Chapter 3

LITERATURE REVIEW:
GRIEF AND BEREAIMENT

Over the past 30 years, since Cain (1972) first edited *Survivors of Suicide* and Shneidman (1968) coined the term ‘postventior.’ to refer to the needs of those bereaved through suicide, research has gained momentum in trying to understand the effects of a suicide death on those bereaved. As poignantly noted over thirty years ago:

[there] are always two parties to a death; the person who dies and the survivors who are bereaved ... the sting of death is less sharp for the person who dies than it is for the bereaved survivor. (Toynbee 1968 quoted in Shneidman 1972:ix)

Despite this insightful observation, recent studies continue to report that the needs of the survivors who are bereaved remain under-researched (Beautrais 1999; Cantor et al. 1999; Patton & Burns 1999). Dunn and Morrish-Vinders (1987/88:175) suggest that the lack of any particular focus on survivors who are bereaved may be a ‘by-product of more concentrated efforts to explain and prevent suicide’. Alternatively, dealing with such a confronting and difficult subject as parents whose young adult son or daughter have just
taken their own life may dissuade all but the hardiest researchers from researching this area. Nevertheless, this area is in need of further investigation (Commonwealth Department of Health and Aged Care 1999).

Suicide bereavement is the focus of this chapter. I will begin with a discussion of contemporary grief frameworks, then turn to reviewing parental grief and bereavement, followed by the bereavement experience of suicide. The chapter concludes with an overview of the small number of studies that have addressed wholly or in part parental bereavement through suicide.

**Grief and bereavement**

Grief is the living response to loss. Grief comes when individuals lose certain primary relationships, but not when less intimate ones are lost. Primary relationships are defined as those that are close, face-to-face, and emotionally important (Weiss 1993). The loss may be real or perceived, yet grief will still occur. It is a universally human phenomenon, yet experienced in a highly individualised and multidimensional manner (Reed 1998). Grief encompasses sensory, behavioural and cognitive systems showing 'multiple and interactive behavioural, cognitive, emotional, social, somatic and spiritual components' (Bailley, Kral & Durham 1999:256). Individual
characteristics of the bereaved person also play a part in the way their grief is experienced. For example, personal vulnerability, personality traits, age, social behaviour and familial patterns in dealing with grief, and the circumstances around the death contribute to any one individual's grieving experience (Muller & Thompson 2003; Peterson 2004).

The type of death can also influence the way that the grief is experienced. Muller and Thompson (2003) categorise death in five ways: natural anticipated (for example cancer), natural unanticipated (for example heart attack), accidental, homicidal, or suicidal. Although there is some suggestion that the type of death does not influence the resultant grief, Muller and Thompson (2003), along with others (Peterson 2004; Stroebe & Stroebe 1993), postulate that the nature of the death influences the grieving process.

Authors, such as Sanders (1993) suggest that the shock of sudden death prolongs grief reactions; some indicate that four to seven years can pass prior to a return to prior to bereavement levels of functioning. Raphael (1992 cited in Peterson 2004:646) reports that in addition to the circumstances of the death, the nature of the lost relationship, the support available and other stressors present in the bereaved's life also influence the ability to cope with death.
Current grief theories and frameworks

There are two theoretically derived frameworks for understanding grief in industrialised societies. The first being a stage model originally developed by Freud (1917), that has seen many evolutions and adaptations since and continues to inform the social understanding of grief in both lay and professional circles. The second framework is one that acknowledges a continuing bond between the deceased and the bereaved (Klass, Silverman & Nickman 1996). While this second model was mentioned in Freud’s (1917) earlier work, it has only recently begun to receive widespread acknowledgement. Each theoretical framework will be discussed in turn.

Stage or phase models of grief

The stage or phase model of grief has dominated the understanding of the grief process in recent decades. This framework was first noted by Freud (1917) in *Mourning and Melancholia*. Follow-up work by Bowlby (1980) extended the model to conceptualise death as a loss of attachment to the deceased. He argues that the bereaved person must adjust to this loss of attachment by detaching his or herself from the deceased before being able to move forward from their bereaved state. Kubler-Ross (1969) suggests that this grief as occurring in five stages through which the bereaved person passes. Her research was based on the experiences of people anticipating their own death, rather than in response to the death of a loved one.
Nonetheless, these stages rapidly became prominent and the accepted model of grieving across the field of grief and bereavement in industrialised societies.

While many variations of this model have appeared over the years, the core stages in the Kubler-Ross (1969) model continue to dominate the field. These stages include: Denial that the death may happen or has occurred; Anger at everyone and everything; Bargaining to stop the inevitability of the death after the anger has finished, and also to tie up loose ends; Depression once everything is tied up, an extreme sadness engulfs the person; and Acceptance, a gradual emergence that the death has been accepted (Peterson 2004).

This stage model emphasises the breaking of bonds with the deceased characterised by reaching a point of acceptance that they are gone. Acknowledgement that the loss of a loved one is a significant event in one’s life may be reported in the following way:

it is not without good reason that scientists have formulated the notion that one has to process, or work through, grief. Bereavement is, after all, a major upheaval in one’s life, and grief work involves the cognitive process of dealing with such a disturbing event. (Stroebe 2001:855)

Stroebe and her colleagues (1992:1205) earlier suggest that when locating the stages of grieving model in ‘historical and cultural context reveals that it is
largely a product of a modernist worldview'. In the past, such a bond breaking would 'destroy ones identity and the meaning of life' (Stroebe et al. 1992:1205). However, breaking bonds with the deceased is viewed as the part of modernist 20th century, which emphasises that people need to adjust to the loss and return to normal levels of functioning as quickly as possible. These authors question the relevance of bond breaking to deeply dependant relationships, such as those between parents and children or between spouses (Stroebe et al. 1992:1207).

The stage framework, underpinned by a developmental process, is characterised by working through of a number of tasks associated with loss. Grief is assumed to be a linear process, with stages that will be moved through, in no particular order, before reaching the final goal of resolution. Shuchter and Zisook (1993:23) challenge the notion of linear stages explaining grief as 'not a linear process with concrete boundaries but, rather, a composite of overlapping, fluid phases that vary from person to person'. They suggest that the recommended stages should be used as guides only as to what a person may experience during bereavement in response to the death of a loved one rather than an all encompassing view of how grief will occur.
Despite the warnings of Shuchter and Zisook (1993) and others of an over-reliance on prescriptive interpretations of the phase conceptualisation of grief, the assumption is often made that when an individual does not pass through these stages of grieving, she or he must be experiencing an ‘abnormal’ grief reaction. Most often this is conceptualised as ‘unresolved grief’. Many authors suggest that unresolved grief is not a valid conceptualisation and describe prescriptive stages as ‘somewhat overly simplistic’ given that the majority of ‘bereaved individuals never totally resolve their grief, and significant aspects of the bereavement process may go on for years after the loss’ (Shuchter & Zisook 1993:25).

Stroebe (2001) reports that there is very little empirical evidence that working through grief is more effective at coming to terms with loss than not working through it even though such a premise has been the foundation of prior grief research. As a consequence of this critical analysis of the stage model by Stroebe and her colleagues (1992) and Klass, Silverman and Nickman (1996), the emerging framework of the continuation of a bond with the deceased is gaining recognition. While not totally discounting aspects of the stages and phases framework, these authors acknowledge the presence of a continued connection with the deceased person once the physical bond is broken through death.
Continuing bonds after death

Seminal work on grieving and in particular continuing bonds after death published by Klass, Silverman, and Nickman (1996), in their book titled *Continuing Bonds*, identify that bereaved people struggle to find a way in which to stay connected to the deceased. This concept contradicts the finalisation-resolution phase of the traditional stage frameworks presented earlier. While many see the stage process and the continuing bonds frameworks as in opposition to each other this is not necessarily so. Bowlby (1979) previously acknowledges that while all forms of mourning lead to detachment, many individuals do continue a bond with their deceased loved one.

From his research, Bowlby (1979) reports that while some respondents finalised their grief, at least half the widows and widowers in the sample continued to report a presence of their deceased partner. He further suggests that this continued presence might be a way for the bereaved spouse to find a continuation of the sense of identity that was involved in the spousal relationship. Bauer and Bonnano (2001:155) propose that such continuing bonds enable the bereaved ‘to recognize the personal meaning of past goals and relationships and then to understand how those meanings can continue in the present’. Thus, the continuation of the bereaved persons identity and relationship with the deceased may indeed be important in the overall
grieving process, which the previous stage framework failed to acknowledge.

This alternate model examines a series of transformations, both internally and socially, that occur within the bereaved as they come to terms with the death. The primary purpose of these transformations is the integration of the representation of the deceased into the social and psychic world of the bereaved (Klass 1996). The conclusion of the continuing bonds conceptualisation of grief is where the inner representation of the ongoing relationship sits comfortably with the bereaved and for the most part functions internally.

The current debate dominating bereavement research, according to Stroebe (2001), surrounds the issue of whether the purpose of grief is to break attachments with the deceased as previously thought, or whether detachment is unnecessary. Contemporary opinion seems to favour the continuing bonds model whereby continued attachments with the deceased are not seen as detrimental, as was originally claimed:

[the] criticism has frequently been voiced that focus on grief work has limited understanding of grieving to dysfunctional processes, dictating a return to normal functioning and neglecting adjustment in a broader sense. (Stroebe 2001:855-856)
The needs of the bereaved are typically a major concern to mental health and counselling practitioners. The total cost of unmet needs of those bereaved in terms of suffering, health problems and economic losses are unknown and incalculable (Muller & Thompson 2003). Many factors may influence the ways that one grieves a loss, including the relation to the deceased, the type of death, historical approaches to bereavement, social influences, cultural norms, the quality of the relationship with the deceased and the age of the deceased, as reported earlier. Walter (1996:20) reports that ‘in our reflexive society, it is also undoubtedly true that what bereaved people do and how they talk about what they feel is influenced by theories of grief’ in that society at that time. The next section reviews how the death of a child impacts the bereavement of parents, and then parental bereavement specifically following suicide is examined and critiqued.

**Parental bereavement**

Throughout the grief and bereavement literature the claim is often made that the death of a child is the worst death that a parent can endure (De Vries, Dalla Lana & Flack 1994). In industrialised societies where child death is uncommon, parental bereavement may not be able to be explained easily and parents may be ill equipped to deal with such an event (Braun & Berg 1994; Wheeler 1993/94; 2001). Some writers even suggest that the death of a child
may create an existential wound (De Vries, Dalla Lana & Flack 1994; De Vries, Davis, Wortman & Lehman 1997) from which total recovery is not possible.

Due to the intimate and unique nature of the parent—child relationship, it has been suggested that the death of a child has the ability to shake the basic identity of the bereaved (Davis, Wortman, Lehman & Silver 2000:516). This is particularly pertinent as part of a parent’s character is shaped through the bond they shared, so when a child dies a parent can feel that a part of him or her has died too (Sanders 1993:264).

Disorientation may result for parents, where the experience of child death does not fit with prior meaning structures (Braun & Berg 1994). The death of a child potentially can shatter assumptions that the world is a fair and just place, that it is predictable and controllable (Davis et al. 2000; Janoff-Bulman 1992). The parent must endeavour to understand why this event occurred and adjust their worldview to incorporate the event. In doing so, the parent reviews the events leading up to the death to make some sense of it (Wheeler 2001).

Parents grieving the loss of a child may experience poor mental and physical health (especially depression), decrease in marital satisfaction, increased
morbidity and even increased risk of suicide (De Vries, Dalla Lana & Flack 1994; De Vries et al. 1997; Jordan 2001; Kneiper 1999; Van Dongen 1990; Weiss 1993). Such bereavement impacts on all aspects of an individual's life and is particularly resistant to recovery.

Due to medical advances, high life expectancy and low mortality rates, parents are not accustomed to their children dying, and thus such an event has elements of trauma (Rando 1997). The death of a son or daughter during adolescence or young adulthood interrupts the continuity of the family, shaking the foundations upon which a shared future is planned. As Wheeler (1993/94:261) explains, a 'child holds multiple meanings for a parent: a connection with the past, investment in the future, and an extension of the self'. Together, the relationship between parent and child is seen to be so substantial that such bereavement through the death of a child is thought to be unique.

Parental bereavement continues over the long term, with significant levels of depression three years after the death reported by Klass and Marwit (1988) and an elevation of bereavement signs up to seven years after the death. While the period immediately following the death receives much attention, the longer-term issues that parents must face also deserve recognition that is currently not visible in the literature.
In addition to the reported physical, emotional, and mental aspects of parental bereavement, there are practical issues continuing over the long term that parents must face. For example, Brabant, Forsyth and McFarlain (1994) report difficulties parents face when describing their family members post death. Is the deceased child included when describing family members to a new acquaintance? These authors suggest that many families develop two stories to deal with this conflict: the back-stage account where the deceased child is included, and the front-stage account where the deceased is excluded.

Research such as this contradicts the belief that parents finalise their bereavement as suggested by stage frameworks. Additional support comes from authors who claim that severing ties with the deceased is not applicable in relation to parents losing a child, an event from which a parent may never recover (Braun & Berg 1994; Cleiren & Diekstra 1995; De Vries, Dalla Lana & Flack 1994).

**Gender differences in parental grief**

Despite varying methodologies, as reported by Dijkstra and Stroebe (1998), researchers have concluded that death of a young adult child manifests different physical and mental health symptoms in mothers to those
experienced by fathers. Mothers appear to suffer more distress, more trauma, poorer loss accommodation, poorer physical health, more depression and less marital satisfaction than fathers and they show symptoms for longer periods of time (Brent, Moritz, Bridge, Perper & Canobbio 1996; Ellenbogen & Gratton 2001; Kneiper 1999; Murphy 1997).

Relationship closeness is often cited as one aspect of a parent’s life that falls victim to the parental bereavement process. In a review of the parental responses to child death literature, Dijkstra and Stroebe (1998:178) report a polarising effect in couples after the death of a child, with some experiencing closer marital relationships while others become more distant. Although these findings appear paradoxical, these authors suspect that couples may experience both closer relationships through increased support and protection, as well as a more distant relationship from mutual stress and aggravation simultaneously.

From the available literature, it appears that the death of a child is difficult to resolve for parents from industrialised societies. Such an event is outside what is expected of parenting, and therefore not normative. The following section reviews the few studies that specifically deal with parental bereavement through suicide.
Parental bereavement through suicide

It is generally acknowledged that the death of a child is the most traumatic of all bereavements. In addition, sudden death such as suicide, has been found to be more difficult to resolve, as oftentimes there is little or no time to prepare for the death (De Vries, Dalla Lana & Flack 1994). Furthermore, while death by suicide has always existed, no one really understands 'why' someone would end their life this way (Leenaars 1996). The suicide death of a young adult child straddles these two dimensions leaving parents in a unique situation of grieving (Brabant, Forsyth & McFarlain 1994). Debate as to the accuracy of the claim that parental bereavement through suicide is the most difficult to resolve continues among researchers in the field.

Within the extensive general suicide literature only a small number of studies mention the bereavement process of a parent who has lost a young adult child to suicide. These studies typically use a comparative method to determine if bereavement differences exist between type of death, such as through suicide, homicide and accident (see Cleiren & Diekstra 1995; Ellenbogen & Gratton 2001; Murphy 1996; Murphy, Johnson, Cain, Gupta, Dimond, Lohan & Baugher 1998; Reed 1998). To date, while some have found differences in responses to different types of death, others have not. More recent research reports more similarities than differences (Ellenbogen &
Presented below are the factors that are thought to be unique to suicide bereavement.

Factors unique to suicide bereavement

Several factors are reported to be unique to bereavement through suicide. These are thought to be due to the particular nature of the type of death occurring in combination with the transition to adulthood. In short, suicide death, along with accidental death, is viewed as a life cut short, a waste of life. Because suicide death is sudden there is no time to clear up any unfinished business with the deceased, which is particularly problematic where the prior relationship was ambivalent, as may be the case between parents and their adolescent or young adult son or daughter (Murphy 1990).

From a developmental perspective, adolescence is a time when young people are preparing for increased independence. Such changes coincide with parents redefining their parental and marital roles as the responsibility and care-giving tasks for their child lessen. For these reasons, families where a child is going through the adolescent and young adult years, it is often a time of family conflict as new roles and identities are established. This period can be particularly troublesome for parents when a young adult child dies from suicide and the parent is left with a feeling of ‘unfinished business’ with their child as conflicts can no longer be resolved (Murphy 1990:174). While all
suicide death is final, it seems even more tragic when a teenager or young adult dies as they are viewed to be in the prime of their life, with much still to contribute and achieve (Fielden 2003:74).

Analysis in the recent literature on suicide bereavement identified seven primary concerns typically found in response to a family member’s suicide. These include shock, guilt, blame, shame, stigma, lack of social support, particular familial characteristics and for some, ‘relief that the deceased child is no longer in pain or suffering. While such factors may also be identified in other forms of bereavement, for parents grieving their young adult son or daughter these have the potential to overwhelm the suicide bereaved individual and prolong the grief process (Dunn & Morrish-Vidners 1987/88).

Each of these factors will now be explored.

Shock

On finding out about the death, the bereaved individual has questions of where and how the suicide occurred. There may be high levels of shock experienced in response to learning of the suicide death. Some authors suggest that the levels of shock could be linked to post traumatic stress disorder (Clark & Goldney 2000). Following the initial shock there are questions about why the person chose to suicide. Clark and Goldney (2000:472-3) suggest that the ‘bereaved examine the events and relationships
leading to the death, and explore the state of mind of the deceased to
determine why they acted as they did. Although, ‘why’ is an important part
of the grieving process of survivors of suicide, research has failed to examine
why survivors need to explain the act or what purpose this serves internally
(Dunn & Morrish-Vidners 1987/88:176).

Suicide and other accidental deaths are viewed as unnatural, and therefore
more time may be spent ruminating and speculating as to what the bereaved
could have done to avert the death (Ellenbogen & Gratton 2001:86).
According to Van Dongen (1990; 1993), it is only once the survivor of suicide
comes to terms with there being no answers to their ‘agonizing questions’
that they are able to move forward with their life after the death.

**Guilt**

First and foremost, guilt experienced by survivors of suicide is thought to be
caused by a perceived inability to prevent the suicide from occurring (Clark
& Goldney 2000; Ellenbogen & Gratton 2001). In industrialised societies few
young people die and when they do, it is generally through accident or
suicide. These deaths are seen as preventable (De Vries, Dalla Lana & Flack
1994; Silverman, Range & Overholser 1994/5) and give rise to parental
reactions including ‘feelings of incompetence, guilt, anger, and deprivation’
(De Vries, Dalla Lana & Flack 1994:61). Parents feel a responsibility for the
death of the child (Cleiren & Diekstra 1995), often being able to identify reasons for the suicide after the death, when it is too late to help their child (Kneiper 1999).

Guilt may also be experienced if the parent speculates that it may be their care giving skills that contributed and they should have seen the signs of suicide intent (Clark & Goldney 2000). Parents of young adult children who have died by suicide report guilt associated with their role as a parent in the past, and even ‘moral guilt related to [the suicide death being] perceived punishment for past wrongdoings’ (Miles & Perry 1985:75).

**Blame**

Many authors report survivors of suicide describing feelings of blame, either internally, within the family or from the wider community (Bailley, Kral & Dunham 1999; Dunn & Morrish-Vidners 1987/88; Jordan 2001). Additionally, horror may be experienced upon realising the pain the bereaved was experiencing before their death, that the survivor had not been aware of (Clark & Goldney 2000).

There may be a tendency to blame the self, spouse, child’s partner or ‘anyone who had been close to the deceased at the time of death’ although Dunn and Morrish-Vinders (1987/88:185) argue that such blame may be distorted and
unrealistic. In reference to the young person's partner, Conner (2004:91) finds a correlation between partner-relationship disruptions and suicide planning in the last week of life. This finding indicates individuals may be at a dramatically increased risk of suicide for a period of time directly following a relationship breakdown.

Shame

A survivor of suicide may also experience feelings of shame. Shame appears to be elevated among this group, when compared with people bereaved through other deaths and feelings of shame can lead to social isolation (Clark & Goldney 2000). For example, Dunn and Morrish-Vinders (1987/88:195) note that isolation of survivors of suicide is due to society reacting 'negatively to those perceived and defined as not fitting the norm'. The historical taboo of suicide, the emotionally complicated bereavement, and the extraordinary fear of suicide in our culture, leads to a 'tendency not to reject the suicide, but the bereavement' that follows (Dunn & Morrish-Vinders 1987/88:196). Rejecting the bereavement leaves the bereaved outside the normal responsibility of parents. That is, keeping their child safe. Internalising this exclusion can result in feelings of shame for parents thus bereaved.
Stigma

Due to the complex dynamic of suicide deaths throughout history, stigma is often associated with suicide. People bereaved through suicide often report feelings of being stigmatised by the death of their loved one. For example, in a phenomenological study of parents and siblings bereaved through suicide, Fielden (2003) reports that due to the stigma involved in suicide death, open discussions about the death did not readily occur. This suggests that not being attuned to the possibility of suicide meant that there was no language to deal with suicidal individuals or those bereaved through suicide.

Stigma is not always easy to detect. For example, the term ‘stigma’ was avoided by the participants in Dunn and Morrish-Vinders (1987/88:198) research. Stigma however was in evidence in the other terms used by their participants such as feeling ‘ashamed’ and ‘embarrassed’ by their loved one’s actions. Some have questioned whether stigma is real and that survivors of suicide have to deal with this or whether suicide survivors are self-stigmatising. For example, Van Dongen (1993:139) concludes that social isolation thought to be brought on by the stigmatisation of suicide death ‘may be more self-induced and stigmatization, if it does occur, is likely to be subtle’.
Death in industrialised societies has become part of the medical and scientific domain, primarily out of the public realm. Thus, we are often alienated from death. Dunn and Morrish-Yinders (1987/88:196) argue that the isolation and loneliness that an individual experiences 'can be traced to the essentially problematic status of death in our culture,' rather than being directly associated with the suicide death.

Regardless of whether stigma is real or perceived, it can result in parents being socially isolated at a time when most need access to social support networks (Brabant, Forsyth & McFarlain 1995; Thompson & Range 1992). This position is explained by Dunn and Morrish-Yinders, who suggest:

since suicide is still socially unacceptable, the bereaved lack the support systems normally available to those grieving other kinds of death. Consequently, the suicide survivor is placed in a kind of double jeopardy. On the one hand, the survivor suffers a traumatic loss; on the other hand, the taboo act generates feelings of disapproval and shame. (Dunn & Morrish-Vindners 1987/88:176)

As suicide appears to be a taboo topic talking about it is often discouraged. Campbell (1997:330) suggests this results in 'society's inability to deal with survivors in an honest and caring way remains a negative legacy of suicide'.

Public displays of grief are generally socially discouraged, and as such parents may feel awkward with previous social supports and find themselves drawn to support with people who have experienced similar
loses, such as The Compassionate Friends, a self help group for bereaved parents that has local groups throughout most countries including Australia (Brabant, Forsyth & McFarlain 1995; Seguin, Lesage & Kiely 1995).

Support for those bereaved through suicide

The value of social support has been measured in many areas of personal distress, including for parents who have lost a young adult child to suicide (Brabant, Forsyth & McFarlain 1995; Thompson & Range 1992; Trolley 1993; Van Dongen 1993). In general, social support networks have been found to facilitate the grieving process in bereaved parents at the same time as lowering separation anxiety, feelings of rejections and depression (Reed 1998). Furthermore, social support is reported to be ‘the most crucial element in aiding someone who is recovering from a loss to death, regardless of the cause of the death’ (Kneiper 1999:356).

Initially, support appears to be available for the bereaved. However as Van Dongen (1993) finds, after only a short time, perhaps a few weeks, survivors of suicide begin to judge emotional strength and availability in their audience before discussing the suicide. This limits the social support available as only some became aware of the suicide survivor’s position with the bereaved often withholding their emotions.
Despite the strong influence that social support offers, blame, guilt and shame may create an environment that inhibits discussion about the suicide death in spite of parents wanting to talk through the experience. The participants in one study were reported to be:

eager to talk in great details, confirming a problem we sought to investigate: Suicide survivors have a dire need to talk about their tragedy; however, they usually have little opportunity to express their thoughts and feelings openly. (Dunn & Morrish-Vidners 1987/88:181)

Further isolation from their social support networks may occur if parents have lost confidence in their parental ability and are unsure of their future parental role (Seguin, Lesage & Kiely 1995).

Paradoxically, researchers have found that members of social support networks of the suicide bereaved individual attest to offering support, while at the same time the bereaved report that social support is not available, or when available is not sustained over a long period of time (Brabant, Forsyth & McFarlain 1995; Seguin, Lesage & Kiely 1995; Thompson & Range 1992; Van Dongen 1993). An explanation may be that suicide survivors:

tend to isolate themselves more than other bereaved thus making it hard for family and friends to give support. In turn, the survivors do not perceive their family as potential supporters, thus creating an even larger sense of isolation. (Seguin, Lesage & Kiely 1995:495)
Thus, while individuals bereaved through suicide have often been characterised as being stigmatised and socially isolated, this may be as much due to their own projections as to others perceptions of them Kneiper (1999) suggests. However, such claims have not been tested or validated to date, remaining speculatory.

To further complicate the issues relating to social support for survivors of suicide, supporters may hold unrealistic or undesirable attitudes or misconceptions about the ways in which people react to suicide, potentially resulting in support attempts being inappropriate or counterproductive (Kaplan & Maldaver 1993:66). The bereaved too, have misconceptions about suicide bereavement, which in turn generates a low or unrealistic level of expectation of support being offered (Dunn & Morrish-Vidners 1987/88:189). This is evidenced by parents not being able to recognise offerings of support, especially due to changes to their perceived social standing post-suicide (Van Dongen 1993), rather than the support not being offered. Regardless, support for parents bereaved through suicide is difficult to access, and often it is not maintained after initial contact.

*Family characteristics*

Some factors are over-represented in families where a young adult has died by suicide. These include domestic violence; over- or under- protective
parenting or a mixture of the two; drug and alcohol problems; and/or a predisposition to mental illness especially depression (Kaplan & Maldaver 1993; Morano, Cisler & Lemerond 1993; Samy 1995; Seguin, Lesage & Kiely 1995). These factors are related only and not predictive of suicide. Not all families that experience these issues experience a suicide death, nor do all families who experience suicide death exhibit these factors.

Seguin, Lesage and Kiely (1995:494) note that in families where a young person dies by suicide, boundaries between the deceased individual and the parent, prior to the suicide death, are often blurred. The examples given by these authors include a mother who stated that she was in love with her son, and parents who described their children as their best friend or confidante. Conversely, these researchers also reported that other parents described their relationship with their children prior to the death was a conflictual one. These authors conclude that these blurred boundaries may result in the developmental task of separation from parents being disrupted leading to a predisposition to suicide (see also Seguin, Lesage & Kiely 1995). Ellenbogen and his colleagues (2001) proposed that the blurred boundaries in a family that account for the differences between the grieving processes of a parent bereaved by the suicide death of a child as opposed to grieving over other forms of sudden death, such as accident or homicide. However, this claim is yet to be tested.
Parents who have experienced the suicide of their young adult son or daughter may also be intensely fearful and anxious that another suicide will occur, usually within the immediate family. This can result in them being extremely over-protective of the remaining family members in turn causing stress on individual members of the family. Such a phenomenon may influence the conclusions drawn above by Seguin, Lesage and Kiely (1995). An additional factor identified by Clark and Goldney (2000) is that the survivor of suicide may also contemplate ending their life with the thought of joining the deceased making this group even more vulnerable to suicide.

The findings of the above research generally conclude that the focus in suicide prevention needs to concentrate on developing secure parental patterns from early infancy to try and curtail the number of people who die by suicide in their adolescent and young adult years (Kaplan & Maldaver 1993). Positive parenting programs are now widely accepted as a long-term strategy in suicide reduction and mental health promotion initiatives. Such programs have been included in the Second National Mental Health Strategy launched in Australia in the year 2000 (Commonwealth Department of Health and Aged Care 2000d).
Even though such programs have been found to reduce mental health problems in children and young people, and it is hoped that this in turn will influence suicide rates in the long term (Commonwealth Department of Health and Aged Care 2000d), these claims must be treated cautiously. The assumption underpinning this approach is that the suicide death of a child stems from the parents and their parenting ability and this assumption is yet to be empirically demonstrated. Additionally, such a position removes the influence of societal influences and public responsibility for citizens.

Relief for some

Suicide death is typically thought of as unexpected and sudden. The review of the literature demonstrates that all suicide death leads to bereavement and that this event is extremely traumatic for families. Over and above this however some families may feel relief, especially where the suicide may be 'the epitaph to a visibly troubled life' (Ellenbogen & Gratton 2001:86). This is not to suggest that the person will not be greatly missed, but rather the family may experience reduced stress and be relieved that the individual is now free from distress (Clark & Goldney 2000; Ellenbogen & Gratton 2001).

The notion that suicide may not be sudden and unexpected has received almost no attention. However, close consideration to findings in earlier studies suggests this may be the case in some instances. For example, in Van
Dongen’s (1990:226) study of 35 individuals bereaved through suicide, 25 reported knowing that their loved one was troubled ‘and retrospectively could see indications of suicide risk’, a further seven anticipated that suicide was a likely outcome for this individual. The remaining three reported having no idea that a suicide might occur and still could not recognise signs even after the death. These findings do not suggest that the suicide death could be prevented but rather that some families do have an ‘inkling’ even though this may not be acknowledged until after the event, that the suicide death would occur.

In short, some aspects of the parental bereavement process appear to be unique to suicide. Suicide bereavement appears to cause an existential crisis in the parent as they struggle to find meaning in a world that feels meaningless, while suffering feelings of blame, guilt and responsibility for the death of their child. Further, such parents may suffer from adverse health consequences for some time after the death and find their relationship with their partner altered due to the suicide death of a young adult child.

Research to date has focussed primarily on barriers to grief and recovery observed in the clinical setting rarely acknowledging the unique experience of individual parents, or exploring the parents’ point-of-view on this critical life event. Although many of the above grief related factors are thought
unique to suicide bereavement, consensus does not exist. Many still hold that suicide bereavement is not different from following other forms of sudden, or unnatural death.

Critique of the existing knowledge of suicide bereavement

The current debate among researchers in the suicide bereavement field is summarised below. First, the position that suicide bereavement is different from other forms of bereavement is presented, followed by a critique of the reasons proposed that such an event is essentially the same as bereavement following other forms of sudden and unnatural death.

_Suicide bereavement is different_

Suicide bereavement is thought to differ from other bereavements due to its nature, including the deceased’s choice to end their life, the cultural and historical perceptions of suicide and the involvement of officialdom based on legislative requirements to determine cause of death. In addition, rejection, shame and separation anxiety which typically occur in suicide bereavement are not necessarily found in other forms of sudden death (Reed 1998; Silverman, Range & Overholser 1994/5).
In a comprehensive review of previously reported research, Jordan (2001:91) suggests three important differences evident in a person bereaved by suicide. These are that suicide survivors; struggle to find meaning in the death; experience high levels of guilt at not being able to prevent the death; and experience higher levels of abandonment by the deceased. However, while conceding that there are many similarities, Jordan (2001) maintains there are also important differences that need to be acknowledged in the suicide bereaved. Thus he concludes that the thematic content of the grief, the social processes the survivors must face, and the impact the death has on the family system are unique to this form of death.

Seguin, Lesage, and Kiely (1995) present a slightly different picture to argue a similar point. They report that families who experience a suicide death have also experienced more previous losses than those bereaved by other means, that they are more vulnerable, experience higher levels of shame following the death, have reduced social support available and experience increased stress of providing for the surviving family members. They also note that the clinical and policy focus on prevention reinforces feelings of blame in parents who fail to prevent their own children from dying by suicide, which in effect silences their experience.
Dunn and Morrish-Vidners (1987/88) take a societal perspective noting that suicide functions outside societal convention and cultural norms. Feelings of exclusion or marginalisation may elevate isolation in a survivor resulting in the grief process becoming individualistic and privatised. The potential outcome of this is further aggravation to adjustment following such a death. Moreover, with no acceptable norms for grieving after suicide negative social attitudes toward suicide and negative stereotyping of parents involved tend to mirror this ‘silenced’ experience (Jordan 2001:93).

The difference between suicide bereavement and bereavement following other deaths may appear less distinct due to the nature of the deaths to which suicide is often compared. The available literature compares suicide bereavement with other sudden and traumatic deaths such as death through homicide or motor vehicle accident. Such comparisons may potentially dilute the difference and effects of sudden and/or traumatic bereavement due to suicide by obscuring, particularly in the case of young adults, feelings of responsibility held by others toward the suicide victim. These comparisons also obscure the inevitably confronting nature of suicide, that is, that the individual has not died by accident but has purposely chosen to take his or her own life. As Jordan (2001) proposes, it is important to understand whether there are significant differences as these will effect service delivery and planning.
Suicide bereavement is similar

Although many studies that examine parental bereavement have examined the differences between suicide bereavement and other forms of bereavement, most present inconclusive findings. In other words, suicide deaths generally speaking are not found to be fundamentally different (Ellenbogen & Gratton 2001). As Callahan (2000:104) summarises, 'the consensus appears to be that bereavement after suicide is more similar than different from after other modes of death' (see also Clark & Goldney 2000). However, limitations in measuring differences may account for these findings leading to inconclusive results and the need for further investigation (Clark & Goldney 2000:468).

There is some concern that the continuing focus on whether difference exists between suicide bereavement and others for:ns of bereavement may be contributing to a 'crisis atmosphere′ that may be more stigmatising to suicide survivors than anything else (Cleiren, Diekst:a, Kerkhof & van der Wal 1994). An alternative approach focuses on understanding how grief affects individuals, rather than the manner in which the deceased died, to illuminate diversity in bereavement as a critical step to designing effective policies and practices to support suicide survivors.
To overcome the limitations of current research endeavours, Bailley, Kral and Dunham (1999) suggest that as suicide survivors are unlikely to be an homogenous group, research needs to focus on within-group difference, rather than continue to focus on between group comparisons. This focus of understanding within-group differences suggests that continuing to only use measures that compare groups limits the possibility of expanding societal responses to suicide in innovative and productive ways.

In addition to the rather limited focus on comparisons between suicide survivors and other individuals experiencing bereavement from sudden or unnatural death, there is little qualitative research seeking understanding of individual difference. For the most part research in this area and reviewed here is quantitative in nature. Some suggest that while grief after suicide appears to quantitatively similar to grief experienced after other deaths, there is likely to be qualitative differences between the two. To date, there has been limited uptake of this suggestion (Ellenbogen & Gratton 2001).

With the fundamental premise underpinning most suicide research that suicide is unexpected, the research endeavours to date are primarily limited to examining whether suicide bereavement is different from grief following other sudden and unanticipated deaths. With some authors beginning to
suggest that suicide may be anticipated a new approach to examining bereavement following suicide is warranted.

An expected death has identifiable reasons to determine why it happened. The bereaved person has time to make the necessary adjustments prior to the event occurring, thus reducing the trauma of the event itself. Sudden or unexpected deaths do not allow for such forewarning. To date there has been no published research that examines reactions toward expected versus unexpected suicide death, although this type of distinction is well established in the research literature into widowed older people (for example Carr, House, Wortman, Nesse & Kessler 2001).

While some suicide bereavement fits criteria for sudden and unexpected death, it may be the case that not all bereavement is in this category. Therefore, while those bereaved through suicide death are treated as a homogenous group with respect to expectation of death it is unlikely that comparative studies of this group with others will provide conclusive results. There is also the possibility that there are those who expect the death prior to the suicide event as well as those who anticipate the event after it has occurred by retrospectively reviewing prior actions and events (Van Dongen 1990).
Concluding remarks from the review of literature

Understanding the way in which suicide is viewed in our society helps explain how bereaved parents are 'seen' by the wider community. Examining risk groups as the primary framework for demographic information assists in targeting young people for suicide prevention strategies. While not ideal, such a framework does allow policy developers and service delivery agencies to target sub-groups of young people for prevention and intervention programs. It is this risk framework, with its strong links with mental illness, which has been publicised through the media and is thought to be primarily responsible for current community attitudes toward suicide. These attitudes have an impact on parents who have lost a young adult son or daughter to suicide, and in response their attitudes and perceptions of the suicide death and their 'part' in this (Kneiper 1999). Parents are influenced too, by the way that society views grief more broadly (Walter 1996).

Components of the prevailing suicide risk framework, such as the familial factors and mental health links, potentially contribute to the exclusions of parents in their grief experience. The social world of the parent may unintentionally reinforce their lonely experience, further alienating potential support systems. In addition, stigmatised by the taboo nature of suicide, parents can feel sentenced to suffer their grief in silence. It is imperative that
we gain insight into these parents' experiences, both for their own sake and to make the broader community aware of lonely and intimate world of families experiencing youth suicide.

In summary, it appears that the risk framework provides only an overview of causes for, and factors influencing, youth suicide. The impact that such a suicide has on individual parents, family or community remains largely unexplained in the literature. The following chapter details the rationale for, and the methods used, to undertake this research and achieve the aim of understanding parents' experience of living through and living with the suicide death of their young adult son or daughter.
Chapter 4

RESEARCH METHODOLOGY

This chapter is divided into two sections, and describes the methods and design used to undertake the research. The first section presents the theoretical orientation of narrative inquiry, the framework used to guide this research. The broad narrative orientation is discussed, followed by the specific approach used for this study, primarily based on the work of Polkinghorne (1988; 1995). The second section of the chapter provides a detailed description of the research design, including sampling, data collection and analysis, ethical considerations, and issues in researching sensitive areas, such as suicide bereavement. In conclusion, I introduce myself as the researcher.

Statement of the problem

The experience of parents who have lost a young adult child to suicide is not well understood. The limited literature that examines these experiences can be divided into three groups. The first examines parental bereavement typically using comparative techniques to examine similarity and difference between bereavement through suicide, accident and homicide (see Bailley,
Kral & Dunham 1999; Cleiren & Diekstra 1995; Ellenbogen & Gratton 2001; Thompson & Range 1992). The second could be termed 'clinical understandings of survivors of suicide' (for example, see Brent et al. 1996; Clark & Goldney 2000; Dunne, McIntosh & Dunne-Maxim 1987; Kneiper 1999; Martin 1990; Mishara 1995; Van Dongen 1993). This literature makes use of comparative studies to examine the unique factors of suicide bereavement in light of health professionals' work with survivors of suicide. The third group comprises literature written by parents about their experience of living through the suicide death of a child (see Deveson 1998; Flory 2000; Heffner 1989). The first two groups allow for empirical and theoretical understandings about aspects of the experience of parental bereavement through suicide. The third gives some insight into parents who feel able to tell their story in the public domain.

In the literature it is reported that parents who experience the suicide death of a young adult child not surprisingly find their whole world disrupted. Potential outcomes include feelings of blame, guilt, and responsibility, and for some an existential crisis, leaving the parent potentially floundering in a meaningless world as they try to adjust to this traumatic event. The research literature cited in the previous chapters suggests that this process is not sufficiently understood within traditional grief models (Klass 2000; Stroebe 2001).
Limited understandings of parents' experiences, along with recent questionings of the validity of traditional grief models for this group, provokes the subject at the heart of the study reported here. That is, what are the experiences of parents following youth suicide, and do current bereavement models adequately explain these experiences? For most of us it is difficult to imagine the impact a child's death has on parents, particularly where that death is caused by suicide. This study aims to redress the gap in knowledge through seeking parents to share their experiences of living through and living with the suicide death of their young adult son or daughter.

To achieve this aim, a method was required that would allow me to reveal the complex breadth and depth of parents' stories. Narrative inquiry, inspired by a social constructionist framework, was chosen as it provides autonomy in exploring diverse events, in this case suicide death of a child. Narrative inquiry, with its focus on meaning making through the process of narrating a story, provided me with the framework and tools to gather intimate and personal stories from parents who have lived through the suicide death of their young adult son or daughter.
The research set out to examine the following question: *How do parents live through and live with the suicide death of their young adult child?* To address this research question and gain an understanding of this event in a parent’s life, I needed to engage parents in a dialogue that would allow space for them to tell me of the ways that they interpreted their experience over time. I would need to hear about the time before their child’s death to the present day, with room for predicting how they would feel in the future. I wanted to listen to stories from parents who may not otherwise be able to share details of their experience, and a narrative inquiry approach would allow this.

**Rationale for narrative inquiry**

I selected a narrative inquiry design for this study for two reasons. The first was to allow for the deep exploration of another’s experience. I anticipated that through each parent’s narrative an appreciation of his or her meaning of the event under investigation could be developed and co-constructed in the interview to be later analysed as text following transcription of the interview material.

Second, in attempting to understand parents’ experiences I wanted to ensure that their experiences inductively drove the unfolding of the interviews to allow for a fuller understanding of how they made sense of their son or daughter’s suicide. My aim was to create a space for each parent to express
their story in whatever manner they felt comfortable. In keeping with Polkinghorne's (1988; 1995) narrative orientation, I viewed the drawing together of the parts of life into narrative as a way in which to impart meaning to our lives. The narrative creates a coherent plot which links events that would otherwise occur randomly. The way in which narrative inquiry has been used to orient the interviews and data analysis in this study is described later in this chapter.

A narrative approach

Many terms are used in the research literature to describe narrative approaches. Narrative inquiry, narrative analysis, and narrative life history are some of these. The term narrative inquiry will be used to explain the design and analysis of this study. Narrative inquiry most accurately expresses my purpose – to explore parents' storied experience of suicide and subsequently to use these stories as data for analysis.

Developed from a social constructionist perspective, narrative inquiry provides an approach for understanding human experience that is consistent with the ways in which individuals make sense of their shared lived experience (Gergen 1994; 1999; Grbich 2004; Rice & Ezzy 1999). Social constructionism refers to what we do with the events that happen in our lives;
how we make sense of what happens to us. This constructionist approach proposes that meaning attributed to objects or events is not discovered, it is constructed. Constructing meaning takes place in an ongoing manner through interaction and engagement with our environment (Crotty 1998).

Another way of saying this is that we use our taken-for-granted socio-cultural and historical knowledge, to construct meaning from our interpretation of events that occur, also taking into account our individual personal and social experience. This is not done in an isolated shell, rather we build on shared knowledge and practices that are customary or embedded in our culture and add to these our own personal perspective (Schwandt 2000). Evolving out of each new experience, old events are reinterpreted in the light of the new knowledge generated by these novel experiences. Concepts, models, and schemas are developed and continually evolve to test and modify our newly constructed knowledge by the stories we tell ourselves and others (Schwandt 2000).

Listening to and recording each individual’s narrative story presents a way of understanding human experience that is congruent with the manner in which people make meaning and understand events (Polkinghorne 1988). Importantly:
people do not deal with the world even: by event or with text sentence by sentence. They frame events and sentences in larger sentences ... These larger structures provide an interpretive context for the components they encompass. (Bruner 1990:64)

This practice of framing meaning within context is further contextualised within the social and cultural environment of the narrator. Importantly, our views of ourself are shaped in part by our experiences of our social environment (Gergen 1994). Yet, our social environment does not wholly determine our perceptions of ourselves, as noted by Bruner (1986). Rather, we reflect individually on the events that shape us. Kirkman (2002:32) suggests there is a connection between our ability to ‘reflect on ourselves and to alter the present in light of the past, or reinterpret the past in light of the present’. As social as well as reflexive beings, our stories inform our lives and our lives are in turn shaped by our stories.

Another way of thinking about the social and reflexive nature of story telling is to think of the stories we create as the means by which we order disorder and find meaning in the meaningless (Gilbert 2002:236). The focus of narrative inquiry therefore is to examine how order is imposed on the events under investigation, the rules that govern the narrative, and how the listener is persuaded of the authenticity of the story (Riessman 1993). This process is
influenced by the social, environmental, and personal situation and the beliefs of the narrator.

In essence, the stories we each tell reflect our own reality, shaped by our interactions with others over time, yet at their foundation lies our ‘truth’. Thus, our social context provides us with the opportunity to test and retest our view of our self and our world in relation to others (Riches & Dawson 1996). Such processes highlight the importance of the social and cultural context of developing narratives. While influenced by the socio-cultural environment of the person, the narrator is not simply making up the story as she or he goes along, but rather it is part of the evolving meaning making process that is inherent in the telling of the story. This meaning making is equally important to the content of the story, and the audience inextricably influences this. Riessman reports from a personal narratives group she was involved with:

When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they are revealing truths. These truths don’t reveal the past ‘as it actually was’, aspiring to a standard of objectivity. They give us instead the truths of our experiences. (Riessman 1993:22)

This raises awareness that the narrative a person tells can never be viewed as an exact replica of the events being narrated. Rather, narratives are representational and change with the telling (Gilbert 2002; Riessman 1993).
The retelling of events provides the narrator with the opportunity to develop newer, and potentially deeper understandings. In effect, Gilbert (2002:225) suggests being involved in research changes the participant’s story and the researcher becomes a collaborator in the ‘new and evolving story’, a co-constructedor of new narratives. Thus, narrative inquiry does not seek truth as such, but rather how the narrator perceives reality at a particular time and place which is influenced by their audience, in this case the researcher.

In research interviews, where the researcher is involved in the evolving story with the participant, Riessman (1993:1) suggests this process is also ‘what we do with our research materials and what informants do with us’. Following the constructionist paradigm (Berger & Luckmann 1966; Gergen 1994; 1999) is a belief that individually we construct meaning out of our interactions with others in our socio-cultural context. This applies both to the parents’ constructed meanings that are narrated in the interview and then again to the text that is analysed and interpreted (or co-constructed) by the researcher.

**Polkinghorne’s narrative inquiry**

In light of the social constructionist framework and in order to understand human experience, we need to pay attention to the stories or narratives that people tell (Polkinghorne 1988). Polkinghorne suggests attending to these stories provides a window to the lived experience of the narrator, and it is
these narratives that act as illustrations of how people make sense of, and respond to life events, as he explains:

Experience is meaningful and human behavior is generated from and informed by this meaningfulness. Thus, the study of human behavior needs to include an exploration of the meaning systems that form human experience. (Polkinghorne 1988:1)

For the purposes of this research, I have adopted Polkinghorne’s (1995) definition of narrative inquiry, where narrative is defined as story. Each narrative consists of particular components, including a plot that organises the story thematically and where the happenings of the story unfold with a beginning point, a middle, and an end point. In this view, narratives are sequentially ordered and are configured in such a way that events and happenings are drawn together into a temporally organised whole (Polkinghorne 1995).

Of particular importance in this form of narrative is the plot, which is viewed by Polkinghorne (1995:7) as a ‘type of conceptual scheme by which a contextual meaning of individual events can be displayed’. A plot serves four functions to configure events into a meaningful story, Polkinghorne (1995) suggests it plot provides a temporal range for the narrative; selection criteria for inclusion in the story; an unfolding movement that culminates in an endpoint; and clarification of events meaning in relation to the whole story.
The plot relates events through causal linkages that connect prior choices to later outcomes. These links are often made retrospectively 'within the context of the outcome of the total episode' (Polkinghorne 1995:8). Events that may have previously seemed insignificant when re-evaluated in light of the outcome, may take on new meanings. The truth of narrative story 'transcends historical factualness', providing the audience with a sense of coherence and meaning through linking of past events with present outcomes (Wilson 2002:28). For the purposes of this research the plot will be used as the focus of analysis to examine the way that these parents attribute meaning to their experiences of their child’s suicide death.

*Limits of using narrative inquiry*

While there are many attributes that make a narrative inquiry approach to this study appealing, there are also some limits that need to be mentioned. First, in light of the above discussion about the reflexive and evolving nature of our stories, it is important to note that the way in which being involved in the research changes the story of the narrator. Second, this method is not useful for large numbers of participants as it is 'slow and painstaking', (Riessman 1993:69), in that the aim of understanding what the story reveals about the narrator and his or her environment is time consuming (Patton 2002).
These limits have been minimised in the current study by accepting that what the parents tell in the interview is their current ‘truth’. This study set out to collect stories at one point in time in a cross-sectional manner, and thus the parents’ truth at that particular time. Secondly, this study aimed to recruit a small sample of parents and delve deeply into their stories through in-depth interviewing, and thus the limits of using this method with large numbers did not affect the timeliness of completing this work.

**Sampling**

In qualitative research, where an in-depth understanding of an individual’s life experience is sought, a sampling procedure that allows for thorough exploration is required. Parameters of the population under study were set through critical examination of previous empirical and theoretical literature. Careful selection of potential informants was then necessary to identify where they would fit with the specific criteria under investigation (Silverman 2000). A purposive sampling strategy, where parents were sought by their experience of the suicide death of a young adult son or daughter, was employed in this study following the criteria set out below.
Parent to a young adult child deceased by suicide

The first criterion used to determine participation was that the informant had to be the parent of a young adult child deceased by suicide. 'Parent' in this instance included parental figures, not only the deceased child’s biological parent. This broader definition of parent was used to allow for contemporary family structures and enabled adoptive parents, foster parents and guardians the opportunity to participate. Some parents indicated that they wanted to be interviewed with their spouse, while others wanted to participate alone. Thus, individual parents determined if they were to participate alone, or with their spouse or partner if applicable.

Child, at time of death, aged between 17 and 29 years

Suicide occurs among the population at different times along the lifespan from early adolescence to late older age, with childhood suicide being rare (Apter 1997). As discussed in Chapter 2, during the last few decades of the twentieth century, suicide deaths among young people rose dramatically. At the outset of this study, young men in their twenties comprised the largest group of suicide fatalities (Australian Bureau of Statistics 2003). This study identified parents of suicide deceased individuals in the their late teens to late twenties as the primary focus.
To minimise potentially confounding influences related to stages of parenting, a criterion was developed to include those participants at a similar stage along the developmental trajectory. The point established was where the young adult child was becoming independent from the parent (for example, through leaving formal education, gaining a driving licence or moving out of the family home). These criteria were in concordance with the Australian Bureau of Statistics age groupings of 17—24 and 25—29. The age range of 17—29 years at the time of death of the deceased child was identified as the selection criterion for parents participating in this study.

Gender and geographic residence
Suicide occurs among groups of young people from different geographic locations and among males and females at varying rates (Australian Bureau of Statistics 2000). The sample aimed to include a mix of rural and urban parents of both sons and daughters to inform the study. In addition, the literature identifies differences in how men and women experience bereavement through the loss of a child (Brent et al. 1996; Ellenbogen & Gratton 2001; Kneiper 1999; Murphy 1997), so both mothers and fathers were invited to participate.

My aim was not to gain a representative sample of parents. Rather, my aim was to interview parents who felt concerned and motivated to share their
experience with me. This type of sampling, frequently referred to as sampling information-rich participants, is also known as purposive sampling (Patton 2002). My purpose was to interview parents who were prepared to come forward and talk about their experience after the suicide of their young adult child.

**Recruiting parents**

To locate potential participants, a media release was sent to outlets by the University of New England’s publicity office to their national and regional print, radio and television group mailing list (Appendix 1). This material was used by a number of outlets in most media genres in the New England and Mid North Coast regions of New South Wales and throughout the Australian Capital Territory. Full details of media exposure are contained in Appendix 2.

The Support After Suicide Group, run through the New South Wales Department of Forensic Medicine, put a short description of the study in its monthly newsletter (Appendix 3). This group consists of families bereaved through suicide where the case has been heard at the Glebe Coroners Court in Sydney. The majority of parents on this mailing list reside in the Sydney metropolitan area.
Through this media exposure I requested parents who had experienced the suicide death of a young adult child (within the specified age range) to contact me by telephone at the university. I had no influence over which media outlets would run the story, however the mix of rural and urban areas provided coverage for a range of geographic locations. This recruiting strategy may have limited connections with Aboriginal or Torres Strait Islander populations as potential participants. This is discussed further in Chapter 9.

Some snowballing did occur where parents passed information about the study to other suicide-bereaved parents within their own networks. However, to my knowledge, no parent was recruited in this way. A number of media outlets outside the regions identified above made contact wanting to further publicise this study. However, the number of informants already recruited at that time meant that the recruitment potential of these avenues were not explored. To provide feedback to interested people, contact was maintained with these outlets as a method of distributing the results to interested parties at the conclusion of the project.

Once parents made contact by telephone, a pre-interview took place (Grbich 2004). This was to make sure parents understood what was required to participate in the study and for me to establish their suitability in relation to
the aforementioned selection criteria. For those families who wished to proceed ($N=26$) an information package was posted which contained detailed information about the project (Appendix 4). A number of people who made contact with me during this stage ($N=9$) were not eligible for inclusion in the study. In three instances this was due to not being the parent to a young adult child deceased through suicide (two grandmothers and one sister), in four instances the deceased child was outside the age criteria for the study (one below and three above the age limit at time of death), and in the remaining two instances the callers were interested to learn more about the study, but had not experienced the suicide death of their own child.

A follow-up telephone call was made two weeks after the information package was sent. At that time one parent chose not to participate further in the study. This mother explained to me that she was very angry about previous references made by health professionals in relation to her two sons, both of whom had suicided, and had decided that she did not want to talk to me. I was unable to make contact with another mother to whom I had sent an information package. This mother was a resident in a retirement village and when I contacted the number she had provided, the staff told me she had been moved to a higher care facility. As I was not family they were unable to provide me with contact details of her new residence.
Attrition through the length of the interview phase of the study (13 months) saw another two informants discontinue involvement. One mother moved to a distant location and decided that she no longer wanted to participate in the study. During our last telephone conversation, this mother explained that she was moving to start a new life afresh, trying to leave behind the painful memories of her son. The second mother to discontinue with the study was unable to be contacted during the interview phase of the project. I had made an appointment with this mother to meet her at her home, but at the appointed time she did not respond to the doorbell. I telephoned her over the next hour and left three messages on her answer-machine, to which she did not respond. On returning to the university, I phoned another three times, with no response. Finally, I sent a letter explaining that I would not contact her again and that if she still wanted to be interviewed for the research that she could contact me, which she did not do.

Two families joined the study where the child's age was outside the criteria for inclusion. The first, where the daughter was aged thirty-one when she died was included as this young woman had been actively suicidal since the age of twelve. I felt this provided an example of what Patton (2002) calls extreme case sampling as this mother's experience could elaborate on dealing with potential suicide over a prolonged period of time. In the second family the son was four days older than the set criteria and his mother joined the
sample. Portraits of the final twenty-two parents involved in this research are presented in the following chapter, along with brief demographic information.

Data collection

In all but one instance I met with the parents face-to-face, on one occasion, for a period ranging from one to three hours. One telephone interview was performed. All interviews were recorded with audiotapes. The one exception was the telephone interview, where extensive notes were taken and the mother mailed in some additional written comments. Twelve interviews were conducted in the informant’s home, one in my office at the university, and four in public places (coffee shops, bar and a park). The location of the interview was selected according to each parent’s choice of venue and availability for the interview.

The interviews took place over a period of 13 months from late October 2002 to the beginning of November 2003. When the timeframe from initial contact to the time of the interview was more than three months, I sent parents follow-up letters (see Appendix 5 for an example) and telephoned them to keep them informed of progress of the study with projected timeframes updated as necessary.
After each interview, I sent parents a card to thank them for their time and update the projected timeframe of the study. Further letters were sent periodically (at mid year and an end of year Christmas card) through the duration of the project to keep parents up-to-date with progress and to maintain contact details for a final report to be sent at the conclusion of the project. Two mothers made contact with me during the final stages of the project, after interviewing was complete. These mothers were added to the mailing list to receive the final copy of the report. However, they did not participate in the data collection for the research.

Background to interviews

My rationale for using a narrative inquiry approach was to allow parents the opportunity to tell their stories as they occur in everyday life (Bruner 1990). In keeping with this purpose, I chose to use Holstein and Gubrium's (1995) approach to interviewing, termed the active interview. The approach suggested by these authors, acknowledges that the interview process is part of the ongoing meaning making of the event being examined.

Guided by the researcher, an active interview is a meaning-making endeavour. It is both active and collaborative, while at the same time being planned and organised (Holstein & Gubrium 1995). What occurs within the
interview influences the meaning making and shapes the narrative that is co-constructed between the interviewee and interviewer. Holstein and Gubrium (1995:3) report that ‘the emerging lesson is that interviewers are deeply and unavoidably implicated in creating meanings that ostensibly reside within respondents’.

In this manner, the discussions that took place between the parent and me captured something of what she or he has subjectively experienced with emphasis on the suicide death of her or his son or daughter. The primary aim was to induce parents’ narratives to uncover their meaning of the experiences of their child’s suicide death at the time of the interview. This aim allowed for a ‘snap shot’ of their experience to be recorded. The interviews for this study were planned through the use of one opening question to orient and focus the interview. In keeping with the narrative inquiry style of Polkinghorne (1988) and using the active interview principles from Holstein and Gubrium (1995), the interviews were guided to retain the research focus, while at the same time the parent directed the flow of dialogue. With these interview aims in mind, I was constantly attentive to the evolving relationship that built during the research process between the parent and I, which would ultimately influence the data collected.
When I met with parents, some time had passed since they had first made contact. Telephone calls and letters had been exchanged with parents during this initial period, building a preliminary rapport prior to our face-to-face meeting. This period from initial contact to face-to-face meeting allowed me to develop background knowledge about the participants. My contact with the parents afforded information that ‘provides direction and precedent, connecting the researchers interest to the respondent’s experience, bridging the concrete and the abstract’ (Holstein & Gubrium 1995:46). I also used the background knowledge that developed previously through clinical social work practice with parents and young people, and from the research literature pertaining to parenting, bereavement, and suicide, to further deepen my understanding of this experience.

During these initial telephone conversations, parents were eager to tell me details of their family and their deceased son or daughter. I carefully made note of this information, so that when I met with the parent I was able to use the deceased child’s name and any other information that might assist the comfort of the parent in the interview. For example, using this background knowledge I could say during the interview, *When we spoke previously, you said that you have four children, the youngest being your son, [name], who was 28 when he died*, as a lead into the interview question.
Being conscious of using this prior information to create a comfortable and safe place allowed me to conduct the interviews in an intimate manner. As a result, many of the parents commented on their level of comfort with sharing details of their life with me. As we were not personally connected in a social setting, the artificial environment of the research interview allowed for the safety and security of discussing sensitive issues, the parents knew that they would be unlikely to be personally confronted with them later. In other words, while there was a sense of familiarity between the parent and me there was also a knowing that we were there for a purpose and that our relationship was based on my interest in their experience of the suicide death of their child.

**Interview process**

When I met the parents for the interview the interaction typically began with small talk. This often centred on my journey to the chosen location. Many parents used this time to show me photographs of their son or daughter, and talk generally about their life, and that of other family members. I was often asked about my own children, their ages, and other general information about me and my research.

The research consent form was signed in duplicate by the parent and the researcher and permission was gained to tape-record the interview prior to
the commencement of the formal interview (Appendix 6). An information sheet (Appendix 7) was used to collect demographic information about the family with most of this data collected during previous telephone conversations. Additional material was provided by the parent during the interview without any specific questioning by me.

By the time the tape-recording began both the parent and I were seated comfortably and this action of turning on the tape-recorder clearly marked the formal start of the interview. Once the recording started, I reviewed the background of the study with the parent, including the formation of the project and my interest in the area. I emphasised that the project was concerned with eliciting a narrative of the parent’s experience of the suicide death of her or his daughter or son. The aim of this preliminary overview was to remind the parent of and orient them to the main objectives of the study in line with the active interview process (Holstein & Gubrium 1995). These preliminary remarks were tailored to the particular background of each parent and their family. All interviews began with the following statement:

*I would like to hear about your experience of losing a young adult child to suicide. You can tell your story in any way you feel comfortable, perhaps beginning with telling me a bit about before [child’s name]'s death, and then your journey since the suicide.*
This introductory statement was developed directly from the aim of this study, in order to examine how parents live through and live with the suicide death of their young adult son or daughter and was intended to lead the parent into a narrative that specifically focused on this experience.

Wherever the parent identified as the starting point for her or his story, I accepted as the point at which the narrative would begin. For some this meant going back to their child’s birth, for others the story began in the months preceding their child’s death. Typically, information was provided about their son or daughter’s childhood, through to their death, highlighting particular characteristics displayed in their child that fitted with the overall plot that the parent narrated.

Most parents followed the format suggested by the interview question, providing a temporal frame of before, during, and after the death of their child. Some chose to tell their story in other ways, which that they felt more appropriate to the experience. Using a recursive method of interviewing, I interrupted to clarify points when necessary, using previously provided information to frame subsequent questions (Minichiello, Aroni, Timewell & Alexander 1995). This allowed the parent the autonomy to discuss her or his experience in any way that was comfortable, permitting exploration of the individual experience, while honouring the sensitivity and uniqueness of
each informant’s story. For example, when a parent had been unclear about a particular instance, I would use the information that had been previously given as a reference for further explanation. In one instance with Hal and Gayle, Hal had referred to people being *ripped off* after a death in the family. Later, I asked: *Hal, earlier you mentioned that people get ripped off when they are recently bereaved. Can you tell me more about what this meant to you after Lena’s death?*

As some of the interviews occurred with one parent present and others with two (mother and/or father or step-parent) together, slightly different guidance became necessary to facilitate these interviews. In fourteen individual interviews where one parent was present, the conversation continued at length with very little or no input from me. When the parent had exhausted this line of thought, I would ask questions to clarify or expand on any of the issues she or he had raised during the main narrative.

In the four interviews where both parents were present, I was more actively involved. It was necessary for me to prompt regularly to help facilitate a continuing story. This was done by asking reflective questions based on the previous narrative, using the recursive techniques described earlier (Minichiello et al. 1995). In these instances, I found the interviews to be somewhat disjointed. The two parents attempted to describe their
interpretation of the events and subsequent journey since the death of their child, where they inherently carried a personal interpretation of the events and experiences, as well as relaying their joint story. The information gathered from these response was more limited.

Holstein and Gubrium (1995) explain this in terms of the effect of multivocality that occurs when more than one person contributes to an interview. One may speak more than the other, or on behalf of the other, one may dominate the narrative, or check the information with the other for clarity. Further, one may prompt the other for information that they may otherwise not have elaborated on. Such forces between the two participants may have negative consequences (for example, more information is given than one of the pair is comfortable with). There can also be extended positive attributes to such instances, which Holstein and Gubrium (1995) suggest may lead to deeper understandings of the experience being examined by both the participants and the researcher.

In the first two joint interviews, I felt that these parents had a cohesive joint story that they had developed over time, perhaps as a consequence of counselling they had been involved with at different times. These parents took turns in narrating a clear version of events that they both agreed upon as their 'truth'. The remaining two joint interviews were less cohesive. In the
case of Gayle and Hal, their daughter had died only a few months prior to
the interview, and both of them were still actively trying to make sense of
Jena's death, both individually and together. This, in addition to Hal's
dominance of the interview (discussed later), appeared to drive the
interview. In the other of the less cohesive joint interviews, Abby often
disagreed with Aiden about his report of their experiences and at one point
was clearly agitated.

In comparison to the sole interviews with one parent, I believe that the joint
interviews where a cohesive story was not present did not provide the
opportunity for either parent to fully explore their own narrative about their
son or daughter's death. Those with a more cohesive story may have told a
different sole story had they been interviewed alone. As these parents elected
to contribute together there was value in recognising the importance of the
joint story, as well as the individual story. The strengths and limitations of
this approach to interviewing parents are elaborated on in Chapter 9.

At the end of each interview I summarised the projected research timeline
through to completion of a final report, which was to be mailed out to each
participant. In addition, for those parents who lived in the vicinity of the
university, I discussed the question of what response I should make if our
paths crossed in the future. Some parents indicated they did not wish to be
acknowledged, whilst others wanted to stop and talk. These steps were undertaken firstly as a courtesy in view of their participation and secondly, to help to avoid a feeling of being exploited by sharing their story for this research (Llewellyn, Sullivan & Minichiello 2004). On completion of the interviews I noted these details, along with my reflections of the experience, in my fieldwork journal.

**Ending the research relationship**

Due to the sensitive nature of this study and the level of personal involvement and disclosure of the participating parents, special consideration was taken when leaving the field and terminating the interview. Throughout the process, involved parents were kept up to date with the progress of the research. They were told at the time of the interview that they would be sent a final report of the project and when they could expect this would occur. In the interim the use of letters and Christmas cards assured parents were kept informed of the research progress. From the outset the parents were made aware of what their participation would entail. At the time of the interview, I discussed with the parents the timeline of the project and that their involvement would cease when they received the final report.
Analysing narratives

There are no single set of rules governing analysis of narrative data. Choosing such a design necessitates a departure from formatted or structured methodologies. A number of previous studies were examined, which revealed the multitude of ways in which narrative inquiry has been used (for example Booth 1999; Cottle 2000; Gilbert 2002; Harvey, Stein & Scott 1995; Heffner 1989; Jones 2002; Kirkman 2002; McQuaide 1995). I elected to use Polkinghorne's (1988; 1995) orientation to narrative inquiry for both theoretical orientation and analytic guidance.

The goal of narrative inquiry analysis in this view is to uncover the plots within the data that hold together the story and provide the meaning that the narrator had attributed to the events. To do this, techniques are employed to note underlying patterns across examples through a movement between the original data and the emerging description of a pattern is made (Polkinghorne 1988). To explore the particularity of parents' experience, the manner in which separate events are connected becomes the focus for analysis in order to capture the experience of the suicide death of her or his son or daughter, as described above. The process for doing this follows.
Analytic process

After completing each interview, I transcribed the audiotapes verbatim. This data was then read through numerous times so I could become familiar with the whole story and the narratives within. Parts of the stories that 'jumped out' were highlighted for future reference, and journal notes were made about overall impressions. Typically, these initial markers made on the transcripts referred directly to causal events the parent described as being related to why they believed their son or daughter chose to suicide. The next level of analysis looked at what meaning these events held for the parents through examination of the ways they talked about the importance of these experiences.

The transcripts were examined thematically, for both overarching and key narratives, identifying common and unique experiences across the data. I frequently returned to the audiotapes to ensure that the context of the narratives and plots being examined were not removed from that originally portrayed by the parent, a potential problem with the transcription process (Riessman 1993). I moved the texts around in different ways to uncover deeper meanings, as spoken narrative is often quite disjointed once it is transferred into text through the transcription process. In one instance, I moved text around so that each parent’s narratives became a timeline leading up to their child’s death and since. Mishler (1991:277) refers to this process of
rearranging texts as part of the discovery, being 'a process of testing, clarifying and deepening our understanding of what is happening in the discourse'. From these techniques it became apparent to me that there were three important components that parents used to emplot their experience of living through and living with the suicide death of their son or daughter. The components formed the core elements of the data and provided the basis of the remaining chapters.

**Ethical considerations**

Parents' involvement in this study was voluntary and without payment. Typically parents gave their reasons for participating as a desire to help other parents who in the future may experience suicide death, which suggested that these parents were self-selecting because they *wanted* to talk. All participants made initial telephone contact with me after seeing, hearing, or reading of the study in the media (sometimes in more than one source).

Often the parents involved in this study referred to their reasons for participating as being able to help others in their situation. However, I also had the sense that their reasons were not purely altruistic. At the conclusion of the interview, parents were typically interested in what others had been telling me, and therefore, during the wrap up of the interview I provided an
overview of what had previously been shared within the bounds of confidentiality. My perception of this process was that such information helped to provide a normalising of their own experiences, and seemed particularly important for those who were isolated from other bereaved parents. Three other ethical determinants are discussed below.

**Non-identification of informants**

The informant's right to privacy, anonymity, and confidentiality were respected by providing an alias. As the informant each told their story about the life and death of a daughter or son and the impact this has had on her or his life as a parent, I felt it was important to allow them continued ownership of their involvement as much as possible. While the ultimate end product is my story about their narratives, I wanted the parents to be able to identify their input and have ownership over this. Permitting parents to choose pseudonyms both for their child and themselves assisted this. Nine parents chose their own alias and one for their daughter or son. I assigned aliases to the remaining 13 parents and their children.

**Ethics approval**

Ethics approval was granted through the University of New England Human Research Ethics Committee (Approval No. HE02/059) for the duration of the
study. A key part of the approval included providing all participants with a list of local services that they could contact (either by telephone or in person), should the interview process distress them. Contact numbers for the project supervisors, the Human Ethics Committee, and for me were provided in case the informant might wish to discuss their participation at any time (Appendix 4). This was reiterated to the parents prior to the interview commencing, and a second copy of the information was given if requested.

In the information package (Appendix 4) and prior to the commencement of the interview, informants were advised that they were free to withdraw their participation at any time and that all information would be destroyed. Two parents withdrew their participation prior to the interview phase, as discussed earlier.

**Informed consent**

All participants signed an informed consent form to interview and recording of their responses prior to the process beginning (Appendix 7). All parents agreed to be tape-recorded. In the one instance where a telephone interview was conducted, written informed consent was gained from the mother prior to data collection occurring. This interview was not tape-recorded for technical reasons, instead the researcher took detailed notes. In addition, the
mother sent in some published work that she had authored relating to her experience of the suicide of her son.

**Methodological strengths and limitations**

This project did not set out to gather a representative sample of parents who had experienced the suicide death of a child. The participants were 22 parents of children deceased by suicide aged between 17 and 31 years at time of death participated. This group of parents were motivated to speak about their experiences and self-selected upon hearing of the project. The results therefore are influenced by this, and represent the experiences narrated by this group.

The complete range of parental experience of suicide is not presented here, rather it is a snapshot of these individuals experiences. It is possible (within Western culture) that other parents may have similar experiences and diverse ones. As with all narrative inquiry research, the data reported here is not meant to be representative, but can be generalised to say parents who experience the suicide death of a young adult son or daughter may have some of these experiences. Thus this study provides empirical data to help understand what the suicide death of a child means to the parent.
Further analysis of the data may reveal deeper meanings and understandings beyond the current thesis parameters that would further enhance our understandings of this event in a parent’s life. Another researcher may decide on different foci in the analysis, which would also change the resulting discussions. This will be addressed in Chapter 9.

**Introducing the researcher**

The qualitative methods chosen for this research rely on the researcher’s interpretation of the data that has been collected. Essentially, what is presented in this thesis is my story of their stories. Therefore, my own history, gender, education, age, and other characteristics are relevant to the research process. As previously noted, these characteristics influenced the interviews, data collection and analysis. It is therefore important to briefly introduce myself and the qualities I bring to the research. My own personal characteristics and the ways that I made contact with these parents were vital influences in developing rapport with them.

I am a woman, born in 1971. Trained as a social worker, I completed my Honours thesis, examining the manner in which the natural environment impacts on the health and wellbeing of rural people, with an emphasis on the ways that rural social workers respond to this. This topic combined my
interests in rural communities and the natural environment with my professional social work discipline. This, and the topic of the present study, speaks to my ongoing interest in the way in which our natural, social, economical, and geographical environments affect our behaviours and our local communities, and our responsibilities to ourselves, each other and the environment.

In a variety of settings during my undergraduate education and since, I have worked with young people and those who work with them, in both health and research settings. I feel a strong connection to this age group and deeply believe in investing in the future generation. Further, I am interested in parenting, having worked in research related to this area.

My interest in suicide and suicide bereavement developed from working with young people and seeing and hearing of the ways that a suicide death affects them directly and indirectly. While I have never been intimately affected by a suicide death within my immediate or extended family, I have known a number of people who have chosen this way to die. Many of them were within the age range of this study at the time of their death. As my interest in suicide increased, I became aware of the lack of research that focussed attention on families bereaved in this manner.
I believe my professional training assisted during what were at times quite challenging interviews. I am accustomed to the experience of clients crying during counselling sessions. Therefore, I was not uncomfortable when parents wept when they spoke about their child. Reflective listening, and allowing for silences, are skills that are vital to both professional social work practice, and the art of research interviewing. I believe my skills in this area developed further over the course of this research.

I was born at a similar time to the deceased young adult child in many of the families. This was explicitly or implicitly reflected on by many of the parents. In some instances talking about my own life helped develop rapport and connect with parents thinking about my age and life stage and being involved in this project. Talking with parents about the personal, sensitive and highly intimate concerns of the suicide death of their child meant a unique and close relationship quickly developed between me and the parents. On occasions parents mentioned that they were disclosing things they had not shared with anyone before. Riessman (1993:11), in commenting on disclosure, notes that as each story is told to a particular person, ‘it might have taken a different form if someone else was the listener’. The unique nature of narrative inquiry is in seeking the narrator’s story and in turn narrator and interviewer together bringing another story, the story of the interview, to light.
Self care in researching sensitive areas

From the outset I was aware that speaking with parents about a traumatic life event could impact negatively on my own emotional health and wellbeing. As a trained social worker, I was aware of the potential of vicarious trauma during this research. Prior to the commencement of the interview phase I organised clinical debriefing with a counsellor at the Counselling Service at the University of New England. I made debriefing appointments with the counsellor for the day following each interview or the day after returning to the university for a number of distant or interstate interviews.

After the first interview I attended debriefing. This exercise presented me with an outlet for describing the experience of listening to fairly graphic descriptions of the death scene described. I attended debriefing after the second interview, but found that I did not need it, however I did talk through my experience of the interview. Subsequent opportunities for debriefing after the interviews were not taken as I did not feel it was necessary, although I did keep the appointment times available for if I did find I needed to talk through my experience of any interview. The use of field notes and journaling to record and reflect upon my experiences at the end of each interview, also acted as a debriefing procedure.
Being involved in this study and developing new insights and meanings of the parental experience of suicide bereavement had an emotional impact on me as the researcher. I feel privileged to have been party to hearing these special and unique accounts of the suicide death of young men or women. I feel changed by the experiences that I have heard throughout this project, yet I do not feel emotionally scarred by them. I am the sole parent of two young children. While this potentially constrained timely completion of a PhD, I feel this situation is personally protective. I had to take off my researcher ‘hat’ at 5pm everyday and put on my Mum ‘hat’ for the three and a half years of study. I could not go home and dwell on what I had been hearing or thinking about during the day, as my boys needed me to be there for them to care for their social, emotional, and physical needs. I believe that this project helped to provide a voice for these parents, and therefore while being an extraordinarily moving project, it has also been an incredibly rewarding one.

Summary

This chapter has described the orientation that this research has utilised to obtain and analyse parents’ narratives of the experience of the suicide death of their son or daughter. In the following chapter I introduce the parents informing this research. These portraits use many of the ‘parents’ own words to provide the reader with a sense of the interviews. The remainder of the
thesis then examines the data and what we can learn from these parents’ stories of suicide.