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You don't know how strong you are until being strong is your only option : examining resiliency in survivors of a parent or caregiver's suicide

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You Don't Know How Strong You Are
Until Being Strong is Your Only Option:
Examining Resiliency in Survivors of a Parent or Caregiver's Suicide

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2017

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Until Being Strong is Your Only Option:
Examining Resiliency in Survivors of
or Caregiver's Suicide

You Don't Know How Strong You Are

a Parent

Abstract

Suicide is a prevalent public health issue in the United States as it intimately effects many Americans annually. This study explored the bereavement and coping processes as well as strength and resiliency of adult children who lost their parent to death by suicide. Twelve adult children were recruited for this study through social media and suicide support groups. Participants were interviewed by phone and interviews were transcribed and analyzed using an inductive approach. The following themes were identified: intensity of the loss, secondary trauma of suicide, feelings of stigma, solace in talking about their parent, researching mental illness, attending grief groups, and advocating for suicide prevention. This research is limited in scope but provides important information for clinicians caring for suicide survivors. Future research should explore secondary trauma of suicide survivors as this was a significant theme within the study.

DEDICATION

To my mother, I can never thank you enough for the endless amounts of love and support you have given to me. I would not be where I am today without you.

To my father, who loved life, Chinese food, the sun, and cars. Your life and death have touched me and you will always be remembered and loved.

To my brother and sister, I will forever be grateful for the relationship we have. Thank you for always being there when I need you the most.

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I cannot be more grateful to the individuals who participated in this study. Your willingness and honesty to share your most intimate, painful and personal pieces of your life to help others has been inspirational. I continue to feel moved by your experiences and strength.

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CHAPTER I INTRODUCTION

In the United States, about 42,733 Americans die by suicide each year. However, an estimated 494,169 Americans visit the hospital each year for self-harm (US DHHS, 2015). Considering these large numbers of individuals affected, it is important to bear in mind that for every attempted or completed suicide, an estimated number of at least six people are intimately affected by the act. In our world, suicide has become a concept that many individuals are too afraid to talk about. Considering such a large number of people are intimately affected by suicide, it is astounding that suicide is socially unacceptable to talk about and stigmatized. Stigma, which is defined as; a mark of disgrace associated with a particular circumstance, quality, or person, (Oxford Living Dictionary, 2012) can create an immense amount of shame or humiliation for an individual. It is significant to note that the suicidal act is not the only piece that is stigmatized. In addition, mental illness that is associated with suicide is greatly stigmatized. Considering that suicide is among many concepts that are heavily stigmatized, those who are feeling suicidal or have survived a loved one's suicide frequently report that they feel unable to talk about their feelings regarding suicide and being a suicide survivor (Hacker, 2014).

Consequently, the first research question for this study is: What is the impact of a parent's or caregiver's suicide? Considering that being a survivor of *anything* suggests that one has resiliency and strength, I am interested in researching what helped individuals cope and create a foundation for their resiliency. Keeping this important aspect in mind, the second research question for this study is: What has helped suicide survivors cope throughout the loss of one's parent's or caregiver's suicide? Considering

that there is not a significant amount of research on this specific topic, I am interested in learning more about individuals' stories which include negative or risk experiences as well as strength and perseverance through times that often can feel impossible to get through.

Exploring the literature base of social work & psychology, there has been a significant amount of research conducted about suicide. In fact, there is even a profession known as being a "Suicidologist." A Suicidologist dedicates their career and life to studying suicidal behavior and suicide prevention. Despite this profession and even the copious amount of research about suicide, there seems to be a major lack of research and literature regarding the coping and resiliency of suicide survivors. This lack of understanding of how suicide survivors cope with such a devastating loss may be contributing to the stigma attached to suicide as suicide survivors report not feeling able to talk about their experiences. Perhaps, having such critical conversations with suicide survivors may highlight individual's strength, rather than creating shame by not discussing such experiences at all. Research and literature on the topic of suicide fail to specifically discuss the immense amount of resiliency and strength one displays after having lost a loved one to suicide. However, literature and research exists about resiliency in other areas of life such as, victims of abuse and survivors' medical illnesses to name a couple (Tegnér, 2009). For the discipline of Social Work, Psychology, and Suicidology, it crucial to have continuous conversations with suicide survivors to better understand the coping process one goes through when losing a loved one to a devastating loss such as suicide. Having a better understanding of this process can continue to inform clinicians and researchers on ways to support suicide survivors.

This study focused on 12 individuals who lost either their parent or caregiver to a completed suicide. For the purpose of this study, those who have lost a parent or caregiver to suicide are named “suicide survivors.” Being a survivor means an array of things, however, the most meaningful and valuable definition I have come across is from the Oxford Living Dictionary (2017) has been "a person who copes well with life's difficulties." However, I challenge this definition as the coping process is subjective, rarely simple, and is very unique from person-to-person. I believe that anyone who copes with life’s difficulties is a survivor and resilient. That being said, this study focuses on how individuals cope after losing a parent or caregiver to a completed suicide. The selection criteria for this project are: participants may be anyone currently over the age of 18 who has lost a parent or a caregiver to suicide at any time in their lives. Although the thesis question states "child" it does not only mean those who lost their parent when they were children (under 18 years of age) rather, at any age of their lifetime. In gathering subjects for this topic, I realized that it could have the potential to be challenging to find participants. However, I used word of mouth, social media, and contacting suicide support group facilitators to inform friends and colleagues of my study. It continued to be my hope throughout the study that people would want to participate in order to tell their own story as well as their parent's story, as I view a great deal of importance in furthering conversations of suicide.

This population is of particular interest to me because I am a suicide survivor. On November 28, 2008, my father completed a suicide attempt when I was fourteen years old, just two days before my fifteenth birthday and the day after Thanksgiving. I am interested, as a survivor of a parent's suicide, how others have been affected. In my case, I consider myself to be very fortunate for the way I have overcome this horrible tragedy.

For example, I chose to take my father's death as a way to propel me to be a better, stronger individual. I remember thinking; "this event could either make or break me." I was not willing to let this harm me and decided at a young age to bring about the most light possible from this awful and tragic situation.

I was inspired to study Psychology for my undergraduate degree at the University of Hartford and then have gone on to pursue my master's degree in Social Work at Smith College just two weeks after graduation. In addition, I used exercise, specifically running as a major coping skill. My father always enjoyed watching me run in middle school and the beginning of high school so I became inspired to continue to run not only for me but for him too. I consistently ran throughout my high-school career until I was recruited to a collegiate Division 1 team in which I competed in cross-country, indoor track, and outdoor track at the highest collegiate level. Despite utilizing running as a coping skill, individuals such as teammates, competitors, and coaches that I met along the way kept me grounded through their continuous outpouring support. While I realize how fortunate I am to have been able to make such a negative situation a source for growth, I know that the statistics for children of parents who commit suicide are shockingly scary-- including a 50% chance that the child may attempt suicide one day (Jones, 2012). However, in my case, I acknowledge that I have had a very different outcome than the outcome that research suggests I may have. As suicide rates continue to expand, more people will unfortunately be intimately affected. Therefore, we must engage one another in critical conversations about suicide to bring awareness, work to de-stigmatize and allow space for individuals to feel comfortable in getting help rather than feel isolated.

CHAPTER II

Literature Review

Given the prevalence of suicide and self-harm in the United States, it is imperative that we understand the impact the effects that suicide has on those who survive a loved one's suicide. In the United States, about 42,733 Americans die by suicide each year. However, an estimated 494,169 Americans visit the hospital each year for self-harm (US DHHS, 2015). According to the United States Department of Health and Human Services

(US DHHS), suicide has been the tenth leading cause of death for the past several years in the United States and has only recently become more publicized in the media (2015). Throughout this chapter, I will discuss the complex nature of suicide, unique bereavement process, coping skills, relevant theoretical frameworks, and the need for strengths based approaches.

Despite how unfortunately common suicide has become, there remains a stigma attached to suicide which often can impact how suicide survivors grieve and cope. In the field of social work, we make a commitment to sit with and be a container to hold other's pain. Through this experience, we as clinicians work with many different people who are going through an array of difficult life challenges. It is important to know which evidence-based interventions such as effective coping skills are likely to be more effective in working with an individual who is experiencing grief and bereavement. This topic proves to be relevant in learning how to help those who have lost someone to suicide to gain an understanding of their relative's suicide and process what has happened.

Complex and Unique Pain Experienced by Suicide Survivors

As noted by The Harvard Medical School Mental Health Letter “suicide is more painful for the family than other kinds of death.” (Lukas & Seiden, 2007, p. 27). This information is not to negate how difficult death is in any context, however, to bring awareness to the unique pain experienced by suicide survivors. While there are many reasons why suicide can be viewed as a more painful loss than others, a major contribution to this statement may be if the person who completes a suicide is looked up to by their family and friends. For example, if the individual is tokenized, or thought of

very highly and respected within the family it may cause family members and especially the children to feel confused on how to understand what this death means and how to move forward. These factors can make the death and grieving process much more complex (Beck, 1989). Another way that suicide can complicate the bereavement process is if it goes against the family's personal values and beliefs. It is significant to note that suicide is considered to be taboo within countries, various religions, and cultures. This factor alone may also contribute to the substantial stigmatization surrounding suicide. For the Native American people, completing a suicide is viewed as being a complete contradiction of their cultural beliefs and values. Despite these ethical beliefs within the Native American people, suicide has reached an alarmingly high rate within many of the Tribal communities (Hacker, 2014). Regardless of culture, experiencing a death, especially losing someone to a completed suicide is an extremely difficult and undeniably painful loss for one to go through. Clearly, pain and pathology are not the full story for suicide survivors. This study aims to fill the gap in the literature on resilience and strength of suicide survivors.

Another reason why it is crucial to have a better understanding of how to assist those who are coping with the death of a parent or caregiver from a completed suicide is because of the risk factors that become present for such individuals. Risk factors are defined as the result of exposure to a traumatic event that increases the likelihood for an individual to develop negative symptoms (Kessler, 1993). Given the risk factors, Cain (2009) suggests that suicide survivors may be a vulnerable population. This is mainly because once someone becomes a suicide survivor, they are at a higher risk to develop a mental illness such as depression and anxiety. In addition, there is a 50% chance that the child suicide survivor may attempt suicide one day (Jones, 2012).

Such vulnerability is explored deeper through the article "The Impact of Suicide During Childhood on the Mourning Process and Psychosocial Functioning of Child and Sibling Survivors" by Theresa Wright (1999). Wright (1999) identifies that suicide is an epidemic or contagion-like phenomenon and that it is estimated that each suicide intimately affects at least six other people among the survivors. This study examines several aspects and feelings one may have if one has lost a parent to suicide such as that suicide survivors may experience more guilt, shame, and stigmatization than non-suicide death survivors; that suicide survivors may be initially misinformed about the cause of death; and that suicide survivors may experience distorted communication within the family which can have major mental health effects later in life. That being said, we must have greater knowledge on how to support clients, patients, friends, and family members through such seriously distressing times. Angela Veale, a researcher and author of the 2014 article "Longitudinal Evaluation of a Therapeutic Group Work Intervention with Suicide-Bereaved Children" provides empirical evidence that parental suicide during childhood is a risk factor for mental health difficulties, and that there is a major need for efficacy-based interventions for suicide-bereaved children.

Intricate and Individualized Bereavement Processes

Before further understanding and acknowledging an individual's resiliency and strength after a death, it is important to first understand the bereavement process. In addition, it is important to keep in mind that suicidal bereavement has been understood to be a different process and experience from other types of bereavement (Beck, 1989). Unfortunately, many people who survive a loved one's suicide tend to have guilt, ask themselves "what-if" questions, and can often blame themselves for the death of their

loved one (Cohen, 2011). While this is very common, it is often highly problematic for individuals because it can work against them in the healing process. It is crucial to learn differing ways to help individuals who are grieving the death by a completed suicide. It is clear that survivors are often incredibly resilient but this has not been adequately explored in the literature. The strength one harnesses to overcome such a devastating, life-altering experience is one that should be highlighted and acknowledged instead of being hidden, as many suicide survivors report feeling shameful (Lamb-Shapiro, 2014).

As suggested by a wide range of research, the bereavement and grieving process has been viewed in categorical stages that individuals are likely expected to go through as they go through their mourning period (Beck, 1989, Kubler-Ross, 1969, Bowlby and Parks, 1970). This process is commonly known and referred to as being the Five Stages of Grief (Kubler-Ross, 1969). These five stages include; denial, anger, bargaining, depression, and acceptance. Kubler-Ross (1969) first introduced the five stages of grief in her book *On Death and Dying* in 1993. Denial is recognized as being the first stage as individuals are often in disbelief and utter shock over the experience. The second stage known as anger occurs when people realize that what is going on is real and people can express anger through projection. Bargaining is an important stage in the grieving process in which individuals are likely to express a sense of hope through negotiating their circumstances to have their loved one come back. Depression which is often the result of people going through psychological experiences is demonstrated through individuals experiencing immense sadness over the loss. Lastly, acceptance, which is known as being the final stage occurs as individuals begin to accept that they cannot change what has been done and work towards embracing some kind of future for themselves although that

individual is no longer present (Kubler-Ross, 1969). Kubler-Ross (1969) first suggested that griever go through each of these five stages in a linear matter. However, through extensive research and further understanding on the topic, many professionals and researchers, Kubler-Ross included, as indicated by her later work, suggests that the five stages of grief may not be a direct course that all grievers will experience and that it can be unique from individual to individual (Hung, 2010).

Researchers such as Beautri (2004) have begun taking a deeper look at how death and shock are processed neuro-biologically. This is important in considering how the death of someone by suicide can add another layer of shock, trauma, and complexity. This has been further understood through the work of researchers Bowlby and Parkes (2010). It has been argued that while grief has many different and complex stages, not everyone will be affected by each stage (Bowlby & Parkes, 2010). In fact, Bowlby and Parkes (2010) believe that it is likely for individuals to go back and forth within stages while regressing to earlier stages of functioning. This is crucial information to hold as this can help normalize stages of grief for those who are in the mourning process. In addition, highlighting this very fact for those who are in mourning can help with the grieving process in their understanding of what they are going through. Grieving a death that was either completed through a suicide or not, can affect people differently emotionally, mentally, physically, physiologically, and spiritually. There may be an array of reasons why this may be the case, however, the two that we will explore further below are due to the stigma associated with suicide and the sudden nature of the suicide (Beck, 1989).

As anger is displayed as being one of the five stages of grief, blaming individuals is often a common emotional reaction that can be correlated with anger. Ratanarjah (2007), found within her study of assessing children with whom a parent or caregiver's death resulted from suicide versus not suicide was that blame was more present for suicide survivors. This study suggests that through coping, suicide survivors were more likely to blame themselves, family members, friends, and negligent doctors than those mourning a loss non-related to suicide (Ratanarjah, 2007).

On a personal level, I can attest to this notion as it was easier for me to blame others for not having paid attention enough to my father's illness than accepting the idea that he was incredibly ill and at times lying to his doctors and family about how he was *really* feeling. The aspect of blaming and trying to cope with the understanding of the nature of the death can closely be related to the stigma of suicide as well as the sudden nature of the death. As suicide continues to be a topic that is hardly spoken of, it can make suicide survivors feel rejected, unlovable, not normal, and alone (Wright, 1999). Although death is a complicated and distressing experience for nearly all people, losing someone to a completed suicide adds an entirely new layer of confusion for those who are left behind. For example, individuals may question the love that the individual had for them in the first place. This is often seen as individuals ask themselves questions like "if they loved me, then how could they leave me like this?" Taking a deeper look at this, examining and understanding how children are affected after losing a parent or caregiver to suicide can complicate the grieving process even more as they may begin to question or not understand the attachment that they believed they had with their parent or caregiver. This process can affect people long-term through how they connect and attach

with others in their lifetime. In addition, it can create a fear of separation for individuals who fear their loved ones leaving them (Beautri, 2004).

Coping and Healing

Although there is limited research about resiliency and coping of suicide survivors, there is a small body of evidence to work from. Coping with a loss such as the death of a parent or caregiver from a completed suicide is often an extremely sensitive and devastating experience. Considering there is limited information on how suicide survivors cope, it is necessary to learn from suicide survivors to help inform clinicians on how we can best serve and help our clients. According to a qualitative research study done by Quinlan-Downs (2011) examining suicide survivors of family members such as parents, aunts, uncles, cousins, grandparents etc., suicide survivors have an array of coping skills and mechanisms that they use to adjust to life without their loved one. These coping skills and responses include; endorsing spirituality, attempting to find and/or make meaning of tragedy, experience shock, sadness, and disbelief, but not letting themselves hold such feelings in, rather, expressing and processing such emotions. I am interested in learning which coping mechanisms suicide survivors utilize as they cope with their loss or a parent of caregiver as well as what coping skills have been the most effective for them. This is an extremely important piece of information to identify for clinicians to support clients and patients in identifying their most effective coping skills. As Quinlan-Downs (2011) has started to pave the way for such findings, it is essential to continue this research as their study did not identify cultural differences within coping mechanisms and what specific coping skills were the most useful for each individual.

Evidence from Quinlan-Downs (2011) study which examines protective factors within family systems and resiliency, influenced my choices of theoretical frameworks of Stress and Coping (1984) as well as Social Supports (2004). Quinlan-Downs (2011) appears to have a great contribution to this topic as it is one of the only articles that focuses on resiliency for suicide survivors. It is significant to note that protective factors found to be present for those survivors of a completed suicide include; more than one significant relationship, not having experienced an apparent conflict with family and/or friends, and having been a parent to one or more children.

Dispositional optimism which is defined as; having the general expectation that good things will happen rather than bad, has been found to have a large effect on how individuals adjust and cope to a diverse number of stressors (Nes & Segrestrom, 2006). In a research study conducted in 2006, researchers Nes and Segrestrom (2006) examined how individuals react to stressors. Through meta-analysis, dispositional optimism was found to be positively correlated to the utilization of coping skills such as eliminating, reducing, and managing stressors and emotions. However, it was discovered that dispositional optimism is negatively associated with avoidance coping strategies. Such avoidance coping strategies include but are not limited to; ignoring, avoiding, and withdrawing from stressors and emotions (Nes & Segerstrom, 2006). As suggested by the theory of stress and coping (1984), it appears that individuals who consider themselves to be optimistic are more likely to use problem-focused strategies. However, individuals who identify as pessimistic, are found to use more emotion-focused coping strategies. In regards to culture and ethnicity, Nes and Segrestrom's (2006) findings revealed that the

"optimism-coping" strategies are most commonly found in English speaking languages. While there may be an array of reasons that would suggest this result, it is likely because other cultures may view death and grief differently than English-speaking languages.

Several researchers who conducted separate studies found that for those coping with a suicide one of the most helpful coping skills that they utilized was attending suicide survivor support groups. Rabin Hung (2010) used a mixed method study to examine the outcomes and common themes of offspring survivors of parental suicide such as the strength in group comradery and effectiveness of supportive friends. Hung (2010) suggests that those who experienced the death of a parent or caregiver through suicide found suicide support groups to be especially helpful because they connected the individual with other people who did not make judgments or create stigmatizing environments for them. Similarly, Cohen (2011) found suicide survivor support groups to be helpful because it connected individuals with people who could relate to their own experiences. Cohen (2011) suggests that support groups have been found to be equally helpful for people of all ages because of the supportive and caring environment. Veale (2014) presented a child-centered longitudinal evaluation of a group work intervention for suicide-bereaved children aged 8–12 years. This study was conducted using The Child Behavior Checklist (CBCL) which measures emotional and behavioral problems as well as social competence. The study also used semi-structured interviews to assess how well the children function socially. The study found that 75% of the children scored within the clinical range for internalizing and externalizing problems from the time of their parent's suicide. After the group work intervention was used, there was a follow up with the participants six months later and it was found that symptomatology had decreased

substantially. Four years later, some participants had taken leadership roles in their schools on suicide-prevention initiatives. The results found that the group work helped to enhance connectedness, emotional expression, family communication processes, memory and sense-making, and processes associated with active coping in suicide-bereaved children (Cohen, 2011).

Impact of Stigma Associated with Suicide and Mental Health

In all three studies, many individuals spoke out about the stigma that they experienced and how that affected their coping process. For example, some participants felt that they could not talk to friends or co-workers about the death because they were afraid of the reaction people may have. The personal narrative article “Members of a Very Small Club” discusses the events in the life of the author, Jessica Lamb-Shapiro (2014) as she explains her personal experience of losing her mother to suicide. LambShapiro (2014) lost her mother to a completed suicide when she was only 15 years-old. Within this article, she discusses how aside from being distraught over her mother's death, she felt an immense amount of shame and humiliation. She reports that she avoided telling people that her mom died through a completed suicide and that when people would ask, she would say that she had cancer. Clearly, the author felt very alone after her mother's suicide and was afraid of the stigma attached to someone who completes a suicide. Within this article, Lamb-Shapiro writes about an eye-opening experience that she has when she meets another suicide survivor who had a very similar reaction and experience in regards to her father's death. Lamb-Shapiro (2014), then interviews several strangers who also lost a parent to suicide and realizes that although they have never met before, they have many things in common such as their lifestyle,

aspects of their mental health as well as their relationship styles. The greatest commonality among the children of parental suicide survivors was that individuals felt humiliation and shame resulting from their parent's or caregiver's completed suicide. Many participants in this study reported that they were more likely to lie about what happened to their parent instead of telling people the truth because they were embarrassed. In regards to mental health, all the participants shared that they relied on professional help such as social workers, psychologists, and guidance counselors to help them process and cope with the loss of their parent or caregiver. Considering relationship styles, many of the participants identified as having difficulties trusting other people and getting close to others for fear of them leaving them unexpectedly. Several helpful coping mechanisms identified were finding a hobby, relying on other suicide survivors, advocating for suicide prevention, and doing positive things within their life (Cohen, 2011, Hung, 2010, Lamb-Shapiro, 2014).

Integration of Theoretical Frameworks

This project is mostly informed by Folkman and Lazarus' theory of coping (1984). However, integrating several other theories such as the theory of resilience (2013) and the theory of social supports (2004), also informs my understanding of the topic. As suggested by Folkman and Lazarus' theory of coping (1984), when an individual is faced with stress, the biological and psychological systems within one's body changes in reaction to the situation (Sarafino, 2012). This incredible piece of information suggests that our bodies are inherently created to be resilient as we are biologically and psychologically attuned to survive and cope with life's obstacles. While there are many effective and ineffective ways to respond to stress, Folkman and Lazarus suggest that

ultimately there are two ways of coping; emotion-focused and problem-solving focused. Emotion-focused coping revolves around an individual attempting to eliminate the negative emotional responses such as anxiety, depression, anger, and frustration. Typically, this is done as individual's use coping skills such as; distraction, meditation, over-eating, under-eating, using drugs, drinking alcohol, suppressing emotions, praying for strength and guidance, and journaling. Problem-solving focused coping works differently from emotion-focused coping as it aims to target the cause of the stressors and then to eliminate the stressful situation (Duangdao & Roesch, 2008). Several ways that problem-solving focused coping is utilized includes; problem-solving, time-management, and seeking out social supports. Considering that it is not always possible for one to eliminate stressors in one's life, problem-solving focused coping appears to not be as effective for an individual who is grieving (Pascoe & Richman, 2009). However, Lazarus and Folkman suggest that individuals still may attempt to use problem-solving focused coping while managing with a death as they have used it in the past and found it to be effective (Sarafino, 2012).

While considering the many different lenses one may use in working with someone who has undergone a life-altering experience, strengths-based approaches are often utilized. Within strengths based approaches, clients and patients are validated through their emotional experiences and then supported in finding their strengths (Linley, 2004). In doing this, individuals may feel motivated and determined to use their strengths to help propel them forward rather than feeling defeated from their experiences.

Resiliency theory is conceptualized through using optimistic variables to interfere with negative experiences (Linley, 2004). Such positive factors are known as being promotive

factors. Promotive factors are used to encourage individuals to enhance development while protecting against risk factors (Fergus & Zimmerman, 2005). In a study to better understand resiliency and the strengths-based approach, researchers Fergus and Zimmerman (2005) have identified two types of promotive factors: assets and resources. An example of assets are protective factors that individuals have within themselves such as; self-esteem and self-efficacy. However, resources are defined as being factors that are outside of the individual such as, support from friends and family, mentors, and role models. Fergus and Zimmerman (2005) argue that having both assets and resources have a significant impact on individuals' resiliency and overall well-being.

Similarly, the theory of social supports closely aligns with Lazarus' and Folkman's theory of coping and stress (1984). Social supports, which is defined as, "an exchange of resources between two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (Shumaker, pp. 371) has been proven to have lasting impacts on one's mental health. As life has many unforeseen obstacles, having social supports has historically been recognized to help individual's cope through painful times. Having optimistic and frequent social supports in one's life often helps to positively affect one's mental and emotional health. The social support theory states that having support can reduce the negative effects of stressful events on one's health (Shumaker, 1984). In addition, the social support theory suggests that having social supports can enhance one's coping performance and likelihood to utilize coping skills (Vaux, 1998). A predictor to effectively using coping skills may be related to one having a strong sense of self (Dumont & Provost, 1999). Typically, individuals are more likely to have a higher self-esteem when they feel supported and cared for by their family and friends. However, those who do not feel supported by their peers may be more likely to

use other coping skills that don't require interpersonal relationships (Johnson, 2002). It is significant to note that social supports can be a negative factor in one's life if they are abusive or manipulative. In such case, as one copes with their own grievances, individuals' vulnerabilities are likely to be exposed (Vaux, 1998). If one is relying on an individual who is a bad influence or is taking advantage of the person, then that particular social support can become negative and toxic. Keeping this in mind, it is important for people to have several supports to ensure that they are staying grounded and having multiple people to rely on.

Need for Strengths-Based Approach

Although the literature accounts for risk factors that suicide survivors may experience as well as the bereavement process, it does not provide nearly enough information in regard to the resilience and strength that suicide survivors use for coping and healing. There are many reasons why exploring strengths and resiliency are within the scope of social work research. As noted in the Social Work Code of Ethics, the ethical principle *Social workers respect the inherent dignity and worth of the person* brings up several good points that social workers must ethically possess and practice while in the field. This specific ethical principle states "Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs" (Code of Ethics, 2008). This is an extremely important clinical tool to practice while working with individuals, as everyone has strengths, however, because of situations one may be in they may be unable to pull from their strengths to help themselves cope in that moment. Considering that it is the duty of social workers to provide such a supportive environment for our clients and

patients reiterates the importance of highlighting an individual's resiliencies and strengths. A well-known theoretical orientation in the fields of social work and psychology is a strengths-based approach. According to the Oxford Journal, strengths-based approaches encourage clinicians to engage with their clients through highlighting one's strengths while working towards healing and empowerment for the individual (2012). For individuals who practice a strengths-based approach understand that each individual has the ability to recoup from adversity. Essentially, a strengths-based approach allows individuals to be more hopeful rather than feel hopeless (McCashen, 2008).

Conclusion

The research literature has begun exploring this topic further, however there are significant gaps that need to be filled. While support groups have been identified as being helpful coping mechanisms for suicide survivors, it is important to learn other ways that clinicians can help to support clients and patients through the complicated, distressing, and horrifying loss of a parent or caregiver completing a suicide. Considering that being a survivor of *anything* suggests that one has resiliency and strength, I am interested in researching what helped individual's cope and create a foundation for their resiliency. Keeping this important aspect in mind, the first research question for this study is: What is the impact of a parent's or caregiver's suicide? The second research question for this study is: What has helped suicide survivors cope throughout the loss of one's parent's or caregiver's suicide?

CHAPTER III METHODOLOGY

For this research study, I have used a flexible qualitative research method to interview 12 adults who have lost a parent or caregiver to suicide at any time of their life. All participants were interviewed on the phone from about 25-45 minutes depending on how detailed participant's answers were throughout the study. The purpose of this study is to learn more about resiliency, coping skills, and negative or risk experiences that one may experience after a parent's or caregiver's completed suicide. Additionally, results of the study can further inform clinicians on how to support clients or patients as they grieve the death of a loved one from suicide. Using a qualitative research method has seemed to be most fitting for this research as it allows for a more personal reflection of one's experiences. Considering that suicide and the death of a parent is quite a sensitive subject, this method seems to be the most respectful to broach such an upsetting topic. Qualitative research is typically used when researchers are looking to gain a better understanding of individuals' specific reasons, motivations, and opinions in regards to very specific issues and topics (Engel & Schutt, 2013). Qualitative research uses detailed and concise studies of small numbers of participants to drive the research. Although there are often fewer participants in qualitative research than quantitative, researchers are able to ask more indepth, open-ended questions through interviews on the phone or in person (Engel &

Schutt, 2013). This personal and more open-ended research allows for the study to be descriptive rather than predictive (Beck, 1989). Another reason as to why qualitative research seemed appropriate for this study is that there is immense importance in having individuals share their own story and I believe that plays a major factor in the healing process. Therefore, as the researcher, I felt it was imperative to bear witness to my participants' very personal, emotional stories rather than have them fill out an online survey to discuss their experiences.

Sampling

Prior to recruitment of participants for this research, approval for the study to ensure ethical standards was obtained from the Smith College School for Social Work Human Subjects Review (HSR) Committee (Appendix B). The inclusion criteria required participants to be at least 18 years-old or older who have experienced the suicide of a parent or caregiver at any given time of their life. Participants were recruited in several ways such as; social media, and through facilitators of support groups for suicide survivors in the North East. After having received approval from the Human Subjects Review Committee, I posted on my personal Facebook that I was looking for participants for my Master's Thesis research study. Although I was not expecting this resource to be the most helpful, I was most pleasantly surprised when within hours, the post was shared about 50 times between family, friends, and even strangers. This allowed a wide scope to gain a diverse range of participants as individuals nationwide became informed of the study. Another recruitment strategy in which I used was having contacted 20 group facilitators of survivors of suicide grief groups. At a weekly meeting, the group facilitators shared with the groups the purpose of the study, research criteria, benefits, and

possible risks. When a potential participant contacted me, I emailed them the informed consent document for them to review at their own pace. They were told that if they read and reflected on the informed consent document and wanted to participate, to please sign it and either scan and email it to me directly or mail it to me. Participants were also told that if they were to mail it to me that I would provide them with a self-addressed envelope to send directly to me. Once I received the signed informed consent documents, a telephone interview meeting was scheduled at the participant's convenience. Due to geographical location of myself and the participants, interviews were conducted on the telephone and were audio recorded at the participant's consent using "Go to a Meeting" software. It was crucial to record the interviews in order to have participant's exact words and experiences. Recording the interviews also protects this study from biases as participant's words were used verbatim. (Rubin and Babbie, 2016). Once the interview was concluded, the audio interview was saved in a file on my personal laptop that only I have access to. Additionally, notes were kept in an Excel document to help myself stay organized. Within this document, I recorded participant's initials, the date, time, and length of the interview. As suggested by Drisko (2008), "The transferability, credibility, and verisimilitude of any qualitative research are shaped by the data under examination" (Pp. 20). In this respect, it was very important throughout the study to keep consistent, organized, and reliable notes.

Data Collection

In gathering data for this study, I created a semi-structured interview guide which consisted of both open-ended and closed-ended questions (Appendix, C). The questions were created to gain further information on how individuals have coped throughout the

death of their parent or caregiver through suicide. All interview questions were created by studying somewhat similar research studies on suicide bereavement and were informed by types of coping from theory of stress and coping. However, questions were altered as there are not many studies that focus directly on coping mechanisms used by individuals of parent or caregiver suicide. Kathy L. Beck (1987), an alumni of Smith College School for Social Work, conducted a somewhat similar study in 1987 for her thesis. In creating my interview guide, I reviewed her interview guide and altered some of the questions that she used because I felt they would provide information more relevant to my specific research question.

The closed-ended demographic questionnaire that I created was meant to gain information on participants in the following areas; participant's gender, participant's highest level of education, participant's race and ethnicity, participant's marital status, participant's religious affiliation, individual who is deceased, date of the death of participant's parent or caregiver, relationship between participant and deceased, individual's age when they completed suicide, individual's marital status at the time of the death, individual's work status at the time of the death, and emotions experienced by the participant after the death (see Appendix C). To be certain my interview questions were clear and concise, I pre-tested my interview questions with two colleagues who hold a Master's in Social Work and a PsyD in Psychology. Although these individuals did not fully meet criteria to participate in the study, they offered their feedback on the interview questions to ensure clarity. In addition, the interview questions were reviewed by my thesis advisor, Julie Berrett-Abebe and were discussed at length to ensure they were

ethical, appropriate, and would provide the answers needed to answer my research question.

During the open-ended portion of the interview, participants were asked six questions in which they were able to discuss as much or as little as they preferred. I created question prompts to use in case an individual misunderstood or had difficulty answering the question. However, it is significant to note that the prompts were used sparingly to avoid providing leading answers to questions. In creating the open-ended interview questions, I was cognizant of keeping the interview concise yet also detailed. I was interested in learning further about the emotional experiences the participants have undergone to highlight the intensity of suicide bereavement. In addition, I was also interested in how that emotional experience changed over time through the individual's coping process. Time was spent exploring with the participant of social supports they had or didn't have at the time of the suicide. A major portion of the interview focused on coping skills (negative or positive) and strategies participants used in their grieving process. This is a major piece of my study however, I felt it was important to learn further about the individual's emotional experience at the time of the death. In addition, I was also interested if the participant received professional help and if it was beneficial to them during their coping process. A question that I altered from another study (Beck, 1987) which I found to be interesting was asking participants if they ever felt in their own definition "okay" again and if they could pinpoint when they noticed themselves beginning to adapt to their "new normal" of being a suicide survivor. Although this closely identified with the stage of grief known as "acceptance", literature shows that the grieving process is very different for those who are experiencing a suicidal bereavement (Bowlby and Parks, 2012). This connects with my research question as I feel it can be

normalizing for others to understand how suicide survivors cope and grieve although everyone is unique from one another. Lastly, participants were given the opportunity to share with me anything they felt would be important for me to know or to add to the study. Considering this topic could evoke upsetting and painful feelings and memories, it was imperative for me to move at slow pace but also create a flow between questions for individuals to answer such emotionally-charged questions. When needed, pauses and momentary breaks were taken for participants. All participants were told that once the interview concluded, I would e-mail them a list of referral resource hotline phone numbers if they felt the interview provoked upsetting and disruptive thoughts. It was imperative to send this list to all participants to ensure that everyone had the correct information if an individual needed the support.

Concerning credibility of participant's responses, this study has used individual's words verbatim. If there was a moment where I was unsure of what a participant was saying, I asked them to please explain their answer for further clarification. All participants were asked the same questions and none opted out of answering any of the questions although they were reminded they could do so at any time throughout the study.

Ethics and Safeguards

In accordance to Larossa, Bennett, & Gelles (1981) "most qualitative research would benefit from a thorough risk-benefit analysis and explicitly obtaining informed consent from participants" (Pp.16). Accordingly, risks and benefits to those participating in the study were clearly outlined in the informed consent document. All participants signed an informed consent document prior to participating in the study (Appendix A).

In regards to confidentiality, all participants were assured that their participation would be kept confidential. For phone interviews, I made sure to be in a private, confidential location and asked the participant to also be in a private, confidential location.

Participants were made aware that I would need to collect their name, email- address, phone number, and possibly their mailing address. However, participants were also told that all identifying information will be kept confidential within the study. Considering the need for audio recording for phone interviews, the records of this study will be kept strictly confidential. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. Lastly, I will not include any information in any report I may publish that would make it possible to identify any participant.

The study has the following risks. First, it may be distressing to talk about the death of one's parent or caregiver. Participants were reminded that if they feel at any time that the study is becoming too distressing, to please let me know so that they can immediately discontinue. Participants were also told that they have the right to opt out at any time. Considering this is a difficult and sensitive subject to discuss, I have provided a resource list of counseling resources and emergency hotlines as needed. The benefits of participation include having the opportunity to talk about one's parent or caregiver, and how one has coped with that person's loss.

Data Analysis

For this study, all interviews were recorded and transcribed verbatim. Through transcription, the data was then analyzed for themes. Considering that I used a flexible qualitative research design, an inductive analysis approach was used for analyzing data. Inductive analysis approaches are noted as being one of the most common methods in data analysis (Rubin and Babbie, 2016). This specific method acknowledges specific patterns and themes within data. Additionally, Drisko (1997) suggests that such analysis “...allows researchers to make valid inferences by objectively and systematically analyzing text” (Pp.23). This method of analysis seemed fitting for this study as the research question and purpose is to learn further about specific ways suicide survivors cope. In addition, an inductive analysis approach allows for researchers to arrive at themes and models through inductive analysis by studying and interpreting the raw data (Fortune, 2013). This approach offers an important humanizing layer to my study as it is a very personal and sensitive topic. This method has many purposes such as; “condensing raw textual data into a brief, summary format, establishing clear links between the evaluation or research objectives and the summary findings derived from the raw data, and to develop a framework for the underlying structure of experiences or processes that are evident in the raw data” (Fortune, p. 237).

To analyze demographic data, I used descriptive data analysis to note frequency of answers between participants. Considering all interviews were audio recorded, the semi-structured, open-ended section of the interview was replayed and noted for commonalities and themes between participants. Following, I used an excel spread sheet to organize participant’s responses and charts to demonstrate information gathered from

interviews. Participant's answers were noted for frequent responses, and direct quotations were used exclusively to highlight themes between responses and major differences between answers.

CHAPTER IV FINDINGS

Within this chapter, I will discuss the findings of 12 semi-structured interviews. The findings have been derived from a brief survey of mostly demographic questions followed by themes from qualitative analysis. Themes that I will discuss in this chapter include; emotional responses of participants, community responses to suicide, coping skills, professional support, life after suicide and advice for other suicide survivors.

Interview Section One: Socio-Demographic Data About Participants

Of the 12 individuals interviewed, eight participants identified as female (66.6%) and four identified as male. Participants were not asked of their current age, however, were asked how old they were when their parent completed suicide. The range of ages of how old participants were when their parent completed suicide were between 4 years-old to 39 years-old, for a median age of 27. Considering participants' ages at a parents' completed suicide ranged from preschool age to adulthood, individuals were at different developmental stages. Ten participants identified as Caucasian, one participant identified as African-American, and one participant identified as Latina. Five participants identified as Jewish, one identified as Christian and six reported not identifying with any religion. The highest level of education completed among participants are as follows; High School (0%), Some College (8.3%), Bachelor's Degree (50%), Master's Degree (33.3%) and Doctoral Degree (8.3%). Two participants had backgrounds in clinical social work while one other participant was in the process of actively working towards their MSW. Participants current marital status ranged from married/partnered (50%), single (41.6%), separated (8.3%) and divorced (0%). Seven participants reported having lost their father

to suicide while five participants reported their mother completing suicide. Eleven participants shared their parent was employed at the time of their death, while one participant reported their parent was a homemaker. Eight participants indicated their parent was married at the time of the completed suicide while two were individuals who were separated and two were divorced. Also of note, all twelve participants reported that their parent had completed suicide between the months of August and December. Please see chart below to see further demographic data of participants:

Table 1: Demographic Data (Appendix E)

N=12

Gender	Education	Marital Status
Male: 33.3% Female: 66.6%	High School: 0% Some College: 8.3% Bachelor's Degree: 50% Master's Degree: 33.3% Doctoral Degree: 8.3%	Married/ Partnered: 50% Single: 41.6% Separated: 8.3% Divorced: 0%
Race	Religion	Parent Who Completed Suicide
Caucasian: 83.3% African-American: 8.3% Latina: 8.3%	Christian: 8.3% Jewish: 41.6% No Affiliation: 50%	Mother: 41.6% Father: 58.3%

Interview Section Two: Emotional Responses of Participants

Following the closed questioned demographic questions, participants were asked to answer an emotion tally. In this section, participants were asked if they had experienced 18 different emotions from the time their parent completed suicide until now and their answers were noted for either yes or no. These emotions ranged from anger, sadness, relief, rejection, anxiety, and so on and so forth. The purpose of this section was

to highlight the differences between grief as a general construct and those who are grieving the loss of a loved one by suicide. This closely links to the work of an array of researchers who report that the grieving process is quite different for individuals who are grieving a death by suicide (Ratanarjah, 2007, Bowlby and Parks, 2010). Please see the chart below:

Table 2: Emotional Responses (Appendix E)

N=12

Anger 66.6%	Guilt 75%	Confusion 91.6%	Sadness 100%	Abandonment 83.3%	Rejection 50%
Relief 25%	Shame 50%	Anxiety 100%	Depression 50%	Helplessness 75%	Hopelessness 41.6%
Loneliness 83.3%	Fear 58.3%	Rage 41.6%	Bitterness 58.3%	Disappointment 100%	Unforgiving 16.6%

Within the open-ended questions, participants were asked to describe the first emotional response they experienced from their parents completed suicide and how those emotions changed over time or not. 66.6% of participants identified shock and disbelief as being the primary emotions initially experienced. It is significant to note that 33.33% of participants learned later in life their parent had died by suicide as they were told it was of another reason.

Participant one shared during the interview: “I had just seen my father two days prior. We were very close, it just made no sense how he could leave us like that...” While participant three said: “My dad never showed signs of any [kind of mental illness]. We were a normal family, I had a happy childhood. I didn’t know anything was wrong. I was so shocked and then it became a family secret. I repressed and blocked all feelings until 4 years ago when I found the death certificate. Now I deal with all the emotions all the time.” Participant four reported: “It is still very shocking and traumatic [to this day]. We never thought my mom would do that. She had a profession as a psychoanalyst. We didn’t know how bad things were for her...” And lastly, participant five shared: “We were so shocked and angry. We were raised a religious family. We believed in living and loving. How she could leave us makes no sense to this day. It left me feeling guilty. I used to ask myself; “what did I do wrong?” As displayed in these answers, shock appears to go simultaneously with the trauma associated with losing a parent to suicide. Commonly, participants expressed during the interview that although they knew their parent may have been experiencing some sadness, they were never aware of the severity of their feelings.

Two participants shared their first emotional response was confusion when they learned their parent had completed suicide and has now become more of feelings of sadness and despair. Two other participants shared they experienced a sense of relief upon learning of the death of their parent. Participant two expressed: “I was so confused. [My mom] had been missing for four days, no one knew where she was. When she was found, I became extremely sad, and angry. I am left with feelings of abandonment. Now that I am a mother, I need my own mother more than ever...” While participant ten shared: “I was young, so I didn’t know what had happened at first. But when I found out what had really happened years later, I felt confused and hurt. I did not know him well

but I had idealized what he would be like and to have learned he killed himself was really hard for me to grapple with.” Participant eleven shared: “There was a sense of shock, sadness, and relief. She was very ill which caused a lot of stress for me as I grew up having to take care of her. I was in college when it happened so it left me needing to pick up a lot of pieces. I am still trying to make sense of this.” Participant twelve expressed: “Shock, sadness and relief. He had bipolar disorder and manic symptoms that were scary for the family. He was not very stable. I grew up feeling angry at him for having an affair. This made me really afraid of anger because I believed [as a child] my anger caused his death.”

Community Response to Suicide

In the second open-ended question, participants were asked about how friends, family, neighbors and the overall community responded to their parent’s death. It is significant to note that 91.6% of participants shared that their extended family was not supportive and actually distanced themselves from the immediate family. While some participants accounted this family separation to be due to the stigma of suicide, others believe that their parent who died was the glue that kept the family system connected. Nonetheless, this theme of separation among the extended family appeared to be a secondary trauma for many individuals.

Participant six shared: “After my dad died, our family situation become very complicated. For logistical and other reasons, there has been a strain on my relationship with my mother and extended family. However, I have become closer with my brother and sister. But, it was hard to cope with having these added issues. My dad was the family glue [that kept us together]. Participant three reported: “No one has ever brought it up to me. Everyone has moved on in the family. I expected family to become closer

but everyone distanced themselves. It makes me feel ashamed. People get that look in their eyes when you say the word 'suicide.' I needed support, no one was there. My current boyfriend is very supportive which has been helpful." Participant seven shared: "My friends were supportive and helpful, as helpful as they could be. Extended family who we were close with distanced themselves. It was sad and overwhelming. No one knew what to do. It was really hard to have no extended family support."

It was apparent that many participants experienced silence from their community which brought on feelings of being alienated, shame, and reiterating the stigma attached to mental illness and suicide. Participant nine acknowledged: "People did not talk much about the experience of my [mother completing suicide]. This is left me with many questions and has made grief more complicated." Participant twelve expressed: "The word 'suicide' was never used. Our family pretended it didn't happen... That was ok because I didn't want to stand out. School was not supportive; they didn't do anything. Extended family was completely silent. Forced me to be independent. I had some friends who were supportive but I really did not deal with it for many years... If no one else was going to talk about it, I felt 'why should I?'"

Another theme among participant's responses was wanting friends to be understanding and supportive and feeling disappointed if they were not. Fifty percent of participants acknowledged their friends were supportive while the other 50% shared their friends were unsupportive and distanced themselves. Participant five shared: "My friends were supportive. I relied on my friends, religion and the church to help me. No one knew what to say. But looking back, I would rather have been around people who didn't know what to say rather than to be alone..." Participant one had a different experience in regards to support from friends. "I wanted my friends to reach out, tell me they cared for

me and that they would support me. Their silence was deafening. I have confronted some of them now who say, 'I really did not know what to say and wanted to give you space.' But I tell them, 'space is not what I needed. I needed to feel loved and cared for by my friends.' Why is everyone so afraid of suicide?"

Coping with Suicide of a Parent

The third question of the open-ended interview was asking participants about the different coping skills that they have used to help grieve the death of their parent. It is significant to note, that all 12 participants shared that talking about their experience as a suicide survivor has been extremely therapeutic and helpful for them. Although several participants reported it took years for them to actually talk about their feelings, when they were able to tolerate talking, it was one of the most helpful things for them. In addition, all 12 participants have reported using some method of distraction throughout their grieving process to help focus on something else rather it be positive or negative. 41.6% of participants shared that upon learning of their parent's death, they became more interested and invested in changing their own lifestyle to make themselves healthier.

Participant eleven reported: "I decided to focus on my own health as I had taken care of my mother for a long time. I quit drinking, took up running, yoga, exercise, and invested myself in nutrition. I also began to psycho-educate myself on suicide and mental health. I became more interested in school, improved my GPA, and I am currently working towards MSW." While participant four shared: "I became active with the American Foundation for Suicide Prevention. Did walks and attended international survivor's day. I have made many friends from this organization. I also began to exercise more frequently. I found a lot of strength in soul cycle. It's such intense exercise that you

do with many people in a dark room with loud music. It allowed me to just sit with my feelings and peddle my heart out.”

Three participants found reading and educating themselves specifically on mental health and suicide was helpful and normalizing for them. For many, this was a helpful coping skill because suicide was rarely discussed so it helped individuals feel less isolated and further validated. Participant six shared: “I began to read books on suicide and did extensive research on suicide. Reading about other suicide survivors help normalize and understand my own experiences. Eventually, I found new hobbies and interests in things that brought happiness.” While participant seven reported: “I read a lot about mental illness, suicide, and grief. It made me feel less alone. I became interested in learning about trauma and how it affects us. Trauma is everywhere. Friends eventually came out and said they had also lost someone to suicide. It was weird I didn’t know about it before. No one talks about suicide. Talking was very helpful for me.”

Professional Support

While assessing the use and effectiveness of professional support, all 12 participants shared they received some kind of professional support and found it to be helpful. Six participants saw an individual therapist while only three found the individual therapy to be effective. Eleven participants shared they began to attend groups however, eight individuals found the group to be helpful while others found it to be unhelpful. Overall, group therapy seemed to be the most effective for individuals when it was a small group (8-10 group members), had a professional facilitator, was free of charge, and was specific for survivors of suicide. Some groups had characteristically different

approaches from one another such as starting with a moment of silence to help ground and center participants, having monthly vigil candle lighting ceremonies and having annual groups where past members come back for a reunion.

Participant nine shared: “Individual therapy was somewhat helpful. But, group therapy was much more helpful. I joined the group in 1991, and I still attend to this day as a facilitator. The group had a lot to do with my healing process and has become a major part of my identity.” Similarly, participant eight shared: “Group was very helpful. It’s different when you meet someone who actually understands. Suicide grief is so complex. There are just many layers to the grieving process. I felt validated in group. Individual therapy was helpful to process but I felt like I wanted feedback, not just to be listened to all of the time.” While other participants used phrases to express their group experience such as; “life changing, don’t know what I would do without it, validating, helpful, desensitizing, lifetime connections and finding strength in other’s strength.” However, for some participants, they found group to be an opposite experience and found individual therapy to be more helpful personally. Individuals used these similar words and phrases to describe reasons why individual therapy was more helpful for them; “Group can be triggering, you don’t always connect with group members, big groups get tricky, you get your own space in individual therapy, groups can cause people anxiety.”

The Life Altering Impact of Being a Suicide Survivor

When asked about how participants feel about returning in their own definition of “normalcy” after the death of their parent, all twelve participants shared that they have changed to a different person. Although most participants feel they have reached a stage of acceptance and feel okay with themselves, it is significant to note the impact of suicide on individuals is that it is truly life-altering. Participant two exemplified this by stating:

“I’m a different person today than I was before my mother [completed suicide]. I will always feel confused and uncertain, left with questions and anger. I don’t know if that ever goes away. As a mother now, I question how my mother did that to her own children. I need my mom. I have so many questions for her about how to raise my own kids...” Participant eight shared: “I am definitely a changed person. I understand the difference between pain and grief. I have more empathy for others. I think of others more now. I feel as though I am a better person. The level of shame and guilt is so difficult. I make it a point to have a discussion with new friends about suicide and mental illness to see how they react. I can only have accepting people in my life. And lastly, participant ten acknowledged: “I feel okay with myself and have accepted the death. But, for the most part I am also defined by this experience [fathers suicide]. It follows me everywhere. But I am a strong believer that everything happens for a reason. We must find the good in things.”

Advice for Survivors

The final question in my study was an extremely open-ended question in which I wanted to provide participants with the opportunity to share anything with me that I had not asked. This question provided an array of answers mainly regarding the stigma associated with suicide. However, I was struck by how many answers surfaced around advice for other suicide survivors. In a moment where these individuals could say anything they wanted, they were looking out for others who have gone through similar experiences. I believe this is what is so fascinating about survivors; we are constantly looking out for others.

Participant three shared: “Suicide is so stigmatized. We need to advocate to bring awareness. I want other survivors to know that talking about it helps. I wish I talked

about it sooner. Tell your story. Life is worth living. There's no way to know what others are going through. It's not your fault. Please let people know that.” Similarly, participant seven also shared: “The stigma is so strong that people end up not talking about it. No one talks because of the horrible reactions. How do we de-stigmatize? We talk about it. Please tell people to talk about their pain. It HELPS.” And lastly, participant five acknowledged: “I don't know why people make suicide so hard to talk about it. We need to talk about it. This is our time to talk and spread the word. No one is alone.”

Summary

Major findings from twelve interviews with survivors of a parent's suicide have been presented in this chapter. Significant findings were mostly derived from questions in the second section of the interview. The following chapter will explore the interpretations of those findings. In addition, strengths, limitations, biases, and suggestions for future research will be addressed.

CHAPTER V Discussion

This chapter documents and explores the findings from semi-structured, flexible interviews with 12 individual survivors of a parent's suicide. This chapter further identifies the experience and coping process of suicide survivors. While the most descriptive section of the interview came from the open-ended questions, several interesting themes were noted from the closed-ended questions as well. Although emotional experiences and the complexity of suicide grief were found in the literature, a further understanding of individual experiences of suicide survivors, coping mechanisms and the need for support have been described and understood more thoroughly and in depth within this study.

Throughout this project, it was undeniable that individuals wanted to share their own stories although it was difficult. It became apparent that talking about one's experience as a suicide survivor is an essential part of the long-term grieving and healing process. I remain grateful to all of those who participated and willingly shared their own

personal feelings and intimate experiences with me. This chapter discusses the findings in the following order: emotional experiences of suicide survivors, expected findings, unexpected findings, limitations, issues of bias, issues of generalizability and how the findings may be applied for practice.

Emotional Responses of Participants

From Table 2 (Appendix E), it is compelling to note that all participants reported experiencing anger, sadness, anxiety, and disappointment resulting from their parent's completed suicide. This finding demonstrates the devastation that is associated with death and more specifically death by suicide. Guilt was also a very common emotion, which is significant as many individuals reported asking themselves "What-if" questions throughout their grieving process and wondering if there was something they could have done to have helped prevent the death. Individuals also reported feeling guilty for not noticing how severely ill their parent was or for not taking their illness as seriously as they wished they had. This finding is significant as Bowlby and Parkes (2010) suggest guilt can further complicate one's grieving process. This is particularly insidious because associated to guilt is that oftentimes, individuals experiencing suicidal ideation are less likely to tell someone due to fear, stigma or shame (Wright, 1999). Confusion, abandonment and rejection also had high responses which demonstrates the complexity behind the nature of a suicide as it leaves loved one's behind questioning their own relationship with their loved one and possibly one's own self-worth (Beck, 1989).

Half of participants reported experiencing depression and shame as a result of the suicide of their parent. This is significant to note while considering the stigma associated to suicide and mental illness. The feeling of shame can also greatly impact the grieving

process if individuals feel unable to express how they are feeling if they are fearful of being stigmatized. One quarter of participants reported experiencing relief as a present emotion throughout their grieving process. Some participants shared that they felt relief because they were worrying about their parent and in some cases taking care of their parent and felt relief that they were no longer suffering. It may also be considered that admitting to feeling relief can be a difficult process for individuals, and people may fear how others may respond as it is can be a less conventional or accepted feeling to a death. Helplessness, loneliness, fear and bitterness were all experienced by over half of participants, while hopelessness, rage and un-forgiveness were reported by less than half of individuals.

Expected Findings

While conducting the interviews, there were several expected findings that came to my attention. The first being that individuals used both positive and negative coping skills. For example, some participants shared that they became more vulnerable to using alcohol and drugs to cope with their loss. Other participants shared they became more interested in doing more positive things for their health such as, eating healthy and exercising more regularly. This finding was in accordance with Folkman and Lazarus' theory of coping (1984) in which there are two main ways of coping; emotion focused and problem solving focused.

Another expected finding was the stigma that individuals experienced from friends, peers, and the community. Participants shared throughout the study that the stigma that came from their parent completing suicide became a secondary trauma for many individuals. In addition, several participants shared that when people asked them

how their parents had passed away, individuals would lie because they were uncomfortable telling the truth or felt concerned of what that individual would say which contributed to difficulties in discussing their parent's completed suicide. However, participants also shared they experience a sense of relief and validation when they do talk about their experiences as a suicide survivor. In addition, many participants reported the long-term effects of their parent's completed suicide such as living with on-going depression and anxiety, and intimacy challenges. This finding was in accordance with Jones (2012) who suggests that the suicide of a parent can lead to a negative impact on their child's mental health.

Lastly, recent literature suggests that suicide bereavement is often more complex than other grief experiences because it is more common for individuals to not find out how that individual died until later in the life (Bowlby and Parks, 2010). Within the study, one third of participants shared that they originally did not know that their parent had completed suicide. For some participants, they found out by mistake as they overheard a conversation from a relative, while others found death certificates. Individuals who found their parent's death certificate shared that it was a traumatic experience because death certificates say the method an individual used to complete suicide. Participants identified that learning later in life how their parent died as having been a secondary trauma because such learning caused them to re-experience the grieving process.

Unexpected Findings

An unexpected finding of my study has been how participant's family members have stigmatized the experience and in some cases estranged themselves from the

participant. Several participants expressed how their family completely changed after the death because aunts, uncles, cousins, grandparents and other extended relatives distanced themselves from the participant. It is likely that such estrangement of family members occurred as an extension of broader society stigma. This added an additional layer to my study as it furthered the resilience that such individuals have. For example, participants shared how in these situations their lives changed in many ways, and they were essentially forced to create their own family from friends, or strangers that became friends through support groups.

Another unexpected finding within this study was learning how many individuals report not knowing how ill their parents were at the time of their death. Most participants expressed knowing their parent had a mental illness diagnosis but believed that it was under control and that they were stable. Learning from participants that they were unaware of the severity of their parent's illness, furthered the study's understanding of shock as a major piece of grieving the death of a loved one by suicide. Suggested by Beautri (2004), processing the death of a loved one is already complex and often chemically difficult neuro-biologically. However, processing a death of a loved one by suicide adds another layer of trauma and shock as it leaves one with many unanswered questions and feelings. Another reason why this can be even more shocking is that individuals may feel like if their parent loved them then they could never do something so permanent and life altering such as completing suicide. However, as participants shared their experiences, it appeared that part of the grieving process became accepting that their parent was not who they truly were at the time of their death and rather they were extremely ill and unable to make sound mind decisions.

As previously stated, it emerged throughout the study that individuals wanted to share their stories despite how difficult it was. However, individuals shared feelings of empowerment and purpose in expressing their own, individual story of losing a parent to suicide in order to help spread awareness to others. This need for sharing one's story became a theme within the study as many discussed feelings of not being able to talk about suicide due to the stigma. This was an unexpected finding because I was unsure as to how participants would feel about opening up very intimate, personal details of their life to a complete stranger. To say that I have been touched by each participant's story is a complete understatement. I am truly honored to have had the powerful and moving experience to speak with each and every participant.

Limitations

In order to begin having a better understanding of individuals' coping mechanisms, it is important to have an understanding of the range of emotions a suicide survivor may experience. However, it is also important to note that my sample size of 12 participants is fairly small and does not account for all suicide survivors by any means. Rather, discussing emotional experiences was meant to bring light to the idea that the grieving process for suicide survivors is likely to be complex and intricate. Considering the time allotted and the need to keep the study more concise and less general, the study was limited in questions that could have been asked and explored. For example, I was not specifically addressing secondary traumas that derive from suicide however, many themes of secondary traumas came up and I was limited in exploring those further. I believe that if this study allowed a larger sample and more time available to conduct research, it could have had potentially provided more results as to how suicide survivors

have coped through such experiences. In addition, this research could have provided additional clinical information for clinicians to use in practice.

Another limitation within this study is lack of having a more diverse sample. Although participants were from nine different states including New York, Connecticut, Louisiana, California, New Hampshire, Massachusetts, Rhode Island, Pennsylvania and Wyoming, 83.3% of participants identified as Caucasian. This lack of diversity among participants is a limitation because with a more diverse sample, it would likely add another layer of coping and effects of suicide on individuals from various racial and ethnic backgrounds. It is important to note that all participants self-selected to participate in the study and, they all have sought professional help in the past. Therefore, their willingness to share their story might not be true for all suicide survivors.

Issues of Bias

While assessing possible issues of bias, it is relevant to note that most of the interview questions were designed by myself. Hence, it is possible there is an extent of personal bias involved within the interview questions. However, all interview questions were discussed at length with my research advisor who gave helpful advice and appropriate criticism when needed. It is important to note that the interview process could have brought up distressing or disturbing feelings for participants which may have altered the answers that participants provided. In moments of individuals feeling distressed, breaks were offered as needed and participants were reminded of their right to end the study at any time. With the consent of the participants, all interviews were audio recorded. I transcribed the interviews verbatim while using direct quotes for data analysis. This was very important and useful as it helped to limit my own perception of what individuals said and increased trust as it helped to stay accurate with people's words.

A bias that may be associated with my sampling technique could be participants wanting to talk more about the positives in their situations despite the hardships. This may have occurred for individuals because it may be easier to discuss positive aspects rather than negatives, especially with a stranger. Dis-confirming was sought out by asking participants an array of open and closed-ended questions to best understand their own personal experiences, rather than leading questions that would have provided specific answers. During the interviews, I interpreted participant's responses to be genuine, honest, and in accordance to how their own experiences have been and how they are feeling currently. Brief follow-up questions and clarifying questions were used scarcely but appropriately to ensure that I perceived participants answers correctly.

Another considered bias within this study may be having contacted group facilitators to help recruit participants for the study. This is a considered bias because over half of participants found out about the study from their past or current group facilitators. This is critical information to consider as individuals who are actively receiving professional help and support may be in different places in their lives than individuals who are not currently in treatment or involved in a support group. After careful consideration, I believe that this is ultimately not a bias within the study because not all participants reported support groups to be helpful for them. In addition, such individuals identified other coping mechanisms such as exercise, reading about mental health, distraction, and individual therapy to be helpful while within the grieving process

Issues of Generalizability

Issues of generalizability have been carefully and thoroughly considered throughout this study. In accordance with the belief of Drisko (1997), "The obligation to

seek out, report and weigh contradictory evidence is an important aspect of establishing the transferability (generalizability) of research.” (Pp.19). Through my sampling methods, I aimed to have a diverse group of individuals of different ages, race/ethnicities and education levels from various parts of the nation. This purposeful sampling was to achieve transferable and generalizable data. Considering that my sample was only 12 individuals, I acknowledge my findings were therefore limited. Due to methods, the study is not generalizable, however, still makes an important contribution to the body of literature. Ultimately, this is a limitation of the methods used for the study.

Future Studies

For future research, it is suggested to have larger sample sizes with a greater amount of racial and ethnic diversity. Having such sample sizes will offer further validity within the study in assessing for themes, commonalities and understanding other coping skills between participant responses. In addition, it is possible that larger sample sizes can also help to support clinicians in their work with suicide survivors. This may be facilitated as clinicians can learn new evidence-based treatments to support clients in coping with and working to normalize emotional experiences that suicide survivors may have. For example, clinicians may learn that many individuals experience guilt and can benefit from psycho-education on how that can be a normal experience. As we understand and accept that the grieving process is very different for suicide survivors it can help to inform clinicians interventions and increase empathy. Considering this research is desperately needed, it is my hope that research on suicide survivors coping mechanisms will be furthered and that such researchers will be allotted more time to conduct this very important and scarce research.

Although human-beings are intricate and emotional, and experiences differ from person to person, it would be helpful for researchers studying this topic to adapt specific evidence-based interventions for working with suicide survivors. Such interventions may be working with and addressing multiple levels of trauma as suicide is complex and affects individuals in multiple ways. Additionally, clinicians would likely benefit from specific training in working with suicide survivors to further their own understanding on the impact that suicide can have on loved ones. Although each case is unique and individualized, participants demonstrated that most people want to share their stories. Similarly, suicide survivors' stories need to be listened to not only to further the grieving process but to also spread awareness of the permanency that suicide is to temporary problems.

Another area in which future research is needed is in regards to the complexity of suicide and suicide grief. It is important to note that while some of the coping mechanisms identified by participants were noted in accordance within the literature (Lazarus and Folkman, 1984), a large percentage of participants' open ended responses reiterated the entangled, troublesome, confusing feelings of suicide grief. Such responses echo the need for further research and understanding by professionals.

Future research would also be helpful in learning further about the trauma that suicide has on individuals and how that can become inter-generational trauma. This would be essential research specifically in exploring the long-term effects of a loved one's suicide and how to help support suicide survivors. While thinking about intergenerational trauma of suicide, future research is needed regarding the understanding of why many extended family members distance themselves after a suicide and how that affects families for years to come.

Conclusion

Suicide remains an issue that takes the lives of about 42,733 Americans each year. The conversations about suicide must not end here; rather such conversations about suicide must continue to happen more openly and frequently. Participants within the study shared the importance of talking about suicide, mental health, and their own personal experiences. Within the study, it was empowering to hear and bear witness to stranger's stories of grief, depression, anger, and strength. Listening to individual's weakest moments remind me as an aspiring clinician of the power of validation, kindness, and love.

It is extremely important that individuals who are experiencing suicidal ideation are not pushed toward fear and silence. There are many ways that we as a society, and within professional settings, can help other mothers, fathers, brothers, sisters, extended family, friends and even strangers by helping to remind one another that you are not alone. I believe in the value of beginning each day with an open mind to talk about things that may make us uncomfortable or scared, to question why we feel such feelings and challenge ourselves to consider the importance of having such difficult, yet, crucial conversations.

A world where the topic of suicide is further understood and accepted may allow individuals to feel less alone and more connected. It is possible that if discussions of suicide can be normalized rather than viewed as horrifying, we can learn how to help one another through life's most difficult times, and most of all, learn how to accept such help. My father, Gary Rice, was one individual whose life was taken much too soon by suicide. It is an understatement to say that his death has affected my life in every sense of the word. I am left with a deep sensibility about the harsh effects of suicide and have the

desire to help others overcome detrimental feelings associated with surviving such a loss.

It is my hope that we can further de-stigmatize suicide and create spaces in society where individuals are able to connect with one another and feel the sense of belonging that we all deserve. It is a human right to live—and we must support one another through this journey of life.

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Appendix A

Informed Consent Form

2016-2017

Consent to Participate in a Research Study

Smith College School for Social Work • Northampton, MA

Title of Study: The Impact of Parent's or Caregiver's Suicide on Children

Investigator: Rice, Haley, hrice@smith.edu

Introduction:

- You are being asked to be in a research study to explore the impact of a parent's or caregiver's suicide on yourself as a survivor.
- You were selected as a possible participant because you are over the age of 18 years-old and have experienced the death of a parent due to a completed suicide.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study:

- The purpose of the study is to learn about how individual's cope with the grief that one experiences when their parent or caregiver completes a suicide.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences

Description of the Study Procedure:

- If you agree to be in this study, you will be asked to do the following things: read, approve, and sign an informed consent, and participate in an interview that will last between 30-45 minutes either on the phone or in person depending on your geographical location.

Risks/Discomforts of Being in this Study:

- Considering this is a difficult and sensitive subject to discuss, I will provide a resource list of counseling resources and emergency hotlines as needed.
- The study has the following risks. First, it may be distressing to talk about the death of your parent. If you feel at any time that the study is becoming too distressing, please let me know so that you can immediately discontinue. You have the right to opt out at any time.

Benefits of Being in the Study:

- The benefits of participation include having the opportunity to talk about your parent or caregiver, and your coping with that person's loss **Confidentiality:**

- Your participation will be kept confidential.
- If we were to meet in person, it would be in a library with a separate room to ensure confidentiality. For phone interviews, I will ensure to be in a private, confidential location.
- In order to conduct the study, I will need to collect your name, email address, phone number, and possibly address. All identifying information will be kept confidential within the study.

- In addition, the records of this study will be kept strictly confidential. In agreeing to being recorded, you will make it accurate for me to capture your exact words. Audio tapes would be used for analysis in the thesis only.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

Payment/gifts:

- I am unable to offer you any financial payment for your participation.

Right to Refuse or Withdraw:

- The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits including support services provided to which you are otherwise entitled. You must notify me of your decision to withdraw by email or phone by (add date). After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns:

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Haley Rice, at hrice@smith.edu or by telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is complete. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent:

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information for emotional support.

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[if using audio recording use next section for signatures:]

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix B

HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-
7994 December

2, 2016

Haley Rice

Dear Haley,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,



Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Julie Berrett-Abebe, Research Advisor

Appendix C

Demographic Questionnaire

Demographic Questions

This questionnaire will be kept confidential. Please circle or write in as indicated the answer that best fits your experience

1. Gender of Which You Identify

Female Male Gender Nonconforming

2. Highest Level of Education (completed)

High school/ GRE Some College Bachelors Masters Doctoral

3. Marital Status

Married/partnered Single Divorced Widowed

4. Race (check all that apply)

Asian/Pacific Islander Black/African American White/Caucasian

Hispanic/Latino American Indian/Native American Other: _____

5. Are you affiliated with a religious group?

Yes (please identify) _____ No _____

- 7. Person who completed suicide** ___ Mother/Maternal Caregiver
 ___ Father/Paternal Caregiver

8. Date of Death _____**9. Age of parent's/caregiver's at the time of death** _____**10. Your age at time of parent/caregiver's death** _____**11. At the time of the death, was the parent who completed suicide**

Employed Unemployed Retired Homemaker

12. At the time of the death, was the parent who completed suicide

Married Separated Divorced Widowed

13. There are an array of feelings that one may experience after having experienced the death of a parent or caregiver to a completed suicide. It is important to note that these feelings are a normal part to the grieving process. Please circle as many of the feelings that you experienced a result your parent's or caregiver's suicide.

Anger Guilt Confusion Sadness Abandonment

Rejection Relief Shame Anxiety Depression

Helplessness Hopelessness Loneliness Fear Rage

Bitter

Disappointment

Unforgiving

Thank you for taking your time to answer this demographic questionnaire. Your answers will be kept confidential and are extremely important to this research study.

Appendix D

Interview Guide

Interview Questions

PLEASE NOTE: the letters a, b and c will only be used as prompts if the participant is having difficulty answering the question. They are not intended to provide leading answers and will be used sparingly.

1. What was your first emotional response to the suicide and how did that change over time? How long did those feelings persist? Have these feelings changed throughout your life? If so, how?
2. How did your family, friends and neighbors respond after your family member died?
 - a. Was there someone in particular who responded as extremely supportive? If so, how?
 - b. Was there someone in particular who responded as extremely unsupportive? If so, how?
3. What strategies helped you deal with the loss of your parent?
 - a. Did you use strategies such as; Distraction, meditation, over-eating, under-eating, using drugs, drinking alcohol, suppressing emotions, praying for strength and guidance and/or journaling.
 - b. Did you use strategies such as; problem-solving, time-management and/or

seeking out social supports.

- c. Were these things that you had done previously or did you start to them as a result of the death?
4. Did you seek out professional support such as; a therapist, counselor, school social worker, guidance counselor, psychiatrist, and/or psychologist?
 - a. Was this someone you had a relationship and rapport with before the death?
 - b. What was helpful?
 - c. What was not helpful?
 5. Although the death of a parent or caregiver is a life altering experience to go through, do you feel that you ever felt in your definition “okay” again?
 - a. If yes, roughly how long did that take?
 - b. If no, how has that affected you?
 6. Is there anything that I have not asked you that you believe would be important for me to know?

Appendix E

Tables **Table 1:** Demographic Data

N=12

Gender	Education	Marital Status
Male: 33.3% Female: 66.6%	High School: 0% Some College: 8.3% Bachelor’s Degree: 50% Master’s Degree: 33.3% Doctoral Degree: 8.3%	Married/ Partnered: 50% Single: 41.6% Separated: 8.3% Divorced: 0%
Race	Religion	Parent Who Completed Suicide
Caucasian: 83.3% African-American: 8.3% Latina: 8.3%	Christian: 8.3% Jewish: 41.6% No Affiliation: 50%	Mother: 41.6% Father: 58.3%

Table 2: Emotional Responses

N=12

Anger 66.6%	Guilt 75%	Confusion 91.6%	Sadness 100%	Abandonment 83.3%	Rejection 50%
Relief 25%	Shame 50%	Anxiety 100%	Depression 50%	Helplessness 75%	Hopelessness 41.6%
Loneliness 83.3%	Fear 58.3%	Rage 41.6%	Bitterness 58.3%	Disappointment 100%	Unforgiving 16.6%