

Chapter 9

SURVIVING SUICIDE

Suicide has occurred throughout recorded history, yet in the latter decades of the twentieth century suicide deaths among young people began to rise to alarming rates in Australia. The Federal Government responded by implementing a national suicide prevention strategy aimed at young people, which during its implementation and evaluation appears to have had some effect on the number of suicide deaths. However, young people still die by suicide in unacceptable numbers.

While policy, planning and health services aim to prevent suicide death among young people, little attention has been paid to those left behind. The needs of the parents, families and communities bereaved through suicide remain poorly understood. The present research aimed to address this deficit in knowledge about the experience of parents bereaved through the suicide death of a young adult child. In doing so, a narrative methodology was utilised to allow parents the freedom to talk about of their experience in the manner with which they felt most comfortable. The research question guiding this study was: *How do parents live through and live with the suicide*

death of their young adult child? Using in-depth interviews, 22 parents' narratives were collected and analysed. The findings of this research have been presented as three narrative components or plots used by parents to narrate their stories of living through and living with the suicide death of their son or daughter.

The first plot, the lack of discourse around suicide (discussed in Chapter 6), leaves parents floundering: whom to talk to, what to say, when to say it and how to say it? In response, parents monitor when and how they talk about their son or daughter. Society provides conventions on *who should listen* (close family, professionals, support groups, ministers), conventions about *what should be said* (don't get emotional, come to terms with it), and conventions about *when to say these things* (acceptable immediately after death, but not for very long, acceptable in more intimate situations but not in public). These conventions, as reported by the participants in this study, were not adequate to the task of meeting the ongoing needs of parents confronted by their child's suicide death.

The second plot, presented in Chapter 7, features the level of preparedness parents experience prior to, or after the death of their son or daughter. For some, their child had been living with serious mental illness and/or extreme personal issues for some time preceding their death. These parents felt that

suicide was inevitable. Their stories told of the turbulence of life and then when the death did occur, there were feelings of relief interwoven with grief. For these parents there was a certainty of: 'We will find him or her dead', the taunting question being 'when'?

These parents were able to develop a narrative that included the possibility of suicide well before the event occurred. Their grief was the grief of the anticipated loss of a child, initiated some time prior to the child's death. Additionally, these parents, marginalised to some degree by the mental illness that their son or daughter had suffered during his or her life, felt fewer effects from the more typical suicide-related stigma noted by others.

A second group of parents did not see any sign of suicidal intent displayed by their son or daughter and they spoke of the tragedy of their death. Even years after the death, they were unable to determine why their child would have acted in this way. Their grief was overwhelming and debilitating. Their heightened emotional states had a negative impact on their life, both in the past and continuing into the present.

A third group spoke of the realisation after their child had died that suicide was a possibility, but they had not recognised this previously. These parents appeared to suffer most from feelings of blame and guilt, based on not earlier

identifying their child's suicidal intent. They gained solace through their ability to determine a cohesive narrative that explained the event, which enabled them to incorporate this unwanted event into their life story.

This finding that preparedness influenced the way in which grief was experienced makes a unique contribution to the literature. Previous research on suicide bereavement has ignored this notion of 'anticipating' suicide, suggesting that suicide is always sudden and unexpected. This study highlights the need to examine further the nuances of preparedness by close family members to inform policy and practice in assisting suicide survivors.

The third narrative plot spoke of the ways in which suicide bereaved parents remain connected with their child after their physical bond is broken through death. This continuing bond challenges and reshapes traditional ideas of how grief is experienced and finalised. In essence, the death of a child is not about loss of contact for parents, as all participants in this study experienced an ongoing relationship with their child. These findings add support to an emerging paradigm about the ways in which death only brings the end of a life, but not the end of a relationship.

Contributions of this research

Anticipation and preparedness for suicide

The possibility that some suicides may be anticipated has been touched on by a few authors in the last decade (see Jordar 2001; Van Dongen 1993), however the relevance of preparedness for suicide on the course of bereavement has largely been overlooked. Instead, the focus has been largely on trying to determine if suicide bereavement is different from other forms of sudden and traumatic death. The findings from this study highlight the variability of individual experience of suicide, and in particular, the effects on bereavement of the individual's preparedness for this tragedy. This suggests that suicide survivors are not a homogenous group in either their anticipation of, or reaction to, suicide and that research efforts need to be refocused to explore the subtleties of prior and post suicide experience.

Narrative storying as a consoling, meaning-making device

The ability that individuals have to develop a narrative to explain events in their lives appears to be vital in living through and living with traumatic bereavement. This narrative story making process appeared to play a significant role in managing grief reactions for the parents in this study. For parents who had difficulty constructing a narrative, their ongoing heightened emotional state was debilitating for them and others in their close circle. It is possible that with professional assistance this group could be

assisted in therapeutically re-authoring their grief (Neimeyer 2001). It was beyond the scope of this study to understand how this could occur, nevertheless this is an important future direction to explore how facilitating narrative development could assist healing for parents bereaved through suicide.

Contribution to knowledge

To date, policy and research about suicide among young people primarily focuses on individual risk pathology and risk group membership. These efforts, by and large, have not filtered through to produce a substantial reduction in the rate of suicide (Rogers 2001). As Knox, Conwell and Caine (2004) suggest, a broader framework that understands suicide as a social health issue does not currently exist. Rather than focussing only on the individual at risk, a social health framework is needed to identify why young people take their own lives and the impact this has on their loved ones. The findings from this study provide one part of a potential social health framework, namely, the position of suicide as an integral part of family life within a particular social and cultural context.

The findings from this study suggest there is a need to educate parents about the signs and signals of suicidal ideation and attempts and particularly so when children experience mental illness. Such education activities need to

prepare parents to develop dialogues with their children about suicide, providing them with the language skills that will, in turn, assist access to services for their children and other family members. Such an approach could reduce the number of parents who see suicide intent retrospectively, when it is too late to save their child, thus also reducing suicide death.

Frontline workers, teachers, health professionals, and clergy among others, are trained for suicide prevention. Yet, as Maine, Shute and Martin (2001:320-321) argue, 'any suicide prevention strategies must also involve the wider community' in order to educate other adults and reduce alienation of young people. These authors report most parents do not recognise signs of suicidal intent in their child, even though they are in a perfect position to, in time to help (Maine, Shute & Martin 2001). This is validated by the findings of this study. A recommendation is that education programs for the broader community need to be developed, trialled, evaluated, and implemented to increase social literacy regarding suicide risk. Examples of such programs have been undertaken in the Aboriginal community in Broome (Westerman 2004) which could be adapted and trialled in other cultural groups in Australia.

While some suicides may be averted through increased awareness of suicidal intent, it is important not to blame parents for their child's death, particularly

when the child is a young adult. Parental responsibility for young adult children is not clearly defined, and although they may feel responsible, they may have little influence over their child. Therefore, dialogue about suicide needs to be added to the cultural vernacular to move the focus beyond parents to all in the community. This would go some way to ensuring as many opportunities as possible exist for young adults to seek support and help from the broader community.

Investigating and analysing the experiences of those most intimately involved and affected by a suicide death, such as parents in this study, and for future studies, siblings, family, friends, and broader community, provides a new perspective on piecing together the suicide puzzle. It may never be possible to understand the exact events that led a particular person to suicide death. What is possible however is to understand and build on the experiences of those affected, to challenge assumptions about individual risk and in more broadly understanding this tragic phenomenon, work towards reducing suicide deaths among young people. A significant side benefit of such an approach involving families and friends of young people who have died by suicide could be the reducing the isolation and stigmatisation these families are subjected to.

Contribution to professional practice

The tendency to regard suicide survivors as a homogenous group overlooks the diversity of experiences and responses to suicide and the accompanying grief. Currently, it appears responses to those bereaved through suicide may be too limited. Recognising the different needs of suicide-bereaved parents is important in determining the appropriateness of the services delivered. Neimeyer (2000b) suggests that for those experiencing a 'normal' reaction to the death of their loved one, conventional therapy is not indicated. Indeed, he suggests there are potential negative consequences engaging an individual in therapy where it is not indicated. In contrast, for individuals suffering an extreme grief reaction to a sudden and unexpected death, therapy can be useful. The parents in this study indicated a preference for self-help groups and informal networks, over and above professional therapy services. It is not clear whether this was due to lack of knowledge about, or availability of such services, or previous experience that therapy services were not appropriate to their needs. Some parents mentioned that such services had failed to meet the needs of their son or daughter prior to his or her death.

Amongst the parents involved in this study there was a small group who were highly motivated to be involved in both suicide prevention and helping other bereaved parents. Only a few were involved in The Compassionate

Friends or other formal self-help groups. Some participants suggested their reason for participating in the study was solely that- their desire to help others. There is an untapped potential in exploring the resources offered by bereaved parents, and in understanding what role this need plays in their grief, and to ensure their experiences are translated into actions to assist other parents similarly burdened by suicide death.

Notes on the chosen methodology

The narrative technique used in this study provided unique insight into the ways in which parents construct their worldview to explain the events in their life concerning the suicide death of their young adult child and the meaning they attach to this experience. The design and data collection procedures allowed for a 'snapshot' of the parental story of the death *at that time and place*. Although narratives, as explained in the methods chapter (Chapter 4), develop over time and with re-telling, the development of narrative during the study timeframe was not the goal of this research.

Recently, I was contacted by email by Gary, whom the reader met in Chapter 5. Gary wanted to let me know I had spelled his address incorrectly on previous correspondence. He wrote to me about how he felt that Ted's death was getting more difficult over time and that he still cannot determine why

Ted would have acted in this way. This stands in contrast to my interview with him and his wife, Jean, some months before, when they had provided reasons why they thought Ted had died. From their narrative *at that time* I analysed their data as *Reflective*. From the information sent by email from Gary recently, I wonder if his story now at the *present time* might better be described as a *Tragedy* narrative. It appears that due to the birth of the first grandchild in this family, Jean and Gary's grief over Ted's death has reopened and re-narrated in a different way to what was presented to me in our research interview.

As with all research however, there must be an endpoint to data collection. The cross-sectional design I employed in interviewing the parents once means that this new information could not be included in the data analysis. However, this new information highlights two points that need to be addressed. The first is the ongoing and evolving nature of narratives, and the second is the manner in which the grief can be tapped into at any time. By its very nature, talking about grief, encouraged parents to be reflexive at that time which may have influenced their time-contextual narratives in the time since, and as in Gary's case, his current time-contextual narratives.

My observations here suggest two implications. The first is that we need to be aware of narratives as bounded by the context of time, and concurrently

being duly respectful of their deeply held meaning at that particular point. The second is to remain alert to the changing context of narratives as these are re-created over time as events, circumstances, situations and people interact in complex ways to reshape the meaning we derive from our lives and the stories we tell to explain this meaning making.

Both a strength and a limitation of the current study is the therapeutic nature of the research interview, which developed out of the reflexivity of in-depth interviewing. These particular parents wanted to talk about their experiences and self selected to be involved in the research. Muller and Thompson (2003) report that their participants really enjoyed talking about the deceased person, when given the chance and report:

[it] may be that describing one's experience of grief is similar to teaching others about it. Therefore, the participants may have learned more about their grief experience through the interviewing process. (Muller & Thompson 2003:195)

This could also be said about the parents in the present study. Other techniques of data collection and analysis could have been used for this research, and the outcomes might have differed accordingly. This study is both advantaged and limited by my own personal interest, professional skill and support for the use of narrative as the focus of analysis from the interviews. In-depth interviewing for research attracts some individuals and

not others. Therefore, as stated in Chapter 4, the parents involved in this research *wanted to talk about their experience*. Missing from this study are parents who are reluctant to talk about their experiences. The challenge of engaging such parents was beyond the scope of this study.

Limiting this study was my use of particular terminology (i.e. preparedness) that may have the unintended consequence of negatively implying that parents should have acted to prevent their child's death. The aforementioned preparedness narratives focus on suicide risk. That is, in some cases risk factors alerted parents to the possibility of suicide, or in the case of the *Reflective* parents, the risk was identified after the death. While this focus on risk has the potential to prevent suicide in some young people, it also has the unintended consequence of suggesting that parents should have been aware *prior* to their child's death that their child might suicide. This latter outcome was not intended when discussing the preparedness narrative in this way. The vexed issue of parental responsibility for adult children cannot be overlooked. As mentioned above, there are no rules determining responsibility for children who are adults, yet parents typically feel an ongoing duty of care throughout their child's life.

The lack of culturally diverse participants means that the conclusions drawn in this study relate to the experiences of Anglo-Australian parents. A more

comprehensive investigation of Australian parents responses should include Aboriginal or Torres Strait Islander participants, plus those from culturally and linguistically diverse backgrounds.

The interview process was restrained when two parents were interviewed together. While for the most part the information gained during these interviews provided a joint narrative, it did not allow for exploration of individual views or narratives. This was particularly evident in the interview with Hal and Gayle. With Hal dominating the conversation, Gayle had little opportunity to talk about her experience. Additionally, as discussed in Chapter 4, it was necessary for me to have more input in the interview dialogue to encourage and elicit narratives, which did not occur in any of the individual interviews.

Future research

There are a number of recommendations for future studies that have emerged based on the findings of this study.

Aboriginal suicide is different

Being of Aboriginal and Torres Strait Islander descent was referred to in Chapter 2 as being a 'risk factor' for suicide. Special attention must be given

to this group (see Westerman 2004). Throughout the last two centuries since Anglo-Saxon settlement in Australia, Aboriginal and Torres Strait Islander people have suffered in many ways. In particular, the health status of many Aboriginal and Torres Strait Islander communities is far below that of the general population. Aboriginal and Torres Strait Islander young people die by suicide significantly more frequently than the Australian population norm, with estimates that that suicide risk among this group is 40 times greater than for non-indigenous Australians (Commonwealth Department of Health and Aged Care 2000b).

In a comprehensive report on the state of Aboriginal and Torres Strait Islander youth suicide deaths, *Aboriginal Suicide is Different*, Colin Tatz (1999:10) advocates that indeed, '*Aboriginal suicide has unique social and political contexts and must be seen as a distinct phenomenon*' (original emphasis). Aboriginal communities have been severely disenfranchised over the past two hundred plus years and have lost many of the social boundaries that directed day-to-day life, for example, kinship, reciprocity, mutuality, sharing, care of young and old, incest taboos. Such losses, Tatz (1999:8) reports, are demonstrated through outward indicators such as alcohol and other drug problems and police attention, where 'people with previously ordered lives now have lives which are disordered'.

The present study did not actively recruit Aboriginal and Torres Strait Islanders and none volunteered for inclusion in this research. In line with National Health and Medical Research Council (2003) guidelines on research with Aboriginal and Torres Strait Islander's, their inclusion was considered to be beyond the scope of this study. Yet, it is critically important that research is continued in this field to understand the needs of these communities, who are affected many times more often by suicide death of their young people than are the non-Indigenous populations.

The experience of siblings and peers

Within my group of participants, many impressed upon me the importance of broadening my research to include the siblings and peers of their deceased daughter or son. They spoke of recognising the need to support their surviving children, and yet found they were not able to do this in the initial stages of their grief. They felt 'paralysed' and unable to do anything but survive themselves. Further, they spoke of the needs of their deceased child's girlfriend or boyfriend or partner and other close friends and how these young people and their bereavement were often overlooked.

Of the few studies addressing siblings and friends it appears that siblings are at increased risk of depression, post-traumatic stress disorder, and of suicide and are in need of suicide prevention measures (Brent et al. 1996). There is

some evidence that suicide runs in families, not so much because of a genetic effect, although depression and other mental health problems may leave an individual predisposed to developing the condition, but more because a suicide death identifies the vulnerable in the population (Clark & Goldney 2000). As a public health concern, it seems critical therefore that the experiences and needs of other family members in addition to those of parents are in urgent need of investigation.

Fathers being distant

Mothers in this research commented that they thought one of the contributing factors to their son's suicide death was the emotional distance of the child's father. Some speculated at the reaction the father might have had if the son was same-sex attracted, even though there was no evidence of this in any of the child's behaviours prior to their death. Mainly women volunteered for this study, which is not surprising given the social approval among women, in this case mothers, talking about their feelings. On the other hand, such social approval for men to discuss their emotions does not exist. Further research that explores in depth fathers' relationships with their sons may uncover insights into the progression to suicidal intent or suicide death and specifically so where emotional distance, or same-sex attraction, is present between father and son.

Within group differences

This study highlights the need to examine within group difference among suicide-bereaved parents and other family members, rather than the current focus on comparisons with other forms of sudden death. As noted earlier, both qualitative and quantitative studies are required to examine the effects of preparedness on grief and bereavement to further understand how this factor influences parents' experiences and the implications for service provision to those bereaved by suicide. Using a preparedness framework to further understand the grief processes of those bereaved through suicide could yield deeper insights into this experience.

Relinquishing the active care giving role

Identified above is the issue of parental responsibility for a young adult child. How parents view their responsibility when an adult child dies by suicide is not yet understood. It is well established that part of the grief process for parents is the need to relinquish an active care giving role when a child dies (De Vries, Dalla Lana & Flack 1994). While the parents in this study were chosen based on criteria set around their child's age at death, many of them were still active caregivers for their young adult children. For some there was a relief at the end of the care giving role, for example, Kate, who had been unable to sleep for the months preceding Sallie's death. Yet, there was also a reluctance to relinquish this role. This suggests that part of

parental identity is lost through the suicide process. Investigation of the impact of this loss would add insights with potential application to providing appropriate support services to suicide-bereaved parents.

Furthermore, with much of a parent's identity tied up with their child, it is impossible for the parent/child relationship to cease simply because the child no longer exists in the physical world. Death has typically been viewed in a singular fashion, yet for many there are multiple losses experienced with the death of a family member (for example, loss of identity, loss of future, loss of grandchildren). Such losses have yet to be thoroughly explored among parents bereaved through suicide.

The changing demographics of suicide

Since this study commenced, a trend has become apparent outside seasonal fluctuations in the statistics reported by the Australian Bureau of Statistics (2003), showing that men in their late twenties (25 to 34 years) now have the highest age specific suicide death rate. In 2001 this group was at 20.6 per 100 000, followed by the 35 to 44 year age group with 18.9 suicide deaths per 100 000 (Australian Bureau of Statistics 2001). However this trend had not been identified when this study commenced. Therefore, in the future, older age groups should also be included in any sample examining suicide among young adults.

Summary

The focus of this study was on the parental experience of suicide. While my initial intention was to focus solely on the grief and bereavement experience, the emotional, physical, and spiritual processes that are initiated by the death of a child are so influential in overwhelming parents that these form the focus of the discussion. My use of narrative method provided an in-depth analysis of a one point in time snapshot of the experience of suicide bereaved parents. This position is illuminated by Cleiren and Diekstra (1995), as they suggest:

we are weavers on the patchwork of our own life. The fabric we weave consists of smaller and larger patches of the important and less important people in our lives, our relationships, beliefs, and capacities. The loss of someone close leaves a smaller or greater hole in the fabric: the threads of the fabric do not connect anymore, and all the threads by which we were attached end in the emptiness. (Cleiren & Diekstra 1995:33)

This research aimed to understand the ways that parents live through and live with the suicide death of a young adult child, and the ways in which the fabric of life and relationships is woven and repaired.

In sum, the children lost through suicide are much more to their parents than their death no matter how 'loud' a social stigma suicide death is; they are also their children who they nurtured to the end of life. Helen expresses this so well in her words: *I like to think about James as a person, not just his death.*

Parents want to be able to remember and reflect on their child's life, not only their death. Anne Deveson (1998:274), it seems, speaks for parents who are suicide bereaved, when she shares these thoughts about Jonathon, who after years of suffering from schizophrenia died by suicide:

I suspect that he ended his life because his spirit was exhausted and his body too ill to carry on. But for us, who did not have his illness, we put one foot in front of the other and we kept going because it was better than the alternative. Perhaps this is how and why most people survive. I don't want to waft off into mists of sentimental cliché about finding safe harbour, but life is good now for all of us. Yet I do not suppose a day passes without Jonathan coming into my thoughts, and this is in no way morbid or even sad. Nobody told me that death does not remove a person from life. Jonathan is still very much a part of me, both the sadness of his death and, far stronger, the joy of his being, so that whenever something funny or strange occurs I can still fancy I hear Jonathan's wry comment or see his smile or catch a glimpse of him padding off down the road.

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Appendix 1

MEDIA RELEASE

A researcher at the University of New England is talking to parents about their experience of losing an adolescent/young adult child to suicide.

By gaining an understanding of their experience, she hopes to develop a framework for understanding similarly bereaved parents in future.

Myfanwy Maple, from UNE's School of Health, is seeking parents who would be willing to share their experiences of losing an adolescent/young adult child (aged 17–29 at time of death) to suicide. In addition to biological parents, people who acted in a parental role to the deceased child may also participate.

Ms Maple said the project is encouraging bereaved parents to talk about their grief, and the process of rebuilding their lives after the suicide death of a son or daughter. 'To date, responses to youth suicide have primarily focused on prevention', she said. 'While preventative work is vital, such a focus ignores the experiences of those most intimately involved in the suicide death of a young person. Parents are able to offer a unique insight into youth suicide, allowing us to challenge assumptions, develop more appropriate prevention

strategies, and understand the phenomenon more broadly. As suicide is unlikely to cease entirely, it is vital that we understand the experiences of those most closely affected, whose lives are changed forever’.

All participants, and any information they provide to the research project, would be treated confidentially.

For further information, please phone Myfanwy Maple at UNE on (02) 6773 3661.

Media contact: Myfanwy Maple, School of Health, UNE, Armidale (02) 6773 3661 or Jim Scanlan, Public Relations, UNE, Armidale (02) 6773 3049.

Appendix 2

MEDIA EXPOSURE

Print

Canberra Times 28/9/02

Coffs Harbour Advocate 27/9/02

Armidale Express and Express Extra 2/10 (front page)

Northern Daily Leader (Tamworth and New England/NorthWest) 7/10/02

Radio

Moree local radio 25/9/02 (interview)

ABC New England NorthWest 26/9/02 (interview)

2AD (Armidale) – repeats of above interview with ABC

100.3 (Armidale) – repeats of above interview with ABC

Television

Prime Local News 3/10/02

Other

Department of Forensic Medicine Newsletter + discussion in support group

(approx. 2/10/02) c/o Sister Mary Walsh

TCF suicide survivors Group discussion Canberra (approx. 2/10/02) after one member found it in the newspaper

Appendix 3

SUPPORT AFTER SUICIDE NEWSLETTER POSTING

SUPPORT AFTER SUICIDE GROUP



24TH September

Dear Myfanwy,

I am enclosing a copy of the brochure for the SASG as well as the latest Newsletter. As you can see I added a brief note regarding your research project. I will also encourage people at the monthly meeting next week to get in touch with you. I will make available copies of the forms you sent. Let me know if you have had any response so far.

Did you see the Four Corners Programme a few weeks ago, *Duty of Care?* A number of people who featured in that programme are members of the SASG. Their stories would be very relevant to your work.

I wish you all the best with your study. I think it is an important area to research and look forward to reading the completed paper.

Yours sincerely

Mary Walsh
Coordinator

Support After
Suicide Group



Mary Walsh

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SUPPORT AFTER SUICIDE GROUP

Welcome to New Members

The abrupt ending of a life by suicide leaves unique scars on those left behind. Your link to the Group is the common experience of having lost a relative, partner or close friend as a result of suicide. You would have received an initial letter with the *Care and Support Pack for Families and Friends Bereaved by Suicide*. You may have attended one or more of the Group meetings or had some contact with one of the Counsellors. The newsletter is an important way of maintaining your link with the group.

Aims of the Group

Our primary concern is to provide and foster mutual support for those bereaved after suicide. We do this through:

- ◆ Monthly Group Meetings
- ◆ Individual counselling
- ◆ Telephone contact
- ◆ Newsletters

SUPPORT AFTER SUICIDE GROUP

*Department of Forensic
Medicine.*

*50 Parramatta Rd
GLEBE NSW 2037
Phone: 8584 7800.*

Counselling Department:

*Kate Friis, Lorraine Remers,
Mary Walsh (co-ordinator)
Westmead: Phone 9845 6001
Jane Mowll, Kate Carlin*

**Support Group
Meetings held the
first Tuesday of the
month 7. 30pm at:
BURWOOD RSL
CLUB**

Next Meeting:

1st October
5th November

LIVING THE "GOOD BYES"

"When someone close to us dies we don't just say good bye once. We say it over and over. And we don't just say good bye, we *live* our good byes"

Our good byes involve coming to terms with the need to distance ourselves from a relationship that is no longer the same. The expectations that we once had are now different or even shattered. In living our good byes we gradually adjust to our changed circumstances.

We can acknowledge the enormity of our loss but have more difficulty with the reality. One moment it seems all too real but the next it seems that our loved one will walk through the door any minute. We need to keep saying good bye to help us come to terms with our reality.

Each person will find their ways of saying good bye which is meaningful to them. Rituals, such as talking to a photograph of the person you lost, regular visits to the cemetery, creating a memory book or corner are but some of the ways of doing this.

It is important to allow ourselves as many ways as possible to express our good byes. Writing, drawing or sharing with others how much you miss the person helps us to acknowledge the reality of the loss.

(Adapted from *A Time to Grieve...Meditations for He²⁰²g after the Death of a Loved One* C Staudacher)



HOPE

To those bereaved by suicide the scars are so deep that hope can seem an impossible thing.

Hope is deeper than mere optimism. Hope is intrinsic to being human. Hope gives us a goal, a purpose and meaning in our lives.

Hope enables us to believe that life has value and meaning beyond any tragedy that has happened to us.

Hope gives us the courage and impetus to choose how we respond to others and to our present reality.

Try to spend some time around people who allow you to feel your sadness and express your pain.... yet give you a sense of hope for your healing.

FOUR CORNERS

Recently Four Corners on the ABC featured a programme *Duty of Care* following a Parliamentary Inquiry into Mental illness and the Public Health System.

Some of the people involved in this programme are part of our Support Group. We congratulate and thank them for their courage and commitment in helping to bring this matter into the public arena.

If you saw the programme ring the ABC with your

comments. Feedback is vital to ensure that the issue is not forgotten by the media.

Mary Walsh....Co-ordinator)

Our lives are shaped as much by those who leave us as they are by those who stay.

Loss is our legacy.

Insight is our gift.

Memory is our guide.

Hope Edelman

Research project

A young woman from Armidale University is doing a research project: *Suicide: Parent's experiences of losing a son/daughter.* She would like to interview a number of parents/carers. If you would like to participate in this let me know or ring (02) 6773 3661 Mon -Thurs and ask for Myfanwy Maple. PhD Student.

Shared feelings..enrich and lead to growth and healing



BEREAVEMENT SUPPORT

REMEMBRANCE BOOK

At the Group meetings we remember and pay respect to all those who have died through suicide.

Our Remembrance book honours the memory by the inclusion of a photo and dedication. If you would like to add the photo of the person close to you, who died through suicide, send it in to the Counselling Department here at Forensic Medicine or bring it to a Group meeting.

Life Line: Phone 13 11 14
Telefriend (02) 9419 8367 1
GRIEF SUPPORT INC: 9489 6644

If you wish to add a friend or family member to the mailing list please let me know.

If you no longer wish to receive mail from the Support After Suicide Group phone8584 7808 and leave a message.

Know That You Are Loved.

* Love gives our lives meaning. Look around you for expressions of care and concern.

* There are people who love you. They want to be an important part of your support system.

* Some of those who love you may not know how to reach out to you in grief, but they still love you.

* Think about those people who love you and the ways in which your life matters.

(Healing Your Grieving Heart A Wolfelt)

Appendix 4

INFORMATION PACKAGE FOR PARENTS

**INFORMATION SHEET FOR PARTICIPANT'S INVOLVED IN RESEARCH
PROJECT**

'SUICIDE: PARENTS' EXPERIENCE OF LOSING A CHILD'

This study is for parents who have lost an adolescent child to suicide. To date, much research has been undertaken to establish why young people end their lives. Such research has focussed on what can be done to reduce the numbers of young people dying in this manner. While such research is vital, suicide continues to occur, effecting whole communities, paramount among those affected are the parents. It is important to understand the experiences of parents and thus the objective of this research. Specifically, this study aims to explore how a parent constructs meaning and defines parenthood in the context of the suicide death of an adolescent son or daughter.

To participate in this project you will need to agree to be interviewed by the researcher. During the interviews, the researcher will ask you to talk about being a parent with particular reference to your deceased child. The interviews will take place at a pre-determined location of your choice (for example, your home, my office at university, etc). The length and number of interviews will depend on your story. However, it is envisaged that one or

two interviews will take place for about 60 – 90 minutes each. With your permission the interview(s) will be tape-recorded.

You are under no obligation to participate in this project.

All information gathered from you (including tapes) will be coded to ensure that only the researcher and supervisors know your identity. After a period of five (5) years this data will be destroyed, in keeping with the policies of the University.

The content of these interviews will be highly sensitive and potentially upsetting. All information will be treated with care, so as not to cause you unnecessary distress. At any time, you may contact the researcher to talk about your participation (contact details below). The following are contact numbers of independent counsellors in your local area available to you, if you need to talk further about your experience;

- Life Line: 13 11 44;
- Community Health Centre Counsellors: refer to White Pages under 'c';
- The Compassionate Friends (NSW): 02 9290 2355 – group for bereaved parents.

At any time throughout the research process you may withdraw your participation. If you choose to do this, all information collected from you will be destroyed.

The narratives that you and other parents provide will form the basis of the researcher's PhD thesis and will primarily be published in this manner. It is envisaged that the PhD will be completed by May 2005. On request a summary report will be provided to participants. On completion of the PhD thesis, articles will be written from the findings and it is intended that such papers will be published in appropriate journals and presented at both domestic and international conferences.

You are encouraged to, at any time, contact the researcher or supervisors to discuss your participation in the study, and to have any questions answered.

Thank you for your interest in this project. It is anticipated that this research will benefit both parents and professionals alike. If you wish to participate in this project, or ask any questions regarding the project, please contact Myfanwy Maple on (02) 6773 3661 (Mon – Thu)

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE02/059, Valid to 31/05/05).

Should you have any complaints concerning the manner in which the research is conducted, please contact the Research Ethics Officer at the following address:

Research Services

University of New England

Armidale, NSW 2351

Telephone: (02) 6773 3543

Email: Ethics@metz.une.edu.au

RESEARCH TEAM CONTACT DETAILS

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Appendix 5

EXAMPLE OF FOLLOW-UP LETTER

[Date]

[Participant Name]

[Participant Address]

Dear [Participant],

Just a quick note to update you on the progress of my project '*Suicide: Parents' Experience of Losing a Young Adult Child*'. In my letter of [date], I noted that I would be in [your town] in early April. The dates I will be there are from [date] to [date]. As this time gets closer I will phone you to ask if there would be a suitable time to meet with you during my visit, or you can suggest a time now if you would prefer.

If, at any stage you wish to contact me, please do not hesitate. My contact details are below.

Again, thank you for your interest and participation in this important project and my apologies for the extended period between when you first made contact with me and when our interview may take place.

Sincerely

Myfanwy Maple

School of Health

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Armidale NSW 2351

Phone: 02 6773 3661

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Appendix 6

CONSENT FORM

Appendix 7

INTERVIEW INFORMATION FORM

INTERVIEW GUIDE

Signed Ethics Form Y/N

Demographic Information

[This information was not specifically asked for, information collected from narrative recorded through the interview]

Mum	Dad	Deceased Child
Age at death	Age at death	Date of death __/__/__
Married / separated / de facto	Married / separated / de facto	Age at death ____
urban / rural / remote	urban / rural / remote	male / female
Child living with? Y/N	Child living with? Y/N	Manner of suicide _____
		Suicide note left – Yes/No
Warning signs prior to death Y/N	Warning signs prior to death Y/N	History of mental illness Y/N

Other children in family: _____

Question:

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...

In the study, where I refer to your story an alias will be used to protect your identity.

Would you like to choose the names which will be used for you and your child?

Mum: _____ Dad: _____ Child: _____

Other children: _____