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The Lived Experience of Mothers Bereaved by the Suicide Death of a Child

A dissertation

presented to

the faculty of the Graduate Program of the College of Nursing

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Doctor of Philosophy in Nursing

by

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May 2011

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Keywords: Suicide, Suicide Survivors, Mother, Grief, Bereavement, Phenomenology

ABSTRACT

The Lived Experience of Mothers Bereaved by the Suicide Death of a Child

by

Cynthia Walker Lynn

Suicide has existed throughout recorded history. It is a phenomenon that has been both culturally and morally defined across time and civilizations. It is estimated that over 34,000 Americans deliberately take their own lives annually. Moreover, according to some experts, between 6 and 28 individuals are directly affected by each completed suicide. These individuals are referred to as *suicide survivors*. The consequences for suicide survivors are multidimensional in part because relationships to the deceased play a vital role in bereavement. Previous research studies in the areas of suicidology and bereavement have failed to explore the experience of mothers bereaved by the suicide death of a child. The purpose of this qualitative study was to explore phenomenologically the lived experience of mothers following the suicide death of a child. One-on-one, semistructured interviews were conducted with 9 mothers. The time since the suicide ranged from 1 year and 3 months to 21 years and 6 months. Data analysis was driven by Max van Manen's descriptive-investigative process. This process involved guided reflections using van Manen's 4 existentials: spatiality, corporeality, temporality, and relationality. The interviews began with a general statement; "Tell me about your child." General questions related to the existentials were asked during the interviews to clarify the participants' stories. Data were managed using NVivo 9.0 qualitative data management software. Three essential themes were inductively derived from the data: 1) Know My Child: Not the Act, 2) Frozen Past: Altered Future, 3) Ocean of Grief. The 3 essential themes provide a deeper understanding of the role of stigmatization in the grief process of mothers following the loss of a

child to suicide. In addition, these themes contribute to an appreciation of the role of past memories and future orientation as mothers are enmeshed in the grief process and its unpredictable path. Data from this study clarify the unique circumstances and needs of mothers as they attempt to navigate life after losing a child to suicide. The findings from this study suggest areas for future research and will assist healthcare professionals including nurses, school counselors, and mental health professionals as they approach mothers who are suicide survivors.

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DEDICATION

This manuscript is dedicated to nine mothers and the memory of their deceased children.
May this work serve as a reminder of the beautiful, everlasting bond between mother and child.
Thank you for entrusting me with your story.

And to my friend, Myra Jane McConkey Glandon, I miss you.

ACKNOWLEDGEMENTS

I firmly believe from birth until death the path of each life is influenced by our experiences and others. It is a difficult task to acknowledge all of those in my life responsible for my growth and development, both personally and professionally. It is my sincere desire to recognize and affirm a few individuals who have touched my life over the years.

To my own mother Julia Maureen Warwick, thank you for your care, love, and support. You have always given sacrificially. To my husband of 30 years Gary Ray Lynn, thank you for providing me with a love and life blessed by God. To my children Nathan Craig Lynn, Jessica Price Lynn, and Julia Frances Lynn, thank you for the opportunity to be your mother.

Professionally, I would like to acknowledge those responsible for my growth during this seven year journey. To Dr. Patricia Kraft, thank you for encouraging and supporting me in my educational trajectory.

Finally, I would like to offer my sincere gratitude and thanks to my dissertation committee: Dr. Sadie Hutson, Dr. Joy Wachs, Dr. Linda Garrett, and Dr. Richard Dew. The culmination of this phase of my professional journey will only serve as a stepping stone for further professional growth. Dr. Sadie Hutson, thank you for your organization and detail during the development of this manuscript. Dr. Joy Wachs, thank you for the encouragement to expand and question my philosophical assumptions about myself, life, and others. Dr. Linda Garrett, thank you for your expertise and guidance during the interviewing process. Dr. Richard Dew, thank you for guiding me toward a deeper understanding of bereavement and the loss of a child.

I am immensely aware that few are given the opportunity and resources that I have been afforded. It is my belief that who I am is a gift from God and what I choose to do with it is my gift back to Him. To my Lord, thank you.

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CHAPTER 1

INTRODUCTION

It has been said, "Time heals all wounds." I do not agree. The wounds remain. In time, the mind, protecting its sanity, covers them with scar tissue and the pain lessens. But it is never gone.

-----Rose Kennedy (mother and grandmother)

Anne's Story

Justin Christopher Spoonhour was born to Giles and Anne on October 10, 1969. Justin attended Putnam Valley Junior High School in New York about 50 miles from New York City. He died February 14, 1984. After Justin's death, a classmate, Diana, wrote in her journal; "One of my classmates, Justin Spoonhour, hung himself last night. He's dead. Our class of 115 is now a class of 114" (Colt, 1991, p. 33). For Giles and Anne, a family of four is now a family of three.

Anne and a friend found her son hanging from a tree in a wooded area near their home. Three days later at Grace United Methodist Church, friends and family gathered to honor Justin's life. Reverend Cox asked why: Why he had not recognized the signs or why Justin had not come to him for help? Justin's father Giles reflected on traditions left unfulfilled such as the razor he planned to pass down to his son.; "My God, my son wasn't even old enough to shave yet" (Colt, 1991, p. 35).

Anne, Justin's mother, honored her son with a song. As a desire to see her son live on through the perpetual acts of others, she requested respect and remembrance of Justin through love for and awareness of one another. Anne placed three items in Justin's coffin that day: a piece of his favorite sheet music, some cherished Beethoven tapes, and the valentine with jelly

beans Justin never received. As Justin's funeral came to a close, many participated in the celebration of his life only to leave bewildered by his death. The end of Justin's life did not bring closure to the circumstances surrounding his death only more questions. Justin left no note and no signs. Anne said goodbye with no answers (Colt, 1991).

Justin's death represented one of 29,286 Americans to complete suicide in 1984. The story of Justin Spoonhour is not unlike many accounts found in cultures around the globe. For hundreds of years, suicide was considered a "victimless crime." In many cultures viewed as taboo and a crime against the state, suicide carries with it a stigma that serves to discourage such behavior (Alvarez, 1990; Colt, 1991; Minois, 1999). As a result, individuals and communities tried to separate themselves from suicide and its aftermath. The behavior is still practiced today as many struggle with the personal, cultural, and spiritual implications of suicide. Suicide survivors especially mothers are left to carry this burden as they grieve.

The British writer and historian, Arnold Toynbee, considered death fundamentally two-sided; "There are two parties to the suffering that death inflicts; and, in the apportionment of this suffering, the survivor bears the brunt" (Toynbee, 1968, p. 271). Shock, denial, anger, sorrow, and grief are part of facing the death of a loved one (Kubler-Ross, 1969; McCracken & Semel, 1998). Although the pain is over for the one who died, suicide survivors are left with added guilt, shame, and questions as illustrated by Justin's story. Survivors are left to ask why, seek answers, and cope with the reality that the suicide completer elected to leave those standing at the graveside.

Consider Anne, Justin's mother, in a society that aligns the mother with "protector" and "nurturer". Anne was fulfilling that role as she searched frantically for her son before discovering his lifeless body in a tree. As she laid his body to rest, she placed items of comfort in his coffin,

once again a symbol of the unique and profound connection between mothers and their children. The mother's experience of losing a child to suicide deserves special attention in research to better understand and acknowledge the experience of the one who possesses no other role so close both physically and emotionally in relationship to the deceased.

Suicide Statistics

The World Health Organization (WHO) defines suicide as a deliberate act of killing oneself (WHO, 2009). The WHO Statistical Information System (WHOSIS) compiles data using 70 core health indicators from six world regions: Africa, Americas, Eastern Mediterranean, Europe, South-East Asia, and Western Pacific (WHO, 2009). Self-directed violence is part of the data. Summative for all WHO member countries, suicide is listed in the top three causes of death among individuals between 15 and 34 years of age (WHO, 2009). Given the trends recorded for suicide rates among participating WHO states, suicide and suicidal behaviors have been recognized as a threat to the health and safety of citizens worldwide (WHO, 1999).

According to the WHO Global Burden of Disease (GBD) Report, suicide (referred to as self-inflicted injury) occurred at a rate of 0.8 per million deaths accounting for 1.4 % of total deaths worldwide for 2004. Suicide ranked 16th in the top 20 causes of death worldwide outnumbering stomach cancer, cirrhosis, nephritis and nephrosis, and colon and rectum cancer (WHO, 2008). The GBD projects trends for 2004-2030 predicts deaths collectively by suicide, homicide, and war to rise in the European region in those countries classified as low or middle income countries (WHO, 2008).

The WHO recognizes suicide as a threat to the public health of its 193 WHO member states. However, the WHO also admits that suicide is difficult to define (WHO, 2010). Suicide is categorized under self-directed violence that includes both self-abuse and suicide where the

perpetrator and the victim are the same individual. Although the 193 member states of WHO vary regarding the inception of statistical data on the incidence of suicide, most participating countries have reported suicide mortality data in 5 year intervals since 1950. In 2000 approximately one million people died from suicide worldwide, while 10 to 20 times that many attempted suicide (WHO, 2009). Given the complexities surrounding suicide deaths, many believe numbers to be even higher given suicide deaths often go unreported (O'Carroll, 1989). Although some underreporting or misrepresentation in the data exists, suicide trends overtime do not appear to be affected (O'Carroll, 1989).

Since the inception of WHO reporting, suicide rates for the United States (US), Canada, China, the United Kingdom, and Germany have changed over time (WHO, 2009). For example in the US between 1950 and 2005, suicide rose steadily. Similarly for the reporting period between 1950 and 2004, Canada's suicide rate rose, as well as China's suicide rate reported between 1955 and 2005. In contrast, between 1950 and 2005, The United Kingdom experienced a decline in suicide rates. Germany began reporting suicide rates in 1990. Between 1990 and 2004, Germany, also reported a decline in overall suicide rates.

The US Center for Disease Control and Prevention (CDC) considers suicide a major health concern (Kung, Hoyert, Xu, & Murphy, 2008). In 2005 a total of 2,448,017 deaths were registered (Kung et al., 2008). The CDC cited suicide as the 11th leading cause of death for all ages accounting for 1.3 % of all deaths. This percentage translates to 32, 637 suicide deaths or approximately 11 suicide deaths per 100,000 citizens (Kung et al., 2008). Within these numbers, males account for four times the number of completed suicides compared to females. By age category, suicide ranks second only to unintentional injury for 25 to 34 year-olds; suicide is the

third leading cause of death for 10 to 24 year olds and for those 55 to 64 years old, it is the eighth leading cause of death.

Overall suicide rates in the US have remained steady over the first 5 years of the 21st century (Kung et al., 2008). In 2006 the total numbers of suicides was 33,300 (Heron, 2010). For 2007 this increased slightly to 34,598 (Xu, Kochanek, Murphy, & Tejada-Vera, 2010). The US has sought to reduce these numbers through federal initiatives such as Healthy People 2000 and Healthy People 2010 that focused on recommendations for suicide prevention (US Department of Health and Human Services, 1990; US Department of Health and Human Services, 2000).

Suicide Risk

For the purpose of this study, suicide was defined as *a deliberate act by an individual directed toward the self with the primary intent of ending life*. Several suicide risk factors have been identified during decades of scientific inquiry (Moscicki, 2001). These risk factors include: 1) depression, other mental illnesses, or substance abuse disorders (and family history of such), 2) prior suicide attempt, 3) family history of suicide, 4) family violence, 5) firearms in the home, and 6) exposure to suicidal behaviors by others, e.g., family members, peers, and news media. It is suggested that 90% of those who die from suicide had one or more of these risk factors. In addition, decreased levels of neurotransmitters in the brain, such as serotonin, have been identified along with depression among suicide attempters, suicide completers, and those with impulsive disorders (Arango, Huang, Underwood, & Mann, 2003). According to national statistics, 30% of those attempting suicide became suicide completers (Kung et al., 2008). When a suicide death occurs, the suicide completer becomes another statistic, but the consequences of the act have far reaching implications for those left behind.

According to the American Association of Suicidology (AAS) (1997) for every completed suicide, as many as six close family members and friends are left to grieve the devastating loss. Given this estimate and taking into consideration previous exposure to suicidal behaviors, as many as 196,000 individuals annually suffer as a result of a loss related to suicide. Kneiper (1999) argues between 6 and 28 persons are directly affected by each completed suicide; thus, the numbers of those at risk of untoward effects of suicide grow exponentially each year. Death by suicide confers a unique experience for the bereaved because the deceased voluntarily elected to die rather than coming to death as a result of events beyond their control. The process of bereavement becomes more complex as those left behind attempt to make sense of the death.

Grief, Bereavement, and Suicide

By the later part of the 20th century, medicine and psychology redefined the understanding of death, bereavement, grief, and mourning. Grief models redefined the process of these concepts (Bowlby, 1961; Engel, 1964; Kubler-Ross, 1969; Lindemann, 1944; Parkes, 1972; Wolfelt, 2009). The grief process has moved beyond a conceptualization of stages and phases toward a more fluid, dynamic process encompassing complex factors. These factors are essential components and attest to the complexity of grief and successful mourning. For example, cultural norms and beliefs and closeness to the deceased play critical roles in the way active grief and mourning are experienced. Although these concepts are not new, professionals critically analyzed the influence they have on the grief process.

The terms grief and bereavement are used interchangeably in the literature. Mourning is associated with the acts and rituals used during a period of grief or bereavement. Attig (1996) defines bereavement as an individual's state or condition resulting from a loss by death, while grieving and mourning denotes the processes stemming from the state or condition. For the

purpose of this study bereavement, grief, and mourning are used consistent with Attig's definition.

Within the cultural norms matrix, society delineates and defines both formally and informally acceptable modes of death and the collective response toward those left behind to grieve. The physical and emotional proximity of the relationship to the deceased combined with mode of death and cultural mores create a unique constellation of circumstances requiring special care and attention.

Suicide is one form of death that elicits a variety of responses and reactions from others depending on one's worldview. It has been praised and abhorred throughout history and modern times. Colt (1991) calls suicide an *enigma*. The act of suicide is perplexing as scholars place it within the context of culture, death, bereavement, grief, mourning, and relationships. Interpretations of suicide in recent American culture associate it with mental illness, substance abuse, or a weakness of character or body. As a result, the legacy is passed to those left behind to grieve the loss. In many cultures suicide is seen as taboo and a crime against the state (Alvarez, 1990; Colt, 1991; Minois, 1999). Individuals and communities viewing suicide as taboo have tried to separate themselves from suicide and its aftermath.

Statement of the Problem

Researchers, health care professionals, mental health professionals, and community leaders must understand the emotional, psychological, physical, social, and spiritual implications of the loss of a loved one to suicide. Suicide survivors carry a heavy burden as they attempt to navigate through the grief experience while struggling to understand and answer many unanswerable questions. Suicide has been a controversial concept throughout recorded history: both honored and abhorred. Today, suicide is most often associated with unresolved or

undertreated health issues. Within this social framework, suicide survivors must grieve the loss, and at the same time manage the social implications they experience.

Both qualitative and quantitative research has advanced the understanding of grief, bereavement, and suicide since the early 1970s. It has provided data about the differentiation between grief and complicated grief as it relates to suicide. In searching the nursing literature, a plethora of research reports focused on suicide survivors and complicated grief. Few research studies provided insight about survivors such as mothers of suicide victims. Understanding the unique needs of special populations with social and emotional connections to suicide is a critical component in meeting the needs of suicide survivors as they work toward finding meaning and moving through the grief process.

The group lacking attention and research in the literature is mothers bereaved by the suicide death of a child. Over the past 20 years suicide survivorship has received substantial attention in the literature compared to the early and mid-part of the 20th century; however, the research often relies on quantitative inquiry using rating scales and tools measuring depression, anxiety, coping, adaptation, grief, and complicated grief. Although these studies have provided valuable information about the trajectory of grief and mental status of those bereaved by suicide, they fail to inform the lived experience for mothers following the suicide of a child.

Qualitative studies have produced data about the experience of the suicide survivor, but most studies focus on suicide survivorship within the context of other forms of death referred to as traumatic or violent, such as murder, accidents, and even sudden infant death syndrome (SIDS). Furthermore, these qualitative studies and those that focus only on suicide have not narrowed their focus to include only mothers. These studies inform either about the experience of violent deaths **or** suicide from the perspective of a variety of relationships to the deceased. This

research has failed to recognize both suicide survivorship and mothers as suicide survivors with a unique, individual experience.

The purpose of this study was to explore, qualitatively, the experiences of mothers following the suicide death of a child. Using four life-world existentials: spatiality, corporeality, temporality, and relationality derived from the research of Max van Manen (1990), the investigator identified essential themes expressed by mothers that constitute a more comprehensive understanding of existence in the world following the suicide death of a child.

Research Question

Phenomenological research requires the investigator to frame the initial research questions in a broad manner to encompass the essential components of the phenomenon of interest. The research question the investigator addressed in this study was: “What are the experiences of mothers bereaved by the suicide death of a child?” Within this broad question, the investigator also sought to address this experience as guided by the four existentials.

Relevance to Nursing

Nurses are charged with caring for clients within the holistic paradigm. They are the clinicians most often in close proximity to clients as they attempt to negotiate health and wellness. Nurses must be knowledgeable about grief, bereavement, and the special needs of those grieving a suicide loss.

In addition, nurses must be willing to act as client advocates and client representatives, while helping the client seek acceptable community resources after a suicide death. This is plausible only when nurses caring for mothers bereaved by the suicide of a child are able to understand the experience and respond to their needs during all stages of grieving.

CHAPTER 2

LITERATURE REVIEW

Strange, isn't it? Each man's life touches so many other lives. When he isn't around he leaves an awful hole, doesn't he?

(Clarence Oddbody, AS2, *It's a Wonderful Life*, American Film, 1946)

Introduction

The 1946 American film, *It's a Wonderful Life*, produced and directed by Frank Capra tells the story of George Bailey. With desperation, hopelessness, and helplessness, George stood balanced on the edge of a bridge believing he was worth more dead than alive. Based on a Phillip Van Doren Stern's 1943 short story, *The Greatest Gift*, George Bailey was given a rare opportunity to see what the world would be like had he never been born. After he experienced a glimpse of a world in which he was absent, George had a change of heart and decided life was indeed worth living. More importantly, he realized a life lived and experienced within the context of others leaves a terrible void when no longer there.

For an audience in the 1940s, Capra's reference to suicide was far from the social norm of the period. Capra's use of humor and the small-town based plot softened this controversial subject. A suicide death can leave a much larger void as friends and family struggle to understand the reason for the tragedy. As in the story of George Bailey, one life indeed touches many others, but one must also wonder if George's decision would have been the same had he been allowed to see what life would be like for those left behind after his suicide. Beyond popular culture, there exists a body of literature that speaks to suicide and its impact on the lives of those who have survived and are left behind.

This chapter provides an overview of this body of literature and will uncover some of the unique issues associated with suicide loss, as well as the challenges for health care professionals assisting the suicide survivor through the grief process. Databases used were: CINAHL, PsycARTICLES, PsycINFO, and PubMed. Several well-known books and texts used to investigate suicide and suicide survivorship included: Alvarez (1990), Biebel and Foster (2005), Cain (1972), Chilstrom (1993), Colt (1991), Cox and Arrington (2003), Fine (1997), Hsu (2002), Minois (1999), Myers and Fine (2006), Shneidman (2001), Toynbee (1968), and Wroblewski (1991).

Death and Dying in Society

Death and how individual societal units treat the death of its members are unique and across time and cultures. The philosophical underpinnings about the meaning of death are as old as civilization.

Historical Perspectives on Death

Death is the end of a present existence and the representation of humankind's finite ability to control destiny. Death exemplifies a well-known vulnerability in the human condition. Death exerts its "sting" in a variety of ways: the result of disease, illness, and accidents. Death as a result of the connection with self and others includes: homicide (killing of another), death sanctioned by groups (war and death penalty), and suicide (the intentional killing of one's self). Philosophically speaking, other variations include active and passive euthanasia, i.e., physician-assisted suicide.

Most circumstances leading to human demise result from situations out of the victim's control. As humans, it is natural to want to remain alive and sustain life for as long as humanly possible, not only for the preservation of the one life, but for the preservation of the human race.

This philosophical belief is repeated by many overtime. When death does become an “inevitable possibility” (Toynbee, 1968, p. 259), it is individually and collectively experienced within the cultural and religious backdrop of society. Arnold Toynbee (1968), Professor Emeritus of International History at the University of London and world renowned historian, found humans reconcile themselves to death in many ways. For example, the hedonistic view in its purest form symbolizes the desire to enjoy life through physical pleasures and avoid pain before life is snatched by the grips of death. Immediately after the death of Alexander the Great (356 BC- 323 BC), his empire broke into warring factions and four new schools of thought emerged: the Cynics, the Skeptics, the Epicureans, and the Stoics (Magee, 2001). Because death was an inescapable destiny, the Epicureans believed the goal of life should be happiness and pleasure. A more pessimistic view dictates that life is miserable and death is the lesser of two evils (Toynbee, 1968). Ancient Egyptians subscribed to a more primitive, physical circumvention of death preserving the corpse and supplying the dead items necessary for use in the afterlife.

Western Views of Death

According to Toynbee (1968), Western attitudes about death have changed over the past 300 years. He attributed this change to the faith driven practice of Christianity where the believer commits to action based on moral, spiritual, and intellectual planes. Belief in the immortality of the human soul is viewed from the perspective that a disembodied human spirit is eternal (Toynbee, 1968). Similarly, belief in the resurrection of the body and that it will be united with the soul at an appointed time represents a belief in life beyond an earthly existence. Finally, the hope of heaven and the fear of hell represent the belief in the individual’s desire to avoid hell and anticipate heaven. Christianity provides its believers with a sense of hope in the face of death. In the *Book of Common Prayer* of the Episcopal Church, it states:

In the midst of life we are in death: of whom may we seek for succor, but thee, O Lord, Who for our sins art justly displeased? Yet, O Lord God most holy, O Lord most mighty, O holy and merciful Savior, deliver us not into the bitter pains of eternal death (p. 484).

The Holy Bible conveys a similar hope during death's stronghold. "Precious in the sight of the Lord is the death of His saints" (Psalm 116:15 New International Version). "Those who walk uprightly enter into peace: they rest as they lie in death" (Isaiah 57:2 New International Version). Finally, 1 Corinthians 15: 42-44 (New International Version), Paul refers to the resurrection of the dead:

So it will be with the resurrection of the dead. The body that is sown is perishable, it is raised imperishable, it is sown in dishonor, it is raised in glory; it is sown in weakness, it is raised in power; it is sown a natural body; it is raised a spiritual body. If there is a natural body, there is a spiritual body.

Regardless of the cause, death refuses to compromise its existence; all must experience the sunset of death if one wishes to experience the beauty of life's sunrise. Whether through faith or intellectual endeavors, society recognizes death as a part of the human experience - a journey all must eventually make. Although the thought of death may not remain in the human consciousness daily, paths between life and death will cross, whether it is through one's own demise or the death of others. Death is by no means a stranger, but it waits in the periphery of life no matter religious, cultural, or ethnic affiliation. It is a personal and social event. Those left behind are faced with finding meaning out of the loss. The loss symbolized through human connectedness and ritual after a death. Its presence experienced by virtue of the common element called humanness.

Death: An Event, but Dying: A Process

From the moment of birth there is the constant possibility that a human being may die at any moment; and inevitably this possibility is going to become an accomplished fact sooner or later.

----- Arnold Toynbee (1968)

Mant (1968) provided a historical glimpse into the dilemma of the true definition of death. He chronicled the misfortune of individuals exposed to premature burial as a result of misdiagnosed death. Early accounts relied on the use of a feather or a mirror to the victim's nostrils to detect life, while more invasive means included creating an opening into the intercostal space for the purpose of palpating the heart to detect cardiac activity. Even these methods did not fully eliminate the mistake of a misdiagnosis of death. According to Mant (1968) individuals were occasionally buried alive. In the early 1800s the differentiation between somatic and cellular death was further complicated when the exact time of death could not be identified. Yet many still viewed the only sure sign of death was the "onset of putrefaction" or decomposition of the body (Mant, 1968, p. 19).

Although the human mind struggles with the actual moment of death, the concept of death and dying has attracted the attention of philosophy. Smart (1968) distinguished dying as a process separate from the event of death. According to Smart the process of dying possesses the possibility of interruption, while death is irreversible. Although simplified, this worldview conveys foreknowledge of death under many circumstances. As individuals face death, emotions are experienced by both the dying and those left behind.

Bereavement, Grief, and Mourning

There are always two parties to a death;

the person who dies and the survivors who are bereaved

----- Arnold Toynbee (1968)

Norwegian artist, Edvard Munch (1863-1944), produced a lithograph in 1896 depicting a sickroom just moments after a death (Kuh, 1951). Entitled “Death in the Sickroom”, it is the scene of the death of Munch’s younger sister years earlier (Attig, 1996). Six individuals are portrayed moments after absorbing the loss (Appendix A). The focus is not on the deceased but, rather, on those facing the reality of death. Although the room is filled with people, it does not appear to be crowded. Each figure, alone in grief, is unable to find the words to speak, the glances to exchange, or the physical embrace to express the loss. Each is alone, isolated, and withdrawn in grief. Deprived of the presence of one, the moment is collectively experienced, individually perceived.

Many modern day writers have attempted to understand and explain the process of grief and its impact on survivors (Bowlby, 1969; Engel, 1964; Kubler-Ross, 1969; Lindemann, 1944; Parkes, 1972; Wolfelt, 2009). Although death has always been a companion in life, when its weight is felt on a personal level, the physical and psychological implications are great. Kubler-Ross (1969) poignantly described the stages of an individual’s personal struggle after the realization of one’s own mortality or the death of a loved one. In 1975 Kubler-Ross referred to death as “the final stage of growth” (p. x). According to Kubler-Ross, “death is an integral part of life, as natural and predictable as being born” (p. 5). So, why is it that a familiar experience continues to produce waves of emotion for the dying and those left behind? As social beings, connection with others is an essential part of human existence. Even though death is part of

daily human existence, it has the potential to influence the personal and social fabric of life as survivors struggle to find meaning from the event when it affects them personally.

Whether viewed as a single event or a process, death and dying is both a personal experience and a social experience. Human interaction is the thread that connects lives together. The entire piece of tapestry changes when one thread breaks. Alбом (2003) in his book *The Five People You Meet in Heaven* tells a story about the death of Eddie, an 83 year- old amusement park ride maintenance man. After his death five people illustrate the hidden connections of his life; the story poignantly highlights the connectedness among humans and how the actions of one person touch the lives of others. Human demise is a concern for society as well as individual mourners.

A broad range of literature supports the notion that both personal and social interests provide compassion for others during a time of death. Death rituals connect members of a community together. They represent the value placed on an individual human life. For example, Toynbee (1968) found many variations in attitudes across cultures. Such variations included how members of a community handled experiences with the dead in addition to the meaning that was ultimately derived from the mode of death. In another example, Yudkin (1968) described an adult reaction to the death of a child; recently as the 19th century, the death of a child was commonplace. Moreover, children were exposed to the rituals of mourning at a much earlier age because mortality rates were higher among the younger population. Death was viewed as a part of life; shielding the youngest of society's members was not culturally accepted as necessary.

Theory

Attachment Theory

Attachment theory is the combined work of John Bowlby and Mary Ainsworth; it revolutionized thinking about a child's connection to its mother and the disturbance resulting from separation, deprivation, and bereavement. It is essential to carefully examine the mother-child dyad in relationship to attachment, particularly in the context of a severed dyad. Bowlby's interests evolved into assisting children by helping parents examine their own inadequacies, tracing similar feelings during their own childhood. Many of Bowlby's conclusions were grounded in empirical evidence demonstrating that mentally healthy children experience a warm, intimate, and continuous relationship with their mothers or mother figures in which both parties find satisfaction and enjoyment. Bowlby was criticized for placing mothers in the role of primary caregiver; some researchers do not believe this is an accurate assessment of his work (Bretherton, 1992).

Infant-mother attachment and the processes associated with the relationship are comprised of a complex system of behaviors and motivation (Bretherton, 1992). Given the nature of the child-mother dyad, protection by the mother toward the child services an evolutionary function of survival for the human race. This innate behavior may cause a mother to sense she has failed to protect and defend her offspring when the child completes suicide. Although the need to protect is only one aspect of the attachment between the child and mother, it is a powerful behavioral instinct transcending time and space. For example, mothers often blame themselves for the suicide deaths of their children wondering why they did not die instead (Nelson & Frantz, 1996).

Much of the current understanding of attachment theory is rooted in behavioral philosophy. Behavior is explained without mental activities such as cognition, representation, and interpretation. However, Betherton (1992) contended that attachment theory could be studied in conjunction with perspectives of theorists interested in the social construction of reality.

Role Theory and Spoiled Identity

Although understanding the special relationship between the child-mother dyad is the critical first step in exploring maternal suicide survivorship, roles within social contexts supply a critical piece in understanding the experience as mothers attempt to cope in the world after the death. Individuals serve specific roles within the social context of their existence. Social Role Theory explains how descriptive and instructional social norms maintain traditional gender roles in society (Harrison, 2005). Perceived gender roles dictate how individuals behave in specific situations. For the purpose of understanding the role of the mother, perception of gender role orientation is influenced by the social roles they fulfill. For example, women with children are viewed by society as more community oriented. When the mother is identified as the caregiver and the orchestrator of peace and harmony, society tends to view the mother as a being somehow able to deter such an event such as the suicide of her child (Nelson & Frantz, 1996).

Goffman (1959) introduced the concept of social identity and the presentations of the social self to others. His book *The Presentation of Self in Everyday Life* contributes an understanding of ourselves and explores human behavior within social situations. Goffman attempted to explain individual social interaction through the metaphor of a theatrical performance. Such discussion offers a better understanding of the social impact of customs. Following the death of a child, social presentation may be altered because of cultural beliefs

about suicide. For example during a doctoral class discussion, some in the group viewed suicide as the unforgivable sin. As a result of this outward expression of disapproval, others were likely to alter their comments and interaction changing “the script” of the interaction.

Stigma and stigmatization play a major role in social identity. The evolutionary view of stigmatization provides an account of its essential function consensual nature (Kurzban & Leary, 2001). Stigmatization marks behaviors, actions, or characteristics and by consensus of the group deems them undesirable. Goffman (1963) poignantly examined the impact of stigma on social identity. He discussed such concepts as information control and personal identity in terms of being discredited. For example, when the mode of death of the child is not readily known, the mother is faced with the dilemma to tell or not to tell; to lie or not to lie. It is how information is managed at the risk of becoming a “marked” parent. In a study of the experiences of 35 adult suicide survivors, 26 % reported at least one experience of perceived stigmatization (Van Dongen, 1993). The majority of participants reported role uncertainty in themselves and how they should behave as a suicide survivor. Such ambivalence led to a disruption in social interaction as they felt unsure in their responses toward others.

Bereavement Theory

*When a love tie is severed, a reaction, emotional and
behavioural, is set in train, which we call grief.*

-----Dr. Colin Parkes (1972)

In an attempt to identify and understand individual responses to the death of a loved one, researchers and thanatologists have conceptualized such reactions and behaviors through a number of models and theoretical frameworks (Bowlby, 1961; Engel, 1964; Kubler-Ross, 1969; Lindemann, 1944; Parkes, 1972; Wolfelt, 2009).

Lindemann (1944), one of the first to use the term “grief work”, used the term to refer to the tasks performed by the bereaved following the death of a loved one. Much of his early observations came from working with survivors of a fire at the Cocoanut Grove Night Club located in Boston, Massachusetts in 1942. Lindemann developed a program of crisis intervention to aid the survivors and their relatives, making it one of the first formal programs to assist individuals through acute grief following a disaster. Lindemann acknowledged acute grief could be a pathological condition with psychological and somatic symptomatology. Although symptoms are part of the course of normal grief, he added grief reactions may become distorted into what he referred to as “morbid grief reactions” (Lindemann, 1944, p. 144). For example, a delayed reaction to the loss of a loved one could have a significant influence on the individual grief response resulting in dysfunction and pathology.

Lindemann (1944) identified three principal tasks of bereavement: relinquishing attachment to the deceased, adjusting to the environment and everyday life, and developing new relationships. These tasks are accomplished within three stages: shock and disbelief, acute mourning, and resolution. Lindemann’s model for explaining the needs of the bereaved placed great emphasis on the social aspect of this process. Although Lindemann posited that relinquishing attachment to the deceased is an important task, present day belief is such that attachment to the deceased is never really abandoned but merely redefined (Wolfelt, 2009). Similarly, adjusting to the environment and everyday life is described by some survivors as finding a way of life that represents a new normal (Myers & Fine, 2006).

Engel (1964), a professor of psychiatry and medicine at the University of Rochester Medical Center, studied the grieving process from a theoretical and practical stance. Engel outlined a six stage process for understanding the normal grief reaction: shock and disbelief,

development of awareness, restitution, resolution of the loss, idealization, and outcome. Engel conceded grief to be a universal phenomenon among human beings. He viewed grief as a normal process that could be interfered with or optimized but yet never accelerated. Shock and disbelief represent a period of denial and numbness to the reality of the death. The development of awareness occurs as the bereaved begins to understand the meaning with a potential for anger, physical symptoms, and emotional outbursts. Restitution denotes a time for mourning. This is a period where social rituals such as family gatherings facilitate recovery. Resolution of loss involves the intrapsychic process of letting go. Idealization refers to the processes some type of memory of the deceased that are retained by the bereaved. Outcome is achieved when the bereaved is able to remember the positive and negative, the pleasure and disappointments associated with the deceased. Although Engel described grief as a linear process, the model acknowledged both the social and psychological nature of bereavement as well as the complexity between the two.

Bowlby (1961) stated individuals grieve in three phases: they desire to recover the loss they experience, despair and disorganization, and finally reorganization. Bowlby known for his work with children and mothers in developing attachment theory (Bretherton, 1992), collaborated with Colin Murray Parkes in the area of bereavement. Parkes (1972) modified Bowlby's idea into four phases of grief: numbness, yearning and searching, disorganization and despair, and reorganization. Numbness refers to a period of disbelief. The individual is unable to accept the death as real. According to Parkes (1972) the stage of numbness gives way to a period of yearning and searching. During this time Parkes described the bereaved as "pining" for the deceased (p. 7). Pining results in depression (disorganization and despair) and only after depression can recovery (reorganization) occur. In the foreword of Parkes's 1972 book

Bereavement: Studies of Grief in Adult Life, Bowlby accepted Parkes's modification of the grief stages acknowledging Parkes's work in the field of thanatology and their collaborative partnership. Through the contribution of Bowlby and Parkes, psychological issues that plague the bereaved were addressed within the context of bereavement.

One of the most recognized contributors to the understanding of death, dying, and loss is Elisabeth Kubler-Ross. In her 1997 autobiography, Dr. Kubler-Ross, a physician of Swedish descent, recognized C.G. Jung as the major influence on her work. Raised in Switzerland as a triplet, Kubler-Ross came to be recognized as the expert on issues of death and dying. Based on her extensive work with dying clients, Kubler-Ross exposed the emotional and psychological turmoil experienced when individuals realize they are dying. Kubler-Ross (1969) addressed five stages of dying: denial and isolation, anger, bargaining, depression, and acceptance. The initial shock results in the denial response, a temporary buffer or defense mechanism. Denial allows the bereaved to integrate the death and manage the emotional storm. Social isolation accompanies denial and shock as the individual attempts to self-protect and avoid the overwhelming emotions brought about by the company of others. Stage two is characterized by anger, resentment, rage, and even envy. The question arises "why?". This response is especially true after a suicide death. Most often the news of the suicide comes as a shock and little evidence is available to answer the questions posed by survivors. As the bereaved begins to acknowledge the loss and make sense of the events, anger may be turned toward family members, friends, medical personnel, self, and even the deceased. As the bereaved works through the grieving process, Kubler-Ross described stage three as bargaining. During this period of negotiation, the survivor attempts to neutralize the emotional pain. Psychologically, bargaining represents an attempt to postpone. The dying may bargain with God for "more time" or in the

case of the bereaved may be the result of feeling somehow being responsible for the loved one's death. A period of depression represents stage four. The bereaved begins to recognize and acknowledge the finality of the death. With such acknowledgement come feelings of helplessness and hopelessness stemming from the lack of control and vulnerability. Finally, stage five is labeled acceptance. The bereaved is able to talk about the loss and remember the deceased without intense emotional responses. Hopelessness and helplessness are replaced with hope and healing.

Although the five stages of grief and loss developed by Kubler-Ross is one of the most recognized models for the dying and bereaved, the linear progressive model (like that of Engel, Bowlby, and Parkes) is believed to lack individual variability (Cordell & Thomas, 1997). Grief is not a linear progression, as the "stages and phases" model suggests, but a process characterized by free-flowing events that many times overlap and reoccur during the course of bereavement. Others question the use of the "stages" model of bereavement because of the assumption that the bereaved is a passive recipient of grief. Moreover, linear stages imply "set-backs" occur when the bereaved return to a particular stage (Attig, 1991; Martin & Elder, 1991).

Although researchers acknowledge the limitations of the Kubler-Ross model, they applaud the magnificent contribution she made to understanding bereavement and grief. Kubler-Ross opened the dialogue about death and dying at a time when death was synonymous with failure.

In contrast to the stage or phase models of grief, Attig (1996) acknowledged the work of William Worden from 1982 as a grief process Worden conceptualized as more active. Much like Lindemann (1944), Worden stated grief resolution came about through the completion of tasks denoting an active process. Worden's four tasks are: acknowledging the reality of the loss,

working through the emotional turmoil, adjusting to the environment where the deceased is absent, and loosening ties to the deceased. Attig (1996) argued that what Worden called “tasks” are not tasks at all but rather avenues of social and psychological coping as a way to make sense of the loss and move forward.

The historical development of stages, phases, models, tasks, and coping strategies for the bereaved has undergone a metamorphosis during the last 5 decades. Grief work includes the process of bereavement as well as the tasks of mourning. Grief work has been transformed from professional-lead to client-lead treatment. Grief work has become more fluid in nature where a return to a previous place does not denote setbacks but rather essential work needing to be completed.

Wolfelt (2009) compared and contrasted the treatment model of grief work with what he referred to as a “companioning model” (p. 3). Wolfelt said grief models are ineffective for both the bereaved and the professional. “Any kind of expert model of grief care runs into trouble when feelings of helplessness are encountered by the caregiver” (Wolfelt, 2009, p. 8). In his book *The Handbook of Companioning the Mourner: Eleven Essential Principles* Wolfelt rejects the notion of stages or phases but seeks to listen to the bereaved where they are in the moment. Wolfelt values presence, silence, walking alongside, and respecting disorder without placing expectations on the mourner.

Gestalt Theory

Originating in Austria and Germany in the late 19th century, Christian von Ehrenfels used the term “gestalten” describe psychological events in which the characteristic properties and their effects cannot be reduced to merely the accumulation of the parts (Arnheim, 1998). In other words, the whole is greater than the sum. The founders of Gestalt theory, Germans Kurt

Koffka, Wolfgang Kohler, and Max Wertheimer (King & Wertheimer, 2005), applied the theory to problem solving stating that the parts of a problem should never be isolated but should be seen as a whole. Wertheimer stated that when things are viewed as a whole there is less energy exerted on thinking and the whole is much more valuable than the parts.

Through the Gestalt law of organization, factors are identified that lead to particular forms of perceptual organization (Kohler, 1947). Gestalt Theory comes from a nonbehavioral philosophical premise. Three principles pertaining to the law of organization described by Gestalt Theory have merit for discussion of the experiences of the maternal suicide survivor.

1. Law of proximity: Objects or events that are near to one another in time and space are perceived as a coherent.
2. Law of similarity: Parts of a stimulus field that appear similar to each other are perceived and belong together.
3. Law of Closure: An innate tendency to perceive incomplete objects as complete and to close or fill in the gaps so that the asymmetric stimuli become symmetric.

The process of maternal suicide survivorship within a complex social environment can be examined in relation to the above principles gain a clearer understanding of the suicide survivor, suicide victim (completer), suicide event itself, and the social context of the experience.

Historical Perspectives on Suicide

To be, or not to be: that is the question.

Whether 'tis nobler in the mind to suffer

The slings and arrows of outrageous fortune,

Or to take arms against a sea of troubles,

And by opposing end them. To die: to sleep:

*No more: and by a sleep to say we end
The heart-ache and the thousand natural shocks
That flesh is heir to. 'Tis a consummation
Devoutly to be wish'd. To die; to sleep;--
To sleep? Perchance to dream! Ay, there's the rub:*
(Shakespeare, Hamlet, act 3, scene I)

This excerpt of a soliloquy first spoken by Prince Hamlet in Shakespeare's tragedy, *Hamlet*, illustrates man's ongoing temptation toward self-destruction. Hamlet contemplates whether or not suicide would be the best course of action given the present circumstances. Such scenes are not uncommon in recorded historical accounts and serve to represent humankind's ongoing battle to find a plausible solution to internal and external conflicts of the day. Themes regarding the subject of suicide vary over the course of recorded history within a cultural context. Societal, personal, and spiritual beliefs about the decision to end one's life stem from many diverse worldviews and cultural traditions. Although an individual choice, the decision to end one's life has consequences reaching far beyond one life. Beyond the inner struggle of the suicidal mind, life is lived within the context of and in orchestration with others. John Donne (1572-1631), a Renaissance poet and clergy, conveys this in the poem, *For Whom the Bell Tolls*, written in 1624. Our lives intertwine with those we encounter.

*No man is an island,
Entire of itself.
Each is a piece of the continent,
A part of the main.
If a clod be washed away by the sea,
Europe is the less.
As well as if a promontory were.
As well as if a manor of thine own.
Or of thine friend's were.
Each man's death diminishes me,*

*For I am involved in mankind.
Therefore, send not to know
For whom the bell tolls,
It tolls for thee.*

John Donne, 1624, Meditation XVII (John Donne Society, online, 2011)

In 1933 Louis I. Dublin, Vice-President and Statistician for the Metropolitan Life Insurance Company of New York, began to resurrect the discussion of suicide and its implications in the 20th century and beyond (Dublin & Bunzel, 1933). Drawing from the late 19th century work of Emile Durkheim, Dublin and Bunzel examined suicide from a sociological perspective providing an analysis of suicide rates between 1900 and 1931. The analysis provided a foundation for comparing suicide trends in the US and other developed countries where recorded numbers may be less representative of the phenomenon as a result of the social implications of suicide. During the stated period, Dublin and Bunzel discussed suicide trends by race, gender, and marital status, possible indicators of suicidal behaviors. They also examined variables such as rural versus urban dwelling, seasonal variations, religious affiliations, and economic conditions to compare suicidal behaviors between groups. The early work was grounded in historical accounts of suicide providing a foundation for understanding this behavioral phenomenon from the context of society and group behaviors. Over time and recorded history, the phenomenon of suicide has shaped and been shaped by societal, demographical, biological, and psychological factors. Suicidal behavior does not stand alone but is an individual act that carries with it implications for family, friends, and communities from generation to generation.

The Historical Kaleidoscope of Suicide

Look into a kaleidoscope. The light reflecting off the gems within provides a cascade of brilliance. With each turn of the lens, the colors and patterns change to represent a new, fresh look at the jewels grabbing the sunlight as each unique constellation is formed. In addition, each viewer has a personal interpretation of the brilliance of each pattern. The historical account of suicide and societal beliefs is much like looking through the lens of a kaleidoscope. Just as each viewer looking through a kaleidoscope provides a personal description of what is seen, so is the individual interpretation of suicide. As the gems within the kaleidoscope remain the same, so do individual motives for suicide through history remain the same. Although circumstances may vary, despair and hopelessness color each gem. Like the turning of the kaleidoscope and with the passage of time, humankind's interpretation of suicide has changed. Each person, group, community, or culture offers a different description, significance, and meaning of suicide. An historical survey of suicide has made a 360 degree turn in how it is viewed across time and culture. Although evolving, how the act of suicide and self-destruction has been viewed over time and between cultures offers a glimpse into the human response to a form of death that has been both praised and abhorred since early civilization. Colt (1991) refers to suicide as an enigma, a form of death where the victim holds the "cards" to existence. Both praised and condemned, suicide is shrouded in mystery as those left behind are met with the challenge of processing the behavior within the context of cultural norms associated with death and the consequences of suicide.

Early Evidence of Suicide

Lo, **my** name reeks

Lo, more than carrion smell

On summer days of burning sky...

Lo, **my** name reeks

Lo, more than that of a sturdy child

Who is said to belong to one who rejects him...

To whom shall **I** speak today?

Brothers are mean,

One goes to strangers for affection...

To whom shall **I** speak today?

I am burdened with grief

For lack of an intimate...

Death is before **me** today

(Like) a sick man's recovery,

Like going outdoors after confinement...

Death is before **me** today

Like a man's longing to see his home

When he has spent many years in captivity

(Colt, 1991, p. 129-130)

These words, penned over 4,000 years ago, represent the first recorded reference to suicide. In the excerpts from the work entitled, *The Dispute Between a Man and His Ba*, the gentleman grows tired of the stressors of life and the ill it brings. Dated during the first intermediate period of the Middle Kingdom in Egypt, the writer filled with loneliness, despair, and hopelessness entertains the option to kill himself. With the use of the words I and me, there was a sense of isolation in the words of the writer. There is no mention whether his decision was influenced by or had direct consequences for others because the writer was clearly focused inward on his own pain and desperation without thought of what his actions would hold for others. Although it is unclear from the historical writing whether the man goes on to end his life, his soul (ba) decides to remain despite the man's complaints. His soul (ba) employs him to stay and surrender to his hedonistic pleasures instead of risking abandonment of his soul, thus depriving him of an afterlife. Even during early times, suicide was interpreted as having some form of consequence and, in this example, it is the loss of a man's soul because he died by his own hand. This early depiction of internal conflict and ambivalence is not unlike the struggles experienced by many in modern day.

The Perplexity of Suicide

History documents the struggles pertaining to the meaning of self-death. The act of ending one's life has taken many forms. Although motives for suicide have remained consistent, the individual and social acceptance of such motives has changed. Broadly speaking, motives for suicide include love, poverty, illness, honor, fear, guilt, discontent, grief, revenge, shame, patriotism, and politics (Alvarez, 1990; Colt, 1991; Dublin & Bunzel, 1933; Durkheim, 1951; Magee, 2001; Minois, 1999). Individuals' decision to end their lives reflects a personal view of

self and how the self fits into society, group, or the social condition. Emile Durkheim, renowned French sociologist, observed a varying frequency of suicide across populations and social environments identifying two independent variables: integration and regulation. According to Durkheim high integration within a society, group, or social condition reflects a sense of common conscience (Durkheim, 1951; Johnson, 1965). The degree of commonality and shared beliefs is high. In contrast, low integration denotes a weak common conscience, where interaction among group members is limited and self-interests reign over the interest of the group. In both examples Durkheim found suicide rates to be higher compared to groups labeled as having moderate integration. Similarly, regulation and suicide follow the same relationship. Regulation explains the degree of control society has over the individual; as such high and low regulation yield higher suicide rates. Examples of this phenomenon can be seen when community citizens have low integration into society and such isolation leads to suicide. In contrast, those with very high integration in society, out of fear of not meeting society's expectations, may become suicidal. The early work of Durkheim set the stage for understanding society's influence on suicide rates among members of social groups. Understanding how individuals viewed themselves within their social schema is critical understanding the revolving transformation of suicide over time. As the kaleidoscope of time turned, historical accounts of suicide reflected three broad viewpoints with various degrees of integration and regulation across groups, societies, and social conditions:

1. The individual's worldview of self-determination and self-control
2. The individual's worldview in relationship to others and responsibility to others
3. The individual's worldview in relationship to God or a higher power and responsibility to this higher power

A discussion of major historical accounts of suicide perceptions provides an exemplar for these viewpoints. Even within the same cultural schema, the interpretation of the suicidal act and its consequences are defined according to those looking through the kaleidoscope at the configuration of the phenomenon during that moment in time.

Suicide Among Early Civilizations

Dublin and Bunzel (1933) dispelled the notion that suicide is a product of a civilized society. According to their work acceptance of suicide or its rejection varied across early cultures. For example, Sir G. Grey found tribes separated by geographical regions where suicide was virtually unknown: the Yahgans of Tierra del Fuego of South America, Andaman Islanders in the Bay of Bengal region of India, Caroline Islander in the South Pacific, and Kafirs of the Hindu-Kush in India. Among these groups suicide was virtually unknown. At times, group members found the concept to be incomprehensible inasmuch as it was treated as a joke. In contrast suicide fit into the “general cultural pattern of life” (Dublin & Bunzel, 1933, p. 138) of other civilizations with some degree of variation. For example, suicide among the Navajos Indians was frequent but among the Zuni, a pueblo tribe in New Mexico, it was viewed as foreign (Dublin & Bunzel, 1933).

Among early civilizations a vast difference in attitudes and moral judgments were attached to the act of suicide (Alvarez, 1990; Dublin & Bunzel, 1933). Turtle Island, a part of North America and home to over 500 federally recognized tribes, is described as being diverse in culture and tradition (Leenars, 2003). Even in the midst of such diversity, life was viewed as a precious gift worthy of protecting. Living life in balance prevents suicidal behavior.

Others groups had varying moral and ethical beliefs about suicide. The Accra Negroes of the British Gold Coast and the Pelew Islanders of the South Pacific passed no moral judgment on

suicide (Alvarez, 1990; Dublin & Bunzel, 1933). Although the Chippewas of North America regarded suicide as a foolish act, it was not highly stigmatized compared to the Ossete tribe of Siberia where suicide was considered a sin and punishment followed the soul to the afterlife (Dublin & Bunzel, 1933). Such beliefs about the consequences in the afterlife were found in the Dyak of Borneo who believed an individual who completed suicide would live in the afterlife like they died. For example, the individual committing suicide by drowning would live in the afterlife in water up to the waist. The Karens of Burma considered suicide a cowardly act and those completing the act were denied an honorable burial. The Ashanit of the Gold Coast considered suicide a sin; the body was decapitated and the family denied the right to grieve. This example highlights not only the consequences for the individual completing the act but sanctions for the family as well.

In some early societies a suicide took on mystical or magical thinking (Alvarez, 1990; Dublin & Bunzel, 1933). The Wajagga of East Africa fearing the ghost of a suicide took the rope used by the suicide victim, hung a goat with the same noose, and then slayed the animal (Dublin & Bunzel, 1933). The act served to neutralize the evil represented by the act. Similarly in some cultures, as a form of revenge, it was believed a suicide victim's ghost had the capability to destroy a persecutor. For example, laws and customs dictated that to appease suicides the ones thought to be responsible for the victims ending their lives, must end their own lives (Alvarez, 1990). It was as though another suicide could right a wrong done toward the one initially committing suicide, which in fact the very fear of this occurring prompted others to take matters into their own hands.

Early civilization's experience with the act of self-destruction varied depending on group norms and conceptualization of the behavior. Conceptualization ranged from an unknown

presence of suicide within some cultures to suicide as a reprehensible act with consequences in this life and the afterlife for the suicide. In addition, these consequences fell to relatives left to grieve the suicide loss.

Classical Greek and Roman Heritage

As I choose the ship in which I sail, and the house I will inhabit, so I will choose the death by which I leave life... In no matter more than death should we act according to our desire.

-----Seneca

Considered the birthplace of Western civilization, ancient Greece (510BC-146BC) held suicide as an admirable option (Colt, 1991). The Athenian tragedy by Sophocles provided an account of the first Greek suicide on record and an illustration of the cultural beliefs of the time. Adapted from Greek mythology Sophocles' play, *Oedipus, the King*, chronicled the story of King Laius and Queen Jocasta of Thebes (Colt, 1991). The play, debuting in 429 BC, tells of a prediction that King Laius would die by the hand of his own son and this son would marry his mother, Queen Jocasta. Fearful of the fulfillment of the prophecy, King Laius orders the male son bore by Queen Jocasta to be killed. Through a series of events, the male heir survives, unknowingly kills his father (King Lauis), rises to kingship, and marries his birth mother, Queen Jocasta. Upon the discovery she married her own son, Oedipus, Queen Jocasta hanged herself from a high rafter. Homer commented on the suicide as a natural consequence to an excruciating situation, a behavior emerging from a sense of honor (Colt, 1991). Even during a survey of early civilizations where suicides were taboo, exceptions existed (Leenars, 2003). For example, tribal elders might walk through a snowstorm to preserve food for their young or warriors might choose to die in battle (Cox, 2003; Minois, 1999). Even as early as 500 BC, ancient Greek society officially sanctioned some motives for suicide (Colt, 1991). Although found by some to

possess too much subjectivity in the Greek colony of Ceos, those inflicted with irreversible illness or past the age of 60 were authorized and in many cases encouraged to end their own lives. Among the Greek colony of Massilia (Marseilles) governmental officials allowed citizens to plead their case before the senate who concluded illness, grief, and dishonor were reasonable motives for suicide. Keeping poison on hand for such an occasion, Greeks were granted permission to end their lives and even supplied the means free of charge. The process was meant to prevent impulsive acts made in haste and provide the individual access to an immediate, painless demise. This practice hints at both a sense of personal control over life's hardships and the state's solution to economic and society liabilities.

Although each philosophical school of thought has opinions about suicide, in the Greek world suicide had less to do with moral judgment and more about the abhorrence of violent death and disruption in the natural process of nature. For example, Pythagoras (580 /572 BC- 500/490 BC) and his followers disapproved of suicide on the premise that premature death by suicide disrupted the soul's return to its divine order (Dublin & Bunzel, 1933). Pythagoras, true to his mathematician intellect, believed that at any given moment the world has a fixed number of souls and suicide caused an imbalance, making it impossible for another soul to enter the world. This view highlights a spiritual response against the act of suicide but also takes into account the responsibility each has for another in this life (Stanford Encyclopedia of Philosophy, 2008). Plato (428/427 BC - 348/347 BC) and Aristotle (384 BC – 322 BC) affirmed this view, objecting to suicide on the grounds that exiting this life without the approval of the “commander” (God) or Maker was irresponsible. This view represented a sense of responsibility and relationship to God or higher power for managing the life given to them. Moreover, Aristotle held that taking one's own life was unnatural because individuals have a duty to self and their assets. To Aristotle,

suicide represented a breach of duty and responsibility to self and the state. Suicides served as an economic liability when suicide victims failed to live up to their responsibility as a Greek citizen. From this worldview, self-determination or control over one's own destiny was secondary to the responsibility to God (gods) and the society as a whole.

Conversely, the Epicureans and Stoics welcomed the act of suicide, but for different reasons. Holding that pleasure should be the driving principle in life, Epicureans found death to be neither good nor bad but believed it should be weighted carefully to determine the option that would bring the most satisfaction (Magee, 2001). Epicureans made the decision that suicide was an internal process (self-determination) and argued that suicide is sometimes warranted when individuals cannot live good life lives (Warren, 2001). Lucretius (99 BC-55BC), a Roman poet and Epicurean, killed himself at the age of 45. He was quoted as saying;

If one day, as well may happen, life grows wearisome, there only remains to pour a libation to death and oblivion. A drop of poison will gently close your eyes to the sun, and waft you smiling into the eternal night whence everything comes and to which everything returns (Colt, 1991, p. 147).

Zeno of Citium (334-262BC), founder of Greek Stoicism, believed in no higher authority than reason and rational thought (Dublin & Bunzel, 1933; Magee, 2001). Those adopting the Stoic philosophy found calm while enduring life's hardships and understood a time may come when the wish to go on living ceases. As a result, Stoics believed in the individual right to determine one's own death as well as one's life. The goal was to live life with dignity and honor in the mist of chaos. When this was no longer possible, suicide was an honorable option. According to Colt (1991) suicide for the Stoic represented the ultimate proof of human freedom. It was the pinnacle of control over earthly circumstances and an individual's choice that did not

include any comprehension of consequences for self in the afterlife or to the community.

Although Stoic doctrine was founded in Greece, it became the crowning glory of the Roman Empire (Dublin & Bunzel, 1933). Seneca (2 BC- 65 AD), a Roman philosopher, politician, and Stoic, was consistent in his teachings when informed by Emperor Nero, a former pupil, that he desired his death. Seneca cut his wrists bleeding to death slowly. The act presented an honorable death in the face of insurmountable conditions (Alvarez, 1990; Colt, 1991; Dublin & Bunzel, 1933). In choosing death by suicide, Seneca found control under uncontrollable circumstances, responding to authority in what was viewed as an honorable alternative.

At a time when the earlier philosophers were concerned with the external world, Socrates (469 BC- 399 BC) found the internal human processes a more worthy pursuit. Socrates, credited as one of the founders of Western philosophy and renowned contributor to the field of ethics, had no desire to discredit the works of others but favored the desire to explore the minds of men as being “an infinitely worthier subject for philosophers than all those trees and stones, and even all these stars” (Durant, 2005, p. 9). The political climate of the time did not favor the teachings of Socrates, particularly his monotheistic beliefs. Considered a hero by the Stoics, Socrates while imprisoned in Athens for the corruption of Greek youth was condemned to death by the Greek government. Ultimately, he elected to die by his own hand (Colt, 1991; Magee, 2001). Based on the historical writings of Plato and *Crito* (Critias), Socrates consumed hemlock rather than face execution. In the *Phaedo* (Plato’s thesis) Socrates and *Crito* (Critias) discussed suicide (Colt, 1991). Socrates condemned the act of suicide as the destruction of divine property because man belongs to God. He argued that suicide is desertion unless man leaves his post under God’s order. Socrates justified the consumption of the hemlock explaining he was summoned by God. The suicide death of Socrates represented a prime example of enigmatic nature of suicide. While

suicide represented necessary death, history recorded the anguish felt by his wife and friends as they witnessed his decision and death (Colt, 1991). Although Socrates found peace in his decision, French artist, Jacques Louis David's 1787 painting, *The Death of Socrates*, shows Socrates surrounded by Plato and others mourning his decision; a decision made with deliberate and rational resolve.

Although the Greeks rationalized suicide, the Romans brought suicide into vogue (Colt, 1991). History records a vast number of suicides during Roman rule (500 BC- 476 AD) (Alvarez, 1990; Colt, 1991; Dublin & Bunzel, 1933). Much like their Greek counterparts, Rome's share of suicides occurred for similar reasons: disgrace or dishonor. According to Roman history, the noblest of all suicides was that of Marcus Porcius Cato (Colt, 1991). Cato, a fateful warrior for Caesar and the Roman Emperor, elected to end his life by falling on his own sword after several major defeats in battle. Despite attempts to save his life by suturing the wounds, Cato resisted the help and tore open the wounds exposing his bowels before expiring. Cato's death represented the value the Romans placed on honor and responsibility to country. During Roman times, when life's vicissitudes were found to be insurmountable, Rome felt a sense of responsibility to society to make restitution. To the faithful Roman, responsibility to others meant sacrifice through suicide rather than face dishonor.

Suicide in Early Christianity

The early Christian church was plagued with persecution and torment. The doctrine that man's tortured earthly existence was merely a precursor to an afterlife in paradise was further incentive to consider suicide as an option (Colt, 1991; Dublin & Bunzel, 1933). Furthermore, the longer one lingered in life, the more time there was to sin and less time spent in heavenly paradise. During the rule of the Roman Empire, the state was only glad to provide the means for

self-destruction. Martyrdom was seen as the best method to expedite one's journey to heaven. Following the example of Christ Jesus, giving up the spirit before the crucifixion, martyrdom assured posthumous admiration and annual commemoration, in addition to a stipend given by the church for the martyr's family (Colt, 1991). Christians jumped into flames, embraced the jaws of lions, and enraged the pagans all for the promise of eternal bliss. Although unknown, the true numbers of "indirect suicides" previously discussed during this period of history is unclear. Nevertheless, Rome found the situation an embarrassment as Christians lined up to receive their fate, outwardly viewed as the ultimate sacrifice for the faith.

As the Roman Empire dissolved, so did the idea of martyrdom for the sake of faith. With the rise of church and the public's irritation with martyrdom of the masses, the desire for martyrdom and even the loss of chastity became unfit motives for suicide (Colt, 1991). Living with poverty, pain, or persecution was no longer a socially acceptable motive for ending one's life. As disapproval for such behavior mounted, St. Augustine (354 AD – 430 AD) drew arguments against suicide, surprisingly not from the Bible, but from the teachings of Plato. St. Augustine's *City of God* set forth the position that human life is a gift from God and suffering is a test of the soul. According to St. Augustine, suicide was murder as the one who kills himself kills a man thereby breaking the sixth commandment of God. This shift in worldview supported a human responsibility to receive God's gift of life rather than rejecting it through voluntary death. This argument against suicide became the foundation for the Christian worldview of suicide.

Suicide of the Masses

When groups are threatened with the destruction of their way of life and integration is strong, suicide becomes a viable alternative rather than risking capture, torture, and dishonor.

Durkheim posited that during times of war suicide rates decrease because war increases political integration. He clarified this by explaining only national wars produce such an effect because individuals rally around a common cause and become more connected. Alternately during times of war, killing of the enemy increases thereby providing individuals alternate ways to deal with aggressive behaviors. Ultimately, a lower suicide rate is the result. Marshall (1981) suggested any change in the suicide rate does not lie in the result of war but the result of war on the economic condition of the people. Nevertheless, suicide during times of war has also been associated with suicide on a massive scale.

During times of war ancient Greeks used suicide to avoid enemy capture. The 90 year old Athenian orator, Isocrates, resorted to starvation rather than bow to the rein of Philip of Macedon (Colt, 1991). Communities and entire regiments found suicide a viable option rather than succumb to surrender (Colt, 1991). According to Thucydides (460 BC- 395 BC), a Greek historian and author of *History of the Peloponnesian War*, in the fifth year of the Peloponnesian War (427 BC) the oligarchs of Corcyra took their lives rather than risk capture. They used arrows shot by the enemy, cords from bedding, and strips of their own clothing.

According to Alvarez (1990) the Tasmanian aborigines committed suicide as a race by refusing to breed. They refused to live in a world where their people were hunted down like animals. According to Spanish historian, Girolamo Benzoni, over 4,000 men, women, and children in the West Indies died by voluntarily jumping to their deaths. As a result of suicide and slaughter, less than 150 of the two million Haitian inhabitants survived the invasion of the Spaniards. In retrospect, the Spaniards found themselves with a severe labor shortage. Therefore, they threatened to follow the Haitians into the afterlife by killing themselves if the suicides did not stop.

At Masada in 73 AD hundreds of Jews defending their fortress in Israel chose suicide rather than surrender to the Romans (Alvarez, 1990; Colt, 1991). During World War II the entire Saipan population committed suicide rather than surrender to Allied troops. Instead of surrendering, they drowned in the Pacific Ocean, leapt from cliffs, and soldiers used grenades to blow themselves up.

The Legacy of the Middle Ages

No one ever lacks a good reason for suicide.

----- Cesare Pavese

Suicide in the Middle Ages (500 AD-1500AD) had two distinct facets; economic and social class separated commoners from nobles in life and beyond. The law and theoretical works on morality dictated society's treatment of suicide deaths (Colt, 1991; Minois, 1999). Nobles were afforded exposure to hunting, wars, tournaments, and crusades, which offered a substitute for direct acts of suicide. Those nobles with suicidal tendencies only needed to expose themselves to those activities to accomplish the final outcome of self-homicide. Therefore, suicide by a noble was viewed as a social act connected to honor. Regardless of the reason for which the nobleman of the Middle Ages sacrificed himself, suicide represented death in light of social function and was therefore viewed as altruistic in nature. For the nobleman the act of suicide elevated the individual to a status worthy of respect for providing the ultimate sacrifice. The law of the day did not condemn such behavior nor did it place sanctions on the suicide victims' families. Conversely, the suicide death of a commoner or peasant was seen as behavior stemming from cowardice and egocentrism. A farmer, blacksmith, or tailor was not afforded the same forgiveness. For the Middle Ages commoner suicide was an act of irresponsibility and despair believed to be inspired by demon influence. The common countryman was seen as

abandoning responsibility and succumbing to demonic forces without consideration for self, others, or God.

This double standard was also seen in accounts of suicide among the clergy of the time (Minois, 1999). Although priest or monks rarely completed suicide, the act became an issue for the church and did not demand the same attention as those of the commoner or nobleman. The nobleman would receive accolades and ceremony for the ultimate sacrifice and the commoner was exposed to a civil trial, slander, torture of the corpse, denial of a church burial, confiscation of properties, and disgrace to family. Meanwhile, the suicide death of a priest was stifled to avoid scandal. As a result, the social and moral judgments placed on suicide interfered with collecting suicide data around the close of the Middle Ages.

The Christian Influence

As previously mentioned, St. Augustine (354 AD-430 AD) led the rigorous opposition to suicide by the church. Voluntary martyrdom, asceticism, and even the preservation of virginity were not motives for suicide. St. Augustine's *City of God* solidified the argument for the Catholic Church, becoming the cornerstone of belief even today (Colt, 1991; Minois, 1999). The issue of suicide had evolved into not only a social issue where motives were interpreted by society; it became an issue about the value of life and one's obligation to not only self and community but to the God of creation. St. Augustine clearly attached voluntary death to the Sixth Commandment making suicide a form of murder.

According to Minois (1999) the New Testament offers very little, direct discussion about God's position on suicide. In fact, the religious elite of the Middle Ages found the passages by John accounting the thoughts of Christ an embarrassment to the unequivocal condemnation of suicide. "Just as the Father knows me and I know the Father-and I lay down my life for the

sheep.... No one takes it from me, but I lay it down of my own accord” (Holy Bible, John 10:15 & 18), New International Version). Similar passages invited the faithful to scorn life and aspire to the paradise in heaven with God. “However, I consider my life worth nothing to me, if only I may finish the race and complete the task the Lord Jesus has given me—the task of testifying to the gospel of God’s grace” (Holy Bible, Acts 20:24, New International Version). In contrast, Acts 16:27 accounts Paul’s interference with the suicide attempt of a jailer upon the discovery that Paul and his colleagues were freed from their prison chains. Fearing of punishment for his negligence, the jailer drew his sword to kill himself as Paul intervenes; “But Paul shouted, Don’t harm yourself! We are all here!” (Holy Bible, Acts 16:27, New International Version). For St. Augustine and other Christian thinkers of the time, this philosophical duality had to be dealt with as both civil and canon law to create a moral climate in favor of suicide prohibition.

Suicide: Heaven or Hell

Within a short time, suicide had shifted from an act of honor and martyrdom deserving of paradise to a one-way ticket to hell. For example, Joan of Arc, imprisoned in 1431, threw herself from a cell window rather than face the wrath of the English (Minois, 1999). According to Minois this created evidence used by the bishops of clear proof of her demonic possession, when only a few hundred years before such an act would have raised her to a place of honor and reverence. During this time period it became a direct rejection of God’s divine nature and His control over a life belonging to God to take one’s own life. However, this hostility toward suicide was not driven merely by one’s responsibility to God or a divine power. Between the 5th and 10th centuries, the preservation of human life became a spiritual issue as well as one of economic and demographic implications. With the emergence of a totalitarian system of government, their rights as a person were separate from the master. In a desperate attempt to

save the empire, harsh legislation was imposed upon those choosing suicide. The acute shortage of manpower prompted legislation that made suicide a crime. Suicide moved from the theological realm into secular society as a sinful act with social, economic, and political implications. It became more than just a theological debate for the Christian faithful, but a societal issue with consequences for the populace as a whole. With the fear of the confiscation of earthly goods and eternal damnation, social pressure provided an environment for eliminating individual autonomy and replacing autonomy with power to the master and the Church over life and death.

Between the 11th century and the conclusion of the Middle Ages, both civil and canon law provided a framework for a system focused on making suicide the most reprehensible of acts. While religious scholars explained the suicides of Christian martyrs as acts divinely approved by God, St. Thomas Aquinas (1225-1274) in his *Summa Theologica* asserts three basic tenets for the prohibition of suicide (Minois, 1999): 1) Suicide is an offense against the natural law of self-preservation, 2) Suicide is a direct attack on the community, and 3) Suicide is a clear offense against God, who is the master of life. Ironically, all arguments opposing suicide in the Middle Ages were strangely similar to the same tenets used to rationalize suicide during Greek and Roman times. Over the period of 1,000 years those peering through the lens of time watching the same jewels through the same kaleidoscope began to define the configurations differently. It continued to be about self-determination, social responsibility, and divine responsibility, but what once was viewed as an act of honor and worthy of martyrdom status became an act worthy of punishment for the suicide attempter or completer and their families.

Asian Culture: Sacrifice or Suicide

Throughout Asia history records a diverse response to the act of self-killing (Dublin & Bunzel, 1933). In contrast to Western culture, the caste system within Asian tradition placed women in a degraded position and viewed as servants or drudges to their husbands. Within this tradition, *suttee (sati)* became an acceptable practice for women following the death of their husbands. The Brahmin and Rajpute castes of India sanctioned such behavior as the ultimate display of devotion after the death of the bride's husband. The oldest and most sacred of the Brahminian caste of India, Rig-Veda, was reported not to have directly commended such behavior but later was altered by the religious order to official sanction *suttee (sati)* as an obligation by the wife toward her husband at the time of his death (Dublin & Bunzel, 1933; Harlan, 1994).

Suttee (sati), its original meaning good and faithful woman, was declared at the time of the husband's death (Harlan, 1994). Within the first 24 hours of the death, the wife was allowed to reflect and decline the sacrifice. Once the decision was made, retraction was not an option at the risk of dishonor to self and family. According to Dublin and Bunzel (1933), the act itself first originated as a symbolic gester and was never meant to emerge as an official custom. Interestingly, after *suttee (sati)* was proclaimed, family and friends went through attempts to dissuade the wife against the act, but this behavior was only a formality and never meant to be taken seriously. By Hindu tradition the husband's corpse was displayed on the funeral pyre. After a series of rituals, the wife prayed "that for as many years as there were hairs on her head (45,000,000 according to sacred writers) she might abide in heaven with her husband" (Dublin & Bunzel, 1933, p. 156). After walking around the funeral pyre seven times, the wife was tied to

the corpse already placed on a pile of combustibles. Within the background of spectators, a son or male relative would light the flame.

The British attempted to suppress and prohibit the behavior through legislation in 1829 in response to 500 *suttee (sati)* deaths per year in the preceding decade with the highest number in 1818, 839 voluntary deaths from *suttee (sati)* (Dublin & Bunzel, 1933; Oldenburg, 1994).

Oldenburg (1994) found that although the act of *suttee (sati)* appeared to be a deplorable act, it must be viewed from the Hindu tradition which requires the removal of “western lenses” (p. 165).

Chinese and Japanese Culture: A Matter of Honor

Similar types of ceremonial deaths were common in China although more choice in the mode of death existed, i.e., the use of opium, starvation, drowning, or a public hanging.

According to Dublin and Bunzel (1933) Buddhism was responsible for the prevalence of self-killing in China. Certain motives for suicide represented honor: a soldier’s defeat, the escape of certain doom, dethroned rulers, wives refusing to survive the death of a husband, women whose future husband died before the marriage date, and family members electing self-death in memory of a father or ancestor. Those dying under the umbrella of the correct motive were promised a passport to heaven. Honorable suicide deaths were extended to high ranking official by the emperor. When crimes were committed, it was customary for the emperor to send silk cords to the offenders so they might hang themselves and avoid execution thereby saving their body from mutilation. In contrast as previously noted, the European Middle Age commoner risked punishment and self-mutilation of the corpse after the act of suicide; under certain conditions in China, suicide was the only way to avoid such treatment (Minois, 1999).

In Japanese tradition, self-destruction was taught to male and female children from their early years (Dublin & Bunzel, 1933). Although Buddhism reinforced the social order, other

religious tents included loyalty and honor. Life was temporary and existence must be joyfully surrendered out of duty and honor. Individual fate was to be approached with indifference.

The term, *hara-kiri (seppuku)* means self-disembowelment. The history of this practice goes back to ancient times and was prohibited by Chinese law in 1868. During the time when *hara-kiri (seppuku)* was actively practiced, two types existed: compulsory and voluntary. Compulsory was granted to those of noble rank after committing a crime as a form of punishment. It was considered an honor to die by one's own hand rather than by that of another through execution. The act was viewed as the duty of the offender and was to be faced without question. Voluntary *hara-kiri (seppuku)* was marked by a highly scripted routine and ceremony. The event was in most cases a public event where the method of death was penetrating the abdomen with a dagger. Considered the most painful death in existence, the victim was hailed for extreme courage if performed without flinching or showing outward signs of suffering. Once the fatal wound was inflicted, it was the responsibility of family or close friends to decapitate the victim putting an end to the suffering. This is similar to the family participation in *suttee (sati)* and the victim's rise to honor through voluntary sacrifice of life.

Other causes of voluntary death in Chinese culture included *junshi* (suicide upon the death of one's lord or master) and *shinju* (death of two unhappy lovers). According to Dublin and Bunzel (1933) through ancient times until around the birth of Christ, *junshi* was practiced for the purpose of following the master or lord into the afterlife. Clay images of men, women, and horses were later substituted for the living around the time of Emperor Suinin. Although the practice of *junshi* was forbidden in 1744, isolated cases of voluntary sacrifice existed. For example, in 1912 General Nogi and his wife committed *hara-kiri (seppuku)* at the funeral of

Emperor Meiji. According to Dublin and Bunzel (1933) the act was hailed as a positive example for Japanese youth of the period.

The Renaissance: A Period of Reflection

There is but one truly philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy.

-----Albert Camus (1991)

The Renaissance Period (14th to 17th centuries) brought a rebirth to intellectual inquiry sweeping through Northern Italy and eventually the rest of Europe. This period in history found the re-emergence of ideas from classic antiquity. The dissemination of knowledge enhanced the advancement of printing and new techniques in art, literature, and poetry. Humanism and the importance of living well overshadowed medieval Christian dogma, which included the doctrine that life was to be tolerated, death meant torment, and hell was even worse (Colt, 1991). The kaleidoscope's configuration began to resemble the thoughts and beliefs of thinkers of early antiquity. Scholars of the Renaissance reconnected with Greek and Roman ideas of self-determination and self-reliance. Art, literature, and philosophy reflected these tenets.

During the late Middle Ages and early Renaissance, intellectual thought influenced the philosophical landscape, highlighting the unique ability of the human mind in poetry, grammar, moral philosophy, and rhetoric. No longer did chains imprison the human mind and stifle inquiry. It was now acceptable and fashionable to explore and experience the depths of human inquiry. This was evident in the areas of art where works became more representative of the human condition. Science continued its dynamic and accelerated ascent in the areas of astronomy, physics, biology, and anatomy. Religious turmoil brought about the challenge of the Catholic Church and its hold on the masses. This period found those such as Martin Luther

(1483-1546) willing to challenge the status quo through his development and presentation of *The Ninety-Nine Theses*.

Within this panorama of discontent, suicide began to emerge in literature and the arts. Less than 100 years after Dante denounced suicide, Geoffrey Chaucer (1343-1400), an English author best known for the narrative *The Canterbury Tales*, wrote *Legende of Goode Women* which featured Dido, Lucretia, Cleopatra, and others as heroines and role models (Colt, 1991; Minois, 1999). Chaucer portrayed the suicides of these women as acts of courage and provided artists of the day an opportunity to acknowledge suicide through paintings. William Shakespeare (1564-1616) re-examined the idea of honor suicide through the 14 suicides in his eight tragedies (Cady & Cartmell, 1946). Still others proclaimed the traditional argument against self-killing as exemplified in the work by Edmund Spenser entitled *The Faerie Queene*. The debate between the Red Cross Knight and Despair culminates in a suicidal crisis that ends with life triumphing over Despair.

Old Traditions “Die” Hard

Despite the re-emergence of dialogue about the issue of suicide, 15th and 16th century Europe considered suicide the most reprehensible of sins (Alvarez, 1990; Colt, 1991; Minois, 1999). In France the body of a suicide victim was dragged through the streets as an example to others, hung upside down, and disposed of in a sewer or city dump. Property of the deceased was relinquished to the king and families were denied their inheritance. A religious burial was forbidden and physical remnants of existence were destroyed such as the family coat of arms. Retribution for suicide reached beyond punishment in the afterlife but extended well beyond the boundaries of physical destruction of personal belongings and the corpse. In a final effort by the Church and the legislative bodies to communicate to the masses their disdain for self-killing, the

memory of the suicide victim was formally defamed “ad perpetuam rei memoriam” (Colt, 1991, p. 168). Throughout Europe the goal by both law and religion was to stamp out self-killing, even placing it at the criminal level equal to killing ones neighbor. Well into the 17th century the only recourse for friends and family of the deceased was to attempt to persuade the courts to rule the deceased insane. In fact, according to Minois (1999) a man of wealth and/or position was more likely to be found insane and saved from the treatment commonly reserved for those of modest means. In Austria an individual who attempted suicide but was not successful received “education” in prison persuading the offender that self-preservation and duty to self, others, and God was virtuous (Colt, 1991, p. 168). However, the act of suicide continued to hold social, emotional, and economic consequences for grieving friends and families.

Nevertheless, moral and social debate over suicide did not subside. In 1608, *Biathanatos*, John Donne’s summative arguments for and against suicide, revived the discussion. Written by Donne at the age of 36 and considered the first defense of suicide in the English language, *Biathanatos* devoted a three part expose’ to demonstrating suicide did not belie the laws of reason, nature, and God (Alvarez, 1990; Colt, 1991; Minois, 1999). Donne gave voice to the premise that each is king of his domain and each case must be judged individually. According to Minois (1999) Donne viewed suicide as neither a crime, heroic or an irrational decision, but evidence of “a sickly inclination” (p. 165). For Donne the desire end one’s life was as result of illness. Upon entering the priesthood in 1615, his sermons often had themes and overtones of death. Alvarez (1990) accounted Donne’s insight that suicide came from his own periods of despair and credits *Biathanatos* with saving Donne’s life from the grip of suicide. Even though Donne found solace in producing *Biathanatos*, it was not published until 1646, 15 years after his death. Upon its release, Donne’s work created a whirlwind of comment and discussion. Among

these was the idea that suicide was more than just a weakness, a choice, or an act of sacrifice, but perhaps a symptom of a much deeper issue of the human condition. A new understanding about the nature of suicide was emerging in which issues became more about the human experience and less about moral judgment.

According Alvarez (1990) the term suicide was first officially used sometime between 1635 and 1651. Even in the 1755 edition of *Dr. Johnson's Dictionary*, terms such as self-destruction, self-murder, self-slaughter, self-killing, and self-homicide reflected societies' meaning of the act and the clear equivalency to homicide. Even so, the church found it hard to sustain its strict ban on suicide because religious scholars of the day could not produce New or Old Testament passages that prohibited it. At most, the suicides of Samson, Saul, Abimelech, and Achitophel went without much comment. Even the suicide of Judas Iscariot after his betrayal of Christ was interpreted by some as a form of repentance.

The Enlightenment: In Search of a Cure for Life

If I am assured that I can never be free of [pain], I shall make my exit.

-----Seneca

Sir Thomas More (1478-1535) lived in the age where many conformed to the Christian ideals of the time. The debate between rationalists and moralists was heated. Although the discussion regarding the moral and societal implications of suicide were emerging amidst the social and religious landscape there was no outward defense of one's right to suicide.

In 18th century Europe individual rights gained momentum and any mention of medieval tradition was abhorred. Human right to liberty was now in the "driver's seat" and suicide found favor as an essential individual choice among some of the great thinkers of that time. Jeremy Bentham (1748-1832), an English philosopher and founder of utilitarianism, introduced the

concept that actions should be judged based on their consequences. Rationalists such as Francois-Marie Arouet (Voltaire 1694-1778) and Jean-Jacques Rousseau (1712-1778) questioned why such a private act of choosing to end one's own life was elevated to the level of a crime against the state or a mortal sin; "to elevate an essentially private act into a cosmic blow against the universe is absurd." (Colt, 1991, p. 171). Rationalists found European laws against suicide completely incomprehensible. Although they were motivated in raising awareness about the treatment of suicide, self-death corpses continued to be dragged through the streets, the family name tarnished, and goods forfeited to the state. Although rationalists made excellent strides toward attempting to wash away the stigma associated with suicide, virtually no discussion about the effects of suicide on families and members of the community ensued.

David Hume (1711-1776), Scottish philosopher, economist, and historian, culminated the argument on suicide by examining the act of self-death in relation to iniquities against God, others, and self (Colt, 1991). In the essay *On Suicide* Hume approached each point by great ferociously defending the individual's right to end one's life. For example, Hume maintained that an individual suicide does no harm to society but only ceases to do good. Furthermore, if an individual elects to withdraw from society at the expense of producing at the very least a small harm to it, should this be at a great expense to the individual.

One substitution was the creation of fables or imaginary worlds where a writer could express philosophical issues without the risk of persecution and censorship. Readers could indulge themselves into an imaginary world and contemplate socially taboo issues. In More's 1515 work *Utopia*, he emphasizes the seriousness of his work by treating the issue not merely as an act with consequences for the victim but as a decision requiring strict limits and somber

intentionality. Suicide was interpreted by More as a reasonable option but only with the input of religious and social leaders, a concept closely mirroring the beliefs during classical antiquity.

McManners (1985) summed up The Enlightenment and the emerging conversation on suicide. The period was about removing the concept of the unthinkable. It was about pursuing all possibilities to their logical, rational conclusion including the idea of self- death. Following the rationalist came the Romantic Movement. Johann Wolfgang von Goethe's *The Sorrows of Young Werther*, published in 1771, represented literature of the age preoccupied with a lovesick suicide death (Alvarez, 1990; Colt, 1991; Minois, 1999). According to Colt (1991) Goethe's *Werther* was said to have inspired suicides throughout Europe. Even today, suicidologists point to suicide contagion as a problem when the public reads about the suicide of others. This phenomenon was later coined, "The Werther Effect".

Still in this period of discovery, others were not convinced that suicide was a reasonable and rational act. In 1690 John Locke published *Second Treatise on Government* (Colt, 1991). Although the rationalists pursued the logic that suicide was the ultimate form of freedom, Locke led the way for future antisuicide philosophers with his tenets regarding self-preservation. Locke stated freedom was based on self-preservation and suicide represented the extinction of freedom. Along the same argument, Immanuel Kant (1724-1804) defended Locke's antisuicide tenets with the idea of an absolute moral code that guides one's duty of action. An individual's first duty is self-preservation and anything less degrades humans to the level of animals. Kant said individual behavior should serve as an example to all mankind, thus connecting individual choice or man's free agent status with consequences for others.

However the act of suicide was yet to be clarified during the period of The Enlightenment. In fact, many struggled with idea of self-death on a personal level. French author Madame de

Stael (1766-1817) expressed her support for suicide in the essay *On the Influences of Passions* written in 1796 (Colt, 1991). Seventeen years later in her 1813 work *Reflections of Suicide* she recanted some of her earlier beliefs about one's right to self-death. She later admitted writing *Passions* during a period of suffering and regretted her liberal opinion on the matter. However, *Reflections* did not fully condemn the act of suicide but placed it apart from merely a moral issue of right or wrong rather an issue of personal pain and suffering. Drawing from her own experiences, Madame de Stael made the point that although some suicide could be viewed as commendable when stemming from honor, her view was one of sympathy for the pain experienced by the victim of those contemplating suicide. Stael opened the door to seeing the individual as having an unfulfilled need and suicide was chosen as the cure. The discussion of suicide was moving from an individual choice to looking at the behavior as response to pain and suffering. Through the writings of Kant and Locke, philosophers began to contemplate how individual choice affects others within the context of life.

Throughout Europe, laws and sanctions punishing victims of suicide and their families were slowly abolished (Colt, 1991). For example, indignities toward a suicide corpse were abolished in both Geneva and France in 1770. In 1790 the French National Assembly on the motion of Dr. Joseph Guillotin spoke against all forms of suicide. England, however, refused to soften its laws on suicide during the 18th century. This position was mainly the result of England's reputation as a country prone to suicide. Although there was no official change in the law, the courts provided suicide victims and their families the legal loophole of insanity to spare the suicide's corpse humiliation and the family both public scorn and financial ruin.

Suicide: From Philosophical-Moral Dilemma to Health-Social Problem

The tremendous growth of scientific and health care knowledge in the 17th & 18th centuries led the way for a deeper study of suicide. Although the categorical condemnation of suicide by the church cleared the path for a more secular look at suicide during The Enlightenment, the question in the 18th century and beyond was: Why does suicide occur? Physicians began to approach suicide from two stances: the sociological cause of suicide was approached using statistics and the medical model searched for biological causes of suicide.

Working from the premise that suicidal acts may be connected to the biological functions of the body, physicians began to associate the function of the brain with suicidal behavior. It was hypothesized changes in climate, temperature, and precipitation somehow altered the function of the brain. Other factors such of excessive consumption of rich food, lack of exercise, and environmental pollution were believed to contribute to suicidal tendencies. This work led to further exploration of the mind-body connection and was the forerunner to the study of suicide in psychology. During this period suicide was considered a derangement because it contradicted the natural law of survival. Many theories surfaced to explain the etiology: climate changes, brain injuries, physical pain, liver dysfunction, and melancholia to name a few. Autopsies were performed on suicide victims in search of physical evidence for suicide. The founder of phrenology, Franz Joseph Gall (1758-1828), hypothesized that thickened craniums were characteristic of suicides. The focus continued to gradually shift from suicide as a moral issue to suicide as a bio-medical problem. Frenchman Merian and author of *Memoire sur le Suicide* re-emphasized the belief that suicide was not a sin or a crime but rather a disease. In his 1840 book *The Anatomy of Suicide* Dr. Forbes Winslow (1813-1874), member of the British Royal College of Surgeons in London, shared several remedies for suicide based on suicide as a symptom. For

example, it was postulated that blood-letting removed self-destructive tendencies and playing music soothed the mind (Colt, 1991).

Suicide research was moving toward the bio-medical model. The precipitated belief that suicide was a symptom of insanity challenged philosophers of The Enlightenment period to determine if suicide could be a rational act. Suicide as a symptom of insanity had dangerous consequences in the 19th century. As knowledge about mental illness was in its infancy, many mental illnesses were believed to be hereditary. History and time moved suicide from a moral sin worthy of condemnation to a mental condition with implications for future generations of biological family members. The medical profession, in part, created a social stigma for future generations of family members by passing on the legacy of self-destruction. Suicide was now associated with mental instability.

Although the health care community continued to debate the etiology and treatment of suicidal tendencies, social scientists attempted to examine the influence of society on suicide trends. For economic purposes in the Middle Ages, births and deaths were recorded for taxpaying. This was especially pertinent for suicides and murders, as destruction of property was contingent on the cause of death (Colt, 1991). For example, documents entitled “Bills of Mortality’ were published in England toward the later part of the 16th century providing the public with a periodic report of all births and causes of death. Such information constituted a source of gossip for commoners, while those in the elite class monitored causes of death as a way to make decisions about where they should live to avoid illness or plague. According to Colt (1991) many of the early statistical conclusions, although less scientific and admittedly flawed, hold true today. For example, men kill themselves more often than women, suicide rates

increase with age, and single or divorced citizens kill themselves more frequently than married citizens.

By the turn of the century suicide attempts and suicide were largely viewed as a psychological issue rather than one of morality. In 1910 Vienna hosted the first symposium dedicated to the topic of suicide (Shneidman, 1969). As the only meeting held by the psychoanalytic experts of this period, the symposium was chaired by Dr. Sigmund Freud and Dr. Alfred Adler. Freud, Adler, and other famous figures such as Jung, Stekel, and Friedman convened at a time in history when many psychologists and psychiatrists were splintered regarding the Freudian school of thought. During this meeting Stekel proposed that the desire to die by one's own hand was a mirrored wish for the death of another. The symposium stimulated the development of Freud's further work on death and suicidal behavior. Parallel foci included the role of education, acculturation, and environment on suicidal behavior and prevention. Most importantly, the meeting ended with an acute awareness of how little was known about suicide and the realization that much work remained to be accomplished.

A New Beginning

Most recently the Center for Studies of Suicide Prevention at the National Institute of Mental Health (NIMH) was established in 1966 (Shneidman, 1969). By 1968, over 100 suicide prevention centers were scattered throughout the US compared to only three in 1958 and nine in 1964. The decade of suicide prevention had arrived. Under the guidance of Edwin S. Shneidman (1918 -2009), the American Association of Suicidology (AAS) was in founded 1967. After 58 years of virtual silence on the problem of suicide, the AAS held its first annual meeting in Chicago, Illinois. The climate had changed, recognizing suicide as relevant to both the physical and mental health of all citizens. Suicide was now, at least, a problem that could be

openly discussed among mental health professionals. However, it was still taboo among the main stream public. Even with the US in the mist of the Vietnam War, suicide under any circumstance was, although not a legal crime, still a moral crime. In 1972 Albert Cain published the first book, *Survivors of Suicide*, recognizing those left behind after a suicide death as suicide survivors. What was once a hidden secret now was exposed and recognized for the human devastation that suicide caused beyond those taking their lives.

In many ways suicide and suicidal behavior has come full circle. Cultural and ethical concerns about suicide continue to evoke ongoing debate. Society struggles with how to define the behavior and those directly affected attempt to find meaning and purpose behind the act.

The Label: Suicide Survivor

Since the term, suicide survivor, was introduced by Cain (1972) to refer to those left behind after a suicide death, most of the current literature uses this label when describing those individuals affected as a result of a suicide death. Clark (2001) and McIntosh (2003) proposed the term has a double meaning: 1) referenced as one bereaved by suicide, 2) referenced as one who attempted suicide. Andriessen (2005) in a letter to the editor resurrected the discussion of the term and whether it should describe those bereaved by a suicide. Other terms with the same meaning are “bereaved by suicide” and “loss by suicide”. The conclusion was “suicide survivor” has been the term of choice for experts in suicidology and it should remain as its original meaning, first used by Cain in 1972. Review of the literature revealed that the use of the term “suicide survivor” most often described those “bereaved by suicide”. For the purpose of this study, the investigator chose to remain consistent with Cain’s definition and terminology; “suicide survivor” refers to those left behind who are affected by the suicide death of another.

Many authors have speculated about who falls into the group referred to as suicide survivors. According to Kneiper (1999) a suicide survivor refers to any individual who has been affected by the suicide death of another to any degree. Theoretically, all individuals with the potential to see or hear about a suicide could be labeled a suicide survivor if such contact impacts their life in a negative way. The literature found suicide survivors to include; classmates, colleagues, acquaintances, friends, teachers, and close or distant family members (Kneiper, 1999). In fact, all have the potential to be labeled a suicide survivor depending on the degree of relationship held by the deceased. The consequences of, reactions to, and experiences with a loss by suicide is a multidimensional issue and often seen as a unique form of bereavement requiring special interventions (Batzler, 1988; Dyregrov, 2002; Knight, 1992; Schuyler, 1973). As part of a comprehensive literature review, suicide bereavement will be discussed in its entirety in the forthcoming section.

Suicide Survivors

During the last half of the 20th century individuals left to grieve the loss of a suicide were referred to as suicide survivors (Cain, 1972). Although much has been written about suicide survivorship since Cain first coined the term, the literature fails to highlight the experience of suicide survivorship from the perspective of the mother of a suicide completer. Recent literature has focused on parental loss of a child by violent means (homicide, drowning, accidents, and motor vehicle accidents) (Murphy et al., 1999; Murphy, Johnson, & Lohan, 2003a; Murphy, Johnson, & Lohan, 2003b; Murphy, Tapper, Johnson, & Lohan, 2003). Some research studies have focused on both parents as suicide survivors; however, the maternal experience as a separate and distinct phenomenon is omitted. Furthermore, several of the aforementioned studies only address suicide as a related phenomenon within the context of the violent deaths listed

above. In a recent study Fielden (2003) interviewed family members bereaved by the suicide of a loved one, but this study failed to address the unique perspective of the bereaved mother as suicide survivor.

Suicide Grief: Is it Different?

As previously outlined, numerous models exist to explain the “normal” grief process (Kavanaugh, 1971; Kubler-Ross, 1969; Wolfelt, 2009). Behavioral scientists have attempted to contribute a framework for understanding the phenomenon of grief. Although most theoretical models describe the course of grief similarly, most would also argue the intensity and the time progression through the grief process is individualized, if one can truly define what is “normal”. The context of the death, individual survivor characteristics, and external support systems may account for these variations.

An ongoing debate continues about whether suicide grief is different from other forms of grief. Some research has suggested no differences in suicide bereavement and other forms of bereavement. According to Ellenbogen and Gratton (2001) quantitative research has failed to support the public perception that suicide survivors suffer more compared to other survivors. Their review of quantitative studies comparing suicide survivors concluded that although suicide grief has historically been considered traumatic, research has failed to support this assumption. Possible explanations that may account for these findings include such issues as the concepts under investigation were not clearly operationalized; the study instrument has questionable validity and reliability and was not investigated longitudinally. Moreover, control groups were often inadequate or inappropriate, refusal rates were high among females, and Caucasian, upper class survivors were overrepresented.

Some studies examined suicide and grief by investigating family relationships. Using the Bloom Family Interaction Scale (BFIS) and the Closeness/Distance Questionnaire (CDQ), Nelson and Frantz (1996) found no significant differences in closeness among family members following the suicide death of a loved one compared to those who experienced a nonsuicide death. The study revealed that the mode of death had no effect on family interactions. Dyregrov, Nordanger, and Dyregrov (2003) studied 140 families consisting of 232 parents bereaved by suicide, SIDS, and child accidents. The findings revealed similar outcomes for general health and psychosocial distress. The Impact of Event Scale (IES), the General Health Questionnaire (GHQ), and the Inventory of Traumatic Grief (ITG) were used to measure the impact of the deaths on these parents. The findings produced no evidence that suicide survivors had greater complications in adapting to the death when compared to survivors of accidents or SIDS. However, the study offered limitations when considering the interpretation of these findings such as: some participating groups including the underrepresentation of parents of babies who died of SIDS.

Some research points to specific emotional responses that offer explanations as to why suicide bereavement is different (Cvinar, 2005; Kneiper, 1999). Kneiper (1999) supported the premise that survivors of suicide are at risk for an amplified level of grief responses. Studies revealed that the healing process after a suicide was deeply altered by feelings of embarrassment, guilt, rejection, isolation, shame, and a deep, intense desire to search for meaning (Cerel, Jordan, & Duberstein, 2008; Cvinar, 2005; Lightner & Hathaway, 1990; Seguin, Lesage, & Kiely, 1995; Wagner & Calhoun, 1991). In a review of the literature, Jordan (2001) described suicide bereavement three ways: 1) qualitative aspects of grief, 2) social processes around grief, and 3) the impact of grief on family systems. For example, Bailey, Kral, and Dunham (1999) studied

350 bereaved university students and produced evidence to support previous findings that the grief experienced by suicide survivors differed from other types of grief. Using instruments including the Grief Experience Questionnaire (GEQ), IES, and Texas Revised Inventory of Grief (TRIG), the investigator demonstrated that survivors felt a sense of responsibility for the death, rejection, and higher levels of grief compared to other groups. For example, Cvinar (2005) reported that suicide survivors were more likely to be stigmatized implying a major difference in suicide bereavement compared to the bereavement following death as a result of natural causes or other means. Similarly, Feigelman, Gorman, and Jordan (2009) reported that when grouping suicide survivors with traumatic death survivors mean stigmatization scores were higher for suicide survivors. However, when directly compared the mean stigmatization score between suicide survivors and traumatic death survivors were similar but higher than survivors of a loved one who dies by natural means. As a result of such studies, the literature demonstrated that suicide survivorship is similar to those deaths labeled “traumatic” closer to those of homicide and violent accidents.

Studies have investigated a link between depression and suicide survivorship. Seguin et al. (1995) used the Beck Depression Inventory (BDI), GEQ, and Derogatis Symptom Check List (DSCL-90) to measure aspects of depression, grief, and distress associated with suicide versus death by accident. The study findings indicated suicide survivors experienced more initial depression but no differences were found after 6 and 9 months. The research noted that although there were no significant differences in depression scores between groups, suicide survivors’ scores remained within the depression range. In the same study a comparison of those bereaved by other forms of death and suicide survivors identified suicide survivors as experiencing more feelings of shame measured by a subscale of 16 questions from the GEQ. The authors stated

shame to be “unique and central to the experience of suicide bereavement” (Seguin et al., 1995, p. 495). In addition, suicide survivors experienced more changes in life events (i.e., employment, personal leave time, erratic or variable sleeping patterns, and eating habits) compared to the accident group. In contrast, Dunn and Morrish-Vidners (1987-1988) found the perceptions of negative changes in suicide survivors associated with “negative emotions” (i.e., sadness, anxiety, fear, hopelessness, insecurity, and depression) and positive emotions (i.e., being tolerant of others’ pain). Some participants expressed positive change by focusing on personal improvement or seeking psychological help. Upon review of the studies, the internal mental and emotional processes of the suicide survivor leading up to change may be the precursor to the external life changes.

Patterns of adjustment were addressed in the literature on suicide survivorship. Murphy, Johnson, Wu, Fan, and Lohan (2003) studied 173 parents bereaved by accident, suicide, or homicide in a mixed-methods prospective study. The results demonstrated a difference in the patterns of adjustment for parental dyads grouped according to the three types of violent deaths. The researchers used the 53-item Brief Symptom Inventory (BSI), 18-item Traumatic Experience Scale (TES), 10-item Marital Satisfaction subscale of the Dyadic Adjustment Scale (DAS), and one open-ended item asking the parents’ perceptions of the time required to place the child’s death into perspective. The results supported the hypothesis that interaction between mode of death and time influencing bereavement outcomes. However, the findings of this study also supported the researcher’s hypothesis that over time suicide bereavement of a child did not hold the highest levels of distress and the lowest acceptance levels when compared to homicide and accident. Similarly, Feigelman, Jordan, and Gorman (2008-2009) described mixed results related to adjustment and time since loss. In a sample of 540 bereaved parents using the GEQ,

suicide survivors scored significantly higher for grief difficulties compared to the homicide and natural causes subgroups. However, when these grief comparisons were analyzed with grief indicators from the Complicated Grief Scale (CGS) and the IES, the results yielded no differences among the subgroups. In addition, the passage of time resulted in the decline of scores in all three subcategories suggesting that the passage of time outweighed other factors. Although differences in the grief response may be important early in the grieving process, time maybe a natural healing factor for some.

Hoff (2001) highlighted that social support is most needed early in the grieving process. In addition, Reed (1998) identified that social support significantly lowered separation anxiety, feelings of rejection, and depression in suicide survivors. Although the passage of time aids the healing process, initial pain and suffering is a concern for the suicide survivor. As a result of these variable findings, quantitative studies on suicide survivorship have not captured subtle differences among those experiencing the death of a loved one by suicide versus another mode of death (Clark & Goldney, 1995; Dunn & Morrish-Vidners, 1987-1988; Ellenbogen & Gratton, 2001; Feigelman et al., 2008-2009; Jordan, 2001; Ness & Pfeffer, 1990). One plausible explanation could be that those willing to participate in such research are seeking solutions and identifying resources during their period of bereavement.

Others posited (Jordan, 2001; Sveen & Walby, 2008) that feelings such as rejection, stigmatization, and an elevated sense of responsibility experienced by the suicide survivor may be best captured by more subjective measures to identify the subtle differences. Ellenbogen and Gratton (2001) admitted suicide bereavement may indeed be different from other modes of death because of factors such as suddenness of death, family functioning, and relationship to the

deceased. They suggest that quantitative methods “conceal” these differences when data are analyzed collectively (p. 88).

In a qualitative study conducted by Dunn and Morrish-Vidners (1987-1988), twenty-four suicide survivors were interviewed within 5 years postsuicide of a loved one. The relational composite to the deceased for this study included spouses, parents, children, close friend, and fiancée’. Female participants outnumbered males two to one. The interviews produced four major areas of concern for the suicide survivor: 1) survivor response in the areas of explaining and blaming related to the suicide, 2) gridlock in interpersonal relationships, 3) the role of stigma, “normalessness”, and fear, and 4) occurrence of life changes as a result of the suicide. This exploratory study suggested suicide survivors, in fact, face complex emotional, personal, and social problems requiring special attention.

Suicide Grief: A Complicated Grief?

According to the AAS, a suicide death may directly affect six people connected to the deceased (1997). Consequently in the US where approximately 30,000 individuals complete suicide annually, an estimated 180,000 individuals experience the impact from one suicide death. Krysinska (2003) likened this relationship to a pebble thrown into a pond. One tiny pebble produces a rippling effect that causes a tumultuous impact on the smooth surface of the water. The ripples invade the pond until it is barely recognizable as the once glass-like surface filled with peace and solitude.

According to McIntosh and Hubbard (1998) typical responses to the suicide death of a loved one include: 1) shock and disbelief, 2) guilt associated with self-blame, 3) blaming others and/or scapegoating, 4) searching for answers to the “why” of suicide, 5) feelings of ambivalence to the deceased, 6) feelings of rejection, 7) loss of trust, 8) questioning of personal

values, and 9) destruction of basic views about the world. In addition, the suicide survivor may experience social isolation, stigmatization, and decreased social support during the period of loss (Cvinar, 2005; Dyregrov et al., 2003; Fielden, 2003). The reactions and experiences of suicide survivors place them at risk for complicated grief responses, suicidal ideations, and suicidal behaviors (Cain, 2002; Crosby & Sacks, 2002; Cleiren & Diekstra, 1995; Kneiper, 1999; Pirelli & Jeglic, 2009).

Hauser (1987) provided several explanations for why the grief response in a suicide survivor may result in unresolved or complicated outcomes: 1) suicide deaths are most often sudden or unexpected, 2) death by suicide is frequently violent in nature eliciting a strong emotional response from the survivor, 3) suicide heightens the guilt response, 4) suicide death may occur where multiple stressors already exist, 5) suicide deaths compromise the traditional mourning rituals as a result of stigmatization, 6) suicide deaths may result in unhealthy expressions of anger because of feeling rejected leading to dysfunctional communications patterns among survivors; and 7) normal social supports may be withheld or unavailable. How suicide grief is experienced over time may be associated with individual variables, social support systems and networks, and community beliefs (Rudestam, 1992). Therefore, the interaction of individual characteristics, social support, and community beliefs contribute to grief outcomes.

The hallmarks of complicated grief emerge when an individual “gets stuck” at one particular phase in the grieving process. Within the course of grieving a lack of movement may indicate the grieving person is approaching stability. Prigerson et al. (1995) developed a tool to define 19 symptoms of complicated grief grouped into four categories: thought processes, feelings, behaviors, and relationship to others. The ICG was used in recent studies to measure aspects of complicated grief in suicide survivors (Mitchell, Kim, Prigerson, & Mortimer-

Stephens, 2004; Feigelman et al., 2009; Feigelman et al., 2008-2009). The literature suggested that suicide survivors are at risk of difficulties associated with complicated grief especially when the bereaved has a close familial or social relationship with the deceased. Such grief complications include physical and mental health problems as well as suicidal ideations.

Recent literature points to factors in the grief experience of the suicide survivor and suggests a higher risk of unresolved or complicated grief (Bailey et al., 1999; Cerel et al., 2008; Cvinar, 2005; Dunn & Morrish, 1987-88; Dyregrov et al., 2003; Grad, Clark, Dyregrov, & Andriessen, 2004; Hauser, 1987; Jordan & McMenamy, 2004; Keesee, Currier, & Neimeyer, 2008; Knieper, 1999; Lindqvist et al., 2008; Melhem et al., 2003; Mitchell, Gale, Garand, & Wesner, 2003; Pompili et al., 2008; Reed, 1998; Rudestam, 1992; Van-Dongen, 1993). The literature pointed to three problematic areas in suicide grief: 1) themes surrounding the suicide, 2) social dynamics, and 3) family processes. Although, the thematic content of suicide grief was different, these differences also exposed the survivor to vulnerability toward unresolved or complicated grief. Suicide survivors seem to suffer more with questions of “why?”; For example, why did they kill themselves?, Why did I not see this coming?, Why didn’t I do something?, and How could they do this to me? (Begley & Quayle, 2007; Dunn & Morrish-Vidner, 1987-1988; Jordan, 2001). An exploratory study of the psychological and social experiences of 24 suicide survivors revealed that participants spent significant time and energy trying to construct and explain the suicide (Dunn & Morrish-Vidner, 1987-1988). Participants were able to point to individual characteristics of the suicide victim (i.e., personal problems) that provided a clue, but they were unable to understand why the suicide victim chose self-destruction as the course of action. The suicide survivor is often left to speculate about the thought processes of the suicide victim prior to the suicide act.

In one recent study participants struggled with a deep sense of personal blame and guilt for not preventing the suicide (Begley & Quayle, 2007). According to Melhem et al. (2003) who studied 146 suicide survivors using regression analysis, feeling that the suicide survivor could have somehow prevented the suicide was associated with complicated grief. Fielden (2003), using a Heideggerian phenomenological approach to studying the lived experience of six adult suicide survivors (i.e., four mothers, one father, one sister) found blame to be a result of stigmatization. The findings produced a grief model explaining how suicide survivors moved through several stages to arrive at transformation and discovery of new ways of living in the world without their loved one.

A death from any means places survivors in a period of crisis during a time when social processes and external resources play critical roles in the process of bereavement. This is especially true for suicide survivors as they attempt to absorb the loss and call upon social support resources during various stages of grief and mourning. It is during the initial phase of loss when suicide survivors use the most social support (Hoff, 2001). The use of social processes has the potential for profound consequences for those bereaved by a suicide death (Callahan, 2000; Cerel et al., 2008; Cvinar, 2005; Dunn & Morris-Vidners, 1987-1988; Lindqvist et al., 2008; Murphy, Johnson, Lohan, & Tapper, 2002; Redd, 1998; Seguin et al., 1995; Stylianos & Vachon, 1991; Thompson & Range, 1991; Van Dongen, 1993). Social support during the acute grief period and beyond represents the difference between a healthy adaptation or a life plagued by the experience of this tragic act. These social resources and support systems include community resources, professional health and mental services, faith based opportunities, and friends and family connections.

Social dynamics after a suicide play a role in marginalizing suicide survivors and placing them at risk of a complicated grief response. Within this context, considerable evidence demonstrates that isolation, stigmatization, and self-stigmatization contribute to this phenomenon (Calhoun & Allen, 1991; Cvinar, 2005; Dunn & Morrish-Vidner, 1987-1988; Feigelman et al., 2009; Jordan, 2001; Laasko & Paunonen-Ilmonen, 2002; McIntosh, 2003). Stigmatization has been associated with grief difficulties much like homicidal or accidental death (Feigelman et al., 2008-2009). Prigerson et al. (1995) identified a lack of trust in others as a symptom of complicated grief. In a 2002 investigation of mothers bereaved by the death of a child, participants indicated that those who were close to them were a major source of support (Laasko & Panonen-Ilmonen, 2002). Mothers wanted to talk about the experience and desired that others listen and genuinely care. Conversely, those experiencing the most grief difficulties were those who perceived negative attitudes from others. Cerel et al. (2008) identified that survivors of individuals who die of natural death received more emotional support than suicide survivors. This is consistent with the lived experience of adults bereaved by suicide as they described their need for support. They felt let down by those around them (Begley & Quayles, 2007). The expectations of social support were perceived as inadequate and participants felt neighbors, friends, and the community were uncomfortable in their presence. In turn, participants avoided social interaction and isolated themselves from others. This behavior may have led to further feelings of self-stigmatization. Many studies attributed self-stigmatization to feelings of shame and guilt (Fielden, 2003; McIntosh, 1993; Reed, 1993; Van Dongen, 1993). Feigelman et al. (2008-2009) described isolation and stigmatization as contributing factors to grief difficulties among suicide survivors. In one study self-isolation was the single best predictor of psychosocial distress among suicide, SIDS, and accident death survivors (Dyregrov et al., 2003).

In addition, stigmatization was attributed to depression and suicidal thinking in suicide survivors, as well as other survivors of traumatic deaths such as accidents and homicides (Feigelman et al., 2009; Feigelman et al., 2008-2009; Murphy, Tapper, Johnson, & Lohan, 2003).

Family processes have also been found to play a role in the development of complicated grief. Feigelman et al. (2008-2009) revealed that parents who admitted a strained relationship with the deceased or who endured up to three suicide attempts by the victim experienced more grief difficulty. Mitchell et al. (2004) identified that a close relationship to the deceased also predisposed the suicide survivor to symptoms of complicated grief. Close relatives experienced twice the level of complicated grief than distant relatives. Sixty-seven percent of parents met the criteria for complicated grief. Therefore, the perceived functionality of the relationship was correlated to the participants' ability to grieve. Bowlby and Ainsworth in their recognized work with attachment theory revolutionized thinking about children's connections to their mothers and the disturbance that results from separation, deprivation, and bereavement (Bretherton, 1992). Many of Bowlby's conclusions were grounded in empirical evidence that mentally healthy children experience a warm, intimate, and continuous relationship with the mother or mother figure in which both parties find satisfaction and enjoyment. For example, Dyregrov et al. (2003) identified the mothering relationship as the most critical predictor of complicated grief after a suicide. Furthermore, these results were consistent with studies describing higher levels of grief characterized by loss, guilt, and psychological stress compared to fathers (Bohannon, 1990; Schwab, 1996).

Begley and Quayle (2007) described adult suicide survivors who chose not to give up their attachments to the deceased, even believing that the suicide victim still played a continuing role in the family. According to investigators who used the ICG, this type of relationship with

the deceased may be indicative of a complicated grief response (Prigerson et al., 1995). Mitchell et al. (2004) proposed that more studies are needed to explore the grief responses of suicide survivors based on their relationship to the deceased. This is consistent with the lack of studies in the literature speaking to the experiences of mothers following the suicide death of a child.

Suicide Survivors Speak Out

Was Do Erlebst, kann keine Macht der Welt Dir rauben (What you have experienced, no power on earth can take from you. -----Viktor E. Frankl

Numerous books are filled with testimonials written by suicide survivors. For many of the survivors, the primary focus was to describe and explain the reaction of the suicide survivor and provide information to assist the suicide bereaved. Suicide survivors are willing to speak out on the experience of losing a loved one to suicide (Biebel & Foster, 2005; Bolton, 1998; Chilstrom, 1993; Diedrich & Warelow, 2002; Fine, 1997; Hsu, 2002; Myers & Fine, 2006; Robinson, 2001; Simon, 2003). Biebel and Foster (2005) described the experience of being a suicide survivor as “an exclusive club I joined without wanting to” (p. 13). Survivors of suicide described the loss as one with long-term emotional, physical, spiritual, psychological, and social implications (Biebel & Foster, 2005; Bolton, 1998; Chilstrom, 1993; Diedrich & Warelow, 2002; Fine, 1997; Hsu, 2002; Myers & Fine, 2006; Robinson, 2001; Simon, 2003). Carla Fine understands the impact of suicide well. After 21 years of marriage, Fine’s husband killed himself on December 16, 1989 (Fine, 1997). She described the experience as shattering; “You think that you have lost your mind, that you’re crazy, that you won’t be able to live through the next hour, let alone the rest of your life” (Myers & Fine, 2005, p. 9). For many, this disorganization and turmoil translated into a journey of uncertainty and confusion. Wolfelt (2009) described this as “going into the wilderness” (p. 23). For the suicide survivor, the

“wilderness” means learning to persevere and maneuver through life in the midst of psychological and social barriers. These barriers present in the form of emotional upheaval such as anger, shock, shame, blame, and guilt (Biebel & Foster, 2005; Bolton, 1998; Chilstrom, 1993; Diedrich & Warelow, 2002; Fine, 1997; Hsu, 2002; Myers & Fine, 2006; Robinson, 2001; Simon, 2003). Answering the unanswerable questions becomes a perpetual journey.

As noted earlier, suicide survivors have also spoken about the stigma associated with suicide; stigma that subsequently results in social isolation. This isolation often prevented the survivor from receiving necessary support (Biebel & Foster, 2005; Bolton, 1998; Chilstrom, 1993; Diedrich & Warelow, 2002; Fine, 1997; Hsu, 2002; Myers & Fine, 2006; Robinson, 2001; Simon, 2003). Suicide survivors described the stigmatization as devastating to relationships and role identity. For example, suicide survivors were tempted to avoid, misrepresent, or lie about the circumstances surrounding the suicide death of a family member to eliminate the need to defend or explain the actions of the deceased. Fine (1997) described her temptation to tell friends and family the death of her husband was the result of a heart condition. One mother, Angie, experienced the suicide death of her 21-year-old daughter following a visit with her boyfriend. Although ruled unintentional because there was no evidence of depression, suicidal ideations, or clues, Angie’s pastor waited over a month after the funeral to visit stating he had trouble dealing with death. Angie’s own son, a Protestant minister, sent a letter refusing to absolve her; He stated; “You’ll have to accept that she’s probably in hell” (Biebel & Foster, 2005, p. 80).

Through personal, firsthand accounts of living after the suicide death of a loved one, suicide survivors stated their impetus for writing about their experience was to provide help and hope to others and healing for themselves (Biebel & Foster, 2005; Bolton, 1998; Chilstrom, 1993;

Diedrich & Warelow, 2002; Fine, 1997; Hsu, 2002; Myers & Fine, 2006; Robinson, 2001; Simon, 2003). Suicide survivors acknowledged that grief is individual and individuals grieve in their way and on different timetables.

The Emotional Eruption

*Suicide carries in its aftermath a level of confusion and devastation
that is, for the most part, beyond description.*

-----Dr. Kay Redfield Jamison (1999)

Following the suicide death of a loved one, Biebel and Foster (2005) described the emotional landscape as a “wasteland” (p. 21). As early as 1977 Rudestam described the use of a psychological autopsy as a method of inquiry. He suggested individual suicide survivors were at risk for severe and enduring emotional reactions. The suicide survivor experiences emotional turmoil; life has not prepared the suicide survivor for the future. Some described the experience as life-splitting: before the suicide and after the suicide (Hsu, 2002; Myers & Fine, 2006). After the suicide death of her husband, Harry Reiss, in 1987, Carla Fine called it a “frozen before and a permanent after” (Myers & Fine, 2006, p. 2). According to Fine the event transformed her and she would never be the same. Everything that had been familiar was no longer familiar; the methods used to handle life’s tribulations were no longer sufficient. Hsu (2002) stated the suicide death of his father in 1998 bisected his life “with a thick black line” (p. 20). Within a period of 24 hours, his mother was now a widow and he was without a father.

Suicide survivors attempt to find the analogy that will best describe to others the emotional eruption that occurs after a suicide death (Biebel & Foster, 2005; Cox & Arrington, 2003; Hsu, 2002; Myers & Fine, 2006). Myers and Fine (2006) expressed the difficulty in this task when they said; “How do you explain the inexplicable? Make sense of what seems senseless?”

Speak about the unspeakable?” (p. 1). Suicide survivors attempted to express to others what they could not understand themselves. Myers and Fine (2006) described the event as devastating. This mirrored the description of another suicide survivor, David Cox, who said “an earthquake rocked my world” (Cox & Arrington, 2003, p.1). The event completely destroyed his reality, crumbling his immediate foundation, and sending aftershocks into his future. Similarly, another suicide survivor described her experience stating, “My world went black. I felt ice-cold” (Weber, 1999, p. 7). Yet another described the experience as being hit by a wrecking ball wondering if there was even a chance of survival (Biebel & Foster, 2005). Diedrich and Warelow (2002) described it as an “emotional rollercoaster ride full of unending pain and intense suffering” (p. 170). All these experiences illustrate a backdrop of pure destruction, desolation, and emotional bankruptcy. One event halted the past, collapsed the present, and ensured a changed future while leaving suicide survivors without the emotional equity to deal with the aftermath.

According to the literature, one common thread among all suicide survivors was the overflowing of emotions following the suicide (Begley & Quayles, 2007; Biebel & Foster, 2005; Bolton, 1998; Chilstrom, 1993; Diedrich & Warelow, 2002; Dunn & Morrish-Vidners, 1987-1988; Fielden, 2003; Fine, 1997; Hsu, 2002; Lindqvist et al., 2008; Myers & Fine, 2006; Robinson, 2001; Simon, 2003). Myers and Fine (2006) stated the beginning of this emotional journey can be as long as the 3 years following the death. The literature described the emotional aftermath of suicide survivors with several common emotional responses: shock, fear, guilt, anger, depression, rejection, and emotional lability. Diedrich and Warelow (2002) described such emotional turmoil as resulting in a sense of hopelessness, helplessness, and worthlessness

leading to immobilization. The suicide survivor is unable to take the appropriate action to work through such a psychological crisis.

Shock

Days, weeks, and even months after a suicide, survivors reported an emotional shock reaction (Biebel & Foster, 2005; Cox & Arrington, 2003; Dunn & Morrish-Vidner, 1987-1988; Fielden, 2003; Hsu, 2002; Myers & Fine, 2006; Rudestam, 1977; Van Dongen, 1993; Weber, 1999). At varying levels of intensity, survivors experienced episodes of numbness, disorientation, disorganization, forgetfulness, a decline in focus, and indecision. Suicide survivors described themselves as out of control, even fearing and doubting that they would survive (Dunn & Morrish-Vidners, 1987-1988; Fielden, 2003). Their goal was to exist day-to-day. Such inner chaos plunged suicide survivors into a state of confusion and helplessness (Dunn & Morrish-Vidners, 1987-1988). There was the inability to process and respond to the outside world and its demands.

In one qualitative study of suicide survivors, investigators described emotions in the context of controlling the impact of the suicide (Begley & Quayles, 2007). Controlling the impact of the suicide resulted in feelings of numbness and loss of control. The participants described the need to either serve as “protector” or “peacemaker” even in the midst of numbness or fear (p. 29).

Fear

Many studies indicated that the threat of fear arises from the feeling that another suicide might occur within the family (Begley & Quayles, 2007; Fielden, 2003; Fine, 1997). One parent of an adolescent teen grounded her son prior to the teen’s suicide; he went to his room and completed suicide. Feelings of guilt gave rise to an intense feeling of fear and changed how she

interacted with her other children (Fielden, 2003). This type of reaction has the potential to interrupt healthy family processes, leaving the family vulnerable to dysfunctional communication patterns. In one study, investigators described survivors going as far as developing protective strategies such as waking up each hour during the night to check on the other children out of fear for their safety (Begley & Quayle, 2007). Not only was there a fear of leaving other family members alone, but Rudestam (1977) found that one common reaction among suicide survivors was an overwhelming fear of being left alone.

Dyrgrov et al. (2003) identified that many survivors experience posttraumatic stress reactions after the suicide such as memory loss, intrusive voices, and visions of the deceased. As a result, suicide survivors became fearful to the extent that they deliberately withdrew from others at a time when the social network is critical to managing grief. Fielden (2003) identified through the exploration and interpretation of the lived experience of suicide survivors that a fear of not surviving the experience was linked with an intense range of emotions as well as sensory disturbances.

Guilt

Guilt has been described in the literature to be unique to the suicide survivorship experience (Pompili et al., 2008). Researchers acknowledged that suicide survivors face many of the same emotions as others who mourn and grieve the loss of a loved one. Emotions found to be particularly painful and intense among suicide survivors, however, are guilt and anger. Biebel and Foster (2005) called guilt “the blight of broken hearts” (p. 35). Although viewed as a common denominator in the midst of profound loss, guilt for the suicide survivor resulted from an intense responsibility for the suicide victim that the survivor should have predicted and prevented the suicide.

Parental guilt may be especially difficult. As a parent entrusted with the wellbeing of a child, guilt emerges from the conviction that not enough was done to protect the child (Begley & Quayle, 2007; Biebel & Foster, 2005). In a mixed method study by Dyrgeov et al. (2003), the best predictor of impaired psychosocial health was social isolation of the suicide survivor. In this same study, parents described feelings of guilt as the common explanation for withdrawing from others. Thus a feeling guilt results in a smaller social network.

Suicide survivors tried to go back in time and predict a different outcome as they attempted to manage feelings of guilt, If only....; What if..... (Begley & Quayle, 2007; Biebel & Foster, 2005; Lindqvist et al., 2008). In a grounded theory approach, Lindqvist et al., (2008) identified “why?” as a salient theme. Open interviews with 10 families revealed eight cases in which members tried to understand the why of the suicide when suicide came unexpectedly or no problems were identified. Guilt also emerged when suicide survivors realized they had not thought of their loved one for a day or even a week (Fielden, 2003). Robinson (1989) and Wroblewski (1991) referred to this experience as recovery guilt.

In contrast, self-blame seemed to be connected with guilt in the sense that the survivor had done something to cause the suicide (Dunn & Morrish-Vidner, 1987-1988). A poem by Ginger Bethke following the July 27 1994, suicide death of her 22 year old son, Todd, describes the emotional element of guilt and emerging emotions:

If only we could have just one more chance;

If only we hadn't lost this one.

What if we could go back in time?

If only we could have saved him.

If only we had fully known his pain;

If only we could begin again.

What if we had a little more time?

If only we had known before.

If only we could have read his mind;

If only we could have eased his pain.

What if he could begin again?

If only we could change the past.

If only we could hug him close,

If only just one more time.

What if we could truly live again?

If only for just a little while.

If only we could forgive ourselves;

If only we could make amends.

What if we were given that chance?

If only we could do it again.

(Biebel & Foster, 2005, p. 34)

Anger

Anger was also a common theme among those bereaved by suicide (Cerel et al.,1999; Dunn & Morrish-Vidner, 1987-1988; Fielden, 2003; Lindqvist et al., 2008). In a longitudinal

study by Cerel et al. (1999), children bereaved by suicide were found to experience anxiety, anger, and shame compared to children bereaved by other forms of death. From the aforementioned studies, open interviews with the parents of suicide victims revealed anger expressed at feeling deceived by the suicide victim thus denying them the opportunity to intervene in the crisis prior to the suicide. Subsequently, the anger was mixed with remorse at feeling such disdain for someone who felt despair to the degree that suicide was the only option. The ambivalence was salient throughout the literature.

One variation of anger was directed at mental health care professionals (Fielden, 2003). Suicide survivors described examples of when they were denied information about their loved one prior to the suicide. They felt they received useless information and the interpretation of the Health Information Privacy Act (HIPPA) contributed to the suicide survivors' inability to help the suicide victim.

Stigma, Blame, and Social Support

Recent literature pointed to social support as an influential component to the grief work for suicide survivors (Begley & Quayle, 2007; Cerel et al., 2008; Cvinar, 2005; Dunn & Morrish-Vidners, 1987-88; Dyregrov, 2002; Dyregrov et al., 2003; Ellenbogen & Gratton, 2001; Fielden, 2003; Jordan, 2001; Laakso & Paunonen-Ilmonen, 2002; Lindquist et al., 2008; Seguin et al., 1995; Van Dongen, 1993). This investigator selected a broad definition of social support. Social support (social resources) in this study refers to all external human connections lay, professional, and religious including human resources available to the individual following the death of a loved one that provided the suicide survivor care associated with the suicide death.

According to Dunn and Morrish-Vidners (1987-1988) suicide survivors face difficulty with social adjustment. In their exploratory study of 24 individuals bereaved by suicide, all

reported some form of social support from others. However, most participants expressed that they rarely received the type of support that was genuinely needed during the time of loss. Similarly, Lindqvist et al. (2008) identified that much of the postsuicide support provided to family members was insufficient and came at an inopportune time. Other studies suggested any level of social support following any type of death was a critical factor in the determination of grief outcomes for the bereaved. These effects are more distinct after a suicide (Callahan, 2000; Seguin et al., 1995; Thompson & Range, 1991).

The literature spoke to the disparity between the degree of social support and the suicide survivor's perception of social support. This disconnect was associated with the concepts of stigma, shame, blame, avoidance, isolation, and feelings of rejection. These concepts were identified with the denial of suicide survivors' full benefit of the social support required to properly grieve the loss. In a comparative study of 140 families that examined predictors of psychosocial distress after suicide, SIDS, and accidents, self-isolation was found to be the best predictor of psychosocial distress among all three groups (Dyregrov et al., 2003). Although suicide survivors were not the main focus of the study, evidence supported the need for social support during periods of traumatic grief.

Stigma

The term, stigma, was mentioned often in the literature in association to social support (Begley & Quayle, 2007; Cerel et al., 2008; Cvinar, 2005; Dunn & Morrish-Vidners, 1987-1988; Feigelman et al., 2009; Fielden, 2003; Grad et al., 2004; Jordan, 2001; Laakso & Paunnonen-Ilmonen, 2002;; Knieper, 1999; Reed, 1998; Van Dongen, 1993). Worden (1991) in *Grief Counseling and Grief Therapy* suggested that in today's society stigma surrounds suicide. He indicated that stigma precipitates an intense experience of shame for survivors. Similarly, Ness

and Pfeffer (1990) highlighted issues of stigma through reports of isolation and blame by community members of survivors. Several reports in the literature identified suicide survivors as survivors possessing more feelings of shame and needed professional mental health services (Allen, Calhoun, Cann, & Tedeschi, 1993; Calhoun & Allen, 1991; Stillion, 1996).

Breaking the Silence

Death by suicide is not a gentle deathbed gathering;

it rips apart lives and beliefs, and it sets its survivors on a prolonged and devastating journey.

-----Dr. Kay Redfield Jamison (1999)

Although recent history identifies suicide survivors' willingness to speak out about the pain and suffering over the last 20 years, breaking the silence about suicide began from a more scientific, sociological perspective. Emile Durkheim (1951) along with Louis I. Dublin and Bessie Bunzel (1933) contributed significantly to the body of knowledge about suicide for much of the 19th and 20th centuries. Their sociological explanations of suicide provided a backdrop by which to understand the phenomenon in connection to the human landscape of the time.

Although still a taboo subject, their work broke new ground and provided a foundation of work geared toward understanding suicide and its impact on individuals, families, and communities.

Karl A. Menninger (1893-1990), renowned American psychiatrist and founder of the Menninger Foundation, took on the challenge with his 1938 publication *Man Against Himself*. Menninger attempted to break the silence toward suicide by dismantling the act of suicide and placing it within the context of behaviors and psychological processes. Menninger dissected suicide recognizing the presence of internal and external forces at work in the suicidal mind. The final outcome was the development of clinical and social techniques that would move the individual

from self-destruction to what Menninger referred to as “self-reconstruction” (1938, p. 367). These early contributions provided a foundation for understanding suicide and its aftermath.

Toward Suicide Prevention

When individuals make the decision to voluntarily end their lives, it is not the end. This one single act leaves a legacy felt for generations by those left behind. Over the past 35 years suicide survivorship has received considerable attention in psychiatry, psychology, social work, medicine, sociology, and nursing. Edwin S. Shneidman (1918-2009), renowned American suicidologist, thanatologist, and founder of the AAS, was a major catalyst for the study of suicide and its prevention (Shneidman, 1969; Shneidman, 1980; Shneidman, 1981; Shneidman, 2001). Shneidman coined the term “psychache” referring to the pain felt by the suicidal client. Edwin S. Shneidman died on May 18, 2009, at the age of 91. His robust body of knowledge paved the way for today’s research in suicide and suicide prevention. Shneidman (2001) described the relationship between suicide and those left behind this way:

I believe that the person who commits suicide puts his psychological skeleton in the survivor’s emotional closet- he sentences the survivor to deal with many negative feelings and, more, to become obsessed with thoughts regarding his own actual or possible role in having precipitated the suicidal act or having failed to abort it. It can be a heavy load (p. 154).

In the 20th century mental health professionals from all over the globe realized the long term impact that suicide has on those left behind. Cain (1972) in his book *Survivors of Suicide* identified the unique experience of the suicide survivor and the long-term influence suicide has on this segment of the population. Not only did Cain coin the term suicide survivor to describe those left to grieve a suicide death, he suggests suicide deaths create a unique form of anguish for

the bereaved. As the suicide victims try to stop their own pain and suffering, the pain does not end with the suicide, but rather re-emerges in the lives of those left to experience the aftermath.

Current Issues

The 21st century had brought with it a multitude of challenges. As a result of communication technology, computer technology, and social networking, citizens have become more global and exposed to more news and world events. Suicide survivors face even more challenges as suicide acts are broadcast to a much larger audience and reality shows are the mecca of entertainment. In addition, world events, civil unrest, war, and the threat of war provide a backdrop of uncertainty for troops living under a shadow of stress while defending our country.

Suicide and the Media

Death by one's own hand, is commonly a newsworthy event. It challenges attitudes about life and events leading up to such a course of action. William Farr, an 18th century pioneer in the field of vital statistics, wrote "Why should cases of suicide be recorded at length in the public papers any more than cases of fever?" (Dunne-Maxim, 1987, p. 45). Whether media portrayals of suicide lead to negative societal implications has been long debated. A previously noted, 18th century Europe focused concern for imitative or copycat suicides or the "Werther effect" led to the banning of Goethe's novel entitled *The Sorrows of Young Werther* (Goldney, 2001). According to Pirkis and Blood (2001) until the 1960s the assumption that media reporting of suicide could produce detrimental consequences for vulnerable populations was based solely on speculation with no empirical evidence. In 1978 two British researchers petitioned Parliament to pass legislation to prohibit the practice of reporting suicides in the local newspapers because of the psychological distress it placed on survivors (Dunne-Maxim, 1987).

The two researchers explained that media reporting of suicides was a leftover remnant of medieval times when suicides were and the survivors were publicly punished for the crime of the victim.

Although dialogue concerning the issues surrounding suicide and the media's coverage of it provides an effective backdrop providing global awareness, the true test of change must come at the community level where citizens within the community are directly affected. As a result of personal exploration and interviews within a community in Tennessee, suicide and the guidelines for reporting are seen as little more than recommendations that fills the policy manuals. In a telephone interview with Rusty Pabst (personal communication, April 14, 2006), a journalist for the Knoxville News Sentinel in Knoxville, Tennessee, he admitted that suicide is newsworthy. Although newsworthy, most of the coverage focuses on suicides of public figures, celebrities, and murder-suicides. He acknowledged that the Knoxville News Sentinel has written policies for suicide reporting but declined to give specifics citing the policy is for internal use only. He went on to say that the most newsworthy are those that occur in a public place. He stated if it affects the community, it should be reported regardless of his own personal views about the matter.

Martha Dooley, Public Information Officer for the Knox County Police Department Knoxville, Tennessee, in conjunction with Chief Deputy Tom Spangler (personal communication, April 18, 2006) state that although they are not obligated to report to the media, providing correct information is important to the department. They contended that the way the reporting is handled depends on the experience of the officer assigned to report. Officer Bobby Horner (personal communication, April 12, 2006) of the Knox County Police department reported the police have a "love-hate" relationship with the media. Although the media provides an

invaluable service to the community and its citizens, it can be a source of sensationalism.

According to Officer Horner the news media believes; “If it bleeds it leads.” The news media is mainly concerned with reporting the story accurately and quickly.

As law enforcement and the news media debate the ethical implications of suicide reporting, families are further traumatized by the death of a loved one that may be reported publicly. This exposure only serves to deepen the trauma for suicide survivors as they risk exposure to the stigmatization that so often accompanies a suicide death.

Suicide and the Military

Military service and the impact of suicide on military troops and their significant others deserve special consideration as the stress on men and women during service to their country and the psychological consequences following their tour of duty places this population at risk of suicide. During the 1990s a comprehensive analysis of suicide in the US military suggested rates were actually lower compared to the civilian population (Sentell & Lacroix, 1997; Shaffer, 1998; Rothberg, Bartone, Holloway, & Marlowe, 1990). However, according to Bryan, Kanzler, Durham, West, and Greene (2010) the suicide rate of military service members and veterans has increased in recent years. This increase is a much greater concern as civil unrest globally becomes more prevalent. Deployment settings are of special concern because of identified suicide rates among military personnel. According to Gahm and Reger (2009), 30% of Army suicides and 17% of Marine suicides occurred during active deployment. For June 2010 Insel (2010) reported 32 suspected Army suicides, which was a record high. In addition to the legitimate concern for active military troops, research suggested an increase in suicide rates, attempts, and ideations among American veterans of the Vietnam War (Bullman & Kang, 1996;

Drescher, Rosen, Burling, & Foy, 2003; Hendin & Haas, 1991; Kramer, Lindy, Green, Grace, & Leonard, 1994).

Krysinska, Lester, and Martin (2009) point to several factors that place military personnel at risk for suicide behaviors both during active service and after deployment including: posttraumatic stress disorder (PTSD), substance abuse, depression, schizophrenia, and schizoaffective disorder. In addition, the severity of war trauma, guilt related to combat, poor physical health, and absence of adequate social support play critical roles in the risk for suicide mortality. In fact, Wieland, Hursey, and Delgado (2010) contended the psychological consequences of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) were high. They pointed to the level of combat exposure as a predictor of mental disorders. Consequently, according to Kuehn (2009) the suicide rate of US soldiers on active duty reached a 28-year high in 2008. As a result the Army, in conjunction with the NIMH launched the Army Study to Assess Risk and Resilience in Service Members (Army STARRS) in late 2008 (Insel, 2010). Although the military has recognized the need for screening and proactive initiatives to prevent the loss of life to suicide (Kuehn, 2008), suicide survivors must deal with not only the stress and consequences associated with the deployment and return of a loved one from the military but also the added burden of suicide grief.

The challenge for mental health professionals and military leadership charged with the welfare of US troops is how to most effectively address suicide concerns during active deployment in combat zones and beyond (Bryan, et al., 2010). The stigma associated with suicide makes it difficult to identify those at risk for self-harm and provide preventive interventions. The central focus has been to decrease destigmatizing behaviors such as seeking

help, peer recognition, and direct confrontation (Allen, Cross, & Swanner, 2005). Training for chaplains and counselors has also been a consideration.

As the number of actively deployed military and veterans rise, suicide becomes a critical concern. Family and loved ones, already experiencing the stress of possibly losing a family member to combat related deaths, are now faced with an added worry of the psychological stress of war taking lives of their loved ones.

Suicide and Bullying

In society today technology has resulted in the reception and transmission of information at rapid speeds. Harassment and bullying are no longer activities confined to face-to-face confrontation, mail, or phone calls. With the wide use of e-mail and social networks, cyberbullying has created a unique challenge for mental health professionals. Megan Taylor Meier, an American teenager from Dardenne Prairie, Missouri completed suicide on October 17, 2006, just shy of her 14th birthday as a result of cyberbullying through the social network, MySpace (Megan Meier Foundation, 2010). This tragedy resulted from cyberbullying by a 47-year-old woman posing as a teenage boy. Megan's mother Tina Meier talks about the struggle to protect her daughter from this type of psychological trauma in the fast paced world of communication technology while allowing her daughter to network with friends. CBS: The Early Show (2010) reported the suicide death of Alexis Pilkington, a 17-year-old from Long Island, New York after taunts and harassments on a social network called FormSpringMe.com. According to her parents the harassment continued after her death through postings on a memorial site established on Pilkington's behalf. Rutgers University freshman, Tyler Clementi, ended his life on September 22, 2010, after a video was posted on the social network site, Facebook, revealing a sexual encounter between Clementi and another male (Fox News, 2010).

As a result, 18 year-old Clementi posted on Facebook the plan to end his life by jumping off a bridge. Through the use of such public networking, there is potential for harassment and bullying in addition to multiplying the trauma for those exposed to these suicide deaths as they occur and short after.

Summary

This chapter provided an extensive literature review on the history of death, dying, suicide, and suicide survivorship. In addition, research findings were presented exposing gaps in the literature on mothers as suicide survivors. Suicide has existed since recorded history. It is a behavior that has been both condemned and praised over time and culture. The meaning of suicide will always extend far beyond the boundaries of those completing the act. Suicide has personal meaning for those contemplating it as well as those left to cope with the loss. For mothers this means living with the reality that their children chose to end their lives.

CHAPTER 3

METHODOLOGY

In this chapter the investigator describes the approach to answer: What is the lived experience of mothers following the suicide death of a child? A concise history of the qualitative tradition of inquiry and the basic tenets unique to the naturalistic paradigm are presented. Terms relevant to the understanding of the study and topic of interest are defined. The investigator's own experiences as a suicide survivor are presented to account for underlying assumptions and bias.

Historical Context

Phenomenology emerged toward the close of the 19th century as a response to science's inability to answer questions framed from a positivistic perspective (Sadala & Adorno, 2001). Western philosophy recognized Immanuel Kant (1724-1804) as the first to coin the term, "phenomenology" (Pollio, Henley, & Thompson, 1997). The term phenomenology derived from the Greek word *phaino* meaning "to appear" (Priest, 2002). Edmund Husserl (1859-1938), a German philosopher, is regarded as the primary supporter and founder of phenomenology at a time when scientific inquiry was associated with positivist methods (Valle, King, & Halling, 1997). Danish philosopher Soren Kierkegaard (1813-1855) founded the school of existentialism around the same time. Existentialists believed it was essential for philosophy to address and contribute to the body of knowledge regarding individual human existence through emerging themes consistent with human struggles (Valle et al., 1997). The existentialist regards "existence" as its central theme; it is the way in which a person experiences "being in the world" (Friedman, 1964). Phenomenology became the method most existentialists used to examine the experience of "being in the world".

The emergence of existential tenets and phenomenology provided a philosophical approach to understand the “essence, structure, or form of both the human experience and human behavior as revealed through essentially descriptive techniques including descriptive reflection” (Valle et al., 1997, p. 6). A student of Husserl and drawing from the philosophy of Kierkegaard, Martin Heidegger (1889-1976) was one of the first to combine existential thought and the methodology of phenomenology into an approach referred to today as existential phenomenology (Valle et al., 1997). Existential phenomenology emerged from the common need to understand the human experience within the context of the world and everyday life. The human experience is not a result of the events within the mind or Cartesian mind-body dualism paradigm, but rather a relationship between human beings and their world as it is lived and described, but not explained (Pollio et al., 1997).

Maurice Merleau-Ponty, a French philosopher and contemporary of Husserl, Sartre, and Heidegger, embraced existential phenomenology with the aim to describe the human experience from the unique perspective of the participants and in their own way (Thomas & Pollio, 2002). Thomas (2005) suggested Merleau-Ponty’s military experience in the French army during World War II resulted in suffering, torture, and imprisonment influenced his desire to explore the human experience within the context of world events. The work and influence of Merleau-Ponty led to studying the whole person as “being in the world”, also referred to as embodiment (Merleau-Ponty, 1962). Simply, human action and human experience should be studied in the unity of the mind, body, and world.

Qualitative Inquiry

To understand the experiences of mothers as suicide survivors and contribute to the body of knowledge regarding this topic, the investigator selected the phenomenological approach for

this research. Qualitative research through a phenomenological lens provides rich, detailed information with the potential to illuminate various dimensions of a complex phenomenon (Pollio et al.,1997; Sokolowski, 2008; Valle et al.,1997). Rich data are derived from the viewpoint of the participant (Patton, 2002). Such data assist in a deeper understanding of a phenomenon related to a social situation, group, encounter, social role, group membership, or event where little is known and more understanding is warranted (Creswell, 2003).

Within the qualitative paradigm, the investigator uses methods to examine and understand human experience (Sokolowski, 2008). This captures information using procedures that are flexible, thus allowing the investigator to inductively derive information during the research process.

Methodological Approach

According to Lincoln and Guba (1985) qualitative studies require a deliberate desire to understand a phenomenon from the viewpoint of those most affected by it. This investigator employed a phenomenological approach to examine the experiences of mothers following the suicide death of a child. A European naturalist, Jakob von Uexkull (1934-1957), in his monograph *A Stroll through the Worlds of Animals and Men* described the phenomenal (self) world of each individual living within a bubble (Pollio, Henley, & Thompson, 1997). Whether animal or human, the bubble around each living being represents a unique perception. He posited that all creatures, including human beings, should be viewed not as machine-like objects but as one with a unique perspective about the world (Pollio et al., 1997). William James wrote about the “uniqueness of the human perception” (Pollio et al., 1997, p. 3). He made his point by describing the experience of four Americans on their travels to Europe. Each tourist described

the experience from diverse viewpoints based on each individual's exclusive experience. Each person focused on the aspects of the experience that had personal meaning.

Van Manen (1990) provided a methodological approach to understand the lifeworld of others. He described and grounded the lived experience of others through four fundamental existentials: spatiality, corporeality, temporality, and relationality. To know the world, van Manen (1990) posited that one must be in the world; he refers to this as intentionality. The intentional act of attaching the self to the world is the very core of phenomenological inquiry.

Existential Phenomenology Tenets

Existential phenomenology places the human experience at the center of research. The basic tenets of existential phenomenology provide a framework for inquiry. Reduction, intentionality, and figure and ground are three essential tenets.

Reduction

Husserl (1859-1938) sets forth an assumption that existential phenomenology aims to view phenomena from a different vantage point from those adopted by researchers, which is often referred to as the "natural attitude" independent of perception (Valle et al., 1997, p. 10). In contrast to the "natural attitude" of science where interrelationships between human beings and their world are discovered based on a set of rules or laws, existential phenomenology assumes "transcendental attitude" or "phenomenological attitude" (Sokolowski, 2008; Valle et al., 1997, p. 10). From this paradigm the investigator suspends all preconceptions and presuppositions (bias) about the phenomena under investigation.

Sokolowski (2008) refers to this process as phenomenological reduction, a term that means "leading way". Reduction from the Latin, re-ducer, refers to the withholding, withdrawal, or suspension of judgment until the evidence becomes clear. Van Manen (1990) used reduction

to discover the experience of the lifeworld. He offered four avenues to reduction. First, reduction requires that the investigator engage in a sense of wonderment and amazement about the world. Second, one must work to overcome personal feelings and expectations about the world. Within the phenomenological tradition this process is referred to as bracketing. According to Pollio et al. (1997) bracketing is associated with the concept of reduction where something is “reduced” to its purest form. Bracketing as a subjective process removes those conceptual biases that alter one’s “interpretive vision” (Pollio et al., 1997, p. 47). To bracket one’s own preconceptions and presuppositions, the first step is to make explicit by bringing them out in “clear view” for examination. This becomes a continuous process for the qualitative investigator by using reflective journaling throughout the research study (Polit & Beck, 2008). Ahern (1999) offered 10 activities for effective bracketing:

1. As the researcher, identify personal interests often taken for granted.
2. Clarify and state personal values while making explicit your own biases.
3. Determine areas of role conflict.
4. Recognize the role of gatekeepers, their interest in the topic, and to what degree this positively or negatively impacts the research.
5. Recognize researcher’s feelings lacking neutrality.
6. Be aware of new and unanticipated findings during the collecting and analyzing of the research data.
7. Acknowledge, deliberate, and make use of the methodological problems that arise during the research.
8. After the data analysis phase, set aside time for reflection on how the findings are written.

9. Reflect on the results of the literature review as a clear, accurate account of the phenomenon of interest or merely supporting the researcher's own cultural biases.
10. Be aware of residue bias in the data collection and analysis through re-analyzing or re-interviewing participants as needed.

Husserl (1859-1938) stated that complete reduction can never truly be achieved at any given point in time (Pollio et al., 1997). However, rather than attempting to suspend all world knowledge and bias, the investigator is charged with applying a worldview whereby an accurate understanding of the phenomenological event or situation may emerge (van Manen, 1990).

Third, reduction requires a "stripping away" of formal theories and conceptualizations. The data should be examined from the "transcendental attitude" to extract participants' lived experience. Finally, the investigator must engage in what van Manen (1990) terms "eidetic reduction" where one transcends the concreteness of the living and moves toward the "essence" (eidos) of the lived experience. Merleau-Ponty (1962) emphasized that reduction is a means to an end of phenomenological inquiry rather than an end in itself.

Intentionality

Intentionality was originally described as the human experience being intentional or purposeful in the sense that human experiences always take place within a context or in relation to something. Human beings are never self-contained but rather in consistent interaction with their world seeking to understand and find meaning (Pollio et al., 1997). In Merleau-Ponty's book *Phenomenology of Perception*, he quoted Saint Exupey to illustrate this point: "Man is a network of relationships and these alone matter to him" (1962, p. 530). Intentionality speaks to the continuous facet of consciousness; human beings' experiences are always in relation to their world in the moment and beyond. As an active process, intentionality is essential to

phenomenology (Sokolowski, 2008). It allows the human experience to be accessed from different viewpoints whether the process is conscious or unconscious.

Figure-Ground

Pollio et al. (1997) provided an exquisite demonstration of perception within the area of psychology. Danish psychologist Edgar Rubin uses a black and white figure of a vase to illustrate a difference between what individuals see as the focus (figure) and the ground (background). Rubin described the characteristics of first-person viewpoint (perception) using the concepts of figure and ground:

1. The figure or the focus of the participant's attention has form and shape in contrast to ground or background experiences.
2. The figure (focus) of the participants experience is closer than those experiences perceived as ground (background).
3. The figure (focus) is more identifiable than the ground (background) experience.
4. The figure (focus) is clearer than ground (background) experiences.

In essence no figure or experience exists independent of surrounding experiences. All objects are perceived and experienced in relationship to the total circumstance. No figures or focal experiences exist by themselves but are rather a "figure/ground structures" that shed light on the human experience; the event or experience is defined by both focal and background perspectives. Therefore, understanding the experience of others requires the ability to understand and relate to their personal, perceptual field.

Investigator's Experience with Suicide

According to Polit and Beck (2008) one element critical to the use of self-as-instrument in qualitative research is the concept of authenticity. Authenticity refers to the investigator's

ability to recognize and use personal experiences to respond to study participants. The investigator must expose personal motivations for conducting research. Such exposure and self-awareness ensures that the investigator's behaviors during the research process are congruent with personal attitude, values, and beliefs about the research topic. Investigators are authentic in their desire to know more about the phenomenon, which ultimately influences data analysis and research findings.

This investigator experienced grief and loss associated with suicide. The investigator lost both a family member and a close friend. Both suicides were unexpected but not surprising in hindsight. On December 8, 1985, at the age of 25, this investigator's uncle placed a gun to his chest and pulled the trigger. His wife and 3-year-old son were present. A sister (the investigator's mother) arrived shortly after to witness the aftermath and hold him in her arms during his last moments of life. Over the next few years the investigator experienced the events that transpired both in the community and within the family.

On December 2, 1999, after an extended battle with a debilitating seizure disorder, a close family friend took an intentional overdose of drugs. She left a letter explaining her actions. She left behind a husband, two small daughters, and a mother, who had years prior lost her only son to murder.

In both circumstances the investigator's first reaction was denial. There was a desire to descend upon the scene, provide another explanation, and to some extent return things to the way they were prior to the suicide. The investigator felt a sense of powerlessness in the grief and uncertainty about how to support those suicide survivors closest to the victim.

Study Design

The study design for this investigation was qualitative description. Van Manen (1990) provides four existential lifeworld themes for phenomenological reflection as part of the research process. The complexity of the lifeworld is described within the context of these four existentials: spatiality, corporeality, temporality, relationality. The lifeworld existentials serve as a guide for phenomenological reflection as themes are extracted and thematic descriptions represented in the data. Spatiality (lived space) refers to perceived space; the space individuals inhabit affects the way they feel. Corporeality (lived body) refers to the premise that humans are bodily in the world. Temporality (lived time) refers to the mental connection to time in the world, i.e., past, present, or future. Relationality (lived others) refers to the lived connection to others within interpersonal space. Communion with others serves to fulfill life purposes and meaning.

Participants

The nine participants in this study were mothers who were bereaved by the suicide death of a child for a minimum of 12 months. The participants for this study were one of convenience. Participants volunteered for the study and were screened based on established inclusion criteria. Study inclusion criteria included:

1. The suicide survivor was the biological mother of a suicide victim;
2. The suicide survivor acknowledged the death was a suicide;
3. The suicide occurred one or more years prior to the study;
4. The suicide victim was at least 13 years of age; and
5. The suicide survivor was able to read, speak, and understand the English language.

Ethnicity, race, or culture of the participants or suicide victim were not considered.

An exclusion criterion was:

1. The suicide was not the result of a murder-suicide.

Recruiting

A combination of methods was used to recruit mothers of suicide victims. First, word-of-mouth provided the opportunity for participants to voluntarily approach the investigator after becoming aware of the study. Study flyers (Appendix B) were posted and distributed to churches and grief support group locations. Local suicide support group facilitators, clergy, counselors, and self-help groups in the northeast Tennessee region were contacted to provide information about the study.

Prospective participants contacted the investigator by phone and expressed their desires to enter the study. The investigator screened those expressing interest using the inclusion and exclusion criteria. Once screened, the investigator provided a verbal explanation by phone of the nature of the study. Each participant had 1 week to decide to participate. Next, the investigator scheduled an appointment for the interview.

Research Setting

All interviews were conducted in the participants' homes or similar, private location of the mothers' choosing. Given the topical nature of the interview, the participants were at high risk for strong emotions. Therefore, the investigator was sensitive to the location in which the participant felt most comfortable for the interview. The setting also served to protect participant confidentiality and promote a private and comfortable environment.

Human Subject Considerations

Protection of participants' was assured by the East Tennessee State University Human Research Protection Program following a review of the study protocol and related document

(Appendix C). Study procedures were developed to protect and secure the identity and confidentiality of each participant.

After the participant agreed to the interview, the participant signed the study informed consent document (ICD) (Appendix D). Participants received a copy of the study ICD for their records. Participants were informed of their right to discontinue the interview at any time. If participants experienced high emotions, procedures were in place to provide a counseling referral as needed. On the day of the interview, participants were contacted by phone to confirm the appointment.

During the study audiotapes, transcripts, the field log, and reflective journal were locked in a file cabinet and the office where the file cabinet was located was kept locked at all times with only the investigator possessing a key. Computer access to downloaded transcripts and audio recordings was password protected with only the investigator having access. Pseudonyms were used within the manuscript to conceal the identity of the participants, as well as any information disclosed during the interview that was deemed by the investigator as a risk for breach of participant privacy. The professional transcriptionist signed a confidentiality agreement (Appendix E) prior to beginning the work. Requests for minor revisions were submitted to the East Tennessee State University Human Research Protection Program to change the inclusion criteria from 24 months since the suicide death to 12 months since the suicide to accommodate potential participants interested in volunteering (Appendix F). It was the decision of the investigator that this change would enhance the quality of the data.

Data Collection Procedures-Generation

Prior to granting consent to participate, the investigator described the data collection procedure to the participants, including the use of two digital recording devices during the

interview. Data were collected inclusive of June 2010 through October 2010 with each interview lasting between 45 minutes and 180 minutes. The investigator asked participants background information about themselves and their child (Appendix G). The investigator established interviewer-participant rapport by allowing the participant to tell her story without fear of interruption or judgment from the investigator. It was interesting to note prior to consenting to the interview, participants wanted to know and understand the investigator's age, professional expertise, and motivation.

The investigator began with a very general question such as; "Tell me about (inserted child's name)." This allowed participants to begin their story where it was most comfortable for them. Van Manen (1990) advocates for an interview format focused on the fundamental question, but allowing participants to tell their stories. One element of this process was to allow participants to guide the interview to tell their story. A semistructured format was employed for the purpose of getting to the experience under investigation. The investigator responded to participants comments while using a moderator guide as necessary (Appendix H). This allowed for specific aspects of the mothers' experience to be explored, particularly those aspects that were common among other participants.

The acquisition of trust during the interview process was critical to the success of each interview (Fontana & Frey, 2000). Van Manen (1990) wrote the phenomenological interview serves to explore and gather narratives as a way of developing a deeper understanding of the phenomenon of interest.

Audit Trail

A field log and reflective journal were created representing the investigator's own thoughts about the process and content of the interviews. Field logs were kept to chronicle time

and interviewer observations pertaining to the thoughts, emotions, perceptions, and experiences during the interviewing. A reflective journal was kept to record the investigators thought processes and inductive reasoning while listening to the interview audio tapes and reading the interview manuscripts. The investigator moved between the field log, reflective journal, audio recordings, and the interview manuscripts as themes were inductively derived. Data analysis began with the first interview and proceeded as more data were collected. During the process, certain excerpts from the interviews were replayed for clarification of meaning. Each manuscript was read 6 times during data analysis. Reflective journal entries allowed the investigator to organize, clarify, and verify her own assumptions regarding the data.

Data Management

The services of a professional transcriptionist were used to transcribe the digital recordings of each interview. The investigator managed data using NVivo 9.0 qualitative data management system. The transcribed manuscripts of each of the nine interviews were downloaded into the NVivo 9.0 software. Themes were created using the “nodes” feature to categorize data from the participants’ own words.

Data Analysis

Data analysis used the methods of van Manen (1990) as the guide to understanding the lived experience within the context of the four existentials: spatiality, corporeality, temporality, and relationality. A field log, reflective journal, audio tapes, transcribed interviews, and group collaboration were part of the process of extracting the “essence” of the lived experience of mothers as suicide survivors. The field log and reflective journal were code similarly to those themes identified in the transcripts. This process included the identification of essential themes of the mothers’ experiences following the suicide deaths of their children. The data analysis

involved prolonged immersion in the data creating thematic schemes found among the participants.

Study Rigor

To enhance study rigor the investigator proposed to follow and stay true to the phenomenological method of inquiry. In that vein the data invited the reader into the participant's world, thus the method reflected this paradigm. Guba and Lincoln (1989) provide three criteria for producing a rigorous study: credibility, transferability, and dependability. The assurance of credibility (confidence in truth) was maintained through the keeping of a reflective journal by the investigator for the purpose of capturing the process and content of insights, observations, and interactions between participant and investigator. In addition, these insights were reflected upon during the interviewing process, data transcription, and reading and rereading the data. Transferability (generalizability) refers to the data's ability to have meaning for those of similar world circumstances (Guba & Lincoln, 1989). The research findings were meant to be generalized to mothers of suicide victims within similar contexts. Finally, the investigator maintained dependability of the data by creating an audit trail so the research process could be easily followed and other investigators could reproduce PI's decision trail. Guba and Lincoln (1994) add confirmability as an additional criterion highlighting the need to represent the lived experience by maintaining participants' individual experiences. Prolonged engagement with the data and establishing trust and rapport with participants were considered major contributions to the research rigor.

CHAPTER 4

RESULTS

Parents of a Suicide

Questions left unanswered,

Torturing to the head.

Lie in bed awake at night,

Wondering what you could have said.

Gone forever,

Never to be seen.

Their eyes which did sparkle,

And so brightly gleam.

Are they here or not,

I wonder each day.

Again, questions left unanswered,

Much to my dismay.

Memories are foggy,

Turning into blur.

To speak their name aloud

Has become just another slur.

Forbidden by society,

The silence becomes so loud.

*Don't tell them how they left you,
It might upset the crowd.*

*A wonderful human being has left,
And no one really cares.
All that's left is open mouths,
With nothing but silly stares.
No questions or answers,
There you see.*

*Your shoes they never wore,
It's not a pair for anyone;
Can't be bought in any store.*

*If the price tag was visible,
I know not one would buy.
The cost to wear the shoes,
Is just too friggin' high.*

Author, Denise Bellion (Appendix I)

Introduction

The investigator employed a phenomenological approach to explore the experiences of nine female participants who lost a child to suicide. Van Manen's (1990) analytical approach was used to analyze the interview transcripts guided by the four existentials: spatiality, corporeality, temporality, and relationality. Three essential themes were inductively derived by from interview data.

Participants

Interviews took place inclusive between June 2010 through October 2010. All nine participants were recruited using research study flyers and word -of-mouth. Participants agreed to an initial telephone screening process and further explanation of the study. None of the prospective participants declined an interview after speaking with the investigator. During telephone screening, the investigator explained the purpose of the study and screened potential participants to ensure they met inclusion and exclusion criteria. Several participants voiced concerns about the investigator's age, credentials, level of experience, and expertise with the subject of suicide and grief. Participants' concerns were alleviated once they realized that this research emerged out of a genuine passion for the phenomenon and those it influences. Following a verbal agreement to be interviewed, participants shared parts of their experiences over the phone. Participants were assured of their right to excuse themselves from the study at any time and the information would not be used. Phone conversations lasted as long as 80 minutes. During this time the investigator took notes, but conversations were not audio-recorded.

Participants were given their choice of interview location, date, and time. Eight participants chose their primary place of residence for the interview, and one participant elected to be interviewed at the investigator's home. On the day of the interview, the participant

received a reminder phone call from the investigator with the option to reschedule if needed. None of the participants chose to reschedule at that time.

Prior to the beginning of each interview, the criteria for participation and the informed consent were explained orally. Procedures for protection of participants were conducted as outlined in Chapter 3. The interview began with an initial prompt: “Tell me about (inserted child’s name)”. Care was taken to avoid interruptions as participants shared their stories. After each interview the investigator expressed gratitude to each participant and asked her for verbal feedback regarding the experience. In general, participants reported the experience to be easier than first imagined. Several thanked the investigator for the opportunity to tell their stories and the insights that would come from the data. One participant stated the investigator was too silent and would have preferred more leading questions.

Participant Descriptions

A general description of participant characteristics is provided to protect participant anonymity due to the potential for identification from the combination of information. At the time of the interviews, the age range for the nine participants was 43 years to 72 years. All nine participants were Caucasian females living in the eastern region of Tennessee. Five participants were raised outside the eastern region. At the time of the interview, the time since the suicide death of the participants’ children ranged from 1 year and 3 months to 21 years and 6 months.

Although four children died at the mother’s home, no participant witnessed the suicide of her child. Two of these four children lived with the mother at the time of death. Of the other suicide victims, two children died in their own homes, one in a motel, and two in an isolated location. Participants were notified of the death of their children in various ways. Three

participants were notified of the child's death by telephone: two participants were the first to find the body. One participant received a phone call of a suicide attempt and the child died later while one participant received a visit from the police announcing the death. One notified the police of missing her child after finding a suicide note, but the child's body was never recovered.

Eight participants had other living children. For one participant, the suicide victim was her only child: another mother experienced the homicide death of another child 17 years prior to losing a second child to suicide. This mother still had one surviving daughter. One participant experienced the death of her husband approximately 4 months prior to the child's suicide.

Meet the Participants

Pone was a 59-year-old professional. She is currently married to the biological father of her son. Her son took his life at the age of 28 years leaving behind a pre-teen daughter. At the time of the interview, it had been 4 years and 3 months since the suicide death of her son. Pone has one surviving daughter. Pone described her son as "super intelligent... he was just sweet and he was the kind of guy, I guess you want to say that women loved him because he was such a sweetie."

Ptwo was a 55-year-old working mother married to the biological father of her two children. She had one surviving daughter. Her youngest, a son, took his life at the age of 17 years. At the time of the interview, it had been 3 years and 3 months since his death. Ptwo described the birth of her son; "It was a 5-year prayer and He answered it at the time in my life that I couldn't have picked a better time... At night, when he was small and still nursing... I knew there was nothing in this world that I would rather have been doing or that I would rather have, and then I put him in this bed, and he was back asleep."

Pthree was a 72-year-old mother of three children married to their biological father. She has one surviving daughter and one deceased son. Her older daughter, 38-years old, completed suicide 10 years and 7 months ago. She left behind two teenage daughters. Pthree described her daughter; “She’s always been kind of a bubbly, cheerful person”.

Pfour was a mother in her early 60s with one son and two daughters. She had been married to the biological father of her children for 46 years. At the time of the interview, it had been 3 years and 7 months since the suicide death of her 40-year-old son. He left behind a wife and 7-month-old son. The interview occurred within 3 days of the 3 year anniversary of his death. Pfour described her son; “He was very affectionate. He was very creative...”

Pfive was a 65-year-old retired mother of two sons. She is married to the biological father of her children. At the time of the interview, it had been 21 years and 6 months since the suicide death of her 17-year-old son. Pfive used these words to describe her younger son; “He was a smart kid, a sweet kid, very loving, very compassionate.”

Psix was a 57-year-old working professional. She is single, divorced from the biological father of her only child since he was 3 years old. At the time of the interview, it had been 1 year and 3 months since the suicide death of her 19-year-old son. Psix described her son; “He was a very happy little kid and always had a big smile.”

Pseven was a 72-year-old mother of four children. She is divorced from the biological father of her 37-year-old son who completed suicide 16 years and 9 months ago. She was married her second husband at the time of her son’s death. She described her son this way: “He was a child that needed immediate gratification.....once he got it he didn’t necessarily do anything with it.”

Peight was a 49-year-old mother of six children. She is divorced from the biological father of her 22-year-old son who completed suicide 7 years and 9 months ago. She has been married to her second husband for 17 years. Peight described a memory of her son. “My favorite thing I remember is no matter where he was going or what he was doing he would come and kiss me and say, I love you, Mom.”

Pnine was a 43-year old working mother of three children (1 son and 2 daughters). Her husband and biological father of her children died 4 months prior to the suicide death of her 20-year-old son. At the time of the interview, it had been 3 years and 5 months since the death of her only son. Pnine described her son;” ... he was just so fun, you know... easy going. He loved to make people laugh.”

Description of the Child Suicide Completers

As with mothers, a general description of the suicide victims is provided to protect anonymity of participants and their families. The child suicide completers were between the ages of 17 years and 40 years and included eight males and one female. The child suicide completers left behind children of their own ranging in age from 7 months to 16 years. Six of the nine suicide completers left a written communication prior to the act. The methods of death included four self-inflicted gunshot wounds, two hangings or strangulations, one carbon monoxide poisoning, one drug overdose, and one intentional plane crash. Six mothers reported their children had made previous suicide attempts or threats. Five participants acknowledged that their children had histories of mental illness prior to the suicide completions.

Essential Themes

Children and mothers never truly part - Bound in the beating of each other's heart.

-----Charlotte Gray

The phenomenological analysis of nine interviews conducted over a period of 4 months yielded three essential themes related to van Manen's (1990) lifeworld existentials of lived human relation (relationality), lived time (temporality), and lived body (corporeality): 1) Know My Child: Not the Act, 2) Frozen Past, Altered Future, and 3) Ocean of Grief.

The lifeworld existential of lived human relation (relationality) was expressed through the theme, Know My Child: Not the Act. The theme, Frozen Past: Altered Future represented the existential of lived time (temporality). Lived body (corporeality) was reflected in the theme, Ocean of Grief. In addition to each inductively derived essential theme, structural themes were created within each essential theme. Illustrative quotes from the participants are offered to support the essential and structural themes.

Know My Child: Not the Act

Van Manen (1990) refers to lived others as the relationality we maintain as interpersonal space shared with others in a corporeal way. Humans form physical impressions and relationships as they interact with others. Social connectedness serves to create a sense of purpose and meaning for existence as others confirm or dispute what they believe or represent.

During the time spent with the participants either through the initial phone contact or the interview, they reflected on their deceased children in the context of a life lived and not merely the suicide act. Participants did not idealize their children but reflected on both their children's strengths and weaknesses. They told of the joys and sorrows of mothering these children. During interviews, all nine participants willingly shared photos, scrapbooks, and mementos of their children without prompting from the investigator. Even though Pone did not bring photos to the interview conducted at the investigator's residence, she offered access to photos via the internet. Participants did not initially talk about their children in the context of the suicide act,

rather the suicide eventually emerged as part of the story within the context of providing the investigator with an understanding of the child. Participants wanted their children to be viewed as unique individuals rather than a representations defined by one solitary act. The researcher identified two structural themes inductively derived from this essential theme: Sounds of Silence and A Life: Not a Label.

Sounds of Silence. Following the suicide death of their children, participants indicated they felt silence from those around them. The silence was perceived as and encountered through lack of interaction, physical avoidance, and conversation centered upon on the suicide act rather than the child or the well-being of the mother.

I will tell you something that my cousin and I talked about, and I think this is very important. People don't want to talk about your child, and you want people to talk about them. You want people to talk about them because their memories live on, but when you lose a child nobody wants to talk about them. (Pone)

The hardest thing is people not saying anything, and it's as if it never happened. (Pfour)

What I had problems with is that people don't want to talk about him. (Pseven)

Three participants acknowledged the silence along with an explanation for the behaviors of others.

I think the fact that it was her sister [who died from suicide], but it was my child, you know and all of our [place of employment] had kids of their own, that they couldn't fathom, you know, so just don't want to talk about it. (Pone)

But as far as actually saying: "I know you're so sad or I know you miss your T", they don't call his name. People are not comfortable talking about it. (Pfour)

I think people are just really self-absorbed, and they don't want to ask... It's funny because most people don't ask me and I ask them about their kids, and they just get to talking and talking and talking, and they never get around to asking

about mine..... I'll bring [my son] up in a conversation and nobody will ever follow-up on it. (Psix)

Participants even experienced silence from those close to them.

[Referring to husband] No cause he'd [say], "I don't want to talk about it. I don't want to talk about it." So we don't talk about it. [after 21 years] (Pfive)

[My husband], he didn't know how to deal with it either with me, and so he would avoid talking about K, and I still needed to talk with someone about him. (immediately after the suicide) (Pseven)

The silence was also expressed when others approached the participants wanting to discuss the suicide act rather than the child. Others had a sense of curiosity about the act rather than wanting to know about the child. As a result, this caused emotional distress for the participants.

Well, people would ask me... people ask the weirdest things, you know. The eye doctor that we both went to he said: "Do you mind telling me, you know, what happened?" I said: "I don't want to talk about it." So that was my line for a long time. "Just don't want to talk about it." (Psix)

And then some woman that I think her brother had shot himself had said: "Well, where did he shoot himself, in the head?" And I said: "I don't know!" Why would you ask a question like that? You know, I visualize stuff, and that's the worst. I wouldn't go see him because I didn't want to remember him being dead. (Psix)

Participants described a physical avoidance by others.

I... like remember seeing someone that I hadn't saw in a long time... and I thought to myself, oh please don't let them (see me)..... But see, they were thinking the same thing about me, because I totally saw them just do like a 180 (degree turn), yeah, and just go the other way. (Pnine)

One participant related an experience with the clergy when she described her silence as feeling left alone to deal with her grief. Following the funeral, the minister who she referred to

as “very kind, very compassionate” did not continue to contact her. This silence was experienced as abandonment.

This man did a wonderful job. I swear to you in three years’ time, not a week, not a month, never have we had a phone call, a note, anything from this minister to [T’s] parents. How do you hold a service for somebody you say you love and who you’ve spent... He’s been in your church, your church member for all these years and not care enough about their parents to at least send one note, one follow-up not. (Pfour)

A Life: Not a Label. During their interaction with others, participants felt their children were only recognized with the label of suicide, rather than a precious life. Participants also felt labeled by the suicide act. In contrast, participants appreciated others mentioning their children even though it was painful.

I was the oddball with the kid with suicide, and then this older man there [at a grief support group], he said; “Well, it’s just the drugs.” and I’m like, “oh, my gosh”, so I did not go back after that. You know, he just didn’t understand. (Psix)

Then I was talking to another friend when I was there for the funeral, and she’s Jewish, and she said; “Jews don’t approve of suicide.” (Pseven)

Participants felt the suicide label was attached not only to their children, but to them as well.

“Her son, J, committed suicide.” That is like the introduction for me, and you know I sat there with it... Well, that’s one of the reasons you don’t want to tell people because you think they would [judge]... “Oh, my gosh, she wasn’t a very good mother.” (Psix)

I have had people say to me they think you’re a bad mother because your kid killed themselves. (Peight)

Participants experienced the suicide label even as they advocated for their children prior to the suicide. One mother recalled an interaction in the emergency room after her son’s suicide attempt 1 week before his death.

You're going there for help and somebody's being judgmental. It's like value of life is not the same. She [emergency room nurse] said; "ma'am, you just need to face it. He tested positive for opiates. He's just a drug addict." (Peight)

You know, and then they speak to the moms they think the mothers are just emotional and dramatic...where really they know their kid probably better than most...They think either you're an enabler or just ...you know, they just don't take it seriously, and I think they should [referring to attempts at getting help for her child prior to the suicide]. (Peight)

Participants admitted that the mention of their children caused sadness, but they still welcomed the display of genuine concern and recognition of their children's lives.

I ran into his preschool teacher in the grocery store, and she asked me how Z was, and I told her, and we hugged and cried in the grocery store. There have been so many people who have told me how much Z meant to them. (Ptwo)

Well, just the things they say, you know, the nice things about M and about her girls and about M [husband] and about their marriage. I met a friend in the store and she said; "you know, M favored you so much." And I said; "oh, thank you! That means I'm beautiful." (Pthree)

A lot of times after that event, why it will bring back stuff that you really wanted to push out, but yeah, I like people to remember her. (Pthree)

One of his...a member of his church where he goes told me that he [son] would do anything he could for anybody...What he was saying was, I know your son was a good man. (Pfour)

Frozen Past: Altered Future

The concept of time is subjective in the human mind and experienced in a temporal way of being in the world. Van Manen (1990) refers to the temporality as lived time. Dimensions of the past, present, and future encompass the human worldview and meaning attached to life. As the past is reflected upon, it may change depending on whether one lives toward an open future with possibilities and hope or a closed future with dead ends. The essential theme of Frozen Past:

Altered Future was experienced when participants struggled to find meaning from the suicide, while carving out a future without their children. Two structural themes support the essential theme of Frozen Past: Altered Future: 1) Holding On and 2) Letting Go.

I can honestly say that if I could have looked into the future, I thought that I would not even have married or had children knowing what was to happen.
(Pthree)

Holding On. Participants described their desire to hold on to the past and the memories of their children by identifying daily reminders as a way to preserve the past. Mothers described physical items such as photos, scrapbooks, mementos, and personal items belonging to the child as a source of both comfort and pain.

Hearing his voice on his birthday was like... The night we buried him, M [granddaughter] told me that she was upset about two things, that she would forget him. She would forget what his voice sounded like... so we recorded his voice for her [from an old cellphone voice mail]. (Pone)

A couple from our Sunday school class brought over a rosebush and planted it. It has beautiful yellow roses, I take them and set them on my desk, and they are like he was. Everybody that comes by stops and smells them... says what a pretty rose they are and how they smell, and that's the way Z was. (Ptwo)

[Others brought] a lot of her [daughter's] flowers over to me and that was special. I remember we've still got an Easter lily that M [son-in-law] got M [daughter] when they were dating... We carried it. (Pthree)

I have his fishing license. I've got his toothbrush. I've got a housecoat that he had. I've got a whole box of his clothes up in the attic. (Pfive)

It'll hang. It won't be used... I think it swirls like a big comma, but he's the center [referring to a quilt made from the child's clothing]. (Pseven)

Participants expressed holding on by identifying memories during daily life. These encounters were both comforting and painful.

I can often look across the yard, and I can see the two of them [father and son] walking up from the pier down there with their fishing poles. They're [memories] sweet and their precious, but their also painful. (Pfour)

Yeah, but you know you have good times and you have bad times. We always think he's with us. We were going across the bay out onto the island of N---- last year, and C loved the ocean, and right by the side of the road in a pullover that you overlooked the ocean is a bench, and the name on the bench is C--- B---, and it sits underneath a tree [C's nickname was c--- b---]. (Pone)

For so many...there were times that we were sitting in a restaurant and there was a waiter who came by, looked just like Z. We had to get up ... we just got up and left. There are times now that I will get a glimpse of something that reminds me of Z, but I feel that I have truly lost a part of what made me function. (Ptwo)

During the day things will happen, and it will pop that in your mind, you know about M [daughter] or about M [son-in-law]. (Pthree)

Participants held on to past events like a “never-ending movie” mentally chronicling both pleasurable and painful memories. Participants also chose descriptors including “seared”, “branded”, and “flood”.

The phone call the next day at 11:30, noonish, those words are *seared* into your mind. They are *seared* as if they are *branded*. You're playing the never-ending tape. (Pfour)

Yeah, everything, every minute of it. Faces, what people said, everything, It's like a movie. (Peight)

Going, you know, graduating colleges and getting married, and having babies, and all those things *flood* through your mind. (Pthree)

Words such as why, could, should, and what if were frequently used.

But I would say that not being able to be still *should* have been a warning sign [as a child]. So, you look back and after T's suicide you began to look back and maybe think about things you might have missed that led up to that... *what if...what if I'd done this...* (Pfour)

Wouldn't do it again [Tough Love Concept], I'd say you come and I *would* have comforted and try to carry tough love to a reasonable level, but not, not where ...it's like we were taught to just keep'em out there. (Pfour)

But I feel like I still wasn't a good mom in the end because look at the result. I tried to do everything I *could* think of to keep him safe. (Psix)

[Referring to an encounter with a nurse in the emergency room after son's suicide attempt] I still remember her to this day. That what I am saying...there are certain people. That [nurse] was one of them. That I don't like remembering because...that whole experience was terrible. We were at the emergency room, and the doctor was asking him if he remembered doing it, and he goes, no, but my mother told me I did. And he was laying there wrapped in a sheet and everything, and seeing somebody that was so self-sufficient and so okay, and seeing him broken is just...that haunts me now, still. (Peight)

I just look back and think "*why* did I go to work?" I *should* have stayed home... I remember this lady coming in my office that day, and she was talking to me that morning, and I told her, I said, "I'm really worried about A. (Pnine)

Participants expressed the theme of holding on by reflecting on a future that would never come to fruition.

We could see a future that [our son] couldn't. And for a year afterwards, we kept the box...there's a box about this size, not quite that big, that is the little college applications that had been sent to us. They [applications] just kept coming and kept coming. (Ptwo)

I do not think that I will ever have another truly happy day... It's just, you know, special occasions, there's supposed to be four not three [father, mother, daughter, and son]... (Ptwo)

I was cheated out of grandchildren. (Pfive)

He's my only son. I don't feel like a mother, and you know, I won't ever have grandkids or anything like that. (Psix)

Holding on was expressed by focusing on future relationships with grandchildren and others.

We reminisce forever when we get to be around them [grandchildren] and the other three grandchildren. I know that a lot of things that M wanted in life have come to pass and that's a blessing. The only thing that I hope for now, you know, is the families that are left, M [husband] and the girls and the grandkids, that they'll find a good life and know how much M loved them. (Pthree)

I decided well, I wouldn't do anything for a year, but the next thing I am going to try to do is help somebody else so that maybe I'll have a purpose or something....I'm starting this coming week to tutor a fifth grade girl once a week, so I am really looking forward to that. (Psix)

Participants also held on by calling upon their past relationship with God to create hope for the future.

That is it. I don't know how people make it without having a relationship with God. I honestly don't. I mean, I don't know why they just don't kill themselves... I don't know how people make it without that. (Pone)

I don't know what I would say to somebody that didn't believe in God, because that is the way I've gotten through it. (Ptwo)

Participants expressed the structural theme of holding on to life amidst feelings of wanting to die. Although they struggled with taking their own life, they chose to hold on. Sometimes this holding on was a daily decision.

When I was in the hospital having my surgery I went four places (a dream about being in a cart abandoned).... I thought nobody's going to find me... and the I just said "okay, I'm ready to go. I want to give up. I don't want to live anymore." Things like that come to my mind where they never did before. (Ptwo)

While I don't really have any idea why I'm sticking around for the future, but I am trying to hang in there, but anyway... that's the hardest stuff I'm having to deal with is I'm just kind of like hopeless and I don't think anything is going to get better... and then about 6 months into it I like started feeling really, really horrible and started thinking about killing myself and everything and so I thought well, I'm getting pretty bad and I don't want to get as bad as J, so I called up and went to a psychiatrist. (Psix)

...life's hard and there's times where I felt I don't want to be around...(Peight)

Letting Go. The category of “Letting Go” was expressed as letting go of thoughts and memories and, replacing them with others. Letting go was expressed by letting go of the future that will never be because of the death of the child.

Participants expressed letting go of the past by thinking about their children at peace now.

You know you don't sleep much, but I told M [participant's husband] “I kind of close my eyes and it's like, oh my gosh, I see C in all this brilliant white” and I said. “He's standing there in white, got his arms crossed”, and I said, “got on those Birkenstocks.” (Pone)

The only thing I can say is if he were suffering this bad it's selfish of me to want him to.... So that would be a horrible life to have to live, and it wouldn't be right of me to want him to be suffering like that... (Pfive)

Letting go also meant letting go of the thoughts about past actions or the lack thereof.

Well, I think as a mom that you are the caregiver, you're the kiss the boo-boos and make them better, and you just can't make all of them better regardless. (Pone)

I wish I had been there, and then, cause you know, I didn't... I felt like I was...here I was long distance trying to manage something and I didn't have control, and in reality I knew it wouldn't have probably changed anything, but I still wanted to have stopped him. (Pseven)

Participants, also discussed letting go of life as they knew it before the suicide, including their own identity.

We had just finished therapy with learning how to grieve our life, the loss of our life as we knew it [going to counseling to help with the loss]. (Pone)

It's just I have just had to more or less learn to live my life a different way. (Ptwo)

Because you kind of lose yourself along the way, and you don't communicate like you used to. You just change. You're not the same anymore as a person. (Peight)

Participants let go of life's triviality. Objects and events they viewed as important seemed less important after the suicide.

Yeah, it [suicide] brings you right down to the absolute bare bone basics of life. (Pfour)

You know, just there are so many things now that I thought were important that I don't even think about them. (Ptwo)

I get upset sometimes when I hear people talking about things and, on, their life is so hard.....you know like little things.... (Pnine)

Ocean of Grief

The third essential theme is "Ocean of Grief". It is within this theme that participants expressed van Manen's (1990) existential of lived body (corporeality). The human experience with the world is accomplished by bodily being in the world. According to van Manen (1990) parents, while being bodily separate from their children, have a physical connection by being of one flesh. The pain expressed by the participants as a result of the suicide death of their children was described as ongoing, cyclic, and lingering. The structural themes expressed were: Predicting the Storm, Waves of Pain, and Taming the Tide.

Predicting the Storm. Participants described the experiences of recognizing that something was "just not quite right" with their children including during their younger years as well as just prior to suicides. Although some could not succinctly describe it, mothers experienced a feeling. Some participants felt the issues were clearly identified, but they could not convince healthcare professionals that they needed help for their children.

I just had this gut feeling something was going to happen to him [referring to the attempt to tell her son's doctor what was happening]. "He's coming over there and he might not tell you anything, but be sure to check him for depression..." (Psix)

And of course, we were going through it with her, and we... I tried in my mind to be positive about it and think, you know, she'll be better tomorrow... They'll find something to get rid of stuff... I think that in the back of my mind that I knew all the time she was just so stressed with all these things... I realized that she was under so much that it would take a strong person to overcome all of that and get over it, but I would not give in to it. (Pthree)

He gave no reason why he did this, but he had.. I felt like for a long time he was thinking of this. That's like I say, that's when I was talking to him. ... I didn't know where to go for help. I didn't know what to do. You know I thought well, just talk... work this through, and I couldn't, and finally I said "A, I just can't get to you" [when the police notified of death]. When they said that I just collapsed on the floor cause I knew, yeah, this was it. (Pfive)

[As a result of his behaviors and the questions her son was asking] I kind of knew where he was headed. I said, "What do you mean? Where are you thinking about going?" He said, "No, I mean not around at all. What if I was dead?" When I said "You need to see someone..." [As a result of conflict between child and mental health professional, participant tried to intervene.] I went to [county medical association] and said "all we were asking for was a second opinion..." [speaking of her interaction with the psychiatrist] Mrs. F, he [psychiatrist] said "your son is 27 years old. You are not his mommy anymore, and you can't decide for him..." (Pseven)

So, something really was wrong..... You know and then they [mental health professionals] speak to the moms they think the mothers are just emotional and dramatic, you know, where they really know their kid probably better than most, so you should take it, sift it, but use it, you know what I mean, the mother's opinion, because it is important, but they don't. They think either you're an enabler or you're just...you know, they just don't take it seriously and I think they should. She [a nurse in the emergency room after a suicide attempt] was telling me my son was worthless [because he tested positive for opiates]... She was a nurse who took an oath to take care of people. (Peight)

Waves of Pain. Another structural category, "Waves of Pain" refers to participants' descriptions of their physical pain and grief after the suicide.

Yes, nothing will ever fill that hole, ever. You know, and think that if you had four kids and lost four kids that you would have four holes in your heart because I think that that's just the reality of the devastation of it. (Pone)

It's just a piece of me , really, is gone... I feel like that I have truly lost a part of what made me function. (Ptwo)

I mean I cried till I was throwing up all the time. I couldn't eat anything. I was.. I just cried and threw up, cried and threw up. (Pfive)

This is the way it is. It just cuts too deep... it's like a cancer. (Pthree)

It's like a cancer that's always there. It's never going to heal. Till I take my last breath, it's not going to heal. (Pfive)

It's just like a never-ending stab of reality.... I have found a place in myself that I never knew was there. The deepest, as far as the depth that I can go. I've been there. I live there. I never knew it was there. And I think that it's just life as it is... I have sobbed a couple of times with sobs that were absolutely primal animal sounding they came so deep. (Pfour)

If I lost my arm, I would get over not having it, but I wouldn't stop missing it. Just because someone is dead and they're gone, you don't get over that, you know. It's still there. (Pseven)

Participants acknowledged not only the physical anguish but also the cognitive impact of the grief on their day-to-day functioning.

But it is constant changing [grief]. In the beginning it is like people were telling you you're numb, but I didn't feel numb. It was like I didn't like it explained that way because you're not numb. You do feel. You might not encompass everything that's going on, but you're not numb. (Peight)

I tell some of my new friends that I've never known before this [suicide] happened. I say "I wish you had known me back when I had a mind." I do. I say... "I miss it..." My mind is gone. (Pfour)

Participants empathized with the pain they felt their children endured prior to the suicide. Pain was felt before and after the child's death.

Like there's moments where... little, little teeny, weenie moments where I'll feel a little but angry and disappointed that he chose to leave, but most of the time I

just think I know how bad he was suffering, and life's hard and there's times where I felt like I don't want to be around, so I can understand it.... [I]Think as time passes the mom suffers and goes into such dark places, so she actually understands where her child was with his grief. They leave their burden behind to you... as a mom you carry it. (Peight)

He wasn't doing that to hurt us. He was doing it to escape whatever hell he was experiencing is what I think. You can't blame him. I mean, it was just a situation that he couldn't deal with. (Pseven)

Taming the Tide. Participants described behaviors, thoughts, and activities that neutralized the pain. The pain as a result of the suicide was at times unbearable and strategies to cope needed to be used. As a result, participants had to engage in behaviors and activities they felt could ease the pain of the loss.

Some participants spoke of avoiding the pain.

I push it aside... I say I can't do this... (Pfive)

I avoid a lot of things that will remind me of him because I don't want to think of him.... Like if you'll notice, I don't even have a picture up of him. [Participant latter offered to bring out a photo of her son] (Peight)

...the same people would call every day or so, and I got tired of talking to them, and I just told them, I said, "you know, I don't mind you calling, but if I don't want to talk about it I'm not going to answer the phone." (Ptwo)

Participants spoke of using activities to distract them from the triggers of grief.

I do crafts just to have something to do to get my mind off of it. I washed the outside of the house the other day. I try to stay busy. Just work, work, work. (Pfive)

I always exercised before and I'm trying to keep that up.... It's like I don't need to get home to anything, so exercise is helpful. (Psix)

Participants reached out to others as a way to move the tides of pain and grief away from themselves.

[Referring to news of a friend whose son completed suicide] I just went right over to her house, and you know, she was in shock.....I said I was sorry what happened, and that if she needed me she could always call me....Next thing I am going to do is help somebody else so that maybe I'll have a purpose or something. (Psix)

I try and support other people that I hear, I reach out and just say, anytime you want to talk, I'll listen..... I just try and encourage people to talk about the person and keep them as part of their life because they still are here. (Pseven)

I think that's why I thought maybe I should just try to do this (participate in the study), and if it helps someone... (Pnine)

I think I have started doing that more [serving others] because that's what it's all about, you know, is just serving others... It's constant because there's this man in my church... I just saw the sadness in his eyes... I remember making him some banana bread and taking it to him. (Pnine)

Participants had thought about suicide themselves as a viable solution.

[6 months after the death of her son] Oh, yeah, I was gonna do it when I was in (another state) after this happened. I had already decided I was going to go out and hang myself in the garage. [decided against this because of the pain it would cause her surviving son] (Pfive)

Participants felt making a genuine connection with others who understood suicide and the death of a child was important. They embraced the social support available to them.

[Responding to things which help] Well, this is helping a lot [talking] I've not been able to honestly say there's no future, I want death to come. I've not been able to say that because people think, you know that's wrong. You know, you shouldn't say that. You shouldn't feel this way. Well, that's the way I feel and I can't change it... I feel I need to do what I am doing right now, just talking about it... (Pfive)

[Referring to her psychologist] She is really, really, good for grief and she understands losing a kid because... one of her daughters died. (Psix)

I needed to talk to someone medically that had worked, knew him a little bit... It didn't resolve anything, but I just needed to hear from somebody else. (Pseven)

Participants felt the need to avoid the presence of others or talking as a way to tame the grief.

Some people don't get it at all and so I just try not to hang around them... I kind of stay under the radar. (Psix)

You know people would call, pretty much the same people would call every day or so, and I got tired of talking to them, and I just told them, I said, "You know, I don't mind you calling, but if I don't want to talk about it. I'm not going to answer the phone." (Ptwo)

Summary

The existential themes were inductively derived from the data using van Manen's method of phenomenological inquiry (1990): Know My Child: Not the Act, Frozen Past: Altered Future, and Ocean of Grief. These themes were expressed by nine mothers following the suicide death of their child. The theme of Know My Child: Not the Act expresses the role of stigmatization and labeling in regards to suicide. Frozen Past: Altered Future represents the process of reconstructing while looking toward a future. Finally, Ocean of Grief expresses the pain of grief as bodily experienced.

CHAPTER 5

DISCUSSION AND RECOMMENDATIONS

The purpose of this qualitative phenomenological study was to acknowledge, understand, and communicate the lived experience of mothers bereaved by the suicide death of a child. Nine women participated in semistructured face-to-face interviews during which they were provided opportunities to share their personal journeys of loss and grief. This chapter summarizes the essentials and structural themes for this investigation and provides implications for nursing practice, research, and education.

Summary of Findings

Know My Child: Not the Act

Mothers bereaved by the suicide death of a child experienced a sense of discomfort with others. This discomfort resulted in avoidance or a focus on the suicide act by others as expressed in the structural theme, Sounds of Silence. In addition, during their interaction with others, the participants felt their children and themselves were labeled as a result of the suicide act.

Hoff (2001) highlights social support as an essential component to the grieving process. The literature points to evidence that isolation, stigmatization, and self-stigmatization contribute to a complicated grief response (Calhoun & Allen, 1991; Cvinar, 2005; Dunn & Morrish-Vidner, 1987-1988; Feigelman et al., 2009; Jordan, 2001; Laasko & Paunonen-Ilmonen, 2002; McIntosh, 2003). Following the loss of a child, mothers experiencing the most difficulty were those perceived negatively by others (Laasko & Paunonen-Ilmonen, 2002). Participants needed an open system of support and the opportunity to grieve without the added burden of labels and stigmatization.

Sounds of Silence. A structural theme of the essential theme, Know My child: Not the Act, was expressed through Sounds of Silence. Participants experienced others as avoiding the subject of their children or focused on the details of the suicide. As a result, participants perceived others' responses as inadequate and contrary to what was needed. This finding is consistent with Begley and Quayles (2007) who found that adult suicide survivors felt let down by those around them. For the participants this response came from not only those outside the family circle but also those close to participants. Even years after their children's deaths, their children's memories were felt to be taboo. On the other hand, those who may have provided support *initially* failed to maintain a connection with the mothers which was the expectation. If their children were mentioned by others, participants felt it was within the context of the suicide act without regard for the mothers. It was perceived as more of a curiosity about the suicide rather than an encounter of genuine concern for mother or child.

This type of perceived response from others made it particularly traumatic for mothers as they struggled to cope with the loss of their children as well as their loss of identity as a mother to their child. Mitchell et al. (2004) identified that a close relationship with the deceased predisposes the suicide survivor to symptoms of complicated grief. Similarly, Dyregov et al. (2003) suggested the best predictor of complicated grief was being the mother of the deceased. Ellenbogen and Gattton (2001) through quantitative inquiry failed to support the belief that suicide survivors suffer more than other survivors. This is contrary to the view by the participants in this study as they felt that suicide resulted in an extra burden of pain and suffering.

According to van Manen (1990) meaning and purpose emerges in everyday life through our interactions with others. When others fail to acknowledge an event of such catastrophic proportions, the suicide survivor may experience a sense of disapproval that results in the

internal process of shame. Sequin et al. (1995) found that shame was central to suicide bereavement. Even though the motive for the silence can only be speculated, the mere perception of negative attitudes by others has the potential to increase complicated grief (Laasko & Paunonen-Ilmonen, 2002).

Along with the feelings of isolation, mothers often do not have the opportunity to talk about their losses. Frequently, events preceding the suicide create an environment of stress. Feelings of isolation are only magnified when mothers lacked the opportunity to “tell their story”. According to Richard Dew, former president of the Knoxville Tennessee Chapter of Compassionate Friends International, telling the story of loss, when, where, and with whom they choose is the single more important part of grieving the loss of a child (Personal communication, January, 2011). Telling the story of the suicide death in their own way and time allows suicide survivors to reconstruct a reality necessary to move forward (van Manen, 1990). Without others being willing to listen and respond to the current needs of the mother, the grieving process is hindered or halted.

A Life: Not A Label. The participants did not idealize their children but spoke of them within the context of a life lived, not the single suicide act. Participants experienced the label of suicide overshadowing the lives of their children. This label created feelings of emotional distress and stigmatization. Participants felt the suicide label was attached to them, as well as their deceased children even before the children ended their lives. As a matter of fact, participants felt the stigma associated with suicidal behaviors prior to their children’s suicide completion when they tried to seek help for their children and were disregarded by health care and mental health professionals caring for their children. As a result participants withdrew from interaction with others after the suicide to avoid the scrutiny.

The literature supports stigmatization as a delineating factor in suicide bereavement when compared to other forms of death (Begley & Quayle, 2007; Cerel et al., 2008; Cvinar, 2005; Dunn & Morrish-Vidners, 1987-88; Dyregrov, 2002; Dyregrov et al., 2003; Ellenbogen & Gratton, 2001; Fielden, 2003; Jordan, 2001; Laakso & Paunonen-Ilmonen, 2002; Lindquist et al., 2008; Seguin et al., 1995; Van Dongen, 1993). Similarly, Jordan (2001) and Sveen and Walby (2008) all identified the general theme of stigmatization suggesting that a deeper understanding lies within the investigation of the phenomenon from the qualitative paradigm. In this study, the focus on the act in combination with its association with substance abuse, mental illness, and sin only served to further perpetuate and reinforce the label. Worden (1991) suggested that stigma generates an intense experience of shame among suicide survivors. As a result suicide survivors are denied the full benefit of the social support they most desperately need during all periods of the grieve process.

Role identity is a critical component of the mother-child relationship (Bretherton, 1992; Goffman, 1959; Goffman, 1963). Through behaviors, language, and actions, others expressed societal disapproval of suicide without taking into account the life of the child and the needs of the participants. As a result mothers experienced role uncertainty creating confusion about how they should behave and interact with others. This ambivalence and role uncertainty lead to physical and social avoidance of others at a time when social support was a major component of recovery. As participants struggled with their change in role after the suicide death of their children, others were defining for them the role they should play in the event.

In contrast participants acknowledged the experience of kind remarks during the time of bereavement. They admitted that any acknowledgement of the death brought back painful memories; however, the words and actions were welcomed. They felt a sense from others that

the lives of their children mattered and others missed them too. In addition, the lives of these children were reflections of them and when pleasant remarks were made about their children the remarks also reflected on the mothers.

For mothers personal and social identity is part of motherhood (Bretherton, 1992). The connection transcends physical life and is branded into the soul, heart, and mind of the maternal suicide survivor. How the child is perceived by others impacts how the mother sees herself and her role in the life of her child as well as in the wake of this loss.

Frozen Past: Altered Future

The second essential theme was Frozen Past: Altered Future. According to van Manen (1990) being in the world is experienced through the concept of lived time or temporality. The past, present, and future encompass how the worldview of the phenomenon is experienced, as well as the meaning attached. Participants engaged in thoughts, behaviors, and activities to find meaning and make sense of the suicide as well as the future. Two structural themes were expressed: Holding On and Letting Go. Participants were engaged in this conflict of how best to reconstruct the past while looking to the future

Holding On and Letting Go. In the lives of the participants there was clear demarcation between the past and moving toward an uncertain future. At times participants were unable to see a future. On the day of the suicide life as they had known it ceased to exist. The past was frozen or suspended in time: the future dangled in front of them in a state of perpetual change. Mothers continually recognized a past full of memories and an uncertain future. Ongoing decisions were made to hold on to some memories while letting go of others; at the same time participants were living day-to-day but also looking to the future. This rendition is consistent

with van Manen (1990) referring to the reconstruction of the past to fit into the future. Holding on and letting go took place mentally, physically, and spiritually in a perpetual manner.

According to Begley and Quayle (2007) and Biebel and Foster (2005) parental guilt is extremely difficult to manage after the suicide death of a child. In an effort to temper the feelings of guilt suicide survivors reflected on past experiences, often envisioning a different outcome had they taken action to prevent the suicide. Lindquist et al. (2008) found “why” to be a salient theme among 10 family members. Participants in this study were attempting to reconstruct reality to better cope with life without their child. When this reconstruction occurs, internal feelings of guilt emerge from suicide survivors’ own interpretation of the past and their inability to change it. Participants in this study felt guilt was especially true for mothers, as they are most often the parent charged with ensuring their children’s safety. The literature fails to accurately describe this in detail as it relates to the mother’s lived experience.

The dichotomy of holding on and letting go represented the trajectory of the grieving process within the context of losing their children. Participants were in a perpetual state of reconstruction depending on the length of time since their losses and the grief work they had engaged in since the suicide. Wolfelt (2009) affirmed the belief that grief work must be client-led as opposed to professional-led. This is true regardless of the time since the death of a child. This approach values presence, listening, walking alongside the mourner, and respecting the individuality of grief. For participants in this study it was essential that caregivers and professionals recognize the struggles of holding on and letting go from a holistic paradigm: physically, emotionally, socially, cognitively, and spiritually. Previous literature failed to support the differences in an individual’s grief experience overtime within specific context such as suicide combined with the mother role.

Ocean of Grief

The third essential theme was expressed as Ocean of Grief. The literature supports the overflowing of emotions as a common thread among suicide survivors (Begley & Quayles, 2007; Biebel & Foster, 2005; Bolton, 1998; Chilstrom, 1993; Diedrich & Warelow, 2002; Dunn & Morrish-Vidners, 1987-1988; Fielden, 2003; Fine, 1997; Hsu, 2002; Lindqvist et al., 2008; Myers & Fine, 2006; Robinson, 2001; Simon, 2003). Following the suicide death of their children, participants found themselves facing loss of control. Just as the waves of the ocean tosses about a sea-worthy vessel, they were tossed about without control or direction. The suicide left the participants completely helpless. Mothers considered themselves protectors and caregiver of their children. Ocean of Grief was expressed by three structural themes: Predicting the Storm, Waves of Pain, and Taming the Tide.

Predicting the Storm. Participants had either suffered through previous suicide attempts with their children or in retrospect felt like things were just not quite right. As protector and caregiver, they tried to recognize issues but were unsuccessful. Participants felt dismissed by health care and mental health professionals when they tried to advocate or provide a voice for their children during times of crisis. They struggled to make others understand that what they knew about their child was critical to their safety.

Most participants experienced suicide attempts by their children prior to the suicide completion. After the suicide participants acknowledged this same feeling of not being able to fix or correct the situation. This theme of anticipatory grief is documented in the literature. Feigelman et al. (2008-2009) suggest that repeated suicide attempts prior to the actual suicide were associated with “greater grief difficulties” (p. 251). For the participants, the personal

experience of pain resulting from their children's suicide began well before the actual death. Previous periods of struggle and crisis with their children made the grief process more difficult.

For mothers protection of their children was of the utmost importance. Suffering with these children prior to the suicide meant previous stressors were often associated with suicide and warrants further examination.

Waves of Pain. The pain of losing a child to suicide was cyclic and lingering for participants. The pain was expressed in physical, emotional, and cognitive terms. Just as the waves in an ocean, the experience was unpredictable. Waves of pain emerged unexpectedly and with such force that it caused them to lose their emotional footing. Participants expressed their emotional pain as indescribable; there were no words to adequately express their emotions following the loss. Fielden (2003) found a feeling of not making it through was linked with intense emotions. As a result participants found themselves handling pain one day at a time.

Participants also acknowledged their own pain by empathizing with the pain of their children. They speculated that maybe the pain they were feeling after their loss might be similar to what their children felt when they made the decision to end their own lives. This is consistent with van Manen's (1990) concept of mother and child experiencing life as one flesh. The mother-child bond was so deep that mothers longed to feel and understand the pain that precipitated the suicide.

Taming the Tide. Participants engaged in activities, thoughts, and behaviors they felt helped them tame the storm of emotions and pain resulting from the suicide. These activities, thoughts, and behaviors caused the tide to subside and calmed the waves of pain. They used avoidance to deal with daily mental and physical reminders. They voluntarily suppressed memories and physically removed items in the environment to get through the day. Participants

deliberately engaged in activities as distractions from daily thoughts of their children. For the participants, taming the tide was a form of survival. For some this was day-to-day and for others it was minute-to-minute.

Participants actively sought the opportunity to make a genuine connection with others to find someone who could understand their grief and pain. Biebel and Foster (2005) found that finding the proper social support, especially immediately after the suicide death helps in the grieving process. They saw social support as beneficial when others placed no demands or timetable on their grief. This finding is consistent with Wolfelt (2009) and his resistance to placing grief and its trajectory on phases and stages.

In their own time and own way participants voluntarily reached out to others in an altruistic fashion. They acknowledged that being of service and helping others provided meaning and purpose. These encounters were both planned and unexpected. However, with the participants in this study reaching out was suppressed when others showed signs of stigmatization toward them or their deceased children. Consequently, Dyregov et al. (2003) found the best predictor of impaired psychosocial health was isolation. For survival the potential to isolate was common, therefore, stalling the healing process.

Study Implications

This qualitative research study was undertaken to better understand the experiences of mothers bereaved by the suicide death of their children. Findings from this study provide a foundation for understanding the unique circumstances and needs of mothers as they navigate through their lifeworld after losing children to suicide. It is a road only traveled by a few. It is a journey they did not ask to take. Because of the mode of death and the unique relationship

between mothers and children, there are implications for nursing practice, education, and research.

Nursing Practice

The destruction of suicide reaches far beyond just the suicide victim. Findings from previous research, as well as from this investigation, suggest that those exposed to suicide are more likely to contemplate or use suicide as a coping method. Suicide affects those left in the wake of the destruction to cope with past events and move forward into the future. Therefore, suicide prevention is the first step in stopping this cycle of events.

Nurses must master interviewing techniques and therapeutic communication so they can intervene in a behavioral crisis that has the potential to end in suicide. Results from this study indicated that mothers tried to intervene to prevent the self-destructive behaviors of their children by interacting with healthcare providers but felt dismissed with nowhere to turn for help. The health care and mental health professionals they came in contact with disregarded the mothers' assessments of the situations because their children were not minors. It is the responsibility and professional obligation of those working with families in crisis to evaluate data from all sources. Nurses are in key positions to foster therapeutic relationships with suicide attempters and those closest to them. Those individuals with an investment in the welfare of the suicide attempter must feel their concerns are heard and addressed to the extent the law allows.

Nurses must be willing to examine their own personal belief system about suicide, substance abuse, addiction, and mental illness if they are to become a catalyst for change. The belief system of the professional care giver plays a pivotal role in whether critical data are exposed and addressed potentially saving a life. Words and attitudes are powerful forces when dealing with assessment and psychosocial issues. Establishing trust is the first step in

understanding the worldview of others as they often refrain from sharing critical information unless they are convinced the provider possesses genuine concern and caring. Understanding professional obligations as an advocate for treatment is a critical part of addressing the problem of suicide.

Lastly, nurses must advocate for the treatment and well-being of suicide survivors. They must be willing to confront the fear, ignorance, and stigma plaguing those left to pick up the pieces of their lives. The media and the wide-use of communication technology can either help or hinder this initiative. Research suggested suicide survivors adapt and cope better with the loss when social support is available, consistent, and sufficient. Social support must begin with nurses modeling to the community and other professionals those behaviors and attitudes that support effective grieving. Mothers, in particular, need this social support because the biological connection between the child and the mother combined with society's expectation of the mothering role as caregiver leaves mothers in a dangerous position experiencing the effects of unresolved complicated grief processes.

Nursing Education

Entry level nurses and primary care providers have a responsibility to understand and use appropriate techniques to prevent the cycle of suicide and minister to those affected by its aftermath. Schneidman (2001) referred to treating the aftermath of suicide as "postvention". For this type of education to come to fruition, nurse educators must integrate the concepts of suicide and grief into the curriculum. Again, the issues must be introduced in combination with an exercise of self-evaluation about personal suicide beliefs and the reasons individuals elect to end their lives, as well as theories of grief and mourning.

Nurses have long advocated for holistic client care. This holistic approach encompasses all aspects of a client's existence. Nurses must learn about both the internal and external forces surrounding the issues of suicide, the victim, and survivors. Although international and national statistics present a picture of the impact of suicide, the nurse must be aware that the true impact to survivors is seen in the minute details, perceptions, and social connections in each suicide survivor's story. This means that nurses must be trained to listen and respond to suicide survivors within the context of their own unique experience without penalty of judgment or ridicule. Nurse educators must encourage students to address the issues affecting suicide survivors with the understanding that although mourning is a social phenomenon, the work of grief is individual. Nurses must begin to "feel comfortable with being uncomfortable". Providing care for suicide survivors does not mean knowing all the answers and developing a trajectory for their grief, but merely being a *consistent, stable* guide through a process that is different for each individual traveling the path.

Nursing Research

Since 1972 when Albert Cain, professor of psychology at the University of Michigan in Ann Arbor, first coined the term, "suicide survivor", referring to those left behind by suicide, suicide research has taken on a more global perspective. Once thought of as a victimless crime, suicide has emerged as an event that has psychological and emotional effects on others long after the death. Previous nursing literature has focused on parental grief or suicide survivorship within the context of other forms of violent deaths (Davies, 2001; Diedrich & Warelow, 2002; Krysinska, 2003; Murphy et al, 2003a; Murphy et al., 2003b; Murphy et al., 2002; Murphy, Johnson, Wu, Fan, & Lohan, 2003; Murphy, Tapper, Johnson, & Lohan, 2003). In addition, previous studies have failed to delineate the unique experience of mothers (Van Dongen, 1993).

Much of the research literature on suicide and suicide survivorship has treated the phenomena as a category of complicated grief. However, little research has explored the suicide survivor's experience in terms of specific emotional connections or social roles associated with the deceased. This study has added to nursing science and the body of knowledge in the areas of suicide, suicide survivorship, and grief by examining the experience of mothers bereaved by the suicide death of a child. The essential theme of *Know My Child: Not the Act* provides new insight into how mothers perceive the actions, behaviors, and words of others after the suicide death of their children. The second essential theme, *Frozen Past: Altered Future*, has raised the awareness that mothers are in constant struggle to reconstruct the past to fit into a future without their children. *Ocean of Grief*, reflected as the third essential theme, has added a more in-depth understanding of the trajectory of grief, as well as the destruction caused by it. For most of the participants, dealing with their children prior to the suicide was an added burden during a time of grief after the death. Their loss of control and feelings of powerlessness were confirmed as they suffered the loss of their children. As a result, they were tossed about, left to cope and adapt to the realities of the situation.

Further qualitative and quantitative research is needed to examine experiences of specific populations bereaved by suicide such as fathers and siblings. Although grief is individually felt and perceived, it is experienced collectively within familial and social circles. As a matter of fact, one participant felt the effects of suicide on a sibling had been under recognized and understudied. More research on the attitudes of health professionals dealing with suicide and its aftermath warrants more exploration. In addition, community attitudes and behaviors toward suicide and suicide survivors require further investigation; intervention research may be warranted with this group.

Most participants sought out the services of support groups, but not all found them a positive part of their experience. More research needs to be conducted within community support areas to explore the efficiency and benefits of services provided by the community. Given that social support plays a crucial role in successful grieving, clergy, morticians, and the media need to be examined for attitudes and behaviors that either facilitate or hinder suicide survivors' grieving process.

Transferability

Although the lived experience of these nine mothers bereaved by the suicide death of a child was unique, the question is whether the findings are likely to have meaning for those with similar loss. Guba and Lincoln (1989) refer to this as transferability or fittingness. These findings are more subject to be transferable when there exists strong similarities in time (since death and time is history) and culture. In addition given the nine participants were from the same geographical region, this may limit the transferability of the findings. Although the number of participants was small, the homogeneous nature of the group suggests that a larger number of suicide survivors with a different relationship to the deceased may experience the phenomenon differently. However, this judgment may best be made by the suicide survivors themselves.

Strengths

The strengths of this study are found in the use of qualitative inquiry to explore the experience of a group that has not been recognized as unique in relation to suicide survivorship. The specificity of researching mothers as suicide survivors affords the opportunity for a resurrection of dialogue about suicide, suicide survivorship, and the influence of the relationship to the suicide victim on the grieving process.

In addition, this study provided data regarding the true suffering which suicide inflicts on suicide survivors through a one-to-one interaction with the participant. It painted a picture of an experience through the eyes of the one suffering and that few wish to explore with the desire to take the results to the community level. As a result of this study, suicide survivors of diverse backgrounds have approached the investigator regarding the need for local services to assist this population. Therefore, plans to begin a suicide survivor support group have received administrative support from a local health care facility.

Lastly, this study provided a voice for those who have either been unable, previously unwilling, or both a chance to tell their stories. The telling in and of itself has therapeutic value, as well as the knowledge that the information will be used to help others.

Conclusion

Suicide is a phenomenon existing since the dawn of early recorded history. The moral and cultural significances have been debated across time and culture. The continuum is wide and the consequences deep as researchers attempt to unravel the individual and social implications of suicide. One fact remain: suicide brings about change for those left behind to deal with the aftermath.

Previous researchers have attempted to delineate suicide grief as a form of complicated grief. Consequently, studies have focused on complicated grief, a subject deserving of special consideration in the area of bereavement. Suicide may fall within this area. The study of relationships combined with mode of death, creates a new perspective on how others grieve and interact with the world. This study provides insight into a specific group and mode of death rarely detailed in the literature.

This study of nine mothers bereaved by the suicide death of a child produced three essential themes: Know my Child: Not the Act, Frozen Past: Altered Future, and Ocean of Grief. Subtle variances within this experience will illuminate and inform future research so nurses can better understand and provide care for this population.

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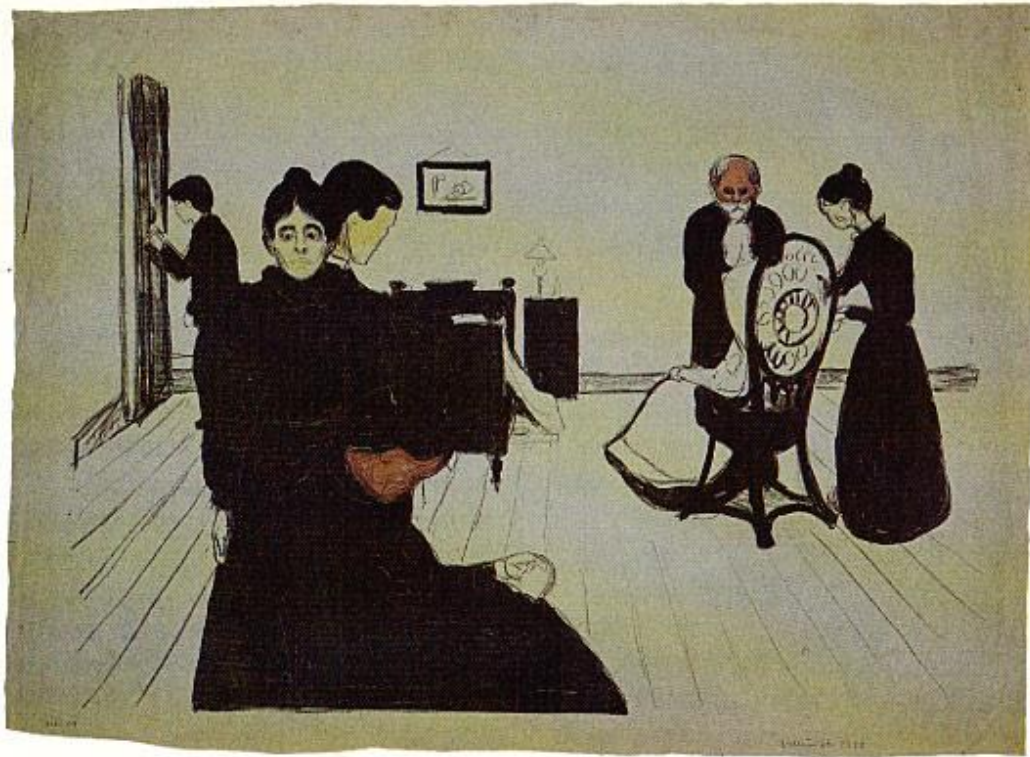
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APPENDICES

Appendix A

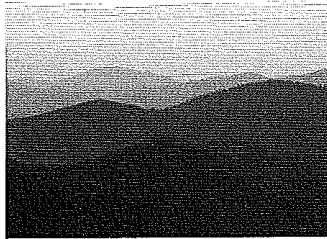
“Death in the Sickroom” Lithograph (1896) by Edvard Munch



Appendix B

Research Study Flyer

Research Study: The Lived Experience of Mothers Bereaved by the Suicide Death of a Child



Study Summary:

The purpose of this study is to explore the meaning and develop an understanding of the mother's experience after the suicide death of a child.

Who's Eligible?:

- ❖ English speaking mothers who have lost a child (13 years or older) to suicide

What's Involved?:

- ❖ One 60-120 minute face-to face interview

Benefits of Joining:

- ❖ Help researchers & other professionals working with bereaved families to better understand the unique needs of a bereaved mother following the suicide death of a child
- ❖ Flexible scheduling of interview time
- ❖ Friendly, supportive environment sensitive to the experience of your loss

Principal Investigator:

The principal investigator for this study is Cynthia W. Lynn, RN, MSN, Nursing PhD student at East Tennessee State University

If you would like to volunteer for this study or request more information, please contact Cynthia W. Lynn, RN, MSN by calling 1-(865)680-3256 or 1-(865)922-6230. She can be reached by e-mail at clynn@cn.edu

APPROVED
By the ETSU IRB

JUN 16 2011

By 
Chair/IRB Coordinator

DOCUMENT VERSION EXPIRES

JUN 15 2011

ETSU IRB

Appendix C

IRB Approval



East Tennessee State University
Office for the Protection of Human Research Subjects • Box 70565 • Johnson City, Tennessee 37614-1707
Phone: (423) 439-6053 Fax: (423) 439-6060

IRB APPROVAL – Initial Expedited Review

June 16, 2010

Ms. Cynthia Lynn
4637 Marshall Dr.
Knoxville, TN 37918

Re: The Lived Experience of mothers Bereaved by the Suicide Death of a Child
IRB#: c0510.5s

The following items were reviewed and approved by an expedited process:

- Form 103
- Project Narrative (04/05/10 stamped approved 06/16/10)*
- Informed Consent Document (ver. 04/20/10 stamped approved 06/16/10)*
- Potential Conflict of Interest (no conflict identified)
- Screening for Research
- Participant Background Information Questionnaire
- Moderator Guide for Interviews
- Professional Advisor Letter
- Flyer (stamped approved 06/16/10)
- CV of PI

The item(s) with an asterisk(*) above noted changes requested by the expedited reviewers.

The following documents with the incorporated requested changes have been received by the IRB office:

1. Project Narrative (04/05/10 stamped approved 06/16/10)
2. Informed Consent Document (ver. 04/20/10 stamped approved 06/16/10)

On **June 16, 2010**, a final approval was granted for a period not to exceed 12 months and will expire on June 15, 2011. The expedited approval of the study *and* requested changes [Project Narrative (04/05/10 stamped approved 06/16/10) and Informed Consent Document (ver. 04/20/10 stamped approved 06/16/10)] will be reported to the convened board on the next agenda.



Accredited Since December 2005

The following **enclosed stamped, approved Informed Consent Documents** have been stamped with the approval and expiration date and these documents must be copied and provided to each participant prior to participant enrollment:


- Informed Consent Document (ver. 04/20/10 stamped approved 06/16/10)
- Flyer (stamped approved 06/16/10)

Federal regulations require that the original copy of the participant's consent be maintained in the principal investigator's files and that a copy is given to the subject at the time of consent.

Unanticipated Problems Involving Risks to Subjects or Others must be reported to the IRB (and VA R&D if applicable) within 10 working days.

Proposed changes in approved research cannot be initiated without IRB review and approval. The only exception to this rule is that a change can be made prior to IRB approval when necessary to eliminate apparent immediate hazards to the research subjects [21 CFR 56.108 (a)(4)]. In such a case, the IRB must be promptly informed of the change following its implementation (within 10 working days) on Form 109 (www.etsu.edu/irb). The IRB will review the change to determine that it is consistent with ensuring the subject's continued welfare.

Sincerely,

A handwritten signature in black ink that reads "Chris A. Ayres". The signature is written in a cursive style and is positioned above the typed name.

Chris Ayres, Chair
ETSU Campus IRB

cc: Dr. Sadie Hutson

Appendix D

Informed Consent Document

PRINCIPAL INVESTIGATOR: Cynthia W. Lynn, RN, MSN

TITLE OF PROJECT: The Lived Experience of Mothers Bereaved by the Suicide Death of a Child

EAST TENNESSEE STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD

This Informed Consent will explain about being a participant in a research study. It is important that you read this material carefully and then decide if you wish to be a volunteer.

PURPOSE:

The purpose(s) of this research study is to explore experiences, meaning, and perceptions of mothers following the loss of a child by suicide.

DURATION

You will be asked to participate in one face-to-face interview which will last approximately 60-120 minutes.

PROCEDURES

You will be asked to participate in one face-to-face interview in the Eastern Region of Tennessee at a quiet, private location of your choosing, including your home. During this meeting you will be asked to provide your account of what it has been like for you since the suicide death of your child. Interviews will be audio taped and will last approximately two hours. You are free to answer or not answer any question that is asked.

ALTERNATIVE PROCEDURES/TREATMENTS

There are no alternative procedures or treatments for this study.

POSSIBLE RISKS/DISCOMFORTS

The possible risks associated with this study are minimal and comparable to other research interviews about grief and loss. Given the subject of the study, the participant may experience some discomfort in answering some questions. The participant has the right to decline answering any question in the interview.

POSSIBLE BENEFITS

The possible benefit of participation is gaining new knowledge about the experiences of mothers bereaved by the suicide of a child. At the conclusion of the study, results will be available to each participant upon request.

APPROVED
By the ETSU IRB

DOCUMENT VERSION EXPIRES

04/20/10

JUN 16 2010

Page 1 of 3

JUN 15 2011

Subject Initials _____

By PK
Chair/IRB Coordinator

ETSU IRB

PRINCIPAL INVESTIGATOR: Cynthia W. Lynn, RN, MSN

TITLE OF PROJECT: The Lived Experience of Mothers Bereaved by the
Suicide Death of a Child

FINANCIAL COSTS

There are no additional costs associated with participating in this study.

COMPENSATION IN THE FORM OF PAYMENTS TO RESEARCH PARTICIPANTS

There will be no compensation for your participation in this research project.

VOLUNTARY PARTICIPATION

Participation in this research experiment is voluntary. You may refuse to participate. You can quit at any time. If you quit or refuse to participate, there will be no adverse consequences. You may quit by calling Cynthia W. Lynn, RN, MSN, whose phone number is 865-680-3256. You will be told immediately if any of the results of the study should reasonably be expected to make you change your mind about staying in the study.

CONTACT FOR QUESTIONS

If you have any questions, problems or research-related medical problems at any time, you may call Cynthia W. Lynn, RN, MSN at 8650680-3256 or Dr. Sadie Hutson at 423-439-6054 for any questions you may have about your rights as a research subject. If you have any questions or concerns about the research and want to talk to someone independent of the research team or you can't reach the study staff, you may call an IRB Coordinator at 423-439-6055 or 423-439-6002.

CONFIDENTIALITY

Every attempt will be made to see that your study results are kept confidential. A copy of the records from this study will be stored for 5 years after the conclusion of this study in the personal locked office of Cynthia W. Lynn in a locked file cabinet accessible only to her. The results of this study may be published and/or presented at meetings without naming you as a subject. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the ETSU/VA IRB (for medical research), and personnel particular to this research (Cynthia W. Lynn, RN, MSN) have access to the study records.

APPROVED
By the ETSU IRB

JUN 16 2010

By 
Chair/IRB Coordinator

DOCUMENT VERSION EXPIRES

Page 2 of 3

JUN 15 2011

Subject Initials _____

ETSU IRB

04/20/10

PRINCIPAL INVESTIGATOR: Cynthia W. Lynn, RN, MSN

TITLE OF PROJECT: The Lived Experience of Mothers Bereaved by the
Suicide Death of a Child

By signing below, you confirm that you have read or had this document read to you.
You will be given a signed copy of this informed consent document. You have been
given the chance to ask questions and to discuss your participation with the investigator.
You freely and voluntarily choose to be in this research project.

_____ SIGNATURE OF PARTICIPANT	_____ DATE
_____ PRINTED NAME OF PARTICIPANT	_____ DATE
_____ SIGNATURE OF INVESTIGATOR	_____ DATE
_____ SIGNATURE OF WITNESS (if applicable)	_____ DATE

APPROVED
By the ETSU IRB

04/20/10

JUN 16 2010

By 
Chair/IRB Coordinator

DOCUMENT VERSION EXPIRES

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JUN 15 2011

Subject Initials _____

ETSU IRB

Appendix E

Statement of Confidentiality

Statement of Confidentiality

Date: June 25, 2010

As the professional hired to transcribe the oral data for the research study, The Lived Experience of Mothers Bereaved by the Suicide Death of a Child, I agree to hold all data in confidence and return all data (digital and typed) to the primary investigator, Cynthia W. Lynn. I will not allow anyone to access the data while in my possession, nor will I discuss the content of the data with anyone other than the primary investigator, Cynthia W. Lynn

Beth Price

Beth Price

Date

June 25, 2010

Appendix F

IRB Approval-Minor Modification



East Tennessee State University
Office for the Protection of Human Research Subjects • Box 70565 • Johnson City, Tennessee 37614-1707
Phone: (423) 439-6053 Fax: (423) 439-6060

IRB APPROVAL – Minor Modification

August 17, 2010

Ms. Cynthia Lynn
4637 Marshall Dr.
Knoxville, TN 37918

RE: The Lived Experience of mothers Bereaved by the Suicide Death of a Child
IRB #: c0510.5s

On August 15, 2010, a final approval was granted for the minor modification listed below. The minor modification will be reported to the convened board on the next agenda.

- Modification request to change inclusion criteria from a minimum of 2 years since the death of the child to a minimum of 12 months. ; *Revised Narrative (8/13/10)*

Unanticipated Problems Involving Risks to Subjects or Others must be reported to the IRB (and VA R&D if applicable) within 10 working days.

Proposed changes in approved research cannot be initiated without IRB review and approval. The only exception to this rule is that a change can be made prior to IRB approval when necessary to eliminate apparent immediate hazards to the research subjects [21 CFR 56.108 (a)(4)]. In such a case, the IRB must be promptly informed of the change following its implementation (within 10 working days) on Form 109 (www.etsu.edu/irb). The IRB will review the change to determine that it is consistent with ensuring the subject's continued welfare.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Ayres", is written over a faint circular stamp.

Chris Ayres, Chair
ETSU Campus IRB



Accredited Since December 2005

Appendix G

Participant Background Information

Demographics

1. Participant
 - a. Name
 - b. Address (to mail informed consent & background questions)
 - c. Age
 - d. Marital status, years
 - e. Number of children
 - f. Occupation
 - g. Education
 - h. Numbers of years as a survivor
2. Suicide child victim
 - a. Name
 - b. Age
 - c. Birth order
 - d. Occupation
 - e. Education
 - f. Residence at time of death
 - g. Date of death
 - h. Method of suicide
 - i. Left a note?

** Background information to be collected after participant provides informed consent, but prior to the interview. It is the belief of the PI that collecting background information immediately prior to the interview will disrupt the participant's story, while it is essential that the PI be able to understand the context of the story prior to the interview.

Appendix H

Moderator Guide for Interviews with Mothers after the Loss of a Child to Suicide

Context of Interviews: The interview will take place at private location of participant's choice, most likely the home. Questions will be used to elicit the experiences associated with the suicide death of a child.

Introduction:

1. Ms. _____, Thank you for agreeing to tell your story.
2. Can you tell me a little about _____?

Guiding Questions:

1. I understand it has been _____ years since the death of _____. Tell me about what it has been like for since _____'s death.
2. What do you recall about your experiences dealing with others people? (e.g. family, friends, co-workers, strangers, acquaintances, police, media etc....)
3. What do you recall about how you felt/feel and dealt/dealing with events? (e.g. emotions, health)
4. What do you recall about the passage of time from your perspective, past events, or the future?
5. What stands for you as you live your daily life and your surroundings?

Use of Guiding Questions:

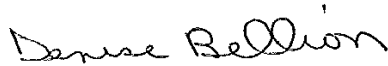
Questions will be used to explore the understanding of time, space, self, and relationships within the context of the mother's own experience. Questions will be used to facilitate exploration and not as a structured format. The interviewee will guide the interview and response from the interviewer will be at a minimum and only to guide the interview forward.

Appendix I

Permission for Use of "Parents of Suicide" Poem

November 5, 2010

I, **Denise Bellion**, give permission to Cynthia W. Lynn to publish my poem entitled *Parents of a Suicide*, in her dissertation entitled the "Lived Experienced of Mothers Bereaved by Suicide". I understand my name will appear as the author but will in no way connect me as a participant in the study.



Denise Bellion



Cynthia W. Lynn

VITA

CYNTHIA WALKER LYNN

- Personal Data: Date of Birth: February 11, 1961
Place of Birth: Knoxville, Tennessee
Marital Status: Married
- Education: Knox County Schools, Knoxville, Tennessee
St. Mary's School of Nursing; Diploma, Knoxville, Tennessee
Carson-Newman College; BSN, Jefferson City, Tennessee
University of Tennessee, Knoxville; MSN
East Tennessee State University; PhD, Johnson City, Tennessee
- Professional Experience: Primary Care, St Mary's Medical Center, Knoxville,
Tennessee, 1982-1989
Baptist Home Care, Knoxville, Tennessee, 1989-1992
Home Care of East Tennessee, Knoxville, Tennessee, 1992-1997
Teacher of Health Sciences, Knox County Schools, Knoxville,
Tennessee, 1997-2002
Assistant Professor, Carson-Newman College, Jefferson City,
Tennessee, 2002-present
- Publications: Dunham-Taylor, J., Lynn, C., Moore, McDaniel, S., &
Walker J. W. (2008). What goes around comes around:
Mentoring new nursing faculty. *Journal of Professional
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- Honors and Awards: United States Department of Health and Human Services (DHHD),
Health Resources and Services Administration (HRSA),
Bureau of Health Professions (BHP) Research Award 2010
- East Tennessee State University Sigma Theta Tau Epsilon Chapter
- East Tennessee State University Nursing Research Grant 2010
- Regional Cooperative Professional Nursing Clinical Excellence
Award 2006
- Highest Academic Standing, Carson- Newman College Division of
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- Honors Member Florence Nightingale Society 1989