just let her talk, you know, vent some of the anger she was having. And so I fell asleep. But before I went to bed I thought I've got to go check on those pills. I've got to go check the pills. When my husband came home I woke up, and right away I thought *Oh my God Lynn*. I ran downstairs, and she was just sitting there listening to music. I said, "Lynn . . . you have to come to bed. I want you to go and get ready and get into bed." She wouldn't let me touch her, wouldn't let me hug her, or anything. Once in a while she was just like that. . . . She went to bed. I was just exhausted and I went to bed, and my husband came to bed. . . . I never did look at the pills. . . . I never even thought of them at that point. Totally forgot.

The next morning, Alice went into Lynn's room at 7 o'clock to wake her up and found her dead.

> Usually she'd sit straight [up] in bed, and this time she didn't. I walked over to her and I said, "Lynn," and I touched her and she felt cold, and she slept on a [very warm] queen-sized waterbed. I thought *she's dead. Do I have the courage to turn the light on*? . . . So I went over to the light switch and I turned the light switch on, and there she was. Her eyes were half open, and her mouth, and she had one hand across her body, and all the blood had pooled in her body. So she'd been dead for quite some time. . . . [I saw her alive at] 11:30, and this was seven in the morning. She had rigor mortis already. She was very stiff. I went in to Pebbles, and I said, "Pebbles, Lynn's dead."

Lynn committed suicide in 1992 at 16 years of age.

Ann

Ann, who was 45 years old when she was interviewed, was 18 years old when her oldest daughter, Jenna, was born, and 20 years old when she gave birth to her twins--her son, Jesse and her daughter, Sarah. Although she was a young parent, she had experience with children, having grown up the oldest of five children. Ann was always a very easy-going person and never had any major disagreements with her parents, who dealt with problems by talking about them. She also never witnessed any arguments or visible conflict between her parents. Her husband, on the other hand, came from an argumentative family, full of conflict, strife, and punishing behaviours. The downside of

Ann's conflict-free upbringing was that she felt unprepared to deal with the arguments that arose between her and her husband.

Ann's husband worked long hours, so she was the children's primary caretaker.

> My husband worked lots, and I spent a lot of time with the kids myself. . . . Our home life . . . was good except my husband worked an awful lot, and he did drink somewhat in . . . our beginning years, but he was dealing with his background also. But there was never any violence. He never used any violence towards us. . . . He left the child raising more to me, because of his background. . . . He's never verbalized it, but I think he just thought that I had a better background then he did, and I would do a better job. . . . [I think he was afraid that he would] . . . . hurt his kids like his parents did him.

Ann's son, Jesse, had a happy childhood. Although he was quiet, he was also outgoing, and had lots of friends that he liked to tease and joke around with. He also liked to play street hockey, ride his motorbike, fish, camp, and party with his friends. He was gentle and loving with children, and enjoyed spending time with his nieces and nephews. He also liked going to work with his father, and learned how to run different machinery, such as a D6 Cat or backhoe, at an early age. Once he got into grade 9, he began working during the summer for his father and other farmers in the area. In high school he excelled in woodworking and mechanics courses. His friends admired his knowledge, maturity, and independence. However, Jesse was always very sensitive about criticism, and Ann always had an intuitive feeling that he was troubled.

> I always had this funny feeling that Jesse was troubled . . . since he was probably in the younger grades. . . . Actually the girls thought . . . he was my favourite. . . you know how kids are with each other. But . . . I always had this intuition thing.

Things were pretty normal until Jesse began attending school. He had difficulty learning and got frustrated, because he was not able to catch on to things the way the other students did. In grade 2, he was assessed and diagnosed with a reading disability, and placed in Special Education classes, which he attended throughout elementary, junior

high, and high school. Jesse did not mind attending Special Education classes. However, he found it stressful when, in grade 6, his family moved from the city to the country and he had to be bussed to a school in town, while his sisters attended a local school.

> Up to that time . . . they were [all] in the same school. . . . And once we moved out here, the Special Ed was in a separate school altogether, so he had to get bussed into [town], and the girls went to the local school out here. And that would be when I'd say that problems maybe started, because he was separated from the girls, plus it was the move, and because up to that time we had lived in the same house and the same everything, and he had to find new friends and kind of be on his own more, when we moved here.

Ann noticed that Jesse became moodier, angrier, more sullen, and spent more time alone in his room. However, because he was entering his teen years, she initially attributed these changes to his stage of development.

During this time conflicts that had begun between Jesse and his father when he was around 10 years old escalated. They had difficulty communicating, Jesse seldom got any recognition from his father, and his father did not like having his friends in their home. When Jesse entered high school, he became even more withdrawn, and Ann discovered he was using marijuana. She and her husband tried to warn him about the dangers of drug use, but Jesse felt they did not understand, and told them it "mellowed him out." Then when Jesse was 17, he had a "blow out" with his father, and moved out of the family home.

> I think he just got to the point where . . . . he felt like it was too much, I guess. . . . I was asking him questions . . . . Like what were you doing last night, or were you doing drugs? Because . . . on an acreage we do our yard work and stuff on a weekend and he would be really uptight and miserable. . . . He found a way out. One of his friends said that he could live there. So he had a blow out with his dad one day, and packed all his stuff and moved out. . . . Joe said to me that he almost felt like hitting Jesse. He said it got to that point, and you could see on his face that he didn't want that to happen. He said that their relationship was getting that bad.

Ann wanted Jesse to come back home, and felt frustrated that his friend's parents allowed him to live in their home, because they felt that she and her husband were too strict. Eventually, Jesse returned home for a couple of months, and then moved out again. During the next two years he moved four or five more times, living with various family members and friends. His relationship with his father remained strained.

A few months after Jesse's first move he quit school and went to work for a man his parents considered a bad role model. However, Jesse looked up to him because of the recognition he received from him.

> He went to work [as a labourer] . . . for a guy who sold plastic. . . Jesse was very good at hard labour, and mechanical things. . . . This guy was into drugs a lot, and Jesse looked up to him, like he was a hero, or something. Like it was unbelievable how much he thought of this guy. The rest of us could see that he was . . . a really bad influence. But . . . Jesse did get pats on the back and stuff from him for the good work he did. So I think that was a lot of it. Like he did get recognition.

Even though Ann never had any conflicts with Jesse, he never phoned her after he moved out of their home, and hardly ever came home to visit, even when he knew his father would not be around. So, to maintain contact with him, Ann phoned him, drove by his residence once in a while, and "snuck in a visit" if she saw his vehicle there. However, although Ann could communicate easily with most people, she often found it difficult to talk to Jesse because of his mood swings.

> Jesse experienced mood swings. Sometimes he was in a good mood and sometimes . . . he'd just be all grumbly. . . . he didn't want to talk, he didn't want to be bothered, he didn't want you to ask questions.

After a while, Ann accommodated to Jesse's mood swings by phoning him when she knew she could handle his bad mood, without letting it affect her.

Ann said that she never realized that Jesse was depressed or experiencing suicidal ideation. After he left home, when she occasionally saw him, she did not notice any overt signs of depression or suicidal ideation. She attributed his grouchiness and mood swings to his personality, and his new lifestyle to him "doing his own thing."

> To tell you the truth, I thought he was going through the same thing his dad had gone through at that age; His dad went on his own, and he did a lot of partying and stuff. I didn't really see the depression part then. I just thought he was doing his own thing.

Furthermore, Ann said her mother had passed away one year before Jesse did, so she may have been too preoccupied with her grief to notice Jesse's deteriorating condition.

Meanwhile, Jesse's mental health continued to deteriorate. He avoided his former friends, and began to socialize exclusively with a small circle of substance abusers. He also began using cocaine, sleeping a great deal, and displaying signs of paranoia.

> Towards the end he started going to see a doctor. . . . [about a] problem with his prostate. His doctor did a bunch of tests and . . . . sent him to a specialist . . . because Jesse wouldn't believe him that people get enlarged prostate sometimes from running equipment. . . . His doctor [said he was] kind of paranoid. He couldn't convince him that it wasn't something that he should really worry about. Jesse had it in his head that he had cancer . . . . or AIDS, or something. He kept on asking to get tested. Paranoia is one of the side effects, I guess, of doing drugs. . . . . And actually some of his friends said that he . . . thought [they] were against him.

Ann last saw Jesse a week before he passed away. They had a wonderful visit and conversation that left Ann feeling very hopeful.

> We went for coffee at the A&W, and we had the best conversation we've ever had. . . . Usually most of our conversations always ended up about him and his dad, and he always got [a] really tight mouth and tight fists. . . . This conversation. . . was just like talking to one of my girls. Stuff flowed back and forth, and he never got upset about anything. . . . It was really different. I told him that if there's. . . ever anything he needed to talk about that he could talk to me about anything. He just kind of laughed and said, "Oh yeah Mom I can talk to you about anything." Like not really sarcastic but . . . I guess he must have thought that there were things he couldn't talk to me about. But I tried to tell him

> that he could talk to me about anything. . . . We visited for probably close to an hour. We talked about a lot of different things, and he was just so open. I came away from it feeling really good (crying), like things might change. . . . And that's the last time I talked to him.

One week later, Ann found herself crying in church. Although she continued on with her day, Jesse weighed heavily on her mind. She had tried phoning him a couple of days before, and had left messages, but had not heard from him. So, later that afternoon, she drove by his place, and saw the police there.

> I walked up there and the policeman's face turned a funny colour when I told him who I was and why I was there. He asked me to wait at the front, and then one of them came out and told us what happened.

Jesse committed suicide in 1995 at the age of 19, one month before his 20th birthday. He shot himself through his chin with a gun, and was dead for three or four days before he was discovered by one of his roommates.

Sally

Sally, who was 43 years old at the time of the interview, grew up the third of four children. Her mother died when she was 13 years old, and her father, who was physically abusive, remarried several times.

> [My dad] married quite a few times after that. That was another reason I didn't want to be divorced. I didn't want to be like him in any way. . . . My mother was very loving. My mother was the opposite from my dad. My mother was . . . strong in her own way, even though she was very soft and quiet. . . . My dad was [physically] abusive. . . . My older brother, in particular, really got it. I mean it was a hammer on the head. It wasn't just minor. It was pretty abusive.

Sally married young and had two children, Anthony, and Krista. Her priority was to be a good mother, and not to be anything like her abusive father. When Sally's daughter turned 13 years old, the same age she had been when she had experienced the

traumatic loss of her mother, Sally began re-experiencing anger and trauma from her childhood.

> I remember when my daughter turned 13, which was probably the most traumatic time in my life. I remember having all these feelings. And I remember going for long walks with my older sister, who remembered. I blocked out a lot of my childhood. I don't remember it. And I'd go for walks, and I'd ask her about this, and ask her about that, and just talked a lot about it. She was 18, so there's a huge difference in what you experience, I think. I felt the anger coming back again, and I thought, oh my God. . . . But I talked to my older sister about that, and we hashed out a lot of our childhood. And that was really good for me.

Sally's son, Anthony, had a normal childhood, and was raised in an intact home, with no overt conflict, abuse, alcohol, or drugs. Anthony was popular, attractive, very quiet, and very bright. He was diagnosed as gifted, excelled in school, and once won a prestigious award for Math. Sally enjoyed a very close relationship with him.

> We were extremely close, him and I. Like we were probably the closest, even though I'm really close with my daughter, but he and I were probably closer.

Anthony was "a really good kid" until about grade 9, when he began drinking and using drugs. Initially, Sally was not overly upset about his substance abuse, because he was not using any of the harder drugs. However, she became concerned when, at the end of grade 8, he once consumed so much alcohol that he had to be hospitalized for alcohol poisoning.

> I knew he was starting to get into the drugs a bit, and smoking and drinking. He actually had one episode where he went to the hospital for drinking. This was [at] the end of grade 8, just before grade 9. He drank so much that he had to be hospitalized, like he had alcohol poisoning. . . . . Didn't realize he was going to get drunk that fast. Didn't feel it right away. . . . He was drinking straight alcohol. So he was hospitalized for that. And that was sort of when I started to realize that there might. . . [be] some problems. But I thought well, let's, you know.

Then Sally noticed a dramatic change in Anthony when he was around 16 years old. He increased his consumption of drugs and alcohol, and began to hang around with

"*really bad kids.*" Sally felt resentful that Anthony was purposely choosing the negative environment she had worked so hard to overcome. She also became alarmed by his mood swings; sometimes he was extremely disrespectful and defiant, and other times he continued to be the loving person that he had always been. During this time Anthony experienced a severe depression, so Sally consulted with their doctor and arranged counselling for him.

Sally and her husband often differed in their parenting approach. For example, they disagreed about buying Anthony a car when he was 16 years old.

> He was spoiled. I have to admit. We bought him a car, and he hadn't worked for it, and I was kind of upset with my husband at the time. I said he should work for half of it. We shouldn't just hand it to him. Plus at that point I knew that there were some problems with the drinking, and I knew that there were drugs. I said, "This isn't what we should do. I don't think this is right. You know you're handing him something that I don't think he should have."

Then, after Anthony "wrecked" the car they bought him, Sally was upset that her husband lent him his car to drive his friends home, even though Anthony was using drugs and acting in a very disrespectful and defiant manner. Finally, even as Anthony's mental health deteriorated, and Sally grew increasingly concerned, her husband denied there was a problem, and attributed Anthony's behaviour to adolescence.

Anthony continued to self-destruct, and at the age of 17 he attempted suicide.

> He went into the car and turned it on and had the garage door closed. He didn't have a hose into the car the first time. . . . My daughter, found him both times. And *he knew* that she would find him. . . . She came home and she phoned me at work, and she was pretty distraught, as you can understand, and then I . . . phoned the ambulance, and . . . I got there in time to be with him in the ride to the hospital in the ambulance, and my husband, at the time, got there as well.

Sally was shocked and horrified by Anthony's suicide attempt. Although she knew he was having problems, she had not realized how "truly bad" things were until he attempted suicide.

The psychiatrist at the hospital told Sally her son might be gay, so she talked openly with Anthony about being gay, and reassured him that it did not matter if he was. But, as it turned out, Anthony was not gay. Then she arranged for Anthony to be seen by a counsellor. However, Anthony convinced the counsellor that everything was fine. Sally tried to get Anthony to open up about his problems, but he refused to discuss them with her, or anyone else. She approached Anthony's school counsellor for help when Anthony decided to quit school, but found him unsupportive. Then when Anthony quit school, she enrolled him in an adult education high school program, and drove him to school every day, only to find out later that he simply turned around and went back home. Anthony believed that his life was ruined, and Sally was unable to convince him that he could turn it around.

> He was also very self-critical. He wanted to succeed, and I think he felt like he trashed his life and now he'd ruined it. And he couldn't get out of it. I said, "Anthony you can always get out of it. . . . . You don't have a criminal record. There isn't anything permanent. You can go back to school at any age. It's just easier if you're younger. . . . Just do something in life, even if you work part-time, or full-time, and then go back later."

Sally did not understand how debilitating depression could be, and why her son could not go to school, work, or do something, even part-time. Because she and her husband did not know what to do, they "virtually gave him a year of doing nothing without bugging him."

After Anthony's suicide attempt, Sally lived in constant fear that he would commit suicide. Outside of two family sessions they had with a nurse at the hospital, where her son was treated, Sally was not provided with any help or support. She phoned her son's psychiatrist four or five times, but he refused to talk to her, citing confidentiality. Sally was horrified that he would not help her. She hoped he would give her some ideas, or some information on depression, because she lacked the knowledge she needed to help her son, and did not know what to do. She searched desperately for help, and contacted numerous community resources. She even tried to get Anthony into the military, and looked into having him arrested, or forcibly committed into the psychiatric ward of the hospital--anything that would help him turn around. However, everyone she talked to informed her that Anthony had to want help before they could help him.

Meanwhile, Anthony continued to self-destruct, and Sally discovered that he was selling drugs at work, and from his home.

> He self-destructed something awful. . . . He had a job at the Co-op, and he wouldn't show up. He was selling drugs, where he was working. . . . His boss . . . was selling them with him. . . . He was selling them out of my house too. . . . I didn't know that till about 2 or 3 months. He'd say, "Somebody's coming to pick up a tape, or this or that." I said, "Anthony, people don't come by to pick up tapes and spend 5 or whatever minutes." So I went to look. We had a crawl space. And he had a bunch of bedding against there. . . . I mean I'm not dumb. And I confronted him on it.

The stress affected the entire family. Anthony and his sister fought constantly, and she reacted to his negative behaviours by withdrawing from normal teenage activities. Sally and her husband, who had gradually drifted apart over the years, separated. Her husband, who was very angry about the separation, and blamed his son for causing them so much stress, reacted by getting a one bedroom apartment, which prevented his children from living with him, further escalating the family's stress. Finally, about one month before Anthony's suicide, Sally gave him the "tough love ultimatum":

> You can come home if you go to school, or you're working full-time, or . . . you promise you will be in a rehab or something. You will have made something on your own. You can come back home. But right now you've got to move out.

Anthony moved in with two friends that were "*really good* people," who were willing to help him in any way they possibly could, and Sally and her husband paid his rent.

Sally had a strong premonition that something was terribly wrong the day Anthony died.

> It was a Friday. But you know I had this feeling, and I was phoning home all day, from work. Just a horrible feeling. I kept phoning home, and I'm thinking why am I phoning home because there's nobody at home. . . . It was horrible. I kept thinking, I know something's wrong. I had that feeling the first time too. . . . I was phoning home, and I was thinking, why am I phoning home, cause logically there's nobody home. He doesn't live at home. My daughter's at school. There's nobody at home. I even thought of going home. Then there's a part of me that goes, I don't want to face anything. I don't even want to go home. So that night I didn't want to even go home. . . . It was really strong.

That morning Anthony drank a lot of alcohol, consumed mind-altering drugs, and then went over to Sally's garage. To ensure his suicide would be successful this time, before turning the car on he taped up all the joints in the car, to prevent the air from entering in.

> [His sister came home and found him] And he was dead. He had a beer in his hand, and the car was still running. . . . She opened the garage door, and turned off the motor, and took the beer out of his hand, cause she didn't want anybody to find him that way.

Anthony died in 1999 at the age of 20.

Kate and Bill

Kate and Bill, who were both 51 years old at the time of the interview, got married when they were both 18 years old, and had four children. Kate's first experience with suicide occurred when her father committed suicide more than 35 years prior to this interview. Her mother denied that it was a suicide, and the children were not allowed to question her about it, speak about their father, or grieve his death.

Scotty, their eldest child, did not experience an average childhood. He had a hearing problem, which limited his vocabulary, until the age of eight, when he was finally considered normally fluent. At the age of three, he had fluid drained from his ears, and attended a children's hospital three times a week for speech therapy. Kate, who did not drive at the time, accompanied Scotty on the bus to his speech therapy, with her two younger children in tow. Eventually, her friend took care of her two younger children, while she and Scotty travelled back and forth from his speech therapy. Then, when Scotty entered grade 1, he began receiving speech therapy in school.

Scotty experienced stress and instability throughout his schooling. Shortly after he entered grade 1, Kate was informed that he was unruly and a troublemaker, and would have to attend school elsewhere. She was surprised to hear this about Scotty, because she knew him to be very considerate, and protective of other children.

> He wasn't there for more then 3 months and all of a sudden the school was having an interview with me. They told me that Scotty had to go to school somewhere else because [he] was too unruly. He wouldn't listen. He was totally a troublemaker. I said, "Huh"? I don't know. He doesn't strike me that way. . . . Because any kids that he was around he would protect from everything. He was always there helping them. . . . He was a very, very considerate kid.

Kate believes that the principal of Scotty's new school must have been unduly influenced by the report he received from his previous school, because when Scotty got involved in a fight with another youngster, he was the only one that was reprimanded.

> I guess the principal must have paid a lot of attention to this warning that came from the other school. . . . A fight broke out, and Scotty was in it, and so was this other kid. Well Scotty was the one that was reprimanded. And this principal was . . . one of these principals that did literally pick you up and give you a damn good shake. . . . . Anyway, Scotty shook from that time every time that principal was around him.

In grade 2 their family moved to another area, and Scotty began attending another school. However, the principal Scotty feared was transferred to his new school, so Scotty spent another two years with him. Finally, in grade 4 Scotty was transferred to another school that he enjoyed attending. The staff there described him as "calm and happy-go-lucky," and could not believe he was the same boy that they had received a report about from his previous school. However, part way through grade 5, Kate was informed that Scotty would have to be transferred to another school, because he was sexually advanced compared to the other children.

The school Scotty was transferred to did not provide classes for his grade, so he went from grade 5 to grade 8, and attended there until he completed grade 12. Scotty had some problems with the other students in this school "because a lot of them were real troublemakers, and . . . were trying everything in the world, and he wasn't. He had lived [a] fairly sheltered [life]." Academically, he just managed to pass his subjects.

Kate volunteered and actively participated in her children's schools, and in her community, serving as Block Captain for the neighbourhood Block Watch program. However, she was unable to be as involved in Scotty's school because of its distance from her home.

Bill recalled some of Scotty's mischievous tendencies, his developmental lag in abilities, and some of his strengths.

> When he was a youngster he was a little mischievous. There was a point in our old house where we actually almost had to lock him up at night because he'd get up in the middle of the night. . . . One night he got out a can of paint and he painted the kitchen floor. . . . . He had mischievous tendencies. He'd get something in his mind and take off in that direction. He was comical at times, of course. . . . . He was a slow learner, because of his early speech problem, and maybe it was just . . . *him*. . . . . He wasn't Einstein. He didn't have the developmental abilities of say his brothers, or his sister, academically. . . . But he also had abilities that they haven't achieved as far as working towards a goal, and saving, in that same respect. He was very good that way. . . . I guess you could say [he had] a sense of innocence in that he had a deep regard for Santa Claus. . . . I think he was 7 and he left out milk and cookies for Santa Claus, cause he really thought Santa was coming down the chimney, cause we had a fireplace.

Scotty was compassionate, caring, and family oriented. He openly demonstrated his love for the people he cared about, and went out of his way to support them. He loved building models, and spent countless hours with his school chum talking, laughing, and putting together huge warship models on a special table he had set up downstairs for that purpose. Scotty also shared his father's interest in old cars, old trains, places from the past, ghost towns, railroads, and history. As well, he enjoyed camping with his family, especially in Nordegg, at the site of an abandoned coal mine and railroad--an area they all loved.

Scotty was also a very responsible and hard worker. He began delivering a city newspaper when he was in grade 4. He was conscientious, did his job well, and received many notes of commendation from his customers. Occasionally, if the family had plans to go somewhere, they all chipped in and helped him deliver his newspapers. But usually, he delivered them by himself. He saved most of his earnings and accrued a large savings account. However, when he was in grade 10, and 15 years old, a fellow student convinced him to spend his newspaper money on drugs, so Scotty had to withdraw money from his savings account to replace the newspaper money he had spent. The second month he had to do this, he decided to quit delivering newspapers. Kate questioned him about what was happening, and quickly and firmly ended his experiment with substance abuse.

Although Scotty was a responsible, hard worker, he experienced stress at the first few places he worked at after completing grade 12. In his first job as a janitor in a service station he was required to climb and clean windows, even though he feared heights, so he quit that job. At his next place of employment at a fast food restaurant one of the workers, bigger and heavier than the rest, intimidated the other workers to do his work, so Scotty quit that job. Finally Scotty got a job at McDonalds, where he did a really good job, and was valued. Scotty enjoyed a very close relationship with his mother, and always consulted with her about his work stresses, and job options.

Scotty experienced several traumatic experiences that Kate believes may have contributed to his deteriorating mental health. When he was 17 years old, and in grade 12, he came home early from school one day, and walked around his house, looking in the windows to see if his mother was at home. A neighbour, who had observed this behaviour, phoned the police, and six policemen arrived at their home with their guns drawn, thinking they were apprehending a criminal. They harshly interrogated Scotty, who got very shaken by the experience. His second traumatic experience involved his solo bicycle trip up to Hay River to hike the 360 km. Canal Trail in May 1991. During this trip Scotty was picked up by intoxicated Natives shooting ducks from their truck windows, rode his bike alongside of carelessly driven vehicles, and had several bear encounters. Although he survived the trip, he never completed his mission, to hike the Canal Trail, and returned home with "*a look of failure about him*."

Shortly after arriving home from his Northern trip, Scotty seemed unable to deal with stress, and was hospitalized for 3 months, and diagnosed with Schizophrenia. He experienced difficulty with the medication he was prescribed, and became very discouraged.

> [Initially] he was over-dosed on [his medication]. The first time I went down to see him [it] was like he had drunk 14 bottles of scotch. He was in another world. He was holding his frame with his arms and rocking. . . . And this is from somebody that never drank. If he drank a bottle of beer it made him pass out. . . . .

> He was in another world totally. He was just comatose. But then they changed that, and when he . . . [came] home on a visit he had the shakes so bad he could hardly hold a cup of coffee, or pop, or whatever. . . . Because they overdosed him. . . . He and his school chum . . . would buy and build models of warships. They did a great job. So for a kid that enjoyed doing these great, huge ships with all the fine little things, all of a sudden he couldn't do them because he was shaking so hard. He tried, [but] he busted them up in his hands. . . . I think . . . [he was] getting discouraged over the whole thing. You know, the last few months he was really going down hill, in that respect. (Bill)

After Scotty was released from the hospital, he re-admitted himself a few times when things became too challenging for him. For example, he returned to the hospital when his youngest brother accused him of sexually abusing him, and threatened to kill him.

> [My youngest son] came to me and said, "I'm going to kill Scotty." And I said, "Why would you kill Scotty?" He said, "Because he sexually abused me.". . . . So I was kind of put in the centre of that heavy duty experience. . . . The next day when Scotty went down to his . . . drop in course [at the hospital] . . . he said, "I'm not going to go home. If I go home I'll be dead, so I'm going to stay here." So he stayed . . . [for] a couple of days. (Kate)

Scotty remained under psychiatric care for a full year, and attended an outpatient program every day. Kate and Bill attended weekly meetings at the hospital to stay apprised of his condition.

However, Scotty's mental health continued to deteriorate, and he talked about suicide.

> He talked about suicide for a whole year. From the time . . . when he was admitted [to the hospital] that was his cry for help. I guess you could say. . . . I think with (his younger brother) he shared, "If I'm not gone on this day I'm going to be gone on this day." . . . But [his younger brother] never shared that with us, until after. (Kate)

Scotty also gathered pictures of himself to ensure his loved ones were left with memories.

> But then there came a point where he started gathering pictures of himself, from childhood up to the present. (Bill) I never knew this. But he actually took those pictures and got them made into other pictures, and stuff like that. He also made a gift for each of his siblings. Had I been aware of that, that's a sign of suicide, when you want to make sure people are left with memories. (Kate)

Although Bill and Kate were aware of Scotty's suicidal threats, they never believed he would actually follow through on them. Bill felt discouraged because he did not see Scotty improve, and was concerned about Scotty's hints that he did not want to live anymore, but the thought of his son actually committing suicide was too unbelievable for him to fathom. And even though Kate lived on "pins and needles" during the last year of Scotty's life, because of his suicidal threats, she never believed he would actually commit suicide. She also believed that his daily attendance at the psychiatric clinic would protect him from acting on his suicidal impulses.

The last time Kate saw Scotty alive he seemed fine, and thanked her for making his favourite meal of lasagne.

> I came home from work, and I made a lasagne, and was going to put it in the oven, and he was all better. I said, "How are you?" "Oh not bad. *Oh my favourite meal. Oh I'm so thankful mom.*" I mean he was fine. He was fine. . . . I phoned the horoscope for him, for his birthday, which was in April. . . . and they said, "You are in complete control of whatever you're going to do. This is your day." And I thought, *wow*, I wish I had one of those days. I got off the phone and I said, "What's up?" And he said, "Well, I've been asked to go bowling. There's a group of youth bowlers. I'm not sure what I'm doing." You know, he seemed *to be fine.*

Kate left for Bingo at about 6 o'clock that evening and Scotty left the house 20 minutes later to take the dog for a walk. He returned home, went downstairs for a while, and left the house again at 20 minutes to 7. Bill saw Scotty leave, but thought nothing of it until two days later.

> I was sitting on the couch watching TV, and he went out the door. . . . The kids were always coming and going. But I happened to notice him going out the door.

> OK, so I guess he's going to the store, or wherever he's going. Didn't think anything more of it until two days later.

Scotty walked over to the school playground and hung himself on the playground equipment—ironically, playground equipment that been constructed in large part due to Kate's involvement and hard work. Two young brothers found Scotty hanging on the climbing apparatus and ran to get their parents. It is uncertain if Scotty was still alive at that point. The boys' parents were occupied and did not pay attention to them until they came home a second time with their news. Then the father returned to the playground with his sons, saw Scotty, and phoned the police. Scotty did not have any identification on him, so the police were unable to identify him. Because of his slight stature, they assumed he attended junior high or high school, and began checking the schools to see if anyone knew him.

Meanwhile, Bill and Kate were becoming increasingly concerned because Scotty had not come home for a couple of days, and Kate urged her husband to contact the police. She phoned Scotty's psychiatric daycare and was shocked to find out that even though Scotty had been suicidal when the staff last saw him the day before, they had let him go home because he had not finalized his suicide plan. That evening the police posted a sketch of Scotty on the evening news, and Kate, Bill, and their youngest son, who were watching the news on TV, found out that Scotty had died. Scotty was 24 years old when he died in 1992.

Sharon

Sharon, who was 38 years old during the interview, never knew her biological father. Her stepfather was very violent, and he and her mother were alcoholics, who often fought physically. Sharon learned to shut down during these crises, handle them, and fall

apart later. She also learned to speak only when she was spoken to. She became the caretaker in her family, and jokes that she raised her mother and her sisters. Sharon experienced suicidal ideation most of her life, but only attempted suicide once, when she was 13 years old. She finished grade 11, and then completed training as a nurse's aide.

Sharon married and had two children, Benjamin and Lisa. Sharon's husband was a violent man, who was especially punitive towards Benjamin, so Sharon divorced him when Benjamin was 10 years old. She and her children seldom saw him after that, even though Sharon encouraged him to have a relationship with his children. Sharon found out after Benjamin's death that he had been fabricating stories about his absentee father.

> We hadn't seen him for 3 years before Benjamin died, or really heard from him. . . . My ex . . . figured it was just best to not be around.. . . I didn't find out until after he died, at the funeral as a matter of fact, that he had told children that his father was rich and lived in France. The only thing close to that is his father's French. Like *that's it*. So I found out that he was making things up, after.

As a reaction to her own upbringing, where communication was discouraged, Sharon raised her children in a climate of open communication and negotiation. She talked openly with her children about many things, including organ and tissue donations, and did not punish them for disobeying if they could convince her, by writing her an essay, that they had valid reasons for doing what they had done. Benjamin's arguments were always so good and convincing that Sharon used to tell him he should become a lawyer. Sharon had a close relationship with Benjamin, and allowed him to make many of his own decisions. She always wanted a son, and Benjamin was her "big boy." He took care of her, advised her, and willingly helped his younger sister, frequently offering to do her chores. Sharon used to tell people: "I was really lucky because he was a *good* kid."

Sharon struggled with depression and suicidal ideation the entire time she was raising her children, and often stayed up late at night contemplating how she could get

out of this life. Benjamin was aware of her suicidal ideation, since she discussed it with others, and sometimes even with him.

Benjamin was a very sensitive, artistic child, who wrote poetry, and had a good sense of humour. He liked people and animals, and was "really good with little children." He was also very caring, and always willing to help others in need. He once offered to move out of his home so that a girl, who needed a place to stay, could move into his home and have his room. However, although he had a few friends he was close to, and a lot of female friends he often counselled—once receiving 14 phone calls in a day from different girls seeking his counsel--he always felt like he did not fit in with his peers. He differed from them with regard to his clothes, his music, and other interests, and experienced "incongruity"; what he was really like versus what he was expected to be like to fit in with his peers. For example, he enjoyed listening to country music, and occasionally even the Smurfs, whereas his peers listened to rap music, or "*heavy, hard stuff*." He also enjoyed discussing the Bermuda Triangle, space travel, and different phenomenon with his grandmother. The difference between Benjamin and his peers had been apparent since his infancy.

> Benjamin had been a little old man since he was 2. He used to wear . . . slippers and old knit sweaters. You take him into a restaurant, no, he didn't want a hamburger and french fries, he'd have some fish and a salad, please (laughs). The waitress would look at him and go, "What? Go figure."

Sharon noticed that Benjamin was experiencing difficulties making new friends after they moved from the west end of the city to the south side, about one year before his death.

> He became depressed because he didn't have the friends he wanted to have. And although he wanted to, he didn't drink, or smoke, or party like the other kids did, because he was a good kid. . . . They were into different music, and he wanted to fit in. Even though he had a few friends in the west-end, it was a different crowd of kids. So, he'd finally got into a place where he felt comfortable in the west-end, where now he had to redo everything. And he had kids that used to bug him

> about his hair, bug him about his clothes, bug about this and that. And because Benjamin was a different kind of kid, it was really hard.

In addition, Benjamin was experiencing difficulty in school with academics and sports. Although Sharon realized Benjamin was feeling badly, and considered getting him professional help, she found it difficult to determine if his problems were typical teen-age dilemmas, or serious issues that necessitated psychological intervention. And even though a few weeks before his death Benjamin stated, "Well, I might as well just go and kill myself," Sharon did not take his threat seriously, since she herself had experienced suicidal ideation for most of her life, and had often talked about it.

The day of Benjamin's death was the coldest day of the year, so Sharon allowed him to stay home from school, while her daughter, who had a ride, went to school. Sharon and Benjamin watched a video, drank cocoa, talked, and had a "wonderful time." Then Sharon's terminally ill mother phoned, because she needed groceries and cigarettes, so Sharon left to buy them for her. While she was away on her errand, she received a phone call from her fiancé, who had returned home from work early and caught Benjamin in their room. Sharon dropped the groceries off at her mother's place, and left for home, which was less than 10 minutes away. Before she left, she asked her mother, "Would you please phone my house and tell everybody just . . .hang tight and I'll be there. . . . Like don't anybody flip out." However, although her mother indicated she would call, Sharon reported, "She never did. *She didn't phone my house*."

When Sharon arrived home the house was dark, and she noticed that her fiancé's car was gone. She went upstairs, and found her daughter sitting on her bed colouring. She asked her where everyone else was, and about the encounter between her fiancé and Benjamin. Her daughter replied that she thought her fiancé was in their room, Benjamin

was downstairs, and that the encounter was not unusual—"no big blow up with yelling and screaming." So Sharon went to check her room, and found nobody there and everything in order. Then she went downstairs to talk to Benjamin. When she entered his bedroom, Benjamin was not there, but she noticed that he had left a little table lamp on, and two notes on his bed--a suicide plan and a suicide note. Just as she began reading the second note, the telephone beside the laundry room rang. Thinking that it might be Benjamin, or her mother calling, Sharon ran through the rumpus room and into the laundry room to answer the phone, without turning the lights on. As she reached for the phone, she missed and stumbled, so she reached out to grab the deep freeze that she knew was within arms length to steady herself, and answered the phone.

> When I went to reach out to steady myself, I felt this something. I went, what is this? This is not the deep freeze. And I did it a second time, and it sounds like it took so long, but it was just seconds. Well, just as I picked up the phone, cause it had only rang like a couple of times, *I looked up*. I thought, well this is strange. When I looked that's when I saw Benjamin. . . . Apparently, I had answered the phone at the exact same time. I just *screamed* into the phone and hung up. Flipped the light on, and because of my nursing I immediately, he was taller then me, so I tried to lift him up to undo, he'd used an extension cord. . . . I was trying to hold him up, and untie . . . past him, which . . . doesn't make any sense. I remember thinking, where's that superhuman strength you're supposed to *have*? . . . It didn't show up. Lisa . . . heard me scream, so she came running downstairs. I didn't want her to see Benjamin, so I told her [to] get back upstairs. . . . So she went back upstairs and said, "Do you want me to phone 911?" I went, "Oh, what a great idea." Even though she didn't know what was going on. So she phoned 911. In the meantime I'm still trying to get him undone, and I remember thinking, I can't untie this. I have to go and get a knife to cut this. . . . I remember saying to him, "I'll be right back. . . . I'll be right back." It was so hard just to let go of him to run upstairs. In the meantime Lisa's going, "Mom, they want to talk to you." So she handed me the phone, and I'm looking through the drawer for this knife, and this guy said, "Do you need an ambulance?" I said, "Yes". Like I said, I remembered nursing, it's like give your address twice clearly. OK. So I did that, and said, "I've got to go," and I threw the phone and went running downstairs with this knife. Lisa's like, "What's going on?" I went, "Nothing. Stay up here.". . . So I went running downstairs with this knife, and somehow, whatever I'd loosened, he'd fallen to the floor. So when I went downstairs, I looked up and he wasn't there....but he was laying on the floor, and I went huhu (makes a noise).

> So I quickly got him set up so I could do CPR. I remember the hardest thing was taking that knife and cutting that extension cord from around his neck. It was like when they're babies and you cut the umbilical cord. Strange concept. Lisa was still with 911 and said, "They want to talk to you again." It was like, *do I have time for this*? So I grabbed the phone again, and I'm trying to talk to this guy, while I'm doing CPR. I said, "I can't talk to you. I have to go." He said, "Don't hang up the phone. They're on their way." I went, "Yeah, OK." Again, I just kind of chucked the phone. And next thing I know there was a fireman there, and they took over. I heard people upstairs with Lisa, and she was freaking out and crying at this time. . . . They [told me] to go [and take care of] Lisa, because Lisa was by herself, and . . . . [she] had just turned 11. So I went upstairs.

Benjamin was transported by ambulance to the hospital, and when Sharon arrived there with the police she was informed that he had died. Benjamin was in grade 9, and had just turned 15 years old one month before he died in 1996.

Andy

Andy, who was 49 years old at the time of the interview, grew up in a large, poor family, the second oldest of 11 children, with a father, who was an abusive alcoholic. He helped take care of his younger siblings, and shared a bedroom with three brothers. Andy completed grade 9, went into a trade, and achieved financial success. When he was 38 years old, he completed his high school diploma just to prove to himself that he could do it.

Andy got married when he was 23 years old, and although he initially did not want to have any children, because of his impoverished childhood with so many siblings, he and his wife had four, three sons and one daughter. Their children usually approached their mother, rather than Andy, when they wanted something, and she in turn would discuss their requests with him. These family dynamics were similar to those in Andy's family of origin. Andy was involved in his children's extra-curricular activities when they were younger, and for a while had three children in hockey at the same time.

Andy's third child, Kris, was a "bundle of joy," when he was young. He was well-behaved, smart, happy, and had a good sense of humour--always laughing, and telling jokes and wild stories. He always woke up really early, at about 5 o'clock in the morning, and watched television constantly from morning until night. Kris was very independent from an early age. "He had his own mind. . . . [I] could walk away from him and he'd stand there and not care if he'd ever see me again, even when he was 4 or 5 years old." He was also very popular, and had many friends, and as he grew older many girlfriends.

Kris's behaviours began to change when he turned 14 years old. When he was 15 years old, he once took Andy's car without permission. From that point on he became increasingly stubborn, rebellious, and destructive. He once burned holes on his upper arms to see how much pain he could tolerate. Another time, on his way to church with his mother and siblings, he became very angry, cursed God, and said he would like to die so that he could punch God in the face and not have to go to church anymore. He argued incessantly, broke curfews, "wrecked a couple of cars" that Andy and his wife bought him, received failing grades, behaved aggressively, and was expelled from three schools for fighting. Andy and his wife were bewildered by Kris's destructive behaviours, and met with him and his teacher to clarify their expectations and rules, to try to help Kris turn his schooling around. However, although Kris seemed remorseful for his bad behaviour, and seemed to want to succeed, and said he would try harder, he continued on with his destructive behaviours.

When Kris was almost 17 years old, Andy's daughter informed him and his wife that Kris was using cocaine. Although Andy was upset and concerned about Kris's drug

use, he felt helpless to intervene, since Kris always ignored his counsel. However, Andy's wife confronted Kris about his cocaine use, and tried to warn him about the dangers of substance abuse, but he laughed it off and told her he had only used it once. The stress in their home increased significantly as Kris tried to manipulate them to get money.

> The next couple of months were hell for us . . . as Kris played games with our heads, giving us stories to make us think someone was going to kill him if he didn't give them money, or he was hungry, or he needed cigarettes. Anything to get money. Probably for drugs.

Kris experienced mood swings, and "was like Jekyll and Hyde." He fought with his siblings, and often beat up his younger brother, who idolized him. He was also very cruel, especially to his mother, constantly reducing her to tears, and he and Andy had many physical altercations. Andy went with him to see a counsellor because they were fighting so much, but felt frustrated and unsupported by the counsellor, who informed them about Kris's rights, and Andy's lack of rights. Andy believes the counsellor was too young and inexperienced to correctly assess the situation, and to provide them with any help. Kris became so difficult to live with that Andy and his wife gave him the "tough love ultimatum" several times, and asked him to leave their home until he reformed. However, each time Kris expressed remorse they let him return.

Kris was involved with the police on several different occasions because of his violent behaviour. Once the police were called to restrain him, because he was fighting with Andy on the lawn. Another time he beat up "some kid," was charged with assault, and was incarcerated for five days. A third time the police were called because he threatened his mother and assaulted his sister. They charged Kris with assault causing bodily harm, incarcerated him for a couple of days, set a court date for him to face his

charges, and placed a restraining order against him, so that he was unable to contact Andy and the rest of his family for about 3 or 4 months. When Kris was incarcerated, Andy felt "sick to his stomach" worrying about the harassment he might be experiencing from the other prisoners, and did everything he could to get him out of jail.

> I told [my daughter] to drop the charges if [she could] . . . Cause he was locked up one time, earlier. . . . He was phoning us and he was remorseful, and he wanted out of there. . . . [He said], "Dad the [other prisoners] are picking on me.". . . And I knew exactly what he was talking about because I was incarcerated when I was 18 and 19, that part of my life. They weren't picking on me, but I had to live with them. I *was sick to my stomach*. . . . cause I've seen guys "shaking" rough time in jail. . . . I was just sick. I couldn't sleep. I . . . went to court. [I] would do anything to get him out. I told the prosecutor I want that kid home with me today. So we got him out.

During this time, Andy's daughter informed him and his wife that Kris had been asking her what she thought they would be worth dead, so Andy and his wife began to fear that Kris was going to kill them. Andy believed Kris was capable of harming them, because he liked having money but hated working, and although he received a substantial allowance, it did not compare to the large amount of money his wealthier friends were getting. Andy felt frustrated by his children's dissatisfaction with the comfortable home life and material benefits he had worked so hard to provide them. He began to realize that his impoverished childhood had given him the incentive to get ahead. During the last few months of his life Kris also began threatening to commit suicide. However, Andy did not take his suicidal threats seriously because, at the time, he believed that "those who talk about it don't do it."

Things became so stressful for Andy and his wife that, in an attempt to achieve a more peaceful life, they bought half a duplex for their daughter and youngest son to live in while they attended school, while they, themselves, moved to a town 25 miles away,

and commuted back and forth to work. Shortly after their move, Kris phoned them, seemed repentant, and wanted to resume contact with them. He also expressed resentment that Andy had provided his two siblings with a duplex to live in. So Andy built him a suite in the basement of the duplex, so he could live there without bothering his siblings.

The Friday before Kris died Andy came over to the duplex to work on Kris's basement suite. Kris had just been expelled from his last school and wanted to apply to another school, so he asked Andy for money to pay the school fees. Andy wrote him a cheque, and drove him to the school, so that he could pay his fees. Kris seemed happy that he got accepted into this new school and that he was going to complete his grade 12.

On Sunday Andy returned to the duplex to paint the basement suite and heard Kris arguing loudly on the phone with his girlfriend. However, because he was used to Kris being loud and argumentative, he did not say anything or get involved. Later, Andy's wife phoned, and Kris informed her that he was going to church. Although his wife was pleased, she was very surprised, because Kris had not attended church for the last 3 or 4 years. Kris left for an hour and returned, and, once again, Andy heard him arguing on the phone with his girlfriend. Andy left the duplex at around 5:00 p.m. As he was leaving, he asked Kris, who was watching TV at the time, if everything was OK, and if he needed any money. Kris indicated that everything was OK, and that he had money, so Andy wished him a good first day of school and left.

Later that evening, Kris phoned his girlfriend, using a cordless phone, and told her that he was going to see their baby that she had aborted. So, when the phone went dead, his girlfriend phoned 911 and informed the police about Kris's threat. The police arrived

at the duplex, woke up Kris's sister, and asked if anyone there was trying to commit suicide. She replied that she did not know, and indicated that her brother lived downstairs. The police went downstairs and found Kris hanging in the closet. They tried to revive him, but it was too late. Soon after, Andy and his wife got "the dreaded call" and Andy heard screaming on both ends of the phone. Kris was 18 years old when he died in 1999.

Terry

Terry, who was 47 years old at the time of the interview, got married and had two children, a son and a daughter. Her daughter, Dawn, was a very strong-willed little girl, and very challenging to raise. Even as an infant she was very definite in her likes and dislikes. Dawn experienced a lot of ear infections in childhood, and was treated with antibiotics for them, until she finally had tubes inserted in her ears to prevent infections. She also experienced a kidney infection, for which she was hospitalized, when she was 6 years old.

Dawn had a "heart of gold," and was very affectionate, honest, and always willing to help others. She often counselled her friends, who frequently phoned her and sought her advice. She also had a very strong sense of right and wrong, and was tenacious about maintaining her point of view, if she thought she was right. Terry admired her daughter's strong will, and believed it would protect her from being taken advantage of.

> She had a really strong sense of right and wrong. . . . almost from the time she started school, you know. "No, this is right. This is what I want to do." She was very strong willed, and I always thought that was good, because nobody would get the better of her, and that she would be OK, but it didn't turn out that way.

Dawn was also very smart, and caught on to things quickly. However, she did not apply herself in school, so her marks did not reflect her ability. Nevertheless, if she was interested in an assignment, she worked hard, surfed the Internet, and got very involved in it. Although she did not like to sit in class or study, she liked school, especially the social aspect of it.

> She was a very smart little girl. She didn't study a whole lot in school, but she was very smart. Things came easy for her, I think. Maybe you wouldn't know it by the marks, because she didn't apply herself. If she would, she would've done a lot better. She . . . really liked school, but the studying and sitting in classes disrupted . . . the socialization. She was a social butterfly. She enjoyed being with her friends . . . [more than sitting] in class. If it was a class that she enjoyed, and she liked the teacher, she would do anything for him.

Even though Dawn liked school, she experienced stress throughout most of her schooling. In grade 1 she had a "really bad teacher" who disliked her, informed her early in the year that she would be repeating grade 1, and stopped teaching her. Terry and her husband had Dawn assessed privately and discovered she was working above her grade level, so she was passed on to grade 2. In grade 3 Dawn had to repeat her grade because of her difficulties with math. This time Terry and her husband trusted the teacher, and agreed with her assessment. The year Dawn repeated, another child, who also repeated the grade, continually threatened and assaulted her. Although Dawn complained to her teacher, she was always blamed for the altercations. Finally Terry and her husband went to the school and complained, so they called in the school counsellor, who talked to Dawn and the other child and determined that Dawn was not at fault. Rather, the other child, who was later sent to a special hospital to help him deal with his behavioural problems, had, for some reason, taken a disliking to Dawn.

Terry was an assertive parent, and very involved in her children's schools. She believes Dawn's grade 3 teacher sided with the other child because of her involvement in the school:

> The teachers would always side, for some reason, with the other child. I personally think it was cause I wanted to be involved. I wanted to help the teacher as much as I could, so I would go into the school, and try and help out as much as I could. . . . I think I may have intimidated them.

In addition, Dawn was becoming increasingly more vocal, and standing up for herself. Finally, Terry had always instructed her children that if a problem occurred between them and their teachers they were to give her both sides of the issue, and she would back them up one hundred percent if they were right, and had told her the truth. Therefore, whenever Dawn's teacher phoned her to complain about Dawn, instead of automatically siding with the teacher, Terry asked Dawn about the situation, and often concluded that Dawn was in the right.

Dawn first threatened to commit suicide when she was in grade 4. She pointed a knife at her stomach and said "that she may as well kill herself now because she's so stupid." Terry and her husband consulted with the psychologist who had previously assessed her in grade 1. After talking to Dawn, the psychologist concluded that her threat was serious, and advised Terry and her husband to monitor her carefully, and to be very strict with her, because she was so strong willed. The psychologist had 8 or 10 more sessions with Dawn, and things seemed to improve. Then Terry and her family moved to another city, and Dawn had a wonderful grade 6 teacher, and excelled in school.

When Dawn was 11 years old, Terry and her family went through some very challenging times. Her father-in-law, who her children were very close to, died. Initially, Terry and her husband supported and encouraged each other in their grief, and the entire

family willingly rallied to support and encourage Terry's mother-in-law. However, after the first year, Terry's grieving husband began to withdraw from her, and her mother-in-law grew more needy, demanding, manipulative, and interfering. Terry began to resent the time her husband spent with his mother, away from their family, and a tug of war ensued between Terry and her mother-in-law. During this time, three more beloved relatives died, exacerbating and extending the family's grief. Finally, Dawn entered her teen years, became even more strong-willed, and began "playing" her father against her mother.

> At that point . . . hormones are changing, menstrual cycles are starting, everything is coming on. . . . She's . . . becoming more strong-willed, and she started playing one against the other. . . . mom against dad. You know, trying to play us against each other, and it just kind of escalated, got worse. [My son] would get involved. Robert just didn't know how to handle it.

At school, Dawn experienced problems with one of her junior high school teachers. She witnessed him favouring certain students and acting unethically towards others, so she confronted him about his behaviour, and he reacted by treating her punitively and suspending her from his class. When Dawn told Terry about what had transpired, Terry went to school and met with the teacher, Dawn, and the principal, and confronted the teacher about his unprofessional conduct. Terry also informed the principal and Dawn's teacher that Dawn was not to be suspended for any reason. Rather, if they had any problems with Dawn, they were to phone her and she would come and attend classes with Dawn, to ensure her good behaviour. However, although the teacher and principal both agreed, Dawn's teacher failed to comply with Terry's request. Dawn, who had initially worried that her mother was going to go to school and cause a scene, later bragged to her friends about how her mother had put her teacher in his place.

At home Dawn's destructive behaviour escalated. Her verbal abuse towards her mother progressed to physical abuse. She punched and hit Terry to the point that Terry wore long-sleeved garments in summer to cover up the bruises she received from her. Sometimes Terry hit her back--slapping her in the face. Other times, she tried to withdraw, but Dawn relentlessly pursued her. Dawn was like Jekyll and Hyde; ten minutes after verbally or physically abusing Terry, she apologized to her in tears, was genuinely sorry, and said she did not know why she did it. However, at the time, it never occurred to Terry, who had previously experienced depression, that Dawn may have been acting out as a result of being depressed. Instead, she attributed Dawn's behaviour to her stubbornness and teenage rebellion. Meanwhile, Terry's husband, who did not know how to handle all the stress in his family, ignored the altercations between Dawn and Terry, or sided with Dawn, since Terry was the adult. Dawn's abusive behaviour and her husband's lack of support finally convinced Terry to leave the family home. However, after about six months, she and her husband worked things out and reunited.

Soon after they reconciled, several things occurred that caused Terry and her husband to finally realize that Dawn's behaviours were abnormal. First, instead of just directing her rages at her mother, Dawn began to also direct them at her father. Since Terry's husband knew he had not done anything to provoke these outbursts, he finally recognized that Terry was not responsible for them either. Second, Dawn falsely accused her father of physically abusing her, when, in fact, he had inadvertently bruised her while trying to stop her from assaulting Terry. Third, Dawn once tried to attack Terry with a big kitchen knife, and threatened to hire someone to kill Terry and her husband. Finally, she once told Terry that she felt like she was outside of her body watching herself hitting

her, and screaming at her. When Terry heard this, she realized Dawn might be experiencing serious medical problems. So, when Dawn was in grade 8, Terry and her husband took her to see a psychiatrist.

The psychiatrist diagnosed Dawn with depression, put her on medication for it, and scheduled monthly sessions with her. In addition, they had a counsellor come to their home for weekly family counselling sessions. The medication combined with the family counselling sessions seemed to really help Dawn, and her condition began to really improve. Although she still got angry, occasionally, this was not unusual behaviour for her, since she had been that way since childhood. Because things had improved and were going so well, they decided to discontinue the weekly family counselling sessions. For almost a year before Dawn died, they were a "normal" family again, and their home was no longer a "war zone."

However, one year later, Dawn's mental health began to deteriorate again. In September 1995, Dawn, who had always experienced difficulty with math, was humiliated by her grade10 math teacher in front of the entire class when he handed back her test and commented on her very low score. In November 1995, a couple of months before she died, Dawn attempted suicide by overdosing on her medication. Terry drove her to the hospital, and was appalled by the "horrid" treatment Dawn received there. Dawn was simply discharged as soon as she answered the resident's questions to her satisfaction, with no further recommendations. Furthermore, although Terry tried to tell the resident about Dawn's behaviours, problems, and medication, she was not interested in her input. Lastly, even though the resident had told Terry that she would send a copy of her report to Dawn's psychiatrist, she never did. Terry was also upset about the lack of

support and seeming indifference Dawn's psychiatrist demonstrated with regard to Dawn's suicide attempt.

> I called her psychiatrist the next day and I said, "Do you want to see her?" Figuring that he's going to want to see her that day. He said, "No. When's her next appointment?" It was later that week . . . Thursday or Friday. He said, "No. We can leave her appointment as is. You have the numbers of the crisis line if you need it. We'll see you then." I should've clued in then. That guy did *so many things wrong, just so many things. I was so stupid.* But I believed him. I mean he's the doctor. What do I know? So I let it go. Then . . . when she went to . . . that appointment she just laughed it off, and so he believed her. He wouldn't listen to me. . . . I told him that there were pictures in her diary. . . . of a knife with blood. . . . of a hangman. . . . I said, "Do you want to see these?" . . . "No, not necessary. She said it's not a serious attempt." And he let it go.

The psychiatrist changed Dawn's medication, and told Terry and her husband to increase the dosage if Dawn seemed to be getting worse.

On Sunday, the day before her suicide, Dawn and her boyfriend ended their relationship in what appeared to be an amicable manner. Dawn spent that evening with her mother and father, and they had a really nice time together, talking, joking, laughing, and playing cards. Even so, when Dawn went up to bed, Terry asked her if she was sure she was all right, to which Dawn replied, "Oh yeah mom. We're fine with it. We're friends. Who knows? We're going to take a break, maybe we'll get back together."

The next day Dawn did not have to attend school because they were having finals. Terry looked in on her and said good-bye before leaving for work. She also phoned her later that morning from work, and asked her if she was all right, and offered to come home if Dawn wanted her to. Dawn sounded happy, assured her that she was fine, and told her she studied better when she was not there. At lunchtime Dawn left Terry a message on the machine informing her that she was going to a friend's house, where she spent most of the day. The friend she visited was concerned about her because

she was very quiet, very withdrawn, and seemed down, so he asked her to phone him when she got home, which she did. However, later when he phoned to talk to her again, he was unable to get hold of her. At about 4:30 p.m., her father, who was traveling home from another city, phoned and talked to her, and informed her that he would be home in about three hours. She sounded happy and chipper, told him that she was going out for supper with her mother, and cautioned him to drive carefully. Then at around 4:45 p.m. she phoned her brother, who was attending university in another city. However, her brother did not answer the phone because he had been getting too many phone calls while he was trying to complete a school assignment. Terry left work just after 5:00 pm, drove home, sat in the car and talked to her neighbour for a while, and then went into her house.

> The basement door was open and the light was on. . . . I called. She smoked, but she would never smoke in front of me. It was really cold out, so she wouldn't be smoking in the garage, so I thought she was smoking in the basement. So I went down to check. She had hung herself. (crying) She had taken a metal pipe . . . and put it between the rafters. . . . She hung herself with the brown electrical cord. She was facing the steps. She was wearing my white sweatshirt and her white sweat pants. I thought it was a dummy. So I yelled at her. I ran up to her room, and told her it wasn't funny. She wasn't in her room. . . . so I ran back down, and I tried to untie it. I couldn't untie it. So I had to let her back down. Then I ran to the neighbours, and I told them I needed help, and I ran back to the house. I picked the phone up to call 911, and my neighbour ran downstairs. I didn't warn her. I didn't warn her. She got downstairs [and] there was this horrible scream from my neighbour. She ran to get her husband. All that time that was wasted. You know. If I would've thought. So he came and he said, "Get a knife." That whole time she was just hanging there. (crying)

Terry' s neighbour cut Dawn down and tried to resuscitate her. Then a neighbourhood nurse came to help. Soon after the paramedics, firemen, and policemen arrived and took over. Dawn was transported by ambulance to the hospital, while the

police drove Terry there. When Terry arrived at the hospital a nurse informed her that Dawn had died. Dawn was 16 years old and in grade 10 when she died in 1996.

CHAPTER FIVE

FINDINGS

During analysis 23 primary categories emerged, which have been grouped into four common themes that capture the experience of the parents in this study. The first theme, Experiencing Pre-Suicide Stress, encompasses the stress parents experienced before their child's suicide. The second theme, Experiencing Their Child's Death, consists of parents' experiences from the time they found out about their child's suicide until their child's funeral. The third theme, Grieving The Loss of Their Child, includes parents' grief, along with factors that impacted their grief. Lastly, the fourth theme, Experiencing Personal Growth, consists of the personal growth parents experienced during their bereavement. This chapter presents each of the primary categories within the context of the four common themes. Direct excerpts of interview transcripts are included throughout the chapter to illuminate the themes in the parents' own words.

Theme One: Experiencing Pre-Suicide Stress

As evident in their narratives, all of the parents experienced a great deal of stress before their child committed suicide. Although the factors causing their stress were often interconnected, for the sake of clarity and structure, they have been separated into the following stressors: (a) child's stress and parents' concurrent stress; (b) lack of knowledge about suicide and mental illness; and (c) lack of support.

Child's Stress and Parents' Concurrent Stress

Child's Stress

All the parents recalled distinct turning points in their child's life when they became concerned about their child's negative behaviours or deteriorating mental health. Some parents observed an increase in their child's negative behaviours, while others

witnessed a complete reversal in their child's attitudes and actions; that is, their formerly well-behaved child began acting in negative and destructive ways. However, because these changes occurred while their child was entering his/her teen years, most parents initially attributed them to typical teenage behaviours. On the other hand, Alice ascribed her daughter's debilitating stress to her negative school environment, and Kate and Bill felt that their son's sense of defeat and discouragement was due to his inability to complete his mission to hike a northern trail.

Parents became increasingly concerned, and tension and conflict in their homes escalated, as their child's destructive behaviours intensified. Several parents became distraught when they found out about their child's substance abuse, but felt helpless to stop it. Andy had to endure a "hellish" home life while his son relentlessly tried to manipulate family members to get money for drugs. Sally was horrified to discover that her son was selling drugs at work and from her home. Others found it stressful to deal with their child's withdrawal, mood swings, belligerence, defiance, verbal abuse, or physical assaults. Andy had to phone the police on several different occasions to restrain his violent son:

> One time me and him were having a fight out on the grass. . . . [Another time] he . . . beat up some kids. . . [and] was charged with assault causing bodily harm. [Once he] punched my daughter for fighting over the phone. . . . We had a restraining order against him, cause he threatened my wife. He was just wild. . . . The police locked him up for a couple of days.

Then, when his son became incarcerated for his violence, Andy felt "sick to his stomach" worrying that he might be abused by the other prisoners and did everything he could to get him out of jail. Sally became alarmed when her 16 year old son experienced a severe, debilitating depression:

> He went into severe depression. I had him at the counsellor, and I had him at the family doctor. I mean he wouldn't get out of bed. He was hiding his head under the covers, and wouldn't get out of bed. I knew it was serious. But I also didn't know what to do other then to try to get him into counselling.

Lastly, Kate and Bill became distressed when their 23 year old son experienced an "emotional breakdown," and was diagnosed with schizophrenia, and hospitalized for three months.

During this time, most of the parents were also concerned about the academic, behavioural, and/or interpersonal problems their child was experiencing in school. Some parents viewed their child's school problems as an extension of his or her destructive behaviours. However, Alice and Terry felt that the stress their child was experiencing at school was unwarranted, and contributed to their deteriorating mental health. Both of these parents, who were very involved in their child's school, and challenged school practices they considered unfair or unethical, believed that the hostility teachers felt towards them was often directed at their child, as Alice recounted:

> I could see what was happening in school. I was making big waves. I was going into the school. I was trying not to be too involved in junior high, because she didn't want me to be too involved. I again started a parent advisory committee at the junior high level in that school. The principal didn't really want it, but allowed us to. . . . I'm out fund raising for paper, and I find out that gee the school board got $90,000.00 in grants that year. So I was constantly fighting the system to find out where is the money going? Why aren't there services available, and what's going on? So I was really the catalyst of trying to get stuff going. So, of course, when we got this [inferior] teacher I was angry. I mean was really angry. . . . Very angry because it didn't seem like people were listening. When I made waves at the school, she took the brunt of the teachers' anger that should have been put on me.

Both parents were also outraged when their child was publicly demeaned by her teacher, as when Terry's daughter was ridiculed for scoring 15% on a test:

> Like I said, math was a sore spot. She was taking Math 15, I think. At the beginning of the year he gave a test to see where everybody stood . . . and in front of the whole class his comment, as he's handing out the math test, was, "In all my 25 years of teaching I have never . . . had a student, score this low, 15 percent, Dawn."

Parents' stress escalated as their child's mental health deteriorated. Some of their children began making suicidal threats, causing parents to fear for their child's life, as Kate recalled:

> With Scotty that last year was just pins and needles. You take a step and you think, oh, should I put my foot down. Oh I don't want to put my foot. I'm scared to put my foot down. Is he going to go? Is he going to do this? I mean that is hell. I wouldn't threaten that ever. Because you make a threat like that you're hurting everybody that cares about you.

Three of the children attempted suicide before they died, and their parents, Alice, Sally, and Terry, reacted with horror, shock, and disbelief. After the attempts, they frantically sought help for their child, and lived in constant fear that their child would end his or her life, as Sally described:

> [The psychiatrist saw him] only for those few months that he was in the hospital, and then he quit going. As an out-patient he didn't want to go. And what do you do? My only recourse was that I could have had him put into jail for a suicide. If I said that I thought he was suicidal they'd put him in jail. . . . Or I could have had him put in the hospital in the psych ward for I think 24 or 48 hours. He could sign himself out at 18. I couldn't keep him there. . . . I phoned the Adolescent Recovery Centre to try to get him into that for the drugs and the alcohol. I didn't know what it was, if it was depression, or drugs and alcohol. What was fuelling, what was all of it, both of it. I didn't know what the problem was. . . . I phoned AADAC. I phoned the crisis line. I tried to do an intervention. I had somebody come to the house and talk to my ex and I. . . . We tried to get him into the military. I was searching for anything that could help him, anything that would make him turn around. . . . They said he had to want the help, and I understand that. But I didn't know what to do with him. . . . And he was too old, when he turned 18 shortly after. . . . I tried to do all these things. . . . I had all those numbers at my bedside table. That's how horrified I was for four years (starts crying). Sorry.

Two children also threatened to harm their parents, so in addition to worrying about their child, Terry and Andy also feared for their own safety, as they respectively recounted:

> At times I was scared. I remember telling my sister that if Robert and I are found dead make sure that Dawn gets the help, because . . . she threatened us. She came at me with a big kitchen knife. She threatened to hire someone to kill us. (Terry)

> He had told the other siblings that he was going to kill us. . . . So I had a little talk with him . . . cause I know Kris, he was hard to trust, and he was mean as hell, and he was getting too big for me to fight. . . . Kris would be stupid enough, cause all he had in his mind was money. He knew if something happened to us there's a million dollars worth of assets and insurance money that would come somebody's way. (Andy)

Alice was upset that her daughter's school teacher continued to increase her daughter's stress after her suicide attempt. As her daughter's stress increased so did Alice's:

> The teacher was even harder on Lynn [after the suicide attempt]. I said to Lynn, "Don't get into any fights with her. Whenever the stress is too much just excuse yourself from the room and leave." [She did that] quite often. *Well, that would make this teacher livid*, because Lynn was being so disrespectful. So I could just about claw this teacher's eyes out because of what she's doing to this kid. It's just so detrimental. I went to talk to her and try to get her to back off and take some pressure off.

In spite of parents' efforts to help, their child continued to self-destruct. In some cases, the more concerned and protective parents became, the more withdrawn, distant, uncommunicative, angry, and violent their child seemed to become, and the tension in their homes escalated. Some parents' stress reached a feverish pitch. Sally's health began to deteriorate because of the intense stress she was experiencing. Two parents, Sally and Andy, finally gave their child the "tough love" ultimatum, and asked them to leave their homes until they reformed, although they continued to support them financially. Andy's pre-suicide stress became so severe that even though he is deeply grieving his son he stated:

> If we had to have Kris back the way he was, we'd rather have him where he's at now. You just didn't want to be around him.

In contrast to the other children, Sharon's son did not engage in overtly destructive behaviours, nor was his deteriorating condition obvious. As a matter of fact, Sharon always felt fortunate to have such a "good" son, who was always thoughtful, kind, considerate, and willing to help her and her daughter. However, one year before he

died, his family moved from the west end of the city to the south side, and Sharon became concerned about him because he did not fit in with his peers and was finding it difficult to make new friends.

Parents' Concurrent Stress

During this stressful time with their child parents also experienced other stressors. Andy and Sally, who had worked hard to overcome their own difficult childhoods, and had provided their children with material benefits and good home lives, felt frustrated and angry about their child's ingratitude and destructive choices, as they respectively noted:

> We were a poor family. . . . I was sharing a bedroom with three brothers. I wanted my own bedroom. These guys they get their own bedroom, and whatever they want. They're still not happy. It really frustrates me. I try to bring up my past. . . . They don't want to hear that I had no money when I was a kid. It gave me some incentive to go ahead, because I didn't have nothing. (Andy)

> I thought OK if I do this, and this, and this, my life's going to be OK. Like these things can't happen to me. They're not going to happen to me. I'm not going be like my dad. There's not going be any abuse. . . . And when my son was like hanging out with these really bad [kids], I thought, oh my God that's where I was in life. Not by choice. But why would you put yourself into that kind of situation? . . . I guess I was angry. I couldn't understand. We come from a good home, why would you want to . . . experience that crap? Like you don't need to. I guess if you haven't been there . . . you don't know how crappy it is until you experience it. (Sally)

Ann, who never witnessed arguments or visible conflict in her family of origin, found it difficult to handle disagreements with her husband, who came from an argumentative family, full of conflict, strife, and punishing behaviours:

> I felt like how come we can't be like [my parents who never argued] and, also, when my husband and I did argue, cause he came from an arguing family, I didn't know how to argue (laughs). I had to learn how to do this (laughing).

Alice, who was raised in a violent, non-nurturing home, and sexually abused as a child, struggled with feelings of inadequacy and anger the entire time she was raising her children.

> I really was feeling pretty awful about myself. Never adequate. And I really felt I was a bad mother. If anything went wrong, you know, it was always my fault. . . . I went and saw [the psychologist] alone, and I finally disclosed. . . . about the sexual abuse and "Could this be why I'm angry? Could this affect me?"

Several parents suffered the loss of loved ones during this time. Ann was so engrossed in grief for her mother that she, initially, did not notice her son's deteriorating condition. Terry, who experienced the loss of her beloved father-in-law, had to contend with an increasingly "needy," "demanding," and "manipulative" mother-in-law, and a husband, who "withdrew" in his grief, and abdicated his family responsibilities to help and comfort his mother. In addition, shortly after her father-in-law's death, she suffered the loss of three more beloved, extended family members. Lastly, Sharon was worried about her terminally ill mother.

Several couples were divided on how to parent their struggling child. Sally disagreed with her husband when he bought their 16 year old son a car, without having him pay for half of it, and felt that he acted irresponsibly when he lent him his car, after he wrecked his own:

> He had wrecked his own car, and he wanted to borrow his dad's car to drive these kids home, that *were really not what I wanted him to hang around with*. . . . I said no . . . but my ex, now, lent them the car. I knew . . . . [my son] was on drugs. . . . I was just furious with him. I said, "What are you doing? He's got other people in the car. He's got your car. I mean, he has an accident and the insurance is going to go through the roof. I mean he could get killed." And my ex isn't irresponsible either. I don't know how to explain it cause he's not. But he just looked at him and when he gave him the keys [and] *laughed*. . . . [After my son left] I was really livid. I said, "Christ he could have an accident. How do you know he's even going to come back. I mean he's got your car. I mean, anything could happen." I

> just couldn't believe it. I said, "He *laughed in your face*, he looked right at you. He doesn't respect you."

Terry felt unsupported by her husband, who sided with their verbally and physically abusive daughter against her:

> There was one night . . . that really clinched it, and I decided to move out. She wanted to go shopping, and [I said] . . . "No, you didn't do whatever, and we're not going shopping." "Well you said we could a little while ago." I said, "No. Tomorrow." She got mad, and just *flew off the handle*. Robert's downstairs. He didn't say anything. He would take her side. . . . I was the adult, so he would take her side. This particular time she was yelling and screaming at me, calling me every foul name she could think of. I went up to my bedroom and she came up and slapped me, and punched me. Robert had seen this. I remember calling down and saying, "See what she's doing?" His comment was, "Well you deserved it. Let's go shopping Dawn." . . . So I thought, that's it. I can't handle this. So that's when I decided to leave. You know if he's not going to back me.

Both of these parents also experienced marital conflict. Sally decided to end her "dead marriage" during this time. So her husband, who was "hurt and angry," retaliated by getting a one bedroom apartment, so that neither child could come and live with him, increasing the stress for the entire family. Terry, who felt unsupported by her husband when she tried to discipline her verbally and physically abusive daughter, moved out of the family home for a period of time.

Several parents worried about their other children during this time. Andy was concerned about his daughter, who was also engaging in negative behaviours, albeit to a lesser extent than her brother. Sally worried about the negative impact her son's behaviours were having on her daughter, who was angry at her brother and reacting to his behaviours by withdrawing from normal teenage activities. Lastly, Kate was concerned about her youngest son, who accused his older brother of sexually abusing him.

Finally, several parents experienced bouts of depression during the pre-suicide period. One of these parents, Sharon, was severely depressed and thought about suicide the entire time she was raising her children:

> At the time *I was severely depressed.* And *I* had thought about suicide forever. Easy, 20 years. There were days when, before Benjamin had died, I had sat at my kitchen table in the dark at 2 or 3 o'clock in the morning for a couple of hours, stared out the window, and just kept thinking how could I get out of this *life*. I don't want to do this anymore.

Lack of Knowledge About Suicide and Mental Illness

In addition to being concerned about their child, parents also lacked knowledge about mental illness and suicide that might have enabled them to help their child. Even though most parents recalled a distinct turning point in their child's life when his or her behaviours began to deteriorate, because these changes occurred mainly during the adolescent years, many initially considered them typical teenage behaviours, rather than indications of their child's deteriorating mental health. As Ann noted:

> I never really noticed that my son was ever suicidal. . . . He saw school counsellors in his younger years, but to tell you the truth, I thought it he was going through the same thing his dad went through at that age. His dad went on his own, and he did a lot of partying and stuff, and I didn't really see the depression part then. I just thought he was doing his own thing. . . . Once in a while when you talked to him he was grouchy, and my husband tended to be like that anyway so I thought it was just personality more than anything.

Even parents who were concerned about their child found it difficult to determine if their child was experiencing normal adjustments or psychological problems that necessitated psychological intervention, as Sharon reported: "It was so hard. Like I said, Benjamin wasn't a typical teen-ager. So was it just puberty? Was it just moving?" Sharon also summarily dismissed her son's suicidal threat, since she herself experienced chronic depression and had talked about suicide for many years.

Sally finally realized how serious her son's problems were after he attempted suicide:

> It was horrifying. I think I cried the whole time in the hospital. I couldn't stop crying. I guess I was shocked. . . . I knew he was depressed and I knew he had problems, but I didn't think of suicide. I really didn't think of that. I thought there's a depression. There's a probability of something, but I guess maybe I didn't even want to admit to myself that it could have been a possibility.

On the other hand, Terry finally realized that her daughter required psychiatric intervention after her daughter informed her that she was experiencing depersonalization:

> She had said at one point that it was like she was outside her body watching herself hit me, watching herself scream at me, watching herself. As soon as she said that I thought, wait a minute maybe there's a medical problem.

Even after parents realized that their child was experiencing serious psychological problems, many of them stated that they lacked knowledge about depression and suicide that may have enabled them to protect their child. Andy mistakenly believed that people who talk about suicide do not commit suicide. Others were unable to discern their child's signs of suicidal intent. Kate erroneously believed that her son's daily attendance at a psychiatric clinic would protect him from acting on his suicidal impulses. Finally, because of her lack of knowledge, Sally reacted to her son's suicide attempt and debilitating depression with anger:

> When he attempted the first time I was very angry. I was very angry about how could you do that. I didn't understand it. And I didn't understand how he couldn't go to school, or any thing. Anything, part-time, just do something. I guess I don't understand the degrees of depression. I don't understand how you can be totally debilitated with depression, and he was. It had totally debilitated him. And probably with the help of the drinking and the alcohol, which were maybe what he was using as an aid for the depression. I don't know if that was self-medication. . . . I mean I don't know if he had a drinking problem and that made him suicidal. I don't know which came first. I don't know.

After consulting with mental health professionals, some parents were uncertain about how involved they should be in their child's counselling. Some, like Alice, also felt

frustrated and powerless because they lacked the knowledge they needed to make good decisions about their child's treatment:

> Lynn was back to school in January. . . Holidays . . . it seemed like here's our old kid back again. Got back into school and within the week she was just down again. She was on Desipramine at the time. . . . and the psychologist did not want her on that drug. He wanted her on Prozac. So he's trying to get me to get the doctor to change her onto Prozac. I'm scared of Prozac because I've read all the stuff about Prozac . . . how more people become suicidal with it. So I'm going, why does he want her on that? Of course I knew nothing about these drugs. So again I'm saying, "Why don't you phone him and talk to him and then he can tell you why, because I'm telling you that he's telling me that he wants her on this drug because it'll help her sleep better." I said, "I don't know. I just don't know." . . . I was just so frustrated . . . and so worried. . . . It was really difficult. Again, damned if you do and damned if you don't. Who do you listen to? Who's right? Just that terrible feeling of powerlessness. And being so ignorant that you don't have the information. . . . You have to make good decisions with little information. It's impossible.

Lack of Support

During this stressful pre-suicide period, when parents so desperately needed support, it was often unavailable to them and their child. Alice echoed the sentiments of most of the other parents when she stated:

> I just felt like I had nowhere to go, nowhere to turn. No support from anyone. No one knew what to do. . . . I'm scared to death that something's going to happen.

Several parents felt unsupported by their child's school staff. Alice received no support or direction from her daughter's school staff when she approached them for help, because her daughter was missing a significant amount of school due to stress-related illnesses. Moreover, instead of receiving compassion and nurturing from the school staff, her struggling daughter was often treated in an uncaring, punitive manner:

> When she'd have an argument, or whatever, with the teacher, she would go down to the school lounge, because she didn't want to be alone. She was afraid to be alone. She wanted to be around people. . . . She needed to be around people. I suspect that's what was going on inside of her. She told me that. I asked the principal if when she felt like this if she could go into this other friend's

> classroom, who taught art. I said could she go in there, she's not a problem, and she could just sit quietly. She knows she's with somebody that she likes and trusts, and she'll be safe there, and feel safe there. What would they do to her? They'd put her in an empty room, or they'd . . . stick her in an office by herself. . . . [The principal] said, "Absolutely," but that isn't what they did.

Even after her daughter's suicide attempt, instead of making allowances for her deteriorating mental health, the school staff continued to make academic demands on her, and continued to increase her stress. Several parents also found school counsellors unsupportive. When Sally's son was dropping out of school, she asked her son's school counsellor to intervene, or refer her to someone who could help them, but received no support or guidance from him. When Alice's daughter began seeing a private counsellor, Alice was informed by her daughter's school counsellor that due to her code of ethics she had to stop counselling her daughter, leaving her struggling daughter without support in school.

Two parents, Alice and Terry, felt very unsupported by the emergency hospital staff that treated their child after their suicide attempt, as Terry recalled:

> The doctor in the hospital talked to Dawn and asked Dawn if it was a smart thing that she did. Dawn said, "I don't know. Can I go home?" She said, " Are you going to try it again?" "Well, I don't know. Can I go home?" "Well, if you don't know if it was a smart thing, and you don't know if you're going to try it again, I'll be back in 10 minutes. You think about it, and then I'll come back and I'll ask you the same questions. If you give me the right answer, you can go home." *This is the resident.* So I immediately spoke up and I started telling her about the behaviour, and the problems, and all of this stuff, and that she was on medication. The doctor looked up at me and said, "I'm talking with Dawn. I don't need your input." Ten minutes later she came back and asked Dawn the same questions, "Was that stupid?" "Yes." "Are you going to try it again?" "No. Can I go home now?" "Yeah." And she discharged her and sent her home. No further recommendations. Nothing. I said, "Are you going to send a copy of this to her psychiatrist?" "Oh yeah." It's not in her file. . . . I don't know where it is. It's not in the file I have. And I have supposedly everything.

With the exception of two helpful psychologists, all the parents found the mental health professionals they consulted with unhelpful and unsupportive. Alice was appalled

by the psychiatrist she consulted with after her daughter's suicide attempt, who breached patient confidentiality and behaved in an unethical and unprofessional manner, lacked insight into her daughter's underlying psychological problems, and gave inappropriate advice:

> I'm sitting there and the [psychiatrist] comes in, and in front of Lynn and I the receptionist [says] to the doctor, "You left the hospital without signing your orders." And she responds . . . . They can just go ahead and give the stuff without my signature.". . .Then they started bantering names around. . . . Then she says a lawyer's name, phoned and wants to know if you have the assessment done on his client, the name, because he needs it for court today. . . .[After meeting privately with Lynn] the psychiatrist calls me in. . . and she says to me, "Lynn needs to have more fun. She should go to the bars." I said, "Excuse me, this is a 16 year old kid." "Well, lots of kids go to the bar at 16." And I'm going, O.K. So we listened to this nonsense for about 15 minutes.

Terry was dismayed by the lack of concern and support she and her daughter received from her daughter's psychiatrist after her daughter's suicide attempt. Although she tried hard to impress on the psychiatrist the seriousness of her daughter's attempt, and informed him about her daughter's artwork that was suggestive of suicide, he did not view it as a serious suicide attempt, because her daughter laughed it off and told him it was not serious. After reviewing her deceased daughter's medical records, Terry also believes that the psychiatrist misdiagnosed her daughter, who was likely schizophrenic. Kate and Bill felt discouraged and frustrated at the lack of improvement in their son's mental health even though he was under the care of mental health professionals for a full year, as Bill reported:

> [I was] probably [experiencing] more despair then anything. Not seeing any real change in him, as far as improvement, and his *hints* every so often about *not wanting to live anymore.*

Kate also felt frustrated and unsupported by her son's psychiatric clinic staff when she discovered that they had allowed her son to leave the clinic even though they knew he was very suicidal. Several other parents found the counsellors they consulted with

unhelpful, and lacking in discernment. Andy was frustrated and disappointed when the counsellor he consulted with about his violent son told his son "his rights" instead of addressing the underlying issues that were causing him to be violent. Finally, Sally felt abandoned, unsupported and devastated because her son's psychiatrist refused to talk to her:

> The psychiatrist wouldn't talk to us either. He was 17 at the time, and I phoned probably 4 or 5 times. Even the reception nurse . . . who answered the phone was feeling really bad for me, but couldn't get him to talk to me, because of confidentiality, because he was 17 closer to 18. I'm going, "Well how am I supposed to deal with it? Cause I don't know what it is." . . . I really would've liked it if the psychiatrist would have sat down with us. That would have made a lot of difference. Would have maybe made no difference, but maybe it would've made some difference. I mean to think that he won't talk to us just horrified me. I'm going, "How am I supposed to fight when I don't even know what the hell it is? And you left me here all on my own to try to figure it out, try to deal with it." . . . I wanted someone to tell me what to do. And I guess maybe nobody could tell me what to do. But [the psychiatrist could have] given me some ideas. Said, "OK you do this, or yes depression can debilitate to this." . . . I was so desperate for somebody to help me.

A few parents also experienced lack of support from other sources. Initially, when her daughter's verbal and physical abuse was only directed at her, Terry experienced blame and lack of support from her husband. However, after he also became a recipient of their daughter's abusive behaviour, he realized that her behaviour was abnormal, and supported his wife. Ann felt unsupported and usurped by the parents of her son's friend, who allowed her son to stay in their home, when he left home, because they felt that she and her husband were too strict. Finally, Sharon never realized that her son was suicidal, so she never experienced the lack of support the other parents experienced while trying to access help for their suicidal child. Instead, her lack of support entailed raising her children as a single parent, without any support from her absentee ex-husband.

Summary of Theme One

Pre-suicide stress was a common experience among parents, although the source and degree of stress varied. Although all the parents recalled distinct turning points when their child's behaviours began to deteriorate, because of their child's age and their unfamiliarity with mental illness and suicidal behaviours, most parents initially attributed their child's changed behaviours to adolescence. However, as their child's destructive behaviours escalated, most parents realized that their child required psychological intervention, and sought support. Unfortunately, with the exception of a few helpful psychologists, parents found the mental health professionals they consulted with unhelpful and unsupportive. Several parents also found school and hospital staff unhelpful and unsupportive. Parents' stress was exacerbated by their lack of knowledge about suicide and mental illness--knowledge that might have enabled them to help their child. Finally, in addition to being distressed about their child, some parents also experienced other personal stressors such as marital conflict, bereavement, depression, and suicidal ideation during this time.

Theme Two: Experiencing Their Child's Death

During the pre-suicide period, as their child's condition deteriorated, most of the parents feared that their child might end his or her life. Their worst fears were realized when their child committed suicide. This next section depicts how parents experienced their child's deaths by describing the following: (a) how they found out about their child's suicide, (b) their initial emotional reactions to their child's suicide, (c) the comfort they sought and received, (d) challenges parenting a surviving child, (e) their support, (f) feeling understood, (g) lack of support, and (h) their child's funeral.

Finding Out About Their Child's Suicide

During the stressful pre-suicide period most of the parents' children expressed suicidal ideation, and three of them attempted suicide. So most of the parents lived in constant fear that their child might commit suicide. However, in spite of their fears, the reality of their child's suicide was too unbelievable and horrific for them to fathom, as Sally noted: "I guess I could never really, really think about him doing it, cause it's too horrible." Yet, the unimaginable did happen, and parents were confronted with the horror of their child's suicide.

As noted in the previous chapter, parents found out about their child's suicide in a variety of ways. Alice discovered that her 16 year-old daughter had died from a drug overdose when she entered her room in the morning to awaken her. Sharon and Terry discovered their child hanging in their basement, and were informed that their child had died shortly after they arrived at the hospital. Andy, whose son hung himself, and Sally, whose son ended his life with carbon monoxide poisoning, both found out that their child committed suicide when they received the "dreaded call." Ann drove by her son's residence to see if he was home and was informed by the police that he had died of a gunshot wound. Lastly, Kate and Bill found out that their son had hung himself when they saw his sketch televised on the local evening news.

Parents' Initial Emotional Reactions

As the interviews progressed parents revealed their initial reactions to the news of their child's suicide. Some described their reactions in detail, while others referred to their feelings intermittently throughout the interview. All of them were devastated by the news of their child's death. Their initial reactions included shock, denial, guilt and

shame, feelings of isolation and disconnection, relief from pre-suicide stress, and concern about others.

Shock

Most parents reacted with shock when they were first confronted with their child's suicide. Sally said she remained "in shock for a long, long time." Ann, who likened the experience to an unending nightmare, experienced numbness, while Kate reacted to her shock by crying, screaming, and shaking. Terry, who discovered her daughter hanging in her basement, experienced terror as she described:

> I went in the house, and my life died. Basement door was opened. And I'm calling. Now it's the end. . . . I was terrified. Absolutely terrified. I have never been that scared in my entire life. Never. I've never experienced that before. I don't want to experience it.

On the other hand, Alice and Sharon, who also discovered their child, reacted in a relatively calm and controlled manner, which they credit to their nursing background. Sharon had also learned during her dysfunctional childhood to "shut down" during a crisis:

> My parents used to have a lot of physical fights and I would clean up, so I've learned to kind of shut down during the crisis and handle it. I fall apart later.

Thus, when she discovered her son hanging from the rafters, she loosened the rope that held his body up, cut the rope around his neck, and performed CPR on him until the firemen arrived and took over. She also gave her address twice clearly to the telephone operator from 911, and kept her daughter away from the scene of the suicide. Alice, who found her daughter dead in her bedroom, reacted in a similarly controlled manner:

> [I was] very collected. Yeah, I was on automatic, there's no question. . . . [I was] very controlled. Very controlled. But then you know I'm a nurse and in a crisis I'm very controlled. I may fall apart after. . . . It kicked right in. This is what I need to do. . . . I wasn't really sure who I was supposed to call, but I knew the

> police should be there. . . . I knew from nursing, in a sudden death in a home police have to be involved.

Because of her nursing background taking care of children who were in a vegetative state, Alice also became alarmed that the ambulance attendants might try to resuscitate her dead daughter, when she heard one of them remark that her daughter was still warm. However, her fears never materialized, since the ambulance attendants made no attempt to do so.

Denial

Most of the parents experienced denial when confronted with their child's suicide. Sharon and Andy indicated that disbelief was their strongest initial reaction. Terry refused to consider the possibility that her daughter might not survive her suicide attempt after the ambulance transported her daughter to the hospital:

> I took Dawn's jacket, and I took her journal, cause she didn't want anyone to read it, so I wasn't going to leave it. . . . I didn't take her boots, cause she wouldn't need them when she came home. We would carry her into the house. But she would need her jacket. She was coming home. . . .When she came home she would need her jacket. She would need her boots. Robert would carry her.

Ann found it difficult to believe her son had died because she was unable to see his body, due to the length of time he had been dead before being discovered. Andy noted that he was in disbelief for three months after his son's suicide: "I didn't think he'd ever commit suicide. It was disbelief. We had this disbelief. It didn't even hit me for about 3 months." Because of their denial, Sharon and Sally both experienced a strong urge to pick their child up and carry him away when they viewed their child's body, as they respectively recounted:

> He looked like he was sleeping. I just wanted to pick him up and go, OK, come on, you can come home. (Sharon)

> I just wanted to take him out of there and run away with him. I know that sounds retarded. . . . It's just, I just didn't want to admit that he was dead. (Sally)

Lastly, Sharon experienced two conflicting emotional reactions—denial and a sense of reality, simultaneously. On one hand, she found it difficult to believe that her son had really died. Yet, on the other hand, she was realistic about her son's death and the grief she was going to experience, so she refused to take the anti-anxiety pills her doctor prescribed:

> The night we left the hospital the doctors gave me 10 Ativan. Well I think I still have 6 left. It's just like, what, I know what these do, and they're not going to bring him back. They're not going to really change anything. What's the point? I knew I had to deal with it.

Guilt and Shame

Ann and Terry experienced guilt when they were informed about their child's death. They felt that if they had been better mothers their child would still be alive, as they respectively reported:

> If only I had been a better mother, he would still be here. (Ann)

> I'm supposed to take care of her. I was supposed to kiss and make it better, and I didn't. (Terry)

Alice, on the other hand, indicated that she reacted to her daughter's suicide with shame:

> I can't explain the feeling that I had that I had to call someone. The shame I guess it was. Its got to be shame. I can't identify it other than that. I know the thought went through my mind, what are people going to say. . . .My mind was working overtime. What are people going to think, and on, and on, and on.

Her shame encompassed feelings of unworthiness, a lack of rights, and the sense that she deserved everything bad that happened to her. Because of her shame, and because she thought she was "off the wall" for feeling the way she did, she initially did not inform

her friends, who had cleaned up her daughter's room and removed her scents, that they had devastated her by doing this.

Isolation and Disconnection

Most parents had never experienced a suicide, or known anyone else who had, so they felt isolated and disconnected, and uncertain how they would cope, when they found out about their child's suicide. Ann indicated that she experienced this as one of her first reactions:

> Thinking that nobody else knows how I feel. I couldn't think of anybody I knew that had been through a suicide. Thinking that I don't have anybody that I can connect to, to see that they survived it. It was just a real alone feeling (speaks with a sob in her voice).

Relief From Pre-Suicide Stress

Although parents were devastated by their child's suicide, most of them also experienced relief from their pre-suicide stress, as discussed in the next theme, Grieving The Loss of Their Child. Alice experienced relief as one of her first reactions when she discovered that her daughter had committed suicide:

> She's dead. That was my first thought, she's dead. She finally did it. . . . I was relieved. . . . Walking on those eggshells for three months, wondering if every day I went in there I was going to find her. . . . Every morning. And every morning breathed a sigh of relief that she was alive, but scared to death that she was going to die that day. So I was relieved that it was over, but absolutely devastated. Still. (crying)

Concern About Others

In the midst of their trauma, all the parents were concerned about others. Four parents wanted to donate their child's organs, but only three were able to do so. Alice expressed regret that she was unable to donate her daughter's organs: "I felt guilty . . . [and] cheated . . . that I couldn't harvest Lynn's organs." Sharon and Terry were so

concerned about the time frame for harvesting their child's organs expiring that they approached the hospital staff themselves about organ donations, as they respectively recounted:

> I knew that you only have a certain time frame if you're going to do donations. So I actually asked them, "What about this?" They said because of the lack of oxygen to vital organs they couldn't use those for transplant. But the things they could use were skin, corneas, and his heart for valves. I went, "Those are good things." He has *great* eyesight. He had a great heart. And he had the best skin. He could tan. He was just beautiful. So I went, "OK." So leaving the hospital that night I knew that they were going to do surgery. (Sharon)

> I remember asking them about organ donors. . . . They said they didn't think that there would be too much. I remember telling them, "OK we have to do this. This is urgent." I was getting mad cause they were sitting there, and I told them to do whatever they had to do so that she could donate organs. (Terry)

Parents also considered the impact this news would have on other family members. Alice and Terry were concerned about their husbands' safety and well-being. Alice arranged for someone to pick her husband up and be with him when he received the news about their daughter's suicide. Terry would not allow anyone to phone her husband, who was driving home on the highway, because of her concern for his safety. Lastly, Sharon, who had not had any contact with her ex-husband for the last 3 years, insisted that his family notify him about their son's death, so that he could see his son for the last time and attend the funeral.

Kate and Sharon were also concerned about their mothers' well being. Kate arranged for her brother to be with her mother when she heard the news about her grandson's death. On the other hand, Sharon did not inform her terminally ill mother about her grandson's death until the next day, to ensure her mother's sleep that night was uninterrupted.

Alice, Kate, and Bill worried about their surviving children. Soon after discovering that her daughter had died, Alice informed her younger daughter about the death, and reassured her that it was not her fault: "I went and told Pebbles, 'this isn't your fault,' [because] she'd wished that she was dead." Alice also phoned a couple of her friends and asked them to come over to ensure her surviving daughter had support. Kate and Bill were concerned about their youngest son, who was also suicidal, and addressed his suicidal ideation with the help of a suicide resource person. Kate beseeched him not to give in to his suicidal impulses: "I said, "don't you hurt me again (sobbing), don't even think about it."

Sharon and Bill worried about the pain their family members experienced when they received the news about their child's suicide. Alice was concerned about her work responsibilities. So she phoned her co-worker and let her know that she would not be in to work. On the other hand, Terry felt completely indifferent about her home and material possessions:

> The police wanted to make sure I was able to lock the house up. I just remember telling them (laughs), "My whole world is gone. I don't care. Let them come and steal everything. I have nothing left."

In addition to the above initial emotional reactions, the reactions of Ann and Sally alert us to the role intuition plays in our lives. Both of these mothers intuitively knew that their child committed suicide, even before their child's suicide was confirmed. Ann was heavy-hearted and preoccupied with thoughts of her son all day before finding out about his death. As soon as the police informed her about his death she realized that her last "good talk" with him, one week before, was closure for him—his good-bye. Thus, she intuitively knew his death was a suicide, even before autopsy results confirmed the cause

of death. Similarly, Sally experienced a strong sense of foreboding the entire day of her son's death. So as soon as the phone in her fiancé's apartment rang, she intuitively knew her son had committed suicide:

> I got a phone call from my ex-husband. . . . I knew as soon as the phone rang. I had this horrible feeling that it was something. I just said, "He's dead isn't he? Anthony's dead." My fiancé just looked at me. He'd gone white, especially after I said that. . . . He was talking to my ex, and my ex is telling him, get her home, and this is what's happened, and don't tell her. And I said, "He's dead. Anthony committed suicide." He just looked at me, and he's like, "We've got to go." He wasn't going to tell me, but he said, "How could I not tell you? You knew."

Seeking Comfort

Alice and Terry sought and received comfort during this traumatic time. Alice sought comfort in her daughter's scent:

> [After reading Lynn's suicide note] I just needed at that time to . . . hold something of Lynn's, and I grabbed her coat. I just needed to have her smell. . . I carried her coat around.

On the other hand, Terry drew comfort from the presence of a member of the response team that arrived at her home:

> There was an angel there. . . . I remember looking at him and he brought peace. I remember him stepping in and telling the police officer "That's enough. Leave her alone." And then, "I'll go down and check." He kept running down to check, and then he'd come up. He was also the first person that I saw when I went in to the hospital. . . . He didn't really say anything. . . . There was just a peace . . . about him. . . . I don't know if it's his eyes, or his face, but there was something that was so comforting. When he left, I didn't want him to go. I wanted him to stay.

Interestingly, when she tried to track him down later to thank him, nobody knew of him. Lastly, several parents felt comforted when their spouses arrived and embraced them.

Difficulty Parenting Surviving Child

Alice felt unable to parent her surviving daughter after her daughter's suicide, and had no contact with her for three days after the death:

> Pebbles decided she was going to school. . . . Well, I don't blame her. I wouldn't want to be at home either. . . . There were too many people around. . . . She had an exam to write that day. . . . I couldn't argue with her at the time. She wanted to go to school, and I knew she needed to be away from our house. So my girlfriend, who's a teacher, phoned the school and told them what had happened and that Pebbles was coming. . . . After school she phoned and said she was going to her friend's, which was fine. Good family. Both teachers. So she went to the friend's house, and then she phoned and said, "Mom I don't want to come home until everybody leaves." So I didn't see her for three days. It was awful. . . . She'd been mad at her sister. She was mad at us. She didn't even want to be around us. I didn't know if she was going to come to the funeral. I had no energy to even deal with her. *I was a mess*, an absolute mess. . . . So she didn't come home until after the funeral. . . . She was at the funeral, but there again . . . I was in such a numb state I certainly couldn't parent her, and same with my husband.

Although Alice desperately needed help parenting Pebbles during this time, help was unavailable. Furthermore, because Pebbles presented as being fine, she never received the support she needed to help her cope with the trauma of her sister's suicide.

Support

Shortly after their child's suicide, all the parents notified their family and friends about their child's death, and most of them experienced an outpouring of support from them, as Andy reported:

> [Our friends] were all notified, and you wouldn't believe the support we had from them. . . . They were just unbelievable. Flowers and food trays showed up. Then they all came out. Our house was just packed with people that came. . . . The next day my mom and dad and some of the kids started showing up. . . . It was unbelievable the people that were phoning, even the people I have insurance with for my car and house. . . . Friends I hadn't talked to in 20 years from my hometown phoned. It was unbelievable the support. . . . Flowers from work, and the friends I have there. And Kris' close friends came out.

Alice also experienced well intentioned, but misguided support. Although her two friends meant well, they devastated her when they cleaned up her deceased daughter's room, removing her scents:

> While I was giving my statement to [the police officer], my friends were cleaning Lynn's room. . . . thinking they were doing me a favour. . . . I knew they were

> busy doing something, but I didn't know what they were doing, and when I went in her room it was spotless. The sheets had been taken off the bed and washed, and all her clothes were washed, and I was just devastated. . . . because that was my job. That was the last thing that I could do for my daughter. So that was taken from me. . . . All the smells were gone. There was nothing. I couldn't smell anything. . . . I had clutched her coat, and I had that in my hands. I know a couple of people tried to put it away for me, and I wouldn't let them, because that was the only thing I could smell her in, is her coat. But all her clothes, her t-shirts, her everything was gone. Her sheets. . . . There was nothing left.

Several parents found their neighbours tremendously helpful. Sally was thankful for the comfort and support neighbours extended to her daughter, who discovered her brother's body. Terry, who referred to her neighbours as God sent, received a great deal of practical and emotional support from them from the time she first discovered her daughter. Others appreciated their neighbours' condolences and various acts of kindness.

Ann, Sally, and Andy felt very supported by members of the clergy--two Lutheran pastors and one Catholic priest. They appreciated their compassion, comfort, understanding, acceptance, and spiritual counsel, as they respectively recounted:

> The [Lutheran] pastor was a great help. He accepted Jesse. We had only been going to the church for a year, and he accepted Jesse. The church said that we could bury Jesse in the graveyard there. He came and talked to Sarah, cause . . . Sarah was worried that God wouldn't accept Jesse because of what he did. He talked to her about that. So that helped us, cause . . . if . . . we would have been shunned away from the church, and wouldn't have been able to bury him where we went to church, it would have been that much worse. (Ann)

> The [Lutheran] minister actually had a friend that committed suicide. He was *absolutely wonderful. Absolutely wonderful.* He sat down and he talked to us, and he captured . . . . what my son was about. . . . He was really, really good, and it was comforting. He said . . . . help the people that are still here to get by with this, and [that] Anthony had left a legacy for people to have to live with, and it's OK to feel anger. He went in to the you can be mad, it's OK. Even though he's dead you can still be mad at him. That's normal and natural. He went in to a lot of things. He was concerned about his friends, as I was. . . . He was really concerned about my daughter. He was just wonderful. He was really wonderful. And he talked about it openly. (Sally)

> [The Catholic priest] was very helpful. He was a Vietnamese priest, and he was very sympathetic. We prayed with him a little bit. It was good. (Andy)

Lastly, Terry sought and received support from her deceased daughter's counsellor, who arrived at the hospital as soon as he heard about her daughter's suicide, and has continued to provide her with ongoing support.

Because of the nature of their child's death, all the parents had contact with the police, and most found them compassionate and supportive. Most parents were also contacted by Victim Services, a unit of the local police department that provides support, information, and referrals to victims of crime and tragedy, soon after their child's suicide, and found them helpful. Parents appreciated their immediate presence and support, their sensitive and personalized approach, their ongoing non-judgmental and unconditional support, and the information they provided. On the other hand, Terry indicated that she found Victim Services unhelpful:

> We had, in that little room in the hospital, we had Victim Services come in. . . . Two of them came, and they didn't stay. . . . They said, "You have lots of people here.". . . No [support], from Victim Services, no, no. None whatsoever. They notified the school. They said, "What can we do for you?"

Terry also found it difficult to respond to the support that was extended to her. She felt frustrated by people's questions, offers of support, and offers of food:

> They said, "What can we do for you?" . . . People ask these questions like, "Do you have any questions about her death?" "Yeah. Can you bring her back?" "What questions do you have?" "Is there anything we can do for you?" "Uh, bring her back." "Do you want something to eat?" "No." There was a pastor there and he kept bringing food. . . . . My sister said, "Did you eat?" "Well, yeah, I think I had a yogurt at lunch." "Get her something to eat." Well no.

Understanding

As noted earlier, suicide was outside of the realm of most parents' experiences. Therefore, most parents felt isolated and disconnected after their child's suicide. Alice

and Ann felt relieved and understood when they met other suicide survivors, as they respectively recounted:

> I just dreaded that this policeman was going to come. My mind was working overtime. What are people going to think, and on, and on, and on. When he came to the door . . . I invited him in and took him in to see Lynn. He came back out and said, "I need a statement but you don't have to do it right now. I need to do a few things first." He wanted me out of the room. He said to me, "Mrs. (last name), my mother killed herself when I was twelve." I said, "I'm sorry, how did she do it?" He said, "With a gun." And I felt relief . . . I guess mostly relief. Relief for two reasons: Relief that Lynn just took pills, and relief that he understood. . . . It felt like the weight of the world was lifted off my shoulders right then. I can't describe the feeling of him understanding. (Alice)

> [At Victim Services] I just sat there kind of stunned, and didn't know what to think. It was just like a bad dream. Then finally [the lady from Victim Services] came into the room, or she was there, and told me that she wasn't supposed to tell me but . . . she had a daughter that suicided, and it was like, I kind of took a big breath and thought, well at least I know somebody that's been through it, somebody that could help me even comprehend, or you know, generalize what is even going on. I didn't have anything to pull from. . . . I thought to myself, she knows how I feel. (Ann)

Lack of Support

Two parents, Sharon and Terry, also experienced a lack of support. Sharon received very little support from her family and friends. With the exception of her helpful brother-in-law, she felt avoided by the rest of her family after the suicide. On the other hand, Terry found the police, who arrived at her home, lacking in compassion. She also felt accused by them because of the questions they asked her:

> The police kept asking me questions, and I gave them the medication. They kept asking me . . . the weirdest questions. I remember thinking, they think I killed her. . . . I remember him asking about the medication. I remember him asking me if Robert was home. "Are you sure he wasn't home?" Like he was almost accusing one of us of. "Well are you sure?" . . . I felt he was accusing me. In fact, I remember telling him that I didn't kill her.

Terry also felt frustrated that it took the police so long to get her to the hospital.

Funerals

Two parents, Alice and Terry, found it difficult to make their child's funeral arrangements. Alice found it difficult to be assertive about her daughter's funeral arrangements because of the shame she was experiencing that her daughter had committed suicide. Therefore, even though she found it offensive to have her daughter's funeral in a Catholic church, because of the church's negative view on suicide, she did not assert herself when her United Church minister arranged to have it in a large Catholic church to accommodate the large number of attendees. Terry, on the other hand, was unable to make decisions about her daughter's funeral because of her distressed emotional state, so her son assumed responsibility for all the funeral arrangements. Andy's son also made all the funeral arrangements. However, he did it because he idolized his deceased older brother.

All the parents were adamant about having a public funeral for their child during which their suicide was openly acknowledged, because they refused to deny their child's suicide, and because they wanted to help others who were experiencing suicidal ideation. Ann, Sally, and Sharon, and some pastors, were concerned that some of their deceased child's friends might be suicidal. Sharon's pastor was also concerned about his own son, who was a friend of her son's, being suicidal. Thus, during the funerals some of the pastors talked openly about the legacy the deceased left, the feelings of grief survivors are left to grapple with, and the importance of survivors supporting each other.

Although a few parents alluded to the stigma the Catholic Church attaches to suicide, none of the parents experienced stigma from their churches, pastors, or priests. All the funerals were well attended, with the preponderance of attendees being the

deceased child's friends. Kate, Bill, Sharon, and Terry held their child's funeral service in a funeral chapel, with two followed by cremation, and one by burial in a cemetery. Sally and Ann had very large Lutheran church funerals, followed respectively by cremation and burial in the cemetery, and by burial in a church graveyard. Alice had a "huge" United Church funeral held in a large Catholic church, because her church was too small to accommodate all the attendees, followed by cremation. Finally, Andy had a large Catholic Church funeral, followed by cremation, and burial in the cemetery as he described:

> The funeral was in the Catholic Church and we had three priests. We had a Christian Burial Rite (Mass) with prayers and viewing the night before. We also had viewing before the funeral mass, because we wanted the young people to realize what truly happened and to say good-bye. 500 people showed up. . . . It was unreal. Kris had a lot of friends. He spread himself pretty thin. . . .Then they had a reception after with lunch. . . . We had him cremated, and then we bought a plot and a bronze nameplate. We even had his picture put on it. So its been a very popular site.

Alice and Terry found funeral directors and attendants very helpful. Terry appreciated their compassion and understanding when she requested that they remove their ties, and everyone else's as they came in, because of her phobic reaction to anything around the neck, due to her daughter's method of suicide:

> The funeral directors were really good. I asked them to remove their ties, and they just laughed and said, "We can't." I said, "Please. Can you?" They said, "Well, are you sure? If you want it." They've never had that request. . . . I couldn't deal with anything around the neck. Nothing. . . . They removed them. Then I had them stand at the door, and everybody that came in, if they had a tie, I had them remove it. . . . There were absolutely *no ties*.

Overall, parents were pleased with the funeral arrangements. However, several parents had some regrets. Terry, who felt rushed to make a quick decision, regretted not giving more thought to her choice of pallbearers. In hindsight, she would have only kept

two of the original six pallbearers, and would have instead picked four of her daughter's friends, who had a more meaningful relationship with her daughter. She also regretted not having the funeral video taped. Alice regretted not seeking her younger daughter's input into the funeral, because after her daughter's funeral and cremation she discovered that her younger daughter was against cremation. She also felt the funeral was too rushed, and that she did not have sufficient time to plan it, or process what was going on:

> I wish I would've waited for a few more days and taken time. . . . because things were just *so rushed.* I mean she died Wednesday, and she was buried Saturday. So everything was so fast and quick. But I did that partly because the kids were writing exams. . . . I would've waited even two weeks, three weeks. Yeah. I would never have rushed that fast. . . . Just because you've got more time to process what's really going on, and to really plan things, and to do things that I would've liked to have done. Just having more get-togethers with Lynn's friends, which I never really had a chance to do much of before the funeral. . . . I think we just need to really slow down the process for people. . . . People need to take more time for funerals. They really do.

Finally, Sally was horrified that during the viewing of their son's body her ex-husband tried to manipulate her into reconciling with him:

> We're at the viewing, and [my ex-husband] wanted to get back to me. We're looking at our son and he goes, "He would want us to get back together again." I said, "You know what? No he wouldn't." I mean that was pretty horrible. The time of that, that was a horrible time. . . . I didn't want to deal with something like that, at that point. That's a terrible thing to say that your dead son wants us back together again. . . . He was trying to control and to use that to his advantage. That's horrible.

Summary of Theme Two

Most parents' fears that their child would commit suicide were realized when they were confronted by their child's suicide. Parents found out about their child's suicide in a variety of ways. Three parents discovered their child themselves, while the rest were informed by others. Parents reacted to their child's suicide with feelings of shock, denial, guilt, shame, isolation, disconnection, relief from pre-suicide stress, and

concern for others. Two parents experienced premonitions before finding out about their child's suicide. Most parents received an outpouring of support from their family, friends, neighbours, spiritual leaders, a counsellor, police, Victim Services, and other suicide survivors. A few parents felt unsupported by family members, friends, police, and Victim Services. Parents sought and received comfort. One parent was unable to parent her surviving child after the suicide, and a couple of parents found it difficult to make their child's funeral arrangements. All the deceased children had well-attended public funerals during which their suicides were openly acknowledged. Four were held in churches, and three in funeral chapels. Some parents and pastors were concerned about suicide contagion, and tried to address these concerns during the funerals.

Theme Three: Grieving the Loss of Their Child

After the funerals the flurry of activity surrounding the deaths diminished, and supportive family members and friends returned home to resume their lives. However, bereaved parents were unable to resume theirs; their lives were forever changed. Instead, they embarked on painful journeys of grief marked by the following four components: (a) trying to make sense of the suicide, (b) feelings of grief, (c) bereavement experiences that impacted grief, (d) and unique journeys of grief.

Trying to Make Sense of the Suicide

After their child's death all the parents sought logical explanations for their child's suicide. Some became obsessed trying to find answers. Ann spent the entire first year of bereavement like a detective, searching for answers:

> You think there should be a logical reason, so you're searching for it. . . It's just like a thorn in your side that you have to figure out this answer. Why? Why? Why? It can drive you insane. . . . It can get to be almost a lifestyle. That's all you're doing, trying to figure out this thing.

Suicide notes some children left only added to their parents' confusion. Their simplistic explanations belied the complicated psychological trauma they had been experiencing, as Alice and Sally respectively noted:

> There was a note for me and for my husband, and a note for Pebbles. The note for us said something like, "I'm sorry for all the fights we had. I love you. I'm sorry, don't be mad at me. . . . Love Lynn." And to her sister something to the effect that Mom and Dad really love you, and something to the effect that she really loved her. . . . So it didn't make a whole bunch of sense. (Alice)

> He said, "I don't understand the true meaning of life." Then he also said, "I couldn't get a job at the fffffing 7/ll." But I mean he had had jobs, and self-destructed in them, and didn't show up. . . . So I guess he was frustrated finding another job, but that wasn't the reason. Like these aren't any of the reasons. I mean this happened before any of those other things happened. (Sally)

In their search for answers, parents questioned their child's friends, fellow workers, teachers, doctors, and anyone that could provide them with information. Sharon found out from her son's friends that shortly before her son committed suicide he had been trying to arrange a date with a girl he liked, which made his decision to commit suicide even more confusing. While Ann found out, after talking to others in her son's life, that he had used drugs extensively. She also learned about her family's history with depression. So she began to re-evaluate her son's behaviours within the context of familial mental health issues.

As parents gathered information about their child, and learned about suicide, they realized that their child had given definite advance warnings of his or her suicidal intentions. These included talking about suicide, making suicidal plans, engaging in suicidal behaviours, saying good bye to significant people in their lives, giving gifts, paying off debts, and atypically attending church. Most parents believed that if they had

possessed this information beforehand they might have been able to prevent their child's death, as Terry noted:

> Now I can look back, and I can see all the signs. But I have to keep telling myself I did the best I could with the knowledge I had at the time. If I had known what I know now, she'd still be here. I hope. I like to believe.

On the other hand, Sharon felt that even armed with her present suicidal knowledge her son's warning signs would have been difficult to discern:

> He didn't follow the usual pattern. . . . and with being a teenager it was really hard to decide. You know like they say, change in this, change in that. He was 15. Kids like that change *all the time*.

Furthermore, her own life-long struggle with depression and suicidal ideation precluded her ability to recognize her son's distress. Thus, even though a few weeks before his death he had stated, "Well, I might as well just go and kill myself," she had not taken his threat seriously, since she herself had made this threat innumerable times.

Some parents also discovered that their child had experienced psychological distress or trauma that they had hitherto been unaware of. For example, Sally was surprised to learn that her son had experienced depression when he was12 years old:

> When I sold my home, I had to go through all his stuff, and I found the time capsule . . . he had done when he was 12, and that was hard. . . . He was depressed at that point, which I didn't know.

Alice was shocked when she was informed that her daughter had been sexually assaulted before her suicide:

> Pebbles (younger daughter) was working one night with a girl, and my husband and I, and two good friends, went there to have coffee. . . . She came up to me and said, "Guess what?" I said, "What?" She said, "This girl got sexually assaulted the other night." I said, "Really?" She said, "Yeah, and it was the same guy that assaulted Lynn." I said, "What?" And she said, "Yeah, two nights before she killed herself," and walked off and went to look after another customer. So I'm sitting there with our friends and we're kind of going, did we hear right? And

> Pebbles came back and said, "Yeah, I heard she got gang raped two nights before she killed herself," and walked off again.

After accumulating information about their child, three parents seemed to come to terms with why their child committed suicide. Interestingly, two of them were fathers. Bill stopped asking himself why because he remembered Scotty hinting about suicide and because "Scotty decided he had reason enough to do it." Andy stated: "I've kind of figured it out. . . . He was in a lot of pain. . . . because of girl problems, and he was having problems getting his life straightened out." Lastly, Terry concluded that her daughter, who was in the midst of writing final exams, feared academic failure, and was likely an untreated schizophrenic:

> I really think that she was schizophrenic. . . . I have her medical records here too. One of the questions that she answered is, do you hear voices or see shapes? Never, occasionally, sometimes, frequently. She ticked off frequently. . . . She had said at one point that it was like she was outside her body watching herself hit me, watching herself scream at me, watching herself.

Conversely, the other five parents remained baffled by their child's decision to commit suicide. Ann stated: "There were never any answers." And eight years after her son's suicide Kate reported: "It just didn't make sense. It still doesn't."

Several parents experienced multiple bereavements in close proximity to their child's suicide. Ann, who experienced four deaths in the last five years, reported that this bereavement was more difficult to experience and was extended twice as long as the others because of her obsession with why questions, her search for one specific reason why her son committed suicide, her guilt and regrets, and the unnatural order of death. Once she was able to get past the suicidal issues, she was able to grieve for her son simply because he had passed away, and "that felt better."

Feelings of Grief

Parents experienced a variety of intense feelings during their bereavement, as Terry, Andy, and Ann respectively described:

> It's like someone just walked through your throat, ripped your heart out, and is stomping on it with cleats. (Terry)

> It's like somebody's ripped your heart out. I mean you're missing part of your body or something. It's an anxiety attack that you're having for 24 hours a day. (Andy)

> I thought I was going to go crazy. My heart actually physically hurt. It felt like somebody reached in and tore a part of my heart out. (Ann)

Their predominant feelings of grief included denial; relief from pre-suicide stress; guilt; anger at themselves and at others; sadness, loss, and yearning; shame; suicidal ideation; and hope. Parents experienced this range of emotions in different degrees, during different time periods, and sometimes simultaneously. Furthermore, these feelings were often interconnected, however, for the sake of clarity and structure, they are presented separately.

Denial

Parents experienced varying degrees of denial after their child's death. Denial protected them from being overwhelmed by their unbearable pain, and allowed them to slowly assimilate their loss. However, because of their denial, some parents tried to resume their lives too quickly. For example, Sally emphasized during her initial interview, one year after her son's death, that she was doing well, and that she was eager to begin a new life. However, two years later, after reading the transcript of that interview, she realized that she had denied the effect her son's death had on her, and had tried to move on too soon:

> I said I was fine but I wasn't. Bravado. I wanted to be OK. I was starting a new life, but it was too soon, and too much. . . . When I read the interview my thoughts were, wow, that is a very broken person talking, almost like that wasn't me I was reading about. Trying so hard to be brave and pretend everything is okay and that I can handle things. . . . Who was I kidding? I wanted so badly, maybe desperately, to be okay and get on with my new life, but clearly was nowhere near being there.

Denial sometimes manifested itself in parents' illusory sightings of their deceased child. Some parents mistook their child's friends, and other young people for their deceased child. Terry often sighted her deceased child on the highway, and had to pull over to avoid hitting her. She also saw her daughter in television commercials, and experienced her presence in sudden, unexplainable, strong floral scents. Ann, unable to accept the permanence of her son's death, often experienced random illusory sightings of him during the first six months of her bereavement:

> I would see Jesse everywhere. I would drive down the highway and see Jesse coming towards me in his blue truck. I would get so excited and happy, and then my heart would sink. That can't be Jesse, he's dead. I would see a young man in blue jeans, jean jacket, and cap and I would think that's Jesse. Then he would turn around, and it wasn't Jesse. . . . The first three to six months were bad, cause it's just not sunk into your head that that person's gone.

Relief From Pre-Suicide Stress

Although parents were devastated by their child's suicide, most of them were also relieved that the fear and stress they had been living with before their child's death had ended. Alice, Sally, Kate, and Bill were relieved that they no longer had to live with the constant fear that their child would commit suicide. As noted in the theme, Experiencing Their Child's Death, Alice experienced this as one of her initial grief reactions. On the other hand, Terry and Andy experienced relief from their fear that their child would harm them, as Andy stated:

> He had told the other siblings that he was going to kill us. . . . [So I experienced relief] that wouldn't happen. . . . Like I said, if we had to have him back the way he was, we wouldn't want him back.

Guilt

All the parents assumed culpability for their child's death; they felt that they had failed in their responsibility as parents to help and protect their child. Thus, they regretted things they had or had not done, and believed that if they had done things differently, their child might still be alive. Terry's guilt echoes that of the other parents:

> You want guilt? See this arm? I have two of those. All of the should ofs. All of the should ofs. They're all there. . . I feel like I really failed her.

Interestingly, others in their child's life also experienced guilt, either because they had been unaware of their child's struggles, or because they had been aware of them, and had not provided their child with sufficient support. Alice's friends experienced guilt for not having been more supportive:

> I think a lot of [my friends] carried a lot of guilt themselves, because they knew that Lynn was really struggling, and probably weren't as helpful as they could've been, and didn't realize things were so tough.

Sharon was surprised by the number of people who assumed culpability for her son's suicide:

> His teachers, his principal, they all felt guilty for not noticing or seeing some signs. It was just amazing the people that said, "It's my fault, it's my fault, it's my fault."

Anger

All the parents experienced varying degrees of anger during their bereavement—anger at themselves and at others. Parents experienced inward anger for the same reason they experienced guilt; that they had not prevented their child's suicide.

Parents' outward anger was wide-ranging. Kate, Sharon, Sally, and Ann were angry at their deceased child for betraying their love and close relationships by committing suicide. Sally, Sharon, and Ann also felt resentful that in spite of their efforts to overcome their dysfunctional upbringing, and/or do the right things, their child chose to end his or her life. Still others, like Sally, felt that they had lived their lives to the best of their ability and had done nothing to warrant experiencing the suicide of their child:

> The anger that I had was, sometimes I would just feel it boiling up inside of me. It wasn't an anger at anything. It was just sort of a general I'm pissed off and maybe it was like, why does this happen to me? I felt like I went through enough in my childhood, and I had gone through a lot in my childhood. I just thought why is this happening? The only thing I wanted to do was to be a good mother. That was the only thing that was important to me, and that was because of my childhood.

Ann and Sharon blamed family members for their child's suicide. Sharon was also angry at family members for withholding their support during her bereavement. Kate and Terry directed their anger at mental health professionals, because of their lack of support, and/ or their inability to help their struggling child. Alice and Terry were angry with their deceased child's school staff for withholding support from their struggling child, subjecting their child to unwarranted stress, and initially refusing to acknowledge their child in their yearbook. Sharon and Andy also resented their deceased child's friends for the pain they had caused their child. Finally, some parents experienced widespread anger that was easily triggered by a number of things, as Alice and Terry respectively described:

> I was so angry. My anger was just so incredible. I was just angry at the world I think. (Alice)

> It's almost 4 ½ years. . . . I think I have more anger now, not with Dawn, but with other people. With what I'm missing. . . . With family mostly. . . because they're not there. . . Anger with my situation, anger with the loss. . . Anger with other people. What really makes me angry is when I see people abusing their kids, or people driving down the street without their kid seat-belted in, or people putting their children in danger. Then I get angry. (Terry)

Sally reverted to her childhood coping mechanism for dealing with anger and used her anger as impetus to move on with her life:

> I got through my childhood with anger and determination. . . I fell back into that pattern of anger. . . . It's . . . anger that . . . comes out in determination. . . . You're not going to screw with me. I'm going to do what I want to do. . . . I'm getting on with my life. This is not going to destroy my life. I have my daughter to take care of, and this is not going to get me. Those are both good and bad, I think. I mean it gets you through, but . . . I had [a narrow] vision.

Sadness, Loss, and Yearning

All the parents experienced a great deal of sadness, loss, and yearning. Many parents reported that the sense of loss, including the loss of their child's roles, and the loss of their child's future, is their most painful feeling of grief. Eight years after his son's suicide, Bill still experiences the painful void his son's death left in his life. Parents also yearn for their child; they desire to be close to them, hold them, touch them, hear their voices, and look at their faces. Feelings of yearning are usually precipitated by special occasions, such as their deceased child's birthday. However, they sometimes come "out of the blue." Ann and Andy engaged in bargaining; they talked about the sacrifices they would have willingly made to reverse their child's death. Ann and Sharon grappled with the change in the order of death; that is, how unnatural it is for their child to die before them. Finally, Alice and Sharon were so consumed with pain that they sometimes found it difficult to consider the needs of others.

Shame

Alice and Sally experienced shame about the suicide that encompassed their own negative self-judgement, as well as their perception that others would judge them negatively, as they respectively described:

> [I experienced] overwhelming feelings of shame. . . . I mean it just proved to me how awful a person I was, all these things happened to me. My kid kills herself. . . . Why my husband stayed with me, I have no idea. (Alice)

> I was horrified that he knew . . . I thought he would judge me negatively. I thought he'd think I was a bad mother. . . . I guess probably every parent feels that. Like there must be something wrong with the family. You must come from a bad family. Why would he do that? I'm sure there's a lot of that. I think people must think that. I mean when you read about some kid dying in the paper . . . like some kid falling off the dock, you think where's the parent? I guess it's sort of everybody's first reaction. Right or wrong. (Sally)

However, although parents feared and expected negative judgment from others, most of them did not experience it. Rather, most people responded to them with kindness, support, and offers of condolences.

Suicidal Ideation

Terry and Alice felt unable to deal with the pain and reality of their loss, and experienced suicidal ideation during the second year of their bereavements, as they respectively reported:

> After about a year . . . you're coming out of your numbness and it's starting to set in. . . . I *really* hit rock bottom. I was very suicidal. (Terry)

> I was very suicidal at one time. I was working at a lady's house, and I had overwhelming feelings of suicide. . . . I got in my car and I drove home crying all the way . . . traveling at about 160 K, thinking that I would get in an accident and that would be OK. I made it home, and I decided that since I made it home . . . that means that I must call my psychologist. I called him and just started saying, "I'm really missing Lynn. I want to be with her." He finally said, " Are you thinking of killing yourself?" I said, "I'm too chicken." He said, "You haven't answered me." I said, "Yeah, I'm sitting here thinking what could I do to make it look like an accident. Yeah." (Alice)

Hope

Alice and Terry experienced a turning point in their bereavement, and realized that they were going to survive their painful grief. Alice first experienced hope 9 months after her daughter's death:

> My first good day that I had was 9 months after she died, where I felt like I did before she died. That was the day that I knew that I was going to make it. I woke up that morning and it felt good. I phoned my psychologist and said, "I just need you to come for lunch with me today. I hope you've got time. I know you don't normally do this, but I just feel so good and I need to share it, cause I know it's not going to last, and I just need to validate it." I felt wonderful. We went out for lunch and we shared some laughs. . . . I enjoyed every minute of that day. It was a gift. . . . That was the first day I had hope.

Terry's turning point occurred 4 ½ years after her daughter's suicide:

> This year at Easter, it was early but we went out and Robert was up and planting flower boxes, and playing in the dirt and stuff. . . . That was the first time where I can honestly say that I felt like I'm going to make it. . . . The sun was shining and I just remember sitting outside and thinking, OK . . . I'm going to make it. I've had pitfalls since then, but I can remember that feeling, that little bit. . . . It was like, I'm not a bad person. I'm OK. I'm going to make it. Dawn's OK, and I'm going to be OK. And it was a good feeling.

Experiences That Impacted Grief

The following experiences impacted parents' grief: spousal differences in grieving and marital conflict, challenges parenting surviving children, coping with grief, maintaining a connection with their deceased child, seeking comfort, support and understanding, lack of support and understanding, stigma, and critical incidents.

Spousal Differences in Grieving and Marital Conflict

Although initially after their child's suicide Terry and Andy and their spouses "pulled together," all the parents and their spouses eventually withdrew from each other and dealt with their pain in their own way, thereby decreasing their communication and support, and increasing their sense of isolation. In general, all the mothers and one father,

Andy, processed their pain by continuously talking about their loss, while the other father, Bill, dealt with it in his usual quiet and private manner. Alice experienced resentment from her husband when she tried to draw him into her style of grieving, and teach him what she was learning about grief:

> [My husband and I] were over like this (indicates with her hands that they were at opposite ends). He was doing his thing and I was trying to survive. And we were at different levels. Sometimes we would meet on the same level. Rarely would we be there. Mostly either he'd be up and I'd be way down, or vice versa. And it was constantly like that. Just fluctuating. I talked about it all of the time, and he would not talk about it at all. He listened to me at first, and then I just talked so much, always, just like what I'm doing now, yip, yip, yip, yip, yip, and *he hated it*. He couldn't stand it. Then when I started learning and reading stuff, and it started making sense, I tried to teach him, and he got resentful that I was pushing all this stuff onto him.

As a result of their pain and/or withdrawal from each other, all the parents experienced conflict with their spouses, and their relationships became tenuous, as Bill described:

> There were moments [when our marital relationship was rocky] . . . I think when something like that happens you start digging into everything you've experienced, and all the bad things come out, the skeletons out of the closet.

Often, marital conflict was easily triggered, as Andy reported:

> In July I was going to leave. . . . I didn't talk to her for a week. I can't remember what brought it on. It was just a little fight. It doesn't take much to get it going.

Andy stayed in his marriage. However, Sally and Sharon ended their engagements, and Terry, who also experienced marital conflict before her daughter's suicide, is currently contemplating a separation or a divorce.

Challenges Parenting Surviving Children

Most of the parents found it challenging to parent their surviving children during their bereavement. Some, like Alice, found it overwhelming to parent while in the midst of grief:

> Everything is overwhelming. . . . I couldn't parent. I needed some help. And there was nobody to help me. I felt the weight of the world on my shoulders. . . . needed somebody to come in and help me. . . I needed somebody to take on the responsibility of making sure Pebbles was doing OK in school. I couldn't monitor her. I could not physically even sit down with her to do that.

Others, like Sally, found it difficult to parent because they had lost confidence in their parenting abilities after their child committed suicide:

> I absolutely panic at the thought of being totally responsible for another child. . . . I guess I feel so much responsibility, guilt, fear, and remorse at not being able to help my son. I actually start to have a panic attack at being responsible for another life, especially a teenager.

Lastly, four parents, Alice, Kate, Bill, and Andy, found parenting challenging because they were grieving, questioning their parenting abilities, and once again faced with the stress of parenting a suicidal child, as Kate and Andy respectively described:

> With my youngest son I can say that at times it's really testing because if he's not in the best mental state, or whatever, then I find it really hard to deal with him. . . . It's a strain because you're unsure of the follow the leader act. So you're back on the pins and needles, which is *definitely* not a fair place to be. (Kate)

> My daughter overdosed on pills. . . . Now she says she didn't want to die. "I don't know I just wanted some attention.". . . [My youngest son] even wrote a suicide note we found. Because I wasn't going to buy him the car, [and] because he was failing in school, he wrote, "The end is near," on a big piece of paper. . . . I went down and said, "It's going to be real near for you if I see anything more like this." I was frantic. Then about four or five months later my wife found [the second] note. He picked the pallbearers, the suit he wants to wear, and all this stuff. The music he wants played. . . . My biggest [concern] is get these kids grown up. I don't want to have to go through that again. That's just our prayer is to have these kids [grown up]. (Andy)

Coping With Grief

Parents coped with their grief by finding ways to control the pain and/or by focusing on it. Some parents avoided information that could have potentially increased their pain. For example, Alice protected herself by limiting the information she received

about her deceased daughter's alleged rape. Some, like Terry, found withdrawal from others a necessary protective mechanism:

> I don't participate in family events anymore. . . . I've tried it. I've kept going back, and then something has occurred, and its knocked me down. . . . I'm not going to allow it anymore. When I'm strong enough, when I have lots of those peaceful moments, when my life is at a peaceful stage, *then* I will deal with them, but right now I don't want to be in that deep dark pit. I want that peaceful feeling.

Others, like Sally, Kate, and Andy returned to work shortly after their child's suicide and kept busy to distract themselves from their pain. Lastly, Kate displaced her negative feelings onto others in an attempt to decrease her pain:

> I guess I was more short tempered and bitter towards my co-workers, cause I was putting it out at people that didn't deserve it. That's what I guess a person does. If you aren't dealing with it, you're either hovering it in your mind and your heart, or else you're pushing it out at the wrong people, because you're trying to get rid of it, so you can stop the shakey, hurtey, achey feeling.

Long-term avoidance proved harmful to several parents. Kate, who repressed her grief for six years, began experiencing painful emotional and physical symptoms, which decreased once she began to acknowledge and deal with her grief.

Parents, who coped with their grief by focusing on it, talked about it, wrote about it, and learned about bereavement. Most parents found talking therapeutic. Talking to others helped them express their feelings, release their strain, process their grief, and feel less isolated. Most parents stated that it was beneficial to participate in this study because it provided an opportunity to talk about their bereavement experience, and have their feelings validated. Some also found writing a helpful way to express their feelings and process their grief. Ann indicated that in her letters to her deceased son she slowly progressed from writing about her guilt to writing about her loss, her yearning, and her love for him. Finally, most parents found attending bereavement groups helpful because

they learned about grief, how to cope with it, and different ways to express it. Andy indicated that he did not attend the bereavement group with his wife because it would have exacerbated his pain to talk about his son, and then hear his wife talk about him also.

Maintaining a Connection With Their Deceased Child

All the parents found it important to maintain a connection with their deceased child. Most did this by talking openly about their child and his or her suicide, and some, like Ann, even spoke publicly:

> [I want] to be open about [my son's suicide]. . . . A lot of people are secretive or don't want to talk about it, and I'm not going to be like that. [That would be] like saying Jesse didn't exist. . . . And I couldn't live with that.

Terry always includes her deceased daughter in the total, when asked how many children she has. She also engages in rituals on her daughter's birthday and the anniversary date of her death to celebrate and honour her memory. Furthermore, one of the reasons she agreed to participate in this research was to keep her daughter's memory alive. Others keep their child's memory alive by prominently displaying his or her ashes, visiting their child's burial site or special place where the ashes are scattered, staying connected to their child's friends, displaying their child's pictures, or looking through their child's mementoes.

Seeking Comfort

Parents sought comfort from a variety of sources during their bereavement. Most of the parents found comfort in their spiritual beliefs, specifically in their belief in the afterlife. Alice and Terry derive comfort from their belief that before their children were born they had purposely "chose[n] to come to earth to experience" their lives, and had

specifically chosen them to be their mothers, knowing the pain they were going to experience. Andy and Sharon gained peace and comfort from consulting psychics, as Sharon recalled:

> For that moment in time, during the psychic reading, I had a wide-open channel to heaven, and I felt so blessed.

However, Andy noted that although he felt reassured and really positive after his psychic reading, his comfort was short-lived. Finally, parents also found comfort in their child's scent, their non-blaming suicide note, and by maintaining a connection with their deceased child.

Support and Understanding

Most of the parents received an outpouring of support from a variety of people including family, friends, neighbours, co-workers, their deceased child's friends, pastors, counsellors, funeral directors, bereavement support groups, and other suicide survivors. This support significantly impacted their ability to cope with their grief, as Ann noted:

> Without the help and support I got from family, friends and others I wouldn't be able to function at all.

The following section addresses the support parents received, as well as aspects of the support they found most helpful.

Most of the parents found family, friends, and neighbours very supportive. Parents found it helpful when they supported them with their presence, shared special memories of their deceased child with them, affirmed their love for them, refrained from blame or judgement, refrained from using platitudes, allowed them to talk about their child and cry, and provided them with long-term support. Andy gratefully acknowledged the support he received:

> [My family and friends] were really supportive. They all knew. "You did everything you could Andy. You gave him everything, except for the new BMW he wanted." I know nobody was blaming us. Most of them knew the trouble we were going through with him. . . We've had a lot of phone calls from my sisters, and their cards are still coming. One sister sends us a card every month or so and just [writes], "We're still thinking about you." You know it's funny. I couldn't guarantee I'd be doing that. . . .It means a lot you know. Cause I would've never thought of it myself.

Parents also appreciated practical expressions of help. Ann was able to get through a difficult day more easily, because her aunt invited the family over for her deceased son's birthday one month after he died. Sharon, who was struggling emotionally, found it helpful for her and her daughter to be invited to stay in her aunt's home for a while. Sally found it healing to move in, on a short-term basis, with an older friend, who supported and mothered her. And Andy and Alice enjoyed a respite from their grief when their friends invited them on a short vacation one month after their child's suicide.

Overall, co-workers were also found to be supportive. Parents appreciated their caring and sensitivity, as well as their offers of condolence. Bill was deeply moved when a co-worker he admired offered his condolences twice:

> Other than family . . . I think only one [person stands out during this experience]. . . . That was a fellow I worked with. . . After Scotty's death he came to me *twice* and said he was sorry to hear about Scotty.

Most of the parents were surprised and gratified by the support they received from their deceased child's friends. These children demonstrated their caring by coming to parents' homes to talk, expressing sorrow or shedding tears; phoning them on their deceased child's birthdays, or the anniversary date of their death; doing chores for them; visiting their child's graveside; and attending their child's memorial services. Their

support reassured parents that their deceased child was remembered, mattered to other people, and that they were not alone in their grief, as Terry stated:

> Dawn's friends were absolutely incredible, *absolutely incredible*. . . . They would phone. They weren't scared to come up. Very open. They were just comforting. They were just there. Valentine's Day I had three or four calls. My first Mother's Day . . . we're laying in front of the TV, and I'm feeling sorry for myself, and the doorbell rang, and in walked Dawn's friend, with a card and a rose (crying). She said, "I thought you might be having a bad day." So she left her mom and came down to bring me a rose. . . . I still get calls: "How are you doing? Been thinking about Dawn." I go out to [the cemetery], there's flowers, there's wreaths. They remember, even now. Her birthday, they always call. One girl puts a memorial in every year. Even [my son's] friends. One phones on her birthday every year. They've just been incredible.

Parents also received support from pastors and counsellors. Ann and Sally appreciated their pastors' genuineness, understanding, lack of judgement, lack of blame, comfort, and counselling services. Kate noted that her sister's minister came and offered his counselling support. However, she was unable to benefit from his counselling services because her youngest suicidal son required all counselling time that was given. Alice, Sally, Kate, and Terry attended private counselling sessions. Some of the aspects of counselling that they found helpful were: to be counselled by an older counsellor with life experiences, to be treated with unconditional positive regard, to receive information, to have their thoughts challenged, to have a safe environment to come to, to be treated with therapeutic techniques such as Rapid Eye Movement Desensitization (REMD) to help them deal with their trauma, and to receive their counsellors' sustained concern and support. Alice indicated that her counsellor was her best source of support:

> I think the most helpful was when my psychologist told me that he believed in me, and that I was worth working with, and just affirming that I can do this. He fed me some information, and challenged some of the thinking. . . . It was a safe place to come.

Sally and Terry stopped attending counselling prematurely, even though they found it helpful; Sally, because she was still in denial and not ready to deal with her grief, and Terry, because dealing with her issues increased her pain.

Alice and Sharon felt supported by their funeral director and attendants, even after the funeral. Alice visited her funeral director or his helper whenever she needed someone supportive and caring to talk to. Sharon felt supported and cared for when the attendant at the funeral home found out she was going to take the bus home with her son's ashes and insisted on driving her home.

Seven parents attended bereavement support groups and found them very helpful. Support groups provided parents with a safe place to talk about their grief; share their "horrible" thoughts, without condemnation or censor; learn their feelings are normal; give and receive support and understanding; learn about grief and dispel their former erroneous notions about it; gain perspective about their suffering by witnessing the suffering of others; and gain hope and encouragement by seeing those who have been bereaved longer than them progress in their grief and resume their lives.

Four parents attended bereavement support groups specifically for suicide survivors. Ann, who attended both types of groups, found the suicide support group more helpful, because it provided her with an opportunity to meet other suicide survivors, and allowed her to deal with issues that pertained specifically to suicide survivors. Indeed, most of the parents were relieved to meet other suicide survivors and found them to be a significant source of support. First, other survivors provided parents with a sense of connection and understanding, thus ending the isolation they initially experienced after

their child's suicide. Terry said she began interacting almost exclusively with other suicide survivors after meeting them:

> I can remember once I started finding other people who had lost children to suicide. . . I could look at people. *I wasn't alone. It wasn't just me.*". . . [I lost touch with] pretty much all of [my former friends] . . . . I think a lot of that was my choice. Initially they called. I wouldn't call them back. . . . I think it's me. I don't want them in my life right now. The only people that I want in my life are people who truly understand, people who are on the same road. I really surrounded myself with other bereaved parents, and that is *my life*. I feel safe with them.

Second, as noted earlier, most of the parents battled with negative self-concepts after their child's suicide. Meeting other suicide survivors, from a range of socio-economic backgrounds and professions, and seeing that they were "good, kind, caring people," helped them realize that even "good" parents lose children to suicide, thus raising their self-esteem, as Ann described:

> When your child commits suicide you feel like maybe there's something wrong with you. By attending the suicide bereavement group for parents, you meet other parents, and realize they're nice people. You see that they're people like you are, with everyday problems, but they're not monsters or anything. So it helps you to feel better about yourself.

Lastly, since parents shared many of the same feelings and concerns as other suicide survivors, they were able to support each other, learn from each other, and have their feelings normalized. Parents found it reassuring to find out that their pain, frustrations, and feelings were normal. For example, Alice, who thought she was "off the wall" for becoming upset when her friends cleaned her deceased daughter's room and removed her scents, realized her feelings were normal after reading about another suicide survivor who felt exactly the same way she did:

> When I read about Iris Bolton (a psychologist whose son committed suicide) coming home from the hospital, cause her son wasn't dead when they found him . . . and she smelled pine sol, and she walked into his room and somebody had

> been in and cleaned it up, all the feelings that she described were *exactly* what I felt. And I sat there and I just sobbed. I was able to cry. I guess I wasn't in left field after all. Here's somebody else that felt the same way. . . . After reading Iris Bolton's book I realized that this is probably something everybody goes through, and not just something that happened to me.

Not only did parents receive support, they also provided it. Some parents were worried about their deceased child's friends experiencing suicide contagion, and tried to help them. Others were concerned about their spouse and children, and tried to ensure they got the support they needed. Still others worried about all the people who had been affected by their child's suicide and tried to comfort them.

Lack of Support and Understanding

Some parents also experienced a lack of support and understanding. Sharon indicated that she received very little support from her family and friends:

> Family and friends were not supportive. . . . [They responded to me with] avoidance and silence. "Don't talk about him," or, "Oh you're bringing that up *again*." . . . I never felt *we got the real help we needed* that would've made a difference in feeling that we were OK, and that we had worked through some of this. I feel any of the work I've done I've pretty much done *on my own*. I felt like an Eskimo on an ice drift going, "I don't know where I'm going but I'm all alone and it's really cold." But the people just stand on the shore and go, "Yeah, whatever, bye."

Several parents experienced blame from their family and/or friends, which served to exacerbate the guilt they were already feeling, as Terry and Andy respectively recounted:

> [My father] accused me of not listening to him, but listening to all these stupid people, and all of these *rotten* parents, whose children have killed themselves to get away from them. And how I didn't love her because I didn't pick her casket out. I couldn't arrange her funeral. All these things that I've been thinking, he verbalized. . . . So he was almost validating everything I thought. (Terry)

> We had this guilt, and we had the kids rubbing it in too. . . . Our youngest son [is] always throwing it back in my face. "You guys did it to Kris. You forced him out

> of the house.". . . It makes us feel guilt. We've had it from my daughter too. (Andy)

Sharon and Kate felt unsupported when they were unable to access community resources. Sharon was upset because she was not allowed to participate in a community run bereavement group with the other suicide survivors she had met. On the other hand, Kate felt "abandoned" when she was unable to access community support:

> You know what really really hurt me? . . . . I told you this resource person came with the police. Well she gave me all this information in a pamphlet. . . . I phoned this number . . . the first week after . . . every day, maybe twice some days, to get a hold of somebody in suicide services. Well there was no answer on that line. And you just can't imagine the way I felt. I just felt abandoned. Then I phoned the hospital and I asked the clergyman if he would counsel us. And he said, "No, because right now you hate the hospital staff," which was true. I did. So he said, "No, I can't do that." . . . But I really resented the fact that this number did not place us in contact with somebody who knew the feelings, knew what it was all about.

All the parents experienced a lack of understanding. Some, like Ann, experienced pressure from family and friends, who did not understand the grieving process, to stop talking about their child, and to stop grieving:

> A few girlfriends . . . just wanted me to get better. They didn't want me to talk. I wanted to talk about Jesse a lot. That's just about all I wanted to talk about for the first year, and a couple of them, I think, couldn't imagine going through that themselves, so they had a hard time listening to me, or identifying with me. They just wanted me to be my old self . . . and get over it. They just changed the subject. It made me feel like Jesse didn't exist. . . .They were both very good friends and still are. I think they just couldn't handle what I was going through at the time. . . .They wanted me to be over it and to move on when I wasn't ready to. . . . Most people felt that my talking about it made it last longer . . . and I had to talk about it to get through it.

Others, like Sally, were hurt by inappropriate comments family and friends made:

> Some of the comments were . . . pretty crass. . . . I didn't want to think about my son suffering, and I don't know whether you do or not by carbon monoxide, but I wanted to believe that his death wasn't painful, and [my sister] kept going on and on about how horrible it is, and suffocating. And this was *right after.* . . . Well I just sat there. . . . [My brother-in-law] stopped her. I was looking at her in horror, like why are you saying this? Whether it's true or not, I don't need to hear this

> right now, or ever. . . . I didn't say it on my own. I couldn't at that point. I was too shocked.

Stigma

Four parents experienced stigma during their bereavement. Terry and Alice felt stigmatized when their deceased child's school refused to have a memorial service for their child, and/or refused to include their memorial page in their yearbook, as Alice reported:

> The whole school episode to me was stigma, terrible stigma, that they wouldn't have the memorial service. That they wouldn't allow her picture in the yearbook. We had to fight that, and they did finally do that. . . . That was all stigma, and in the guise of not glorifying suicide. I have yet to figure out how you can glorify suicide.

Sharon felt stigmatized by her family and friends, who avoided her after her son's suicide:

> People avoided my house. My mother never came to my house from the time Benjamin died until the day of his funeral, which was like a week later. My sisters came *once*. None of my fiancé's family came. There was my ex-brother-in-law, and my best friend, and maybe a couple of other cousins, but otherwise everybody acted like we had the plague. . . . They couldn't even say the word suicide. . . . When they found out that Benjamin died by suicide, it was like we had the plague.

Kate experienced stigma when she heard a crude remark made in reference to her son's suicide:

> Six months later my daughter had a dinner at her place, and my daughter's brother-in-law came in the door and said, "Oh well, I thought that it was going be another hanging." . . . I thought it was very, very uncalled for, and definitely very hurtful.

Lastly, Terry, who was aware of the Catholic church's view on suicide, felt stigmatized by her Catholic brother-in-law, even though he never made any overt negative remarks:

> This whole Catholic thing with the view on suicide. . . . My brother-in-law is [Catholic]. . . . Nobody has ever come out and said anything, but he hasn't spoken

> to me since Dawn's 40 days, other then, "Hi, how are you doing?" as he's running down the hall. Like you care. Stop and listen. I think that has a lot to do with [the Catholic church's view on suicide]. They believe that suicide is a sin, so you're doomed to hell. I think in the back of my mind that's always there, and I'm thinking that's what they [think].

Four parents never mentioned experiencing stigma, and when I asked them if they had, they replied that they had not.

Critical Incidents

Parents experienced various critical incidents during their bereavement that increased their grieving pain. Some parents' sense of loss increased when they saw their child's friends, because they realized that their child could have easily been among them if he or she had not chosen to die. Several found it difficult to get through their first Christmas, and the anniversary of their child's death. Others found camping, family gatherings, and all the things they used to do with their child painful reminders of their loss. Sharon's pain increased when her daughter turned the same age her son had been when he died:

> My daughter is now 15, which is *really hard* . . . for me, because she's 15, she's in grade 9, and she's going to the exact same school her brother did when he died.

Unique Journeys of Grief

At the time of the interview, the length of parents' bereavements ranged from one to eight years. Although parents shared many of the above commonalities, their individual journeys of grief were unique, encompassing all their past and present experiences. For example, parents found different times of their bereavement most challenging. Ann and Bill reported that their first year of bereavement was the most painful. Whereas, Alice and Sharon felt that their third year of bereavement was the most difficult. Differences were also evident in parents' movement towards healing. Two

months passed before Sharon felt ready to go and pick up her son's ashes, and then another four years before she could move his ashes from her bedroom to the living room. On the other hand, Terry's "incredible step" occurred one and a half years after her daughter's death, when she was finally able to shop for lingerie alone. And four years after her daughter's suicide she was still suffering deeply, and unmotivated to resume life. The following summaries of three parents' bereavement experiences demonstrate the uniqueness and diversity of parents' individual journeys of grief.

Ann's Journey of Grief

> The first year . . . was just pain and grief the whole time. . . And then the next year the high points would be anniversaries, or Christmas, or a birthday . . . but I'm feeling better. After a year and a half or two, I finally grieved just because my son passed away, not anything to do with the suicide. . . . [The third year] it goes down another notch, and it still bothers you, but not as much. [Now in the fifth year] I think I'm at the point where I've gotten as good as I'm going to get. Certain times of the year [are always going to] bother me, but I don't go back, I don't go into that grieving as much, or for as long.

During a telephone call, eight years after her son's death, Ann reported that she was at a 7 or 8 out of a possible high of 10 (the best she has ever felt), and stated: "I do have periods where it doesn't bother me at all."

Sharon's Journey of Grief

> The first year I count nothing. It was almost like remote. . . . The second year things kind of levelled off. . . . The third year was the *worst*. It was like straight down again. The numbness had worn off. The kind of unreality of it was gone, and now it's back to reality. Within that [time] my mother died, and my great-grandmother that had raised me died. The third year was just horrible. . . . There were a few happy spots cause . . . within the second and third year I started talking to people. . . . This year (fourth year of bereavement) . . . I'm back down. I am just way down here. . . . Everything just seems *so hard*. Lack of support in trying to deal with Lisa. Like I said, now she's 15. . . . To look at Lisa and her being 15, at this moment she is older then her brother will *ever be*. . . . It brings up the anger again, of where the hell is he? Why isn't he here? Why do I have to be left to clean this up?

During a telephone call, Sharon, who is now in her seventh year of bereavement, and has recently married a supportive husband, stated: "[I'm] now at a 9.5 (out of a possible high of 10) because nothing is perfect." She reported that this is the best her life has ever been, and that she is very hopeful about the future. She referred to her process of grief as a balloon that got "lighter and lighter."

Terry's Journey of Grief

> It's a horrible, horrible roller coaster. Just when you think you're kind of levelling off, you . . . go further down. When I first found out, the first while, the first couple of weeks, the first couple of months, it [was] all consuming. You can't eat. You can't sleep. You can't do anything. . . . [The first year is] like watching a movie. . . . I don't remember much. It's not real. She's going to walk back in that door. We can't move to [another city]. How's she going to know where we are? . . . The second year, she's not coming through that door. . . . I remember times when the wind would catch, and it wouldn't be latched, and the door would open, and I'd call her name. . . . The second year, OK, she's not coming back. And I'm thinking, it took me a *whole year* to realize this. OK she did die. This isn't a nightmare. I'm not waking up, cause I would've. So the second year reality was setting in. I think the third year I had to really accept her death, really accept that she's gone. . . . Right now [in my fourth year of bereavement] . . . I'm at the level part that's kind of turning the corner. We don't know what's around the corner, but we're starting to turn the corner. . . . Now I just have to figure out how I'm going to go on.

I contacted Terry by phone during her seventh year of bereavement. Her home had recently burned down and she had just quit her job, "not on very good terms." She and her husband were seeing the same counsellor, individually, and she was considering either separating from her husband or divorcing him, because she lacked the energy to fight and save her marriage. Terry remains estranged from her extended family. She found it too painful to read the transcript of her interview that I had sent her.

Summary of Theme Three

After their child's suicide, all the parents tried to figure out why their child chose to end his or her life. However, although they accumulated a great deal of information

about their child and suicide--information they had largely hitherto been unaware of--most of them were unable to make sense of their child's suicide. Parents experienced a spectrum of feelings during their bereavement which included denial; relief from pre-suicide stress; guilt; anger at themselves and at others; sadness, loss, and yearning; shame; suicidal ideation; and hope. Those who experienced other bereavements during this time noted that this one differed from the others most notably because of their obsession with why questions, their guilt, and their regrets. In addition to their feelings of grief, parents were impacted by a variety of experiences during their bereavement. Receiving comfort, understanding, and support, and using helpful coping mechanisms impacted their grief in a positive manner. Whereas, spousal differences in grieving and marital conflict, challenges parenting surviving children, unhelpful coping mechanisms, lack of support and understanding, stigma, and critical incidents all served to exacerbate their pain. Finally, although parents shared many commonalities with other suicide survivors, they all experienced unique journeys of grief that encompassed their unique circumstances.

Theme Four: Experiencing Personal Growth

Most of the parents experienced personal growth during their bereavement as evidenced by the following: (a) knowledge they acquired, (b) introspection they engaged in, (c) insights they gained, (d) meaning they found in their loss, (e) their changed attitudes and behaviours, (f) their growth, (g) their desire to help others, and (h) their anticipation of the future.

Acquiring Knowledge

While grieving, all the parents sought and gained knowledge about suicide, bereavement, and other distressing personal issues they were grappling with. Most parents accumulated a great deal of information about suicide in their attempt to make sense of their child's suicide. Terry believed that if she had possessed this knowledge prior to her daughter's suicide, her daughter might still be alive. However, Alice, who used to hold this view, changed her mind after reading a book by a psychologist, whose son committed suicide:

> I read the book, 'My Son, My Son' by Iris Bolten. Well, here is a psychologist, who owned her own clinic and her son killed himself. Well that blew that theory out of the water in a hurry, didn't it?

Parents acquired knowledge about grief by experiencing it, reading about it, hearing about it, and discussing it with others. As they attained this knowledge, many of their former misconceptions about grief were dispelled. For example, Andy, who before his son's death avoided grieving people, learned the significance of support:

> I would be probably the first one over to somebody, cause I know you don't dodge somebody. Go talk to them. That's what most people want, is to hear something. . . . It was an eye-opener for me cause I didn't want anybody to dodge me but [some did].

Kate, who experienced physical ailments due to her repressed grief, learned the importance of expressing her grief:

> I read, and read, and listened, and talked, and wrote and cried. I think I cried a river, and then I went to this [suicide support group] course. . . . And the course was very helpful.

Most of the parents learned that men and women grieve differently--information that helped heal many of their spousal relationships, as Ann reported:

> At first I thought he wasn't grieving, like he didn't miss Jesse like I do. But . . . I learned . . . that men grieve differently, so that helped me a lot. . . . I think if I

> didn't learn to understand then I think we'd probably be separated. . . .Once I got that into my head then I could start seeing that he was grieving in different ways.

Finally, some parents gained knowledge about personal issues they had been struggling with since childhood. Sally and Alice learned about their childhood anger. Sally realized that the anger she had developed as a child, due to her abusive home life, became her determination to overcome her childhood. She also recognized that although her determination allowed her to surmount her difficulties, it narrowed her focus. Alice, who experienced life-long anger due to her childhood sexual abuse, learned about anger, and realized that it can be an impetus to correct wrongs. She also learned about sexual abuse and the impact it had on her life:

> I started learning and reading stuff, and it started making sense. . . I was like a sponge wanting to learn this stuff, because I didn't like being where I was. And when I started reading about sexual abuse and seeing what damage it does to kids, how it affected my thinking, how it affected my behaviours, it all started to click in and make sense. . . . I did a lot of work, a lot of reading, a lot of figuring out. It took years.

Alice continues to be an avid learner, and continually accumulates information about sexual abuse, suicide, bereavement, and other areas so that she can learn, grow, and help others.

Engaging in Introspection

Most parents were triggered by their child's suicide to engage in "a lot of soul searching." They re-examined themselves, their family of origins, their parenting, their relationships, their beliefs about suicide, and most of their long-held beliefs, as Alice and Sharon respectively described:

> When you lose a child, when you lose someone so valuable in your life, you have to go and re-investigate everything. You have to check out all your belief systems. You have to look at what was truth and what was not true. And you have to question it. . . . Searching my faith . . . dealing with the sexual abuse, dealing

> with my family . . . and going through all that mire of crap to try and figure out what was going on for myself, and figure out all the feelings that were there. Cause I'd shut down [my] feelings for so many years. (Alice)

> I've always believed that everything happens for a reason, I *really* had to sit with that one and go, how could this *possibly be?* How could there be a *reason* for this? Because I always wanted a big boy. And he was *such a good kid.* . . . .Why didn't I kill myself, before he had a chance? . . . I never expected to be in this point in my life, *ever.* . . . I had such *good plans.* And the change that having lost my child has made to my own re-evaluation of who I am, and what *I* should be doing with my life for the betterment of myself, my son who's not here, and my daughter who *is* here. So it makes you reconsider things, or it should. (Sharon)

Gaining New Insights

As a result of their introspection, parents gained new insights that helped them move forward in their journey of grief. Surviving the "worst thing that could happen" caused Sally and Ann to become aware of their inner strength, as Ann described:

> Sometimes it takes a tragedy to help us find a path to that place, deep within us, where lies a strength we never knew we possessed. . . . I never thought of myself as a strong person before. I never thought I could handle this, and I guess it showed me that I could. Cause before anything ever happened to any of my kids I used to say quite often . . . if something happened to my kids I'd never be able to handle that. So I guess I discovered that I was strong enough to handle it and get through it. [Knowing that] makes me feel stronger. It makes me feel that I could just about cope with anything. Not that I want it to happen.

Some parents gained new insights about parenting, such as the importance of affirming their children, and role modeling for them. Several, like Alice, realized that they first had to take care of themselves before they could take care of others:

> You can't boost anybody's self-esteem if yours is low. . . . You have to take care of yourself. The analogy I use is the pitcher of water, filling everybody's cup. Pretty soon if you don't fill this vessel back up it's empty. And you know what it will fill with if you don't fill it with good stuff? It fills with anger and resentment. And you start pouring that into your family.

Most, like Ann, gained a greater appreciation for their children, close family members, and close friends:

> This experience and the death of both of my parents has taught me to enjoy and appreciate my life and the people in it more so than before. . . . Because when all is said and done, all you have left are your memories of the special people in your life.

Conversely, several parents realized that some of their relationships were unhealthy, and even detrimental, as Sharon reported:

> I looked at who I was hanging around with, and what I was doing with my life, and went this is wrong, or this is mediocre, but it's not what *I really want*. . . . [I've] re-evaluated how people have treated me, and how I've allowed it.

Several parents realized that some of their long-held beliefs were false, and that they had developed some destructive behaviours as a reaction to their traumatic childhoods. Alice realized that she had passed her childhood feelings of anger and victimization onto her daughters. Sally realized that she had reacted to her abusive childhood by becoming controlling:

> [I thought] that it was my responsibility to make sure that everything was OK. . . . I guess in a way it woke me up to [the fact that] maybe I'm a bit of a control freak in that way. . . . I found [it] hard to think of myself in that way. And I thought OK, cause it's still control whether you're doing it in a nice way or a bad way. . . . So that *really* woke me up. I thought, oh my God. . . . I just didn't want to be like my dad, and that's what it all boils down to.

Sally has also realized that she is not abusive, so she no longer worries about being like her abusive father. Most parents came to the realization that suicide was their child's personal choice. Sharon felt "uplifted" when she realized this:

> I'm not the one that did it. It was *his choice*. . . . I was so uplifted that I didn't do it. I think that was the biggest thing. I found out *I didn't do it*.

On the other hand, Terry concluded that people who complete suicide are mentally incapable of exercising choice. Finally, most parents realized that their lives were forever changed and that they would never stop grieving their child, as Andy, Kate, and Ann respectively stated:

> It's never going to go away. (Andy)
>
> I am now mourning the loss of a son, and I will for the rest of my life. (Kate)
>
> I think I'm at the point where I've gotten as good as I'm going to get. Certain times of the year [are always going to] bother me. But I don't go back, I don't go into that grieving as much, or for as long. . . . I do know we will miss him for the rest of our lives. (Ann)

Finding Meaning in Their Loss

Sharon and Alice found meaning in their loss. Sharon, who was severely depressed and suicidal for 20 years prior to her son's suicide, believes that her son committed suicide so that she could live and take care of herself and help others.

> He took my option, so that I couldn't use it, so that I could do what I'm supposed to do, which is learn how to take care of *myself,* as well as help other people. Whereas, if I killed myself, there would be two children without a mother. . . . Benjamin's life was for a reason, and I chose *not to kill myself* for a reason, and yet my son did, maybe that's why so that I could somehow break the circle and fix things for other kids.

Alice concluded that her daughter's purpose in life was to teach her, and that she needed to experience her daughter's death in order to re-examine and heal the pain from her childhood, so that she could fulfill her purpose in life— to help other people:

> I am here to learn certain things. . . . And I believe that Lynn came into my family to be the catalyst to teach me. . . . [I] had to go through the whole process from the start until today. . . . because [a lot] of the belief system that I had was not true. Things that my parents had taught me, the beliefs that I had developed as a child, were not true. They were false. [I had to] question everything, and now as an adult to see, yeah, I made this choice because this is the information I had. If I would've had the information I have today I wouldn't have made a lot of those choices. . . . Lynn's death was a real kick-start into healing for me. . . . The more I read, and the more I learn, the more I see that's what it's about. It's about nurturing the gift. It just validates the fact that I'm on the path that I know I'm supposed to be on. It definitely [enables me to] help other people. I can share all kinds of information. People that I come in contact with through this job, through suicide bereavement, and through my . . . volunteer work, know I've walked the path, and that just really validates for them that I kind of know what I'm talking about.

Making Changes

As parents learned, re-evaluated, and gained insights, many of them began to make important changes that allowed them to live more meaningful lives. Ann and Alice put their faith in God and asked him to direct their lives, as they respectively recounted:

> Believing in God and religion was a part of my healing too. Finally, towards the end of the second year or beginning of the third year, I asked God to help me deal with this. Actually, I asked Him the Serenity Prayer, to help me accept what I can't change, and change what I can. After I did that it seemed like I started to get better. I think it was me being ready to get on with my life, plus it was Him, He helped me. I think knowing that He knows the answers helped me. That I didn't have to search for these answers anymore. . . . After I asked Him to help me with the Serenity Prayer, it was like a peace came over me, and I knew I didn't have to search for the answers anymore. I didn't have to do that part of it. I could just miss Jesse for who he was, my son. I knew I didn't have to worry about him cause God was taking care of him. (Ann)

> I finally made, again, a conscious decision that either I'm going to stay feeling like this or I'm going to allow God to help me. My choice. I can make the choice. So I decided to take a risk and see, and test God. I decided that I was going to open that gift [of grace] and I was going to allow Him to work in my life. And so that's what I would pray, that He would give me what I needed for the day. That He would put the people in my path that I needed. That He would open my eyes so I could *see the people in my path*, and that is the gift that He gave me. (Alice)

Sharon consciously forgave herself for her son's suicide, while Ann and Alice accepted their child's suicide. Others released some of their former fears, such as their fear of death, their fear of becoming abusive, or their fear of being judged unfavourably by others. Ann released her feelings of bitterness and resentment:

> I'm able to let go of [resentment and bitterness] because I know it's not like somebody picked me for it to happen. It happens to other people too.

Sharon, Sally, and Alice furthered their education. Alice, who used to believe that she lacked academic ability, challenged her former belief and returned to school as a full-time student at the age of 50.

> I believed that I couldn't go to university, or anything like that, because I didn't have brains enough. So I decided if all this thinking that I had been doing all this time was false, and a lot of it was, maybe this is false too. So I decided to go back to school full-time. I took a program . . . which really interested me . . . and graduated. . . . and when I completed my program I was able to get a job with the Support Network, and then also . . . with Mental Health on the crisis team.

More recently, Alice completed an ethics course and was grandparented into the Social Work program, and is presently working as a registered Social Worker.

Experiencing Growth

Parents experienced growth in their relationships and in their personal lives. Sharing grief, and experiencing and overcoming challenges, strengthened some parents' relationships with their spouses, children, family members, and friends. Ann, Bill, and Alice, who overcame marital challenges during their bereavement, enjoy stronger marital relationships, as Alice described:

> [Now my husband and I are] able to talk to each other, and we're able to share. We're able to live together, laugh together. . . . We are communicating. Our marriage is much stronger, much stronger.

Interestingly, the only married couple in the study had different opinions on the status of their marriage. Bill felt that experiencing their son's suicide strengthened their marriage, whereas his wife, Kate, felt that their marriage, which went through "rocky" times, is now "the same as it was before" the suicide. Sally and Sharon have both improved relationships with their ex-husband, due to their common bond of grief, as Sharon explained:

> Benjamin was our child. It doesn't matter how many times either one of us gets married to other people, that will always be a *fact*.

Alice, Sally, Kate, and Bill have closer relationships with their children, as Bill reported:

> We try to get together as often as possible with our children, and grandchildren. I think there's more meaning to life with the children. . . . There seems to be more closeness.

Finally, Alice, Sally, and Andy, who already experienced close relationships with their friends and/or siblings before the suicide, noted that the grief they shared, and support they received served to further strengthen these relationships.

On the other hand, some parents realized that their relationships were detrimental and demonstrated strength by ending them. Sally and Sharon ended their engagements; Alice and Terry became estranged from their family of origin; and Sharon ended her unsupportive friendships. Finally, Terry, who experienced marital conflict before as well as after her daughter's suicide, is currently considering a separation or divorce from her husband.

Parents also experienced personal growth. Most of them, like Andy, became more sensitive to the suffering of others.

> A young kid got run over here a couple of months ago, a 12-year-old boy. I just grieve with his parents. I never would have done that before. But now I know [what] they must be going through. . . . [So now I grieve] every time I hear something happens to some child.

Terry became more independent, easy going, and open about her feelings. Ann became more assertive, outspoken, and indifferent to unjustified negative criticism. Lastly, Alice, who experienced tremendous growth in many areas of her life, finally became the kind of person she always wanted to be.

> I can really integrate what I wanted to be with who I am now. I always wanted to be this person that people liked, that people trusted . . . honest. . . but I didn't believe I ever could get there. . . . [Now] I can really feel it inside my soul. I really know it's there. And that gives me the courage to do just anything. . . . I like myself a lot better now then I did [before].

Some parents also experienced impediments to their growth. Sally and Sharon were diagnosed with Posttraumatic Stress Disorder (PTSD). Sharon was unable to work, and had to go on social assistance due to this condition. Sharon and Terry, who both found their child hanging, experienced phobic reactions. Terry experienced panic attacks and phobic reactions to a variety of things that she associated with her daughter's hanging.

> I couldn't deal with anything around the neck. . . . I was *terrified* of [the basement] door. . . . Any sort of ropes. My towels, nothing hangs over. . . . These all trigger flashbacks, and panic attacks. People during Halloween put little white ghosts in Christmas trees. . . It puts me right back there, because these little white ghosts are hanging in the tree, and Dawn was wearing white. . . . Basements. I can't do basements. . . . Even now, if I drive around in the evenings, basement windows, if there's lights on, they bother me. . . . nooses, brown extension cords.

Helping Others

Most parents helped others, and found it therapeutic to do so. Helping others increased their feelings of self-worth, allowed them to reciprocate the help they had received, caused them to become aware of their own progress in grief, and helped them find meaning in their child's loss. As noted in the previous theme, Experiencing Their Child's Death, four parents wanted to donate their deceased child's organs to help others, although only three were able to do so. In addition to donating her son's organs, Sharon became a spokesperson for organ donations:

> I'm speaking at different schools . . . as a donor mom on organ and tissue donation. . . . [and] I'm . . . on the media contact list at the [hospital] for donor families.

Terry gave suicide presentations at her deceased daughter's school:

> Six months later [after my daughter's suicide] I attended a memorial service at her school for another student who had just died, and the kids were like magnets. . . . [they] were just all over me. . . . [Some] of the teachers I met said, "Oh you are the one. The kids are all talking about you. They said how much help you've

> been." . . . [A] lot of them too said that the kids wouldn't talk to them. But they saw all the kids around me in the hallways, because I could relate to them. So anyway, I told this one teacher, "If there's anything I can do, call me." Well he called me the following November and asked if I would come into the school and speak to the kids on suicide. I said, "Yeah." So I did that for 3 years.

Ann wrote an article about her son's suicide for her local newspaper to help other suicidal children and their parents:

> I wanted to reach someone out there that maybe was going through something Jesse was going through. Or maybe a parent that was going through the same thing, and maybe their child hadn't suicided yet.

Alice's community dramatically increased their suicide intervention program as a result of her daughter's suicide:

> Through all of this we've done lots and lots of suicide intervention in our community. . . . We had two mental health workers [in our town], and since Lynn's death we now have three full-time therapists. We have a geriatric psych nurse that looks after the geriatric population. We have a psych nurse that looks after our chronic population. We have three of us on the crisis team, two crisis workers and one therapist. We have one child psychologist. We have two psychologists who do therapy for the student health initiative, and six liaison workers in the schools.

Alice and Sharon became resource persons for other suicide survivors. Sharon explained how she ended up becoming a resource person:

> I found that after Benjamin died I was doing more comforting, and consoling, and counselling. I had people phoning me. The mom that lost her daughter, she had an article in the paper, and we started a suicide support group, because there wasn't one in a city as big as [this]. So the journal asked if they could print my name and number, and I said, "Yeah, OK." The day that article came out I had people phoning me and telling me their personal stories of how they lost someone to suicide, or what they thought of the article. . . . So I somehow became a resource person, months down the road, for other people.

Alice, Sharon, and Ann supported others who were bereaved. Ann described her experiences:

> A cousin of mine lost a son to suicide, it'll be 2 years at the end of March, and I've been helping him quite a bit. . . . Just after Christmas a lady and her husband

> lost a son. . . . The dad was the one that worked with my son. So I went to the funeral, and I just expressed to them that I had lost a child, just so that they could see that I had gotten through it. . . . My plans are to go and visit her at her home. . . . Just so she knows that other people have lost a child and [have] gotten through it.

Alice became a social worker, and now facilitates bereavement groups and advocates for suicidal people and their families:

> I'm running groups for any death. I just finished one for moms of suicide. . . Now I can advocate for those poor people that come into the emergency who have attempted suicide, or who are contemplating suicide. . . When people see that I've survived it gives them hope that they can too. . . Now the physicians respect what I have to say. . . . because I have gone back to school, and I have some professional affiliation. It's not just all feeling stuff. Some of it is book knowledge as well. So knowing my personal experience, the stuff that I've done, plus my educational stuff, they're starting to listen.

Finally, all the parents agreed to participate in this research with the hope that their stories would help others who are grappling with suicide, experiencing bereavement, or suffering in any other way, as Ann, Kate, and Sharon respectively stated:

> Certain things I talk about still bother me a little bit, but it makes me feel good, because anything I can do to help anybody that's going through the same thing, if I can help anybody then it makes me feel good. (Ann)

> It's good. . . . There's a few parts of course, because when you go back through things you remember the ties that you have with that person. I had really special bonds with Scotty, and so that pain comes up. But that's alright. If it helps other people, good. If it helps somehow to prevent more, very good. (Kate)

> I think education is really important, especially on this topic. I want to help others. The reason I chose to participate in this [research] is to help educate others who at some point in their life may need this information. This opportunity is one of those rare gifts from Benjamin to help others. (Sharon)

Anticipating the Future

Most parents are looking forward to the future and have specific goals they want to accomplish, as Alice and Sally respectively shared:

> I think the future looks really good. . . . I think lots of good stuff. Right now we've trained a bunch of people to help us with bereavement groups, and I think that's going to grow and grow. Once I get more people trained so that they can facilitate groups, I can do some more specialized ones, like retreats and that kind of stuff, and just supervise the running of the groups. So I think there's lots of big stuff ahead. (Alice)

> [The future looks good.] Its never looked bleak. I've never been negative about that. My daughter's happy, and I'm *so glad* that she's doing well. . . . I am now working at a [chartering accounting] firm, took a course in basic accounting, and will be learning and taking on some new challenges. (Sally)

Sally and Sharon have begun new spousal relationships. Sharon, who recently married a compassionate and supportive man that her daughter likes, said she has never been happier, and that she is very hopeful about the future. Bill and Ann talked about the love and joy their grandchildren have brought back into their lives, and how they are looking forward to watching them grow up. Ann shared similar sentiments:

> My future is my grandkids, and my husband and myself growing older and doing things together. I might look at some kind of a career. I'll probably get into some kind of office stuff, but . . . I see a good future. I don't see a lot of gloom and doom. I see, you know, seeing my grandkids grow up, and seeing my daughters do what they're going to do with their lives, and seeing what's going to happen with me and my husband. It seems like we're growing older by the day (laughs). It's happening so fast (still laughing). . . Yeah, yeah. There's lots of hope.

Finally, Bill, Kate, and Andy are looking forward to retiring from work, and moving to smaller, quieter, friendlier towns, where they can enjoy less stressful lives. Bill and Kate, whose children and grandchildren have already relocated to the small northern town they are moving to, are eagerly anticipating their new life there with their loved ones.

Summary of Theme Four

Most of the parents experienced growth during their bereavement as they gained knowledge, re-evaluated many of their former beliefs, and gained insight. A few parents were also able to find meaning in their loss. As a result of the new insights they gained,

many changed some of their former attitudes and behaviours, and experienced growth in their relationships, as well as in their personal lives. Most of the parents wanted to help others, and found it therapeutic to so do. Finally, although they realize that they will never stop grieving their child, most of them are anticipating the future.

CHAPTER SIX

DISCUSSION

The question that prompted this research, "What is the experience of parents bereaved by the suicide of their youth?" was answered through the four themes that emerged during analysis, as described in the previous chapter. This chapter focuses on four key findings that came to light from this study and discusses them within the context of the current literature. First, the stress parents experienced before their child committed suicide is examined. Then, some of the factors that complicated parents' grief are considered. This is followed by a discussion of how parents became disconnected from others when their child died, and then reconnected. Finally, the factors that influenced parents' growth are examined. This discussion is followed by implications for practice, future research and education, considerations for this study, and my personal reflections.

The Pre-Suicide Period

The pre-suicide period is an important aspect of parent suicide survivors' experience. Similar to Rosenblatt's (2000b) findings in his study of bereaved parents, when the parents in this study were asked to share their experience, they quickly moved to the time before the death. It became apparent that in order to understand parents' bereavement experience it was extremely important to understand their experience before their child committed suicide.

Most of the parents began grieving the loss of their child long before their child committed suicide; that is, they grieved the loss of their child as they had formerly known him or her. Although they did not realize it at the time, in retrospect they all recalled a specific turning point in their child's life when their child began to change, and

became disconnected from them. However, even though parents were concerned and perplexed about the changes, most of them did not realize that their child's behaviours were an indication of their child's emotional distress, and attributed them to their child's stage of adolescent development.

As their child's behaviours deteriorated, most of the parents became increasingly concerned and recognized that their child's negative behaviours (Esposito-Smythers et al., 2004; Kelly et al., 2002; Pompili et al., 2003; Wilcox, 2004) went beyond normal adolescent behaviours and sought help for their child. However, because they lacked knowledge about mental illness and youth suicide, many of them still did not realize that their child's destructive behaviours were signs of emotional distress and suicidal ideation. Three parents finally realized their child was suicidal after their child attempted suicide. The other parents remained unaware of their child's suicidal ideation until after the fact, because their child did not make overt attempts.

Most of the parents experienced an inordinate amount of stress during the pre-suicide period in what appears to be a cyclical reaction between parent and child. Parents found living with their child's emotional distress and destructive behaviours a lengthy and distressing ordeal, marked by such stressors as tension, conflict, violence, repeated crises, suicidal threats, previous suicide attempts, death threats against them, and fear of their child's possible suicide (Cleiren et al., 1996; Esposito-Smythers et al., 2004; Hollenbeck et al., 2003; Jordan, 2001; Mohr, 2003; Seguin et al., 1995). At the same time, most of the parents were also struggling with their own personal problems such as depression, family illness, bereavement, anger and frustration due to family of origin issues, communication difficulties, feelings of inadequacy, parenting differences with

their spouse, concern about their other children, suicidal ideation, a history of sexual abuse, a family history of suicide, alcohol abuse, marital conflict, and separation (Cottle, 2000; Field, Diego, & Sanders, 2001; Hollenbeck et al., 2003), which may have increased the conflict at home and limited their ability to help their child.

Parents' lack of knowledge about their child's emotional condition further intensified their stress during this difficult time. Because they lacked knowledge, they did not understand what their child was experiencing, which caused them to feel frustrated, powerless, and helpless to make good decisions about their child's treatment. They observed their child self-destruct and create havoc in their home, but felt scared and helpless to intervene. Knowledge about youth suicide and their child's emotional distress would have alleviated some of the anxiety they experienced, similar to the findings of Hollenbeck and colleagues (2003).

Their stress was further exacerbated when they sought help for their child, and with the exception of a few helpful psychologists, found most of the mental health professionals, school staff, and hospital staff they consulted with very unhelpful and unsupportive, and in some cases even harmful. Although these parents were their child's primary caretakers, and extremely concerned about their child, most of the mental health professionals did not involve them in their child's treatment, or provide them with knowledge about their child's condition, or support caring for their disturbed child. Instead, most of the parents felt dismissed, and that their input, fears, and concerns were not heard or acknowledged. Some even felt that the mental health professional pitted child against parent, as though they were the enemy the mental health professional had to protect their child from. For example, one father, who retaliated when his son attacked

him or his family, was treated like the aggressor by the counsellor he consulted. However, as Gallagher (2004b, p. 95), who has worked with parents victimized by violent youth noted, "Even well-meaning, non-abusive parents at times retaliate or defend themselves against attack." Another parent, who feared that her son would commit suicide, was devastated when her son's psychiatrist refused to talk to her, in spite of her repeated attempts to contact him. Lastly, two parents, whose child attempted suicide, received no information or support from the emergency hospital staff to enable them to help their child. Instead, the emergency staff blatantly ignored them and only talked to their child. These negative interactions with mental health professionals caused parents to feel even more desperate and hopeless about help being available. Other researchers, who have studied parents and family members of children and youth with mental health needs, have reported similar findings (Gallagher, 2004a, 2004b; Hillian & Reitsma-Street, 2003; Mohr, 2003).

Lack of communication between health care professionals and parents is a critical finding of this study. It demonstrates that although parents were desperate for help, and actively sought it, they were frustrated by the treatment they and their child received from mental health professionals. Similar to the parents in Mohr's (2003) study, most felt diminished and dismissed by them. Instead of being helped, parents were disempowered by the professionals they contacted, excluded from the helping process, and had their guilt reinforced. Although parents are expected to be the primary supervisors, caregivers, and rehabilitators of their struggling youth, they do not receive adequate support or information from professionals, and often encounter exclusion from meaningful participation in important decisions that affect their child and themselves. Most of the

parents in this study experienced a sense of desperation and helplessness as they watched their child self-destruct, because they lacked the knowledge and resources to help him or her. Indeed, their stress became so unbearable that most of the parents felt relieved when their child died that the stress had finally ended.

Factors That Complicated Parents' Grief

Although the parents in this study share many commonalities with other bereaved parents, some of the issues pertaining to their child's suicide that they struggled with are unique and complicated their grief. This section examines the following factors that complicated their grief: relief and guilt, stigma, trying to make sense of the suicide, and challenges parenting their surviving children.

Experiencing relief and guilt simultaneously complicated parents' grief. As noted previously, most of the parents experienced a great deal of stress during the pre-suicide period. Therefore, when their child died, in addition to their intense grief, they experienced relief that the horrific stress they had been living with had ended. This finding is corroborated by other researchers, who have found relief to be a common experience in families of suicide completers due to the fact that suicide survivors no longer have to contend with the deceased's destructive behaviours (Clark and Goldney, 2000; Esposito-Smythers et al., 2004; Jordan, 2001; Seguin et al., 1995).

Most parents' sense of relief was accompanied by guilt, as evidenced by their reluctance to talk about it. Outside of the first parent I interviewed, who voluntarily and openly discussed the sense of relief she experienced when her daughter died, all the other parents only acknowledged it after I asked them about it. As noted by Esposito-Smythers and colleagues (2004), parents may have been reluctant to talk about their sense of relief

because they feared that their comments would be taken out of context, or misconstrued as being unloving or disloyal to their child.

In addition to the guilt that accompanied their feeling of relief, some parents also experienced guilt about the conflict-ridden relationship they had experienced with their child before the suicide, and/or their lack of communication with their child. These findings are similar to those reported by Clark and Goldney (2000) in their study of relatives and friends bereaved by suicide. Some parents also felt guilty when they re-examined the past, armed with their new found knowledge about youth suicide and their child's emotional distress, because they could see things now that they had not seen when their child was alive. Possession of this knowledge back then might have enabled them to prevent their child's suicide. Finally, parents also experienced guilt for failing in their responsibility as parents, being unable to help and protect their child, and for things they had or had not done.

In contrast to the findings of other researchers, who found stigma to be a prevalent experience of suicide survivors (Bailley et al., 1999; Clark & Goldney, 2000; Grad et al., 2004; Hollander, 2001; Moore & Freeman, 1995; Seguin et al., 1995; E. Silverman et al., 1994-95; Sprang & McNeil, 1995), stigma was not a predominant experience for the parents in this study. Instead of experiencing stigma, most of the parents experienced an outpouring of support from their family, friends, neighbours, co-workers, clergy, counsellors, police, Victim Services, and other suicide survivors. The funerals were very well attended, and most of their spiritual leaders were empathic, compassionate, and supportive (Clark & Goldney, 2000; Rolheiser, 2000a, 2000b;

Wertheimer, 2001). The stigma that was experienced was limited and sometimes self-imposed.

Similar to the findings of other researchers (Clark & Goldney, 2000; Kalischuk & Hayes, 2003; Robinson, 2001; E. Silverman et al., 1994-95; Wertheimer, 2001; Worden, 2002) all the parents in my study searched for rational explanations for their child's suicide. Although, as other researchers have noted, asking "why" questions is a necessary component of suicide survivors' process of grief (Kalischuk & Hayes, 2003; van Dongen, 1990), this study found that it also complicates, extends, and blocks parents' grief. Parents felt relieved once they were able to stop obsessing about why their child committed suicide and simply grieve their child's loss because he or she died.

Most of the parents found it difficult to parent their surviving children while in the throes of grief, and/or because they had lost confidence in their parenting ability when their child committed suicide. Some parents found that their surviving children became suicidal, so they were once again required to face the challenge of parenting a suicidal child, with all the accompanying conflict, stress, and fear that entailed. Others were concerned about the effect that the suicide was having on their surviving children and were concerned about their surviving children getting the help they needed to adjust to the suicide of their sibling. Similar to K. Dyregrov's (2002) findings in his study of parent suicide survivors, parents tried but were unable to access the support their children needed, or the support they accessed was unhelpful. All found parenting challenging because they were grieving, and more importantly questioning their parenting abilities.

Disconnection/Reconnection

The isolation and disconnection parents experienced following the suicide was exacerbated by their inability to share their grief with their spouses. As would be expected, they felt very isolated and alone. However, contrary to the findings of other researchers (Hollander, 2001; Moore & Freeman, 1995; Seguin et al., 1995; E. Silverman et al., 1994-95; Sprang & McNeil, 1995), who found that suicide survivors generally experience a lack of support, most of the parents experienced an outpouring of support, as noted previously. Furthermore, most of the support they received was sustained and long-term. Once parents found others to communicate with and receive support from, their isolation dissipated and they began to feel reconnected. This section focuses on the support parents received from Victim Services and other suicide survivors that helped them feel reconnected to others.

The immediate presence of Victim Services, when their child died, provided parents with information, non-judgmental and unconditional support, and a concerned and caring environment, which helped them realize that they were not alone. In addition, most of the parents came into contact with other suicide survivors as a result of the referrals they received from Victim Services.

Parents experienced a special bond with other suicide survivors, with whom they shared similar experiences and feelings. Contact with other suicide survivors, either on an individual basis or as a participant in a support group, provided them with a number of therapeutic benefits. Meeting other suicide survivors helped parents feel reconnected to others, decreased their feelings of isolation and disconnection, and met their need to be understood and have their feelings validated. Support groups provided parents with an

opportunity to meet other suicide survivors, and to experience a sense of belonging. It also provided them with a safe, accepting, supportive environment, in which they could express the complexity of their feelings without censor or misunderstanding, and have their feelings normalized. In addition, parents learned about youth suicide and bereavement, and gained perspective about their suffering by witnessing the suffering of others. They also received and gave support and understanding, and experienced a sense of empowerment when their role shifted from being helped to being a helper. Meeting survivors from a range of socio-economic backgrounds and professions, and seeing that they were "good, kind, caring people," also helped them feel better about themselves. Finally, seeing the progress of other suicide survivors gave them hope that they too could survive their traumatic loss. These findings are consistent with the findings of other researchers who have reported the benefits of support groups (T. L. Martin & Doka, 2000; Moore & Freeman, 1995; Yalom, 1995). In short, the support parents received from other suicide survivors decreased their isolation and helped them feel reconnected to others. As Jackson (2004, p. 12) noted, "In the stories of others, suicide survivors may recognize common threads that help us understand that we are not alone in the confusing sorrow we face."

Personal Growth

Similar to the findings of other researchers (Klass, 1996; Klass et al., 1996; Polatinsky & Esprey, 2000; Rosenblatt, 1996, 2000b; P. R. Silverman & Klass, 1996), who found that bereavement can facilitate personal growth in mourners, this study found that the loss parents sustained served as an impetus for their positive change and growth. Although all parents demonstrated growth, their individual growth varied and seemed to

be influenced by the following factors: the knowledge they accumulated, the support they received, their introspection and new insights, their decision to move on, the changes they made, shifting their focus off themselves and onto others, and focusing on what they have instead of on their loss.

In contrast to the pre-suicide period, when parents felt ineffectual and limited by their lack of knowledge, after their child's suicide most of the parents became avid learners, and gained knowledge about a variety of subjects including youth suicide, bereavement, and personal issues they were struggling with. The knowledge they gained empowered them and equipped them to help themselves as well as others. There seems to be a strong correlation with the amount of knowledge parents attained and their growth, with those attaining the most knowledge achieving the greatest growth.

The parents who grew most also availed themselves of the love and support of family, friends, counsellors, and others, even though at times they felt misunderstood by them. By talking openly about their child's suicide, their feelings, and their needs, they were able to obtain the support they needed—a finding supported by Grad and colleagues (2004) in their study of suicide survivors. Knowing people cared about them seemed to give them the strength and hope to endure their grief, and courage to learn from their experience.

Some parents were triggered by their child's suicide, and in some cases by their child's pre-suicidal behaviour, to engage in "a lot of soul searching." They re-evaluated themselves, their family of origin, their upbringing, their parenting, their relationships, their faith, most of their long-held beliefs and values, society's values, and their purpose in life, and gained insights that allowed them to make some positive changes in their life.

Some realized that, since they had survived the worst thing that could happen to them, they possessed inner strength they had hitherto been unaware of—knowledge that greatly diminished all their other fears and gave them courage to try new things. Others realized that some of their long-held beliefs were false, and that they had developed some destructive behaviours as a reaction to their traumatic childhoods. Some realized that they had to take care of themselves before they could take care of others. Finally, some realized that some of their relationships were unhealthy and even detrimental.

Several parents also searched for and found meaning in their suffering. They concluded that it was necessary for them to experience their child's suicide in order to heal from their childhood pain, and fulfill their purpose in life—to help others. Finding meaning helped these parents endure their loss and grow significantly, which is consistent with Frankl's (1992) findings.

As a result of their new insights, parents made many positive changes in their life such as becoming more independent, open, honest, trustworthy, more able to give and receive, more selective about the people they chose to associate with, and less constrained by the opinion of others. Several developed stronger spiritual beliefs. Some developed stronger and deeper relationships with their spouse, similar to Rosenblatt's (2000a) findings, as well as with their children, family members and friends. Others ended detrimental relationships with their spouse, family members, and/or friends. Three parents furthered their education. One of these parents went back to school to equip herself to work with suicidal and bereaved individuals. Finally, three parents made a conscious decision to move on with their lives, in spite of the tremendous pain they were experiencing.

Initially, most of the parents were completely consumed by their grief. However, as they grew, most of them switched their focus off of themselves and onto the needs of others, and used their experience, knowledge and the insights they had gained to help others. Having developed an increased sensitivity to suffering, they supported other bereaved individuals by sharing their bereavement experience, and giving them hope that since they had survived they also would survive. Other helpful activities they engaged in included being a resource person for other suicide survivors, giving suicide presentations to schoolchildren, being a spokesperson for organ donations, writing newspaper articles about their child's suicide, working to increase their community's suicide prevention program, becoming a social worker, facilitating bereavement groups, and advocating for suicidal people and their families. Finally, similar to the findings of other researchers (Esposito-Smythers et al., 2004; Kalischuk & Hayes, 2003; Romanoff, 2001) all the parents participated in this study because they wanted to disseminate knowledge about suicide and bereavement so that they could help other parents and children who are going through what they went through. Helping others increased their feelings of self-worth, similar to the findings of T. L. Martin and Doka (2000), allowed them to reciprocate the help they had received, caused them to become aware of their own progress in grief, helped them find meaning in their loss, and helped them to heal.

Some parents began to focus more on what they had instead of on what they lost. Experiencing the painful loss of their child gave them a greater appreciation for their spouse, children, family members, and friends. Those with grandchildren talked about the love and joy their grandchildren had brought back into their lives, and how much they were looking forward to watching them grow up. One parent, who had previously

considered her son's suicide to be the worst thing that could happen to her, realized that losing her husband, or one of her daughters, or any of her grandchildren would be just as devastating. Most of the parents are looking forward to their future with their loved ones.

Implications for Practice

There are several important implications for practice based on the findings of this study. The first and most important implication is that we need to ensure that children who are struggling or suicidal receive competent mental health services.

The second implication is the importance of the role of professionals (i.e., educators, counsellors, medical staff) in supporting and educating parents of suicidal youth (Hollenbeck et al., 2003; Rotheram-Borus et al., 2000). Instead of being involved in their child's treatment, and receiving support and information from the mental health professionals who were treating their child, most of the parents in this study felt eliminated from participation (Mohr, 2003); this increased their stress and hindered their ability to help their child. Since parents are responsible for their minor child, and are in a unique position to help their child, it is imperative that mental health professionals working with suicidal youth involve parents in their child's treatment. Furthermore, they should provide them with a list of resources where they can learn about youth suicide and their child's mental disorder, receive help parenting through difficult issues (Esposito-Smythers et al., 2004), learn strategies that they can implement to alleviate the conflict and stress at home, and receive support. Not only would this alleviate some of the stress parents experience, but it would also empower them to help their suicidal child.

Furthermore, since the suicidal youth is part of a family system, and since most families of suicidal youth experience a significant degree of dysfunction, clinical work

with the suicidal youth should also include a family counselling component comprised of as many family members as possible. Family counselling would be contingent on the cooperation of the youth, the counsellor having established a good therapeutic relationship with the youth, and the counsellor being able to provide the youth and his or her family with a safe, supportive, therapeutic environment. Counselling could address the problems the youth and the family are experiencing, explore how family members are impacting each another, and suggest strategies that could be implemented to promote healthier family functioning. In addition, understanding the family dynamics will help the counsellor devise an appropriate treatment plan for the suicidal youth (Hollenbeck, et al., 2003).

A third implication from this study is related to counselling parent suicide survivors. Even though most of the parents in this study received a great deal of support from their family and friends, most of them still needed counselling support to cope with their devastating loss. Although some parents found counselling beneficial immediately after their child's death, most found it even more crucial after their first year of bereavement, when some of their shock, numbness, and denial abated. Overall, counselling was deemed helpful when the counsellor was experienced, and provided them with a safe facilitative climate where they could talk openly about their grief, explore their personal issues, receive education about the psychodynamics of grieving, have some of their thinking challenged, and receive long term support.

Counsellors, who work with parent suicide survivors, should be knowledgeable about grief and bereavement, and how the bereavement of parent suicide survivors differs from other bereavements. They should also be supportive, nonjudgmental, and

encourage parents to tell their stories and express their feelings in their own way and in their own time. They should expect to witness the myriad of intense feelings reported in this study, and view them as normal, healthy and appropriate responses to parents' grief. It is important for counsellors to normalize these complex feelings of grief, since most bereaved individuals fear that their reactions to their loss are abnormal (Moore & Freeman, 1995). Counsellors can use the descriptive themes found in this study, as well in the models of grief (Bowlby,1979, 1980; Kubler-Ross,1969; Parkes ,1972, 1986; Worden, 1991/2002), as useful guidelines to normalize parent suicide survivors' feelings of grief and their experiences during bereavement, as well as to explore their grief process. However, caution must be used to remain sensitive to individual differences, and not view the models or themes in this study as being fixed or prescriptive. Grief counselling should also include a psychoeducational component, in which parent suicide survivors are provided with information about bereavement and strategies to cope with grief. Some parents may also benefit from a family counselling component to help them open up the lines of communication regarding how the suicide has affected the family. Finally, grief counsellors should be aware of the community resources available for parent suicide survivors and their families, and make referrals to these resources as needed. Parents, who have surviving children and have lost their confidence in their parenting abilities, may need to be referred to parenting classes or a parenting group. Bereaved parents should also be informed about the benefit of contact with other suicide survivors, and referred to suicide support groups where they can meet other suicide survivors.

Most importantly, suicide survivors and support groups, especially suicide support groups, may be even more helpful than individual counselling. Contact with other suicide survivors, who share the traumatic experience, decreases isolation and disconnection and provides a safe and supportive community, where they can share their stories and complex emotions without fear of being misunderstood, be reassured that their feelings are normal, and help each other work through the trauma of their child's suicide. Lessons can be learned from each other, as well as from a knowledgeable facilitator, about youth suicide, bereavement, and how to cope with their grief. Finally, suicide survivors experience a sense of empowerment when they move on from being the helped to the helper (Moore & Freeman, 1995).

Implications for Research

A number of worthwhile lines of research can be considered based on the findings of this study. Since the experience of parent suicide survivors is still a relatively unexplored phenomenon, with information about the stress parents of a suicidal youth experience being especially scarce (Wagner et al., 2000), more qualitative studies such as this one are needed.

Furthermore, this study investigated parents who had been bereaved for at least one year. Future researchers should consider extending the criteria to two or more years to allow for the shock, numbness, and denial to abate and the reality of parents' loss to set in. Extending this criteria may also allow for the growth parents attain to become more evident.

The parents in this study were all white North Americans, and only two of the eight participants were males. Future studies could investigate parent suicide survivors

from culturally diverse backgrounds, with a greater representation of males, to reveal differences and/or similarities with the findings in this study.

Another valuable, albeit challenging, undertaking would be a longitudinal study that examines the experience of parent suicide survivors and the changes that take place over the course of their bereavement. A study of this nature could add significantly to our understanding of this phenomenon, and enhance our ability to provide parent suicide survivors with good quality support.

Since parents are in a unique position to observe significant changes in their child's behaviour and detect if their child is at risk for suicide, more studies assessing parents' knowledge of risk factors for youth suicide are needed to ensure parents are receiving the available research about youth suicide that could empower them to help their suicidal child.

Implications for Education

Although researchers have accumulated a great deal of knowledge about youth suicide and the mental distress young people experience, the findings in this study and in the literature suggest that our research findings are not being adequately disseminated to those in need of them. Most of the parents in this study reported that they lacked knowledge about youth suicide and their child's mental illness. Other researchers have also found parents (Maine et al., 2001), as well as physicians and teachers (Scouller & D. I. Smith, 2002; D. I. Smith & Scoullar, 2001) deficient in their knowledge of youth suicide. This finding highlights the need to implement educational programs that will provide parents, physicians, teachers, and others in the helping professions, who work with young people, with accurate information about youth suicide and the mental distress

young people experience, along with the actions they should take in response to a distressed youth (Scouller & D. I. Smith, 2002).

Considerations for This Study

There are a number of considerations in this study that need to be addressed. First, the purpose of my study was to gain an in-depth understanding of the experience of parent suicide survivors from the perspective of the parents involved. Therefore, as is characteristic of most qualitative studies, I used a small number of participants and stopped interviewing when my informants began to repeat similar themes in their narratives. Second, the reader should be aware that participants were volunteers. Parent suicide survivors who volunteer may not be representative of other parent suicide survivors. Therefore the findings must be interpreted with this in mind. A third consideration is that my participants were purposefully chosen because they fit the essential criteria for inclusion in the study. In addition, they were all white, North Americans, and mainly female. It is possible that another group of parent suicide survivors would have different experiences of bereavement.

These findings offer insight and understanding into the experience of the parent suicide survivors in this study. Other parent suicide survivors, who were not involved in this study, may be able to find similarities to their own experience, which they can apply to their own situation.

Personal Reflections

When I embarked on this study I had no idea that it would impact me so profoundly--emotionally as well as intellectually, consistent with Gilbert's (2001) findings. Being immersed in my participants' stories has been a deeply intense and

moving experience. Not only did I witness their incredible pain, but I also witnessed their inner strength in overcoming their situation, as well as their hope for the future. I also had my eyes opened to the complexity of parenting, and the struggles families with a suicidal adolescent experience. In sum, I accomplished my goal to understand the experience of parents bereaved by the suicide of their youth, and learned valuable lessons that will impact how I deal with my clients for ever more. It is my hope that others in the helping professions will also benefit from this study and be more sensitive and responsive to the needs of parents of suicidal youth, as well as parent suicide survivors.

I deeply appreciate the parents who agreed to be a part of this study, and their courage to talk so openly and honestly about such a very painful experience. There is no question in my mind that these parents loved their child and would have done anything in their power to prevent his or her death. Now, by talking openly about their child's suicide, they hope to prevent other adolescent suicides and offer hope to other parents bereaved by this traumatic loss.

Although this study has filled some gaps and has moved us forward in our understanding of what parent suicide survivors experience, it is only one snapshot of a complex phenomenon, based on the information the parents in this study chose to share with me. Other gaps remain awaiting further research.

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APPENDIX A

Eligibility Criteria

Before I invite you to participate in this study, I must ask you some questions to be sure that I will be able to use the information that you may provide.

1) Are you the mother/father of a child, between the ages of 10 and 24, who has committed suicide?

_____YES _____NO

2) Has your child committed suicide at least one year ago and less than ten years ago?

_____YES _____NO

3) Are you interested in learning more about the bereavement experience of parents whose child committed suicide?

_____YES _____NO

4) Are you able and willing to share details of your personal bereavement experience with me (the researcher) at length?

_____YES _____NO

5) Will you allow me (the researcher) to tape-record and publish the data in a dissertation and scholarly publications?

_____YES _____NO

Formal Invitation

If eligible: Given your responses, I would like to invite you to participate in my study. What would be a convenient time for us to meet for your first interview? Would you like to come into the University of Alberta Education clinic for the interview, or would you like it to take place in your home?

If yes, then set and record appointment.
If no, then thank them and end call.

APPENDIX B

Letter to Participants

Dear _____,

Thank you for the interest you have shown in my research project during our telephone conversation. I am sensitive to the pain you are experiencing and am honoured that you have chosen to entrust me with the details surrounding your child's suicide. As I have mentioned to you, I am interested in gaining an understanding of what the experience is for a parent whose child has committed suicide. I value the unique contribution that you can make to my study and look forward to the possibility of your participation in it. This research is being conducted for my Doctoral Dissertation, under the supervision of Dr. B. Paulson from the Department of Educational Psychology, at the University of Alberta. Participation in this study is strictly voluntary and participants have the right to withdraw from the study at any time.

I am using an interview method to obtain comprehensive descriptions of your experience. In this way I hope to understand the question: "What is the experience of parents whose child committed suicide?"

I value your participation and thank you for your commitment of time, energy, and effort. If you have any further questions before our first meeting I can be reached at [telephone number].

Yours truly,

Emily Snihurowych

APPENDIX C

Informed Consent

Project Title: Parents' Experience of Their Youth's Suicide

Principle Investigator: Emily Snihurowych, University of Alberta Doctoral Student

Supervisor: Dr. Barbara Paulson, Professor in the Department of Educational Psychology, University of Alberta

Research Participant:

I,_____, voluntarily consent to participate in interviews with Emily Snihurowych, a graduate student in the Department of Educational Psychology at the University of Alberta. The purpose of the study has been explained to me and I understand the information given by me will be used solely for research purposes. I further understand that every effort will be made to remove all identifying information. I agree to allow the interviews to be taped with the understanding that the tapes will be erased when the research project is completed. I also understand that I may discontinue participation at any point during the research process without penalty. Finally, I am aware that if I have any concerns, as a result of the interviewing process, a referral to counselling will be available.

Participant Signature Date

_____ _____

Witness

_____

APPENDIX D

General Interview Guide

During the first interview each parent will be asked, "Can you tell me about your experience?" After listening to his/her story, I will use the following probes, as appropriate, to generate further description.

1. Do any people or events connected with the experience stand out for you?
2. How did the experience affect you? What changes do you associate with the experience?
3. How did the experience affect your relationship with others in your life? (e.g., family, friends)
4. How did family and/or friends respond to you after the suicide?
5. Can you recall any other specific episodes, situations, or events that you experienced surrounding the suicide of your adolescent ?
6. Is there anything else you would like to tell about your experience?
7. Did you have any beliefs that helped or hindered you in your bereavement experience?
8. Is there any advice you would like to give to parents as a result of your experience?
9. Is there any advice you would like to give helping professionals?

Participant's thoughts, feelings, and behaviours, as well as situations, events, places, and people connected with their experience will be elicited if they have not already been discussed.

APPENDIX E

Letter to Participants

Dear _____,

Re: Interview Transcripts

I am enclosing the transcript of the interview I conducted with you regarding your experience surrounding your child's suicide. I would appreciate it if you would take the time to read it over and let me know whether or not it accurately represents your experience. Please feel free to write your comments all over this transcript, and to include anything else you'd like to add. I have included a stamped, self-addressed envelope so that once you have finished reading and commenting on the transcript you can mail it back to me.

As you may notice while reading the transcript, our oral speech differs from our written speech. I want to assure you that you expressed yourself very well during our interview, using body language and tone of voice. The requirement for my research is that this first copy is word for word. However, in the final copy the grammar will be corrected without changing the meaning.

Once again I would like to thank you for your participation in my research, and for the time, energy, and effort you have put forth. Please feel free to call me collect at [telephone number] if you have any further questions.

Sincerely,

Emily Snihurowych M.Ed., Doctoral Candidate