

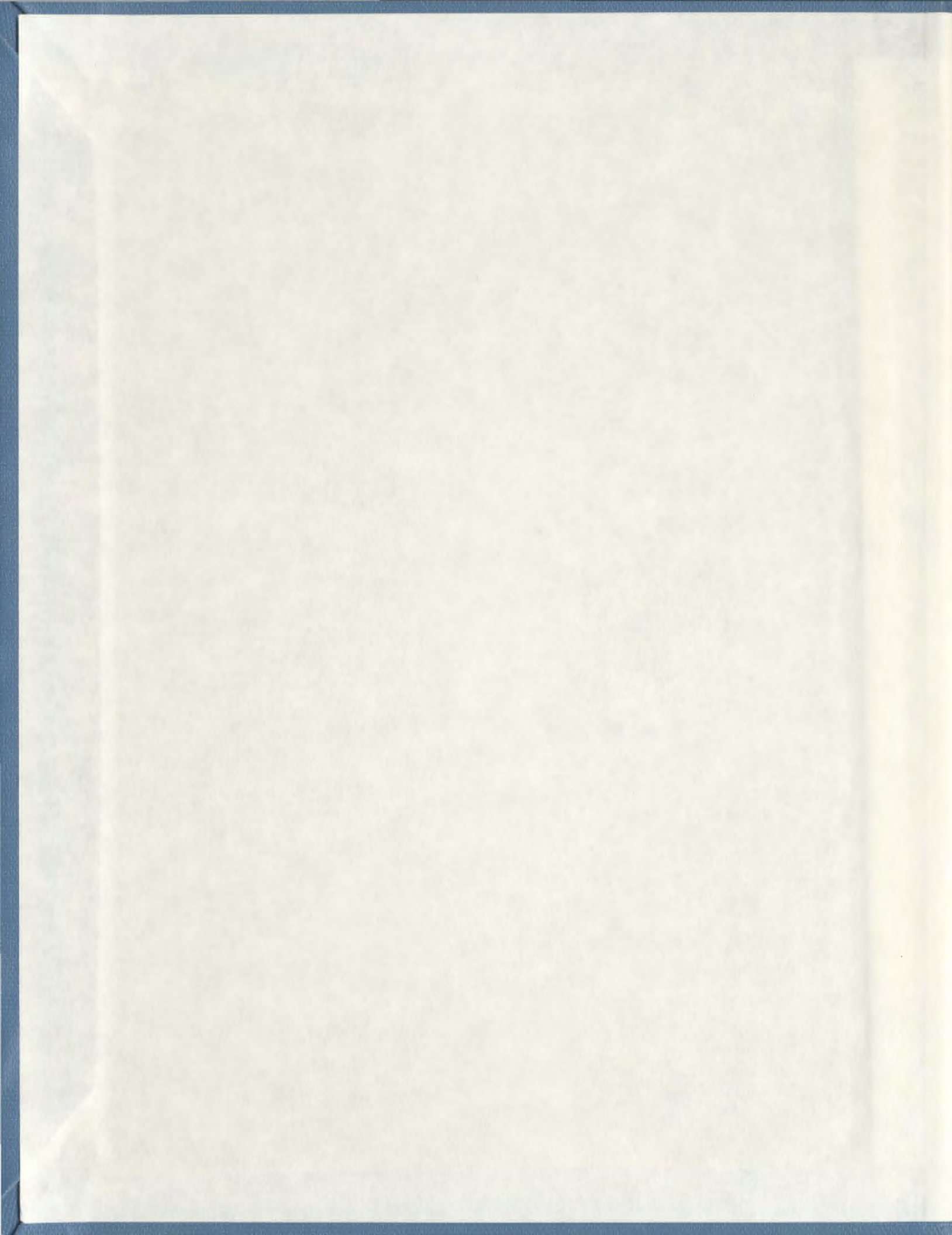
ADOLESCENT SUICIDAL BEHAVIOURS:
A PHENOMENOLOGICAL STUDY OF
MOTHERS' EXPERIENCES

CENTRE FOR NEWFOUNDLAND STUDIES

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ADOLESCENT SUICIDAL BEHAVIOURS:
A PHENOMENOLOGICAL STUDY OF MOTHERS' EXPERIENCES

by

Margaret Ann Torraville

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ABSTRACT

An adolescent exhibiting suicidal behaviours has a devastating impact on his or her mother, but unfortunately the mother's suffering is often a hidden dimension in the family. At present there is a considerable dearth of research into the maternal experience of living with a suicidal adolescent.

The purpose of this phenomenological study is to describe and enhance the understanding of what life is like for mothers living with a suicidal adolescent. The participants included six mothers living with a suicidal adolescent. The data were collected by means of unstructured interviews. Thematic analysis utilizing van Manen's (1997) methodology, identified six themes: (1) failure as a good mother - "Where did I go wrong?" (2) the ultimate rejection - "Is dying more attractive than living with your mother?" (3) alone in the struggle - "You really have to live through it to know" (4) helplessness and powerlessness in the struggle - "It's out of my control" (5) cautious parenting - "It's like walking on eggshells" (6) keeping an emotional distance - "I won't get dependent on your company." The total picture of the mothers' experiences is an interconnection and intertwining of the themes and from this the essence "multiple loss and unresolved grief" was captured.

The findings of this qualitative study have implications for nursing education, practice, and research. In the provision of quality family-centered care, nurses can be educated and guided in their interventions by phenomenological research recognizing the

importance of the maternal perspective in the experience of living with an adolescent exhibiting suicidal behaviours.

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And to the mothers who honestly and willingly told their stories with dignity and courage, my deepest respect and appreciation to you all. I sincerely hope and pray all will be well for you and your families.

DEDICATION

This thesis is dedicated to my wonderful family.

As my mother was my sister Nora's muse, so now my sister has become mine.

Thank you Nora for your support, humor, encouragement, and editing skills which never failed me through these long months.

My three children, Maggie, Paddy, and Aidan have supported me through many years of graduate school and finally, the writing of this thesis. Each of you helped me in your own special way. I love you and thank you all.

CHAPTER ONE: INTRODUCTION

This phenomenological study investigates the experience of what life is like for mothers living with an adolescent exhibiting suicidal behaviours. There currently exists a dearth of research in this area and the findings from this study will therefore, provide much needed understanding and insight into the experience from the mother's perspective.

Living with a suicidal family member has a devastating impact on all family members. When the suicidal person is a child, the situation inflicts a unique crisis in the mother's life. The impact of this crisis can be as profound a shock as the diagnosis of a grave medical illness (Hales & Hales, 1995). If families are the linchpin of support for an ill member, then mothers are often the pivotal member holding the family together. Mothers intimately know the impact of suicide on family life. Unfortunately, in the suffering of suicide within the family the mother's suffering is often a hidden dimension. The suicidal adolescent becomes the focus in the family, but if the focus is shifted and the mother is asked how she is doing, a narrative of pain unfolds.

The mother experiences a unique pain associated with failure to carry out the most fundamental of tasks in caring for the young: giving life; nurturing life; and most importantly, maintaining life. Many mothers view the suicidal behaviours as the ultimate rejection (Ojanlatva, Hammer, & Mohr, 1987; Wagner, Aiken, Mullaley, & Tobin, 2000). The mother feels that she must have done something terrible to provide her own child with a reason to choose death over life with her. To compound this rejection, there also appears to be a social rejection and stigma to the suicidal behaviours. Historically, family

members, particularly mothers, have been blamed for their child's suicidal behaviours (Parker, 1993). The logic is, if she had been a good mother her child would not want to kill himself or herself.

The findings of this study will contribute to the knowledge and understanding nurses and other health care professionals have on the mother's perspective of what life is like living with an adolescent exhibiting suicidal behaviours. Hopefully, it will assist in opening a window of sensitivity and compassion into the mother's suffering and in this way, serve to help alleviate the lingering stigma surrounding mothers during this difficult time in their lives.

Background to the Study

Suicide is a tragic and perplexing phenomenon and a significant mental health problem among adolescents. Suicidal behaviour, which by definition includes suicide ideation, gestures, and attempts, is often viewed as a process starting with the personal thought that life is not worth living, progressing to death wishes, thoughts of taking one's own life, seriously considering taking life, and suicide attempts (Runeson, Beskow, & Waern, 1996). A high and rising rate of adolescent suicide prevails throughout much of the industrialized world (Pfeffer, 1990; Thibault, 1992). Youth suicide rates have been increasing in Canada for several decades. Canada, described by the United Nations in 1995 as the best place on earth to live, has the industrialized world's third highest rate of

adolescent suicide. For persons aged ten to nineteen years, the rates began to increase dramatically in the mid 1950s and reached their zenith in the early 1980s. The rate for fifteen to nineteen year olds rose more than six hundred percent between 1952 and 1992, and for awhile has been the second leading cause of death for this age group, after traffic accidents (Health Canada, 1994). The rising rate of adolescent suicide has caused growing concern among nurses, educators, mental health professionals, and especially parents.

Research on the maternal experience of living with an adolescent exhibiting suicidal behaviours is conspicuously absent from the literature. Only one study was located investigating parents' emotional and behavioural responses to adolescents' suicidal attempts (Wagner, Aiken, Mullaley, & Tobin, 2000). Previous research on the subject of adolescent suicide has focused almost exclusively on attempts to highlight parental risk factors and generate hypotheses about causal mechanisms (Adam, Lohrenz, Harper, & Streiner, 1982; Cohen-Sandler, Berman, & King, 1982; Deykin, Alpert, & McNamarra, 1985; Granboulan, Zivi, & Basquin, 1997; Hollis, 1997; Kienhorst, Wolters, Diekstra, & Otte, 1987; Ross, Clayer, & Campbell, 1983; Shafii, Carrigan, Whittinghill, & Derrick, 1985; Spirito, Brown, Overholser, & Fritz, 1989; Spirito, Stark, Fristad, & Owens-Stively, 1987; Tousignant, Bastien, & Hamel, 1993).

Research has been conducted on parents of adolescent suicide victims to investigate the unique grieving and bereavement process (Bailey, Kral, & Dunham, 1999; Seguin, Lesage, & Kielly, 1995; Van Dongen, 1990). Articles written by concerned health

care professionals and family members help to provide insights and let us gain knowledge in understanding this unique experience (Gyulay, 1989; Hiegel & Hipple, 1990; Hoffman, 1987; Ojantalava, Hammer, & Mohr, 1987).

There has been research conducted in the past twenty years on the burden parents living with a mentally ill child experience (Francell, Conn, & Gray, 1988; Grosser & Vine, 1991; Hanson & Rapp, 1992; Lefley, 1987; Pakenham & Dadds, 1987). However, most of this research has investigated the family burden of parents living with a schizophrenic child. None of these studies on a child's mental illness have specifically investigated parents living with a suicidal child. Articles written by concerned health care professionals have contributed knowledge and insight about families' experiences (Canadian Mental Health Association, 1991; Hales & Hales, 1995; Hatfield, 1987; Holicky, 1996; Parker, 1993).

A dearth of information exists on the maternal experience of living with a suicidal adolescent, leaving health care professionals with a limited understanding of the mother's needs. An understanding of this experience can best be gleaned from an in-depth thematic analysis of narrative descriptions from mothers living through this experience. The development of a knowledge base grounded in the maternal perspective is essential for the provision of quality care by health care professionals.

Rationale for the Study

The impetus for this phenomenological study comes from several sources. My interest began during the advanced clinical component of the Master of Nursing Program. My clinical focus involved working with mothers living with mentally ill adolescents. Over a four month period I regularly interacted with these mothers through two activities. One was an educational session for parents of mentally ill children, assisting them to find positive coping strategies. The other was a support group for mothers of mentally ill adolescents. Many of the adolescents, regardless of the mental illness diagnosis, were exhibiting a variety of suicidal behaviours such as suicidal thoughts, gestures, and suicidal attempts. As my interactions with these mothers continued, I began to view the experience from their unique perspectives, and understand the difficulties they were experiencing trying to cope with their emotions and feelings concerning the suicidal behaviours. The mothers talked about the devastating impact the suicidal behaviours had on their personal lives, and the lack of understanding they experienced from others. Their feelings of isolation from the rest of the world were profound. Therefore, my involvement with these mothers has served as a prelude and a challenge to understand the maternal experience of living with an adolescent exhibiting suicidal behaviours.

A second impetus for this study came from the mothers' perceived lack of understanding conveyed to them by members of the health profession. Their disappointment was striking as they had assumed health professionals especially nurses,

were educated, knowledgeable, and sensitive to their problems. Unfortunately, many experienced the opposite from nurses. The mothers felt they were being blamed for the adolescents' suicidal behaviours. I was disappointed to hear this about my own profession and was forced to question and confront my own possible lack of understanding and sensitivity towards these mothers. Therefore, a motivating factor for this study is to promote a greater understanding, sensitivity, and compassion among nurses and other health care professionals toward this maternal experience.

A final impetus for the study came from the scarcity of research on the mother's perspective of living with a suicidal adolescent. As I attempted to increase my knowledge base from a nursing perspective, I was surprised and disappointed to find a scarcity of research in this area. Therefore, information obtained from the mothers' experiences may help both mothers and the nurses and other health care professionals who work with them. For mothers, the findings may provide much needed guidance and support to assist them cope effectively with the challenge of a suicidal adolescent. For nurses and other health care professionals, an aim is to develop increased sensitivity to the mothers' needs.

Purpose of the Study

Many mothers have had no prior experience with such a devastating stressor as adolescent suicidal behaviour and struggle to find ways to cope not only with the adolescent's safety, but also with the magnitude and complexity of their own emotions and

changed lives. The purpose of this study is to describe the experiences of these mothers. An understanding of the uniqueness of the mothers' experiences will assist nurses and others who read this text to develop an increased sensitivity to, and clearer understanding of, the mothers' needs. This understanding may better prepare nurses and other health professionals to develop interventions geared to the mothers' unique needs.

Due to the dearth of research investigating the maternal experience of living with a suicidal adolescent, this study will contribute to the underdeveloped knowledge base in this area. It is also hoped that this study will provide a stimulus for much needed nursing research in this important area of family-centered care.

Research Question

What is life like for a mother living with an adolescent exhibiting suicidal behaviours?

CHAPTER 2: LITERATURE REVIEW

A literature search on the topic of the mother's experience of living with a suicidal adolescent provided limited information. Only one research study was located examining parents' behavioural and emotional responses to adolescent suicidal behaviours.

Therefore, areas related to adolescent suicide and parents were reviewed which gave some insight into the family dynamics in this situation .

The first section discusses a recent study investigating parents' emotional and behavioural responses to adolescent suicidal behaviours and suicide attempts. This was the sole research study located investigating adolescent suicide from the parents' perspective. The second section includes a discussion of research investigating the influence of parental factors on adolescent suicidal behaviors and suicide attempts. The third section reviews the literature on families' experiences living with a mentally ill child, including research specifically mentioning parents as subjects, and reports from concerned health professionals discussing the burden these families carry. The fourth section reviews the literature on parents of adolescent suicide victims including research studies, reports from concerned health professionals, and family members. The focus in this literature is on the unique grieving, bereavement, and emotional responses of these parents.

The impact on parents living with a suicidal adolescent

One research study was located investigating the effect on parents who live with a suicidal adolescent (Wagner, Aiken, Mullaley, & Tobin, 2000). Even though there is a dearth of research examining adolescent suicidal behaviours from the mother's perspective, it demonstrates a beginning interest by health professionals in understanding this maternal experience. The researchers studied parents' emotional and behavioural responses to adolescent suicide attempts. Thirty-four mothers and fathers of twenty-three adolescent suicide attempters were assessed regarding their emotional reactions the day before the suicide attempt, upon its discovery, and the day after the suicide attempt, using both open-ended and structured interviews. The central question asked was whether the adolescents' suicide attempts were followed by an increase in the parents' caring and supportive feelings, and a decrease in negative feelings toward the adolescent.

The findings showed that positive feelings of caring, sadness, and anxiety were increased from before the suicide attempt to the point of discovery, and for mothers they remained higher through to the following day. Positive feelings were present in approximately fifty percent of mothers across the time points studied. Upon discovering the suicide attempt, parents were less likely to verbalize hostility, more likely to verbalize support, and be more careful of what they said. Mothers reported that they felt hostile even after the suicide attempt, although few verbalized it. The findings are consistent with the idea that suicide attempts elicit feelings of positive concern toward adolescents among

mothers and fathers. However, there was no evidence that suicide attempts precede a decrease in parents' feelings of hostility. Mothers whose children made suicide attempts of relatively higher lethality were more likely to report anxiety, more likely to say something supportive, and less likely to say something hostile, than were mothers of adolescents making suicide attempts of lower lethality.

These findings of Wagner et al. (2000) are consistent with the expectation that suicide behaviour elicits a complex mixture of anger, anxiety, and love in parents. Anxiety was by far the most commonly reported emotion, present in sixty-three percent of the mothers' narratives. Anger was elicited because the suicide would inflict a painful separation and loss. The hostility may contribute to increased worry and concern about the child's safety. Sadness and grief are experienced over the potential loss of the child with a desire to recover the lost person, or to prevent a possible loss through seeking a re-connection. Mothers may interpret the suicide attempt as a sign of their own failure as a parent; therefore, increased feelings of sadness may be linked to guilt, reproach, and decreased self-worth. The increase in caring feelings may follow from the wish to compensate for their failings. Anecdotally, several mothers stated that they wished to avoid upsetting the adolescent after the suicide attempt, and were therefore careful about what they said. The more lethal attempts elicited high levels of maternal anxiety and worry because they presented the highest risk of death. Some mothers became emotionally detached after repeated episodes of suicidal crises to avoid further emotional pain.

The clinical implications of this study are that parents might benefit from being informed about the frequencies of their reactions and similarities to other parents, insofar as that information could aid in normalizing parents' feelings and responses. Additionally, parents might be more willing to acknowledge their own angry feelings once they realize how common such feelings are.

An important limitation of the study is that it relied on parents' retrospective reports of their feelings and verbalizations. These reports may have been biased by any changes in perceptions that occurred in the days after the suicide attempt, or by inaccurate memories of emotions and verbalizations. A second limitation was the small sample size, which limited the power of the analyses. Replication with a larger sample would be necessary for increased confidence in the generalizability of the findings.

The influence of parental factors on adolescent suicide behaviour

There has been considerable interest shown over the past twenty years in investigating family interactions and family factors as contributing causes to adolescent suicidal behaviours and suicide attempts. These studies attempt to highlight parental risk factors for suicidal behaviours and generate hypotheses about causal mechanisms. Considerable debate and controversy exist in the mental health community on the significance of these parental risk factors.

Parental separation and divorce and family functioning have been primarily

investigated as significant risk factors for adolescent suicide. A critical question is: What role has parental separation and divorce played in adolescent suicide behaviours and suicide attempts? The findings from studies conducted in the past twenty years are conflicting. These contradictory findings raise concern about identifying parental separation and divorce as significant risk factors in adolescent suicidal behaviour and attempts.

Several studies have found parental loss through either death, separation, or divorce to be a risk factor for suicide ideation, behaviours, and attempts. Adam, Lohrenz, Harper, and Streiner (1982) investigated the connection between adolescent suicide ideation and suicidal behaviours, and parental loss by either death, separation, or divorce. Their findings indicated that parental loss was a significant variable in the predisposition to suicide behaviour, and that the stability of family life after parental separation lead to less suicide behaviour than a more chaotic but intact family. Life stressors and symptomatology as determinants of suicidal behavior in children were investigated by Cohen-Sandler, Berman, and King (1982). Results showed that suicidal children experienced an increasing amount of stress such as parental divorce, as they matured. Adolescent double suicide attempts were compared to adolescent single suicide attempts and adult pacts, in a study by Granboulan, Zivi, and Basquin (1997). Adolescent double attempters differed from single attempters in terms of having more risk factors related to family disturbances such as parental separation, divorce, death of a parent, or placement in a foster home.

Other studies have not found parental loss to be a risk factor for adolescent suicide ideation, behaviours, or attempts. Results from a psychological autopsy of adolescents who had committed suicide were compared to a matched-pair control group (Shafii, Carrigan, Whittinghill, & Derrick, 1985). Interviews were conducted with loved ones to investigate familial, environmental, and personal characteristics of the victims. The results showed no differences between the victims and the control subjects regarding divorce, separation, step-parents, adoptive parents, or any other arrangements where the natural parents were not living together. Spirito, Stark, Fristad, Hart, and Owens-Stively (1987) compared characteristics of the psychological status of adolescent suicide attempters hospitalized on a general pediatric floor, with a matched sample of adolescents referred for psychiatric consultation while hospitalized for a variety of conditions. The data were analyzed for risk factors believed to be associated with adolescent suicide attempts including: family constellation; psychiatric history; alcohol and drug abuse, physical and sexual abuse; marital conflict; and parental alcohol abuse. The only significant difference between the two groups was that the suicide attempters had a higher percentage of psychiatric difficulties than the comparison group. Approximately three quarters of both the suicide attempters and the comparison group came from intact families.

Several authors point to other factors inherent in separation and divorce such as emotional distress (Spirito, Brown, Overholser, & Fritz, 1989) and the quality of the parent-child relationship (Kienhorst, Wolters, Diekstra, & Otte, 1987). Spirito et al. (1989) reviewed and critiqued research investigating the relationship between parental

separation and divorce and adolescent suicide attempts. The authors found that the rate of divorce was consistently greater in the suicidal group than in control groups of normal adolescents, or adolescents on a medical service. However, when adolescents with other psychiatric difficulties were used as a comparison group, there was no difference in the rate of family breakdown across groups. The authors concluded that parental separation and divorce appear to be risk factors for the development of emotional distress, although not specifically, suicidal behaviour. Kienhorst, Wolters, Diekstra, and Otte (1987) conducted a study to assess the incidence of adolescent suicide and suicide attempts and the forms in which this behaviour occurs. Nearly one-half of the adolescents came from single-parent families, with over three-quarters of the single-parent families due to divorce. The authors believed that the difficulties encountered by children in single-parent families were probably due more to the quality of the parent-child relationship and to the problems associated with a divorce, or a death in the family, than to the fact that the children were living with one parent.

Another critical question to ask is: What role has family behaviour, including family functioning and parental behaviour, played in adolescent suicide ideation, behaviours, and attempts? Prominent areas of clinical investigation include family discord (Hollis, 1997), and negative parent-child relationships (Ross, Clayer, & Campbell, 1983). Parental behaviour such as alcohol and drug abuse, and sexual and physical abuse, has also been investigated (Deykin, Alpert, & McNamarra, 1985; Spirito, Stark, Fristad, Hart, & Owens-Stively, 1987). The studies demonstrated contradictory findings. Current interest

interest in this area is focusing more on the quality of parent-child relationships, particularly the father's role (Tousignant, Bastien, & Hamel, 1993).

Hollis (1997) investigated the influence of family relationship difficulties over and above the effect of adolescent depression on the risk of adolescent suicidal behaviours. Depression in the suicidal adolescent made the most significant contribution, while the specific domains of family discord, and disturbed maternal-child relationship, made small but significant contributions. The parental rearing patterns of individuals who reported suicidal ideation was investigated by Ross, Clayer, and Campbell (1983) who hypothesized that those with suicidal ideation would report a worse relationship with parents, than those without suicidal ideation. The findings indicated that there was a more negative relationship with parents as suicide ideation increased. A high positive correlation existed between a rejecting mother and suicide ideation, and between an abusive, punitive, and rejecting father and suicide ideation.

The exposure to child abuse or neglect and adolescent suicidal behaviour was investigated by Deykin, Alpert, and McNamarra (1985). A comparison of suicide attempters with a control group showed that the former were three to six times more likely to have been abused or neglected as children. In comparison, no difference in the rate of child abuse (physical or sexual) was found in a group of adolescent suicide attempters when compared to a matched sample of adolescents (Spirito, Stark, Fristad, Hart, & Owens-Stively, 1987). Adolescents in both groups were compared for the presence of risk factors, such as family status, psychiatric history, parental alcohol and

drug abuse, physical and sexual abuse, and marital conflict. The suicide attempters differed from the comparison group on only one risk factor - psychiatric history. A review and critique of the literature on the relation between parental risk factors and adolescent suicide behavior was conducted by Spirito, Brown, Overholser, and Fritz (1989). Prominent areas of clinical investigation included: family violence; physical and sexual abuse; disturbed family functioning; family psychiatric history including, drug and alcohol abuse; and rates of separation and divorce. The studies consistently supported the belief that families of adolescent suicide attempters are characterized by substantial levels of dysfunction.

The quality of parent-child relationships has been the focus of research in the past decade. Marital separation, and its effect on the emotional well-being of children was analyzed concurrently with the quality of parent-child relationships (Tousignant, Bastien, & Hamel, 1993). They investigated the contribution of the father's and mother's care, and parental separation to adolescent suicide attempts and ideations. The results indicated that the integrity of the family played a lesser role than the relationship of the adolescent to the parents. The combination of good care and an intact family was associated with the lowest rate of suicidal behaviour. The rate of suicidal behaviour doubled when a marital break-up was present, even in the presence of good care. The situation was worse when the family was intact, but the father's care was poor. In the case when the father's care was poor, the rate of suicidal behaviour did not significantly increase with family break-up. When maternal scores were considered, marital break-up was associated with an increase

in the rates, whatever the level of care. Poor care by the mother and marital status had a significant contribution. The findings indicated that the father's negligence and negative relationship with the child played a very important role in the suicidal behavior of adolescents, but the mother had a much lower influence. Family break-up was found to have an effect on suicidal behaviour, but the magnitude was less than the quality of the relationship with the parents.

There are several limitations to the research conducted on the relation between parental risk factors, and adolescent suicidal behaviour and suicide attempts. The majority of the research to date has been conducted on psychiatric inpatients, who are not representative of the wide spectrum of suicidal manifestations in the community. Many of the studies focused exclusively on the adolescents' perceptions of family functioning and family problems, with no parental input. In addition, the studies have not controlled for potential confounding factors, such as parental age. Therefore, these limitations and the contradictory findings raise considerable doubt about the significance of parental risk factors, such as separation and divorce, and family behaviour to adolescent suicidal behaviors and suicide attempts.

Parents living with a mentally ill child

The parental experience of living with a mentally ill child is pertinent to the experience of living with a suicidal child, since all of the adolescents in the current study

had a concomittent mental illness. Research on parents living with a mentally ill child was sparked due to deinstitutionalization and the resultant burden on families. All the studies agree that families of the mentally ill play an important and increasing role in the management of their relatives' mental illness. (Francell, Conn, & Gray, 1988; Grosser & Vine, 1991; Hanson & Rapp, 1992; Lefley, 1987; Pakenham & Dadds, 1987). Reports by concerned health care professionals agree that the burden families living with a mentally ill child carry, is considerable (Hales & Hales, 1995; Hatfield, 1987; Holicky, 1996; Parker, 1993).

Family burden and coping strategies of families living with a mentally ill child were investigated in a study by Lefley (1987). The categories investigated included: changes as a result of personal experiences with mental illness; personal reactions; experiences with treatment; and, family burden and coping. The findings indicated that parents of mentally ill children suffer emotional burden, unsatisfactory experiences with the mental health system, and a stressful life. A study conducted by Pakenham and Dadds (1987) hypothesized that providing information to parents of a schizophrenic child would help decrease their personal distress and associated burden, change attitudes and coping mechanisms, and lower family tension and stress. Findings indicated that the parents had considerable gains in knowledge and understanding, experienced fewer interferences with family living, had less distress and family conflict, and reported a substantial reduction in anxiety.

Family care-givers' experiences of burden in caring for mentally ill relatives were

investigated in a study by Francell, Conn, and Gray (1988). Two categories of burden identified were the day-to-day care of the child, and interactions with the mental health system. Families described the following as significant contributors to their burden: feelings of hopelessness, powerlessness, weariness, and frustration; feeling blamed by mental health professionals; desertion by mental health care providers causing feelings of abandonment; and a lack of community resources. Grosser and Vine (1991) conducted a survey of family members of individuals with mental illness, in order to assess perceptions of service needs. Survey responses included: a lack of understanding by health professionals concerning the problems family members face in caring for the mentally ill; a strong preference for community-based programs; and worries about the future care of the mentally ill relative. The authors discussed how extensive research is needed in order to portray the experience of families, particularly parents, who care for a mentally ill child.

Recognizing the importance of the subjective experience of families, a study was conducted to investigate families' perspectives of their experiences with community mental health programs (Hanson & Rapp, 1992). The results showed that family members are frustrated due to lack of information from health professionals, unrealistic demands placed on them, and a lack of caring, support, and understanding from health professionals. This study emphasized the need for research into the experiential aspects of the family perspective in living with a mentally ill relative, and recommended that the relationship between professionals and families could be vastly improved if the mental health community would choose to address some of the family's needs.

Research on parents caring for a mentally ill child has primarily focused on evaluating burden, community resources, and social support. Less interest has been shown in investigating what this experience is like from the perspective of individual family members, such as mothers. However, respect and value for parents' opinions and knowledge and the need for future research into the experience of families living with a mentally ill relative was discussed in more current articles (Grosser & Vine, 1991; Hanson & Rapp, 1992). There appears to be a burgeoning interest in understanding this experience from the perspective of individual family members in that recommendations can be found in articles concerning future phenomenological research in this area (Hanson & Rapp, 1992). However, specific interest in studying the parental experience of living with a suicidal adolescent has been limited.

Several reports discuss the concern of professionals for families living with a mentally ill relative (Canadian Mental Health Association, 1991; Hales & Hales, 1995; Hatfield, 1987; Holicky, 1996; Parker, 1993). This concern focuses on the burden families carry, the emotional impact on all family members, their feelings of isolation, and a lack of understanding and caring from the professional community.

A comprehensive document by the Canadian Mental Health Association (1991) discussed the problems and burdens encountered by families of people with mental illness. Asking families from across Canada to write and describe their experiences resulted in mothers sending almost seventy-five percent of the letters. The document reported how families receive little or no recognition of their role and are caught in a tragic

contradiction. They are the major care-givers for a mentally ill relative, but no one seems to have noticed. The experience of being left out permeated the responses. Since deinstitutionalization, families of the mentally ill are described as the “institution of choice” (Parker, 1993). These families need help, and mental health professionals must address their needs because coping with the problems is often outside the experience of most families. Shifting the focus from the mentally ill member to the other family members is necessary in order to understand their emotional distress including grief, guilt, powerlessness, hopelessness, fear, and isolation from the stigma of mental illness.

Hatfield (1987) discussed the importance of understanding the family’s perspective concerning mental illness. Problems faced by family members living with a mentally ill child included: struggling with emotions; difficulty in identifying and accessing mental health providers appropriate to their needs; a lack of understanding from health professionals; and a resistance by the mental health community in knowing about the pain and confusion of families. Family burden and the emotional impact on family members were similarly described by Hales and Hales (1995), and Holicky (1996). Family reactions included guilt, loss, self-blame, anger, insecurity, loneliness, resentment, depression, and bitterness, and feelings of emotional abandonment. Parents of a mentally ill child can feel they have a stranger in their midst, as they see the child they thought they knew change before their very eyes. They face daunting challenges, adjustments, changed family dynamics, and high levels of stress.

Overall, these studies and reports emphasize the significant burden families living

with a mentally ill relative carry. This burden encompasses many areas including emotional problems, a lack of support and understanding from the health care community, and even a resistance to knowing what this experience is like from the perspective of individual family members. Families experience helplessness, powerlessness, and frustration, family conflict, tension, and disruption, and unsatisfactory experiences with the mental health system and health care professionals. Recent articles point to the need for a better understanding about families' experiences, and emphasize the pivotal position nurses occupy in providing help to families.

Parents of adolescent suicide victims

This section was included in the literature review because of the similarities found between parents' suffering after the suicide of their adolescent, and this researcher's findings of mothers' experiences living with an adolescent exhibiting suicidal behaviours. Research has focused on questioning and understanding how the parental grieving and bereavement process differs from other types of parental bereavement (Bailey, Kral, & Dunham, 1999; Seguin, Lesage, & Kielly, 1995). Furthermore, interest has been shown by the nursing community in understanding the experience from a qualitative viewpoint (Van Dongen, 1990). Articles and reports by concerned health care professionals demonstrate knowledge and understanding about the emotional impact and unique grieving process that parents of adolescent suicide victims experience (Gyulay, 1989;

Hiegal & Hipple, 1990; Ojanlatva, Hammer, & Mohr, 1987). Reports from mothers who have experienced a death of a child from suicide, have contributed a deeper insight and understanding into this experience (Hoffman, 1987).

Seguin, Lesage, and Kielly (1995) investigated how the bereavement process following suicide differed from other types of bereavement, by interviewing parents of adolescent suicide victims and parents of adolescent car accident victims. Measures of shame, social support, family adaptation, psychological distress, and prior loss were obtained. The findings indicated that parental bereavement after suicide appeared to differ in several ways from other types of bereavement. Compared to parents of car accident victims, parents of adolescent suicide victims were more depressed, experienced greater feelings of shame, and felt they had failed as competent providers. They felt awkward with families and friends and tended to isolate themselves, making it hard for family and friends to give support. The authors concluded that the bereavement process following suicide may be an interaction of both a qualitatively different grieving process and related to the personal vulnerability and resiliency of parents. Current research has recognized the unique and multi-dimensional qualities of grief. Bailey, Kral, and Dunham (1999) investigated how the loved ones of adolescent suicide victims grieve differently from the loved ones of victims of other modes of death. The most substantial of the findings concerned differences in the highly specific grief reactions of the loved ones of suicide victims. They reported more frequent feelings of rejection and abandonment, responsibility for the death, shame, embarrassment, and stigmatization. A great proportion of their time

was spent asking, "Why?" The results indicated that the loved ones of suicide victims evidence more variability in grief reactions than do the loved ones of other bereaved groups.

Insight was provided into the perceptual experiences of parents of adolescent suicide victims in a study by Van Dongen (1990). The theme, "agonizing questioning," related to the emotional turmoil, cognitive dissonance, physical disturbances, and altered socialization parents experienced. Searching for answers was a major survival strategy used by the parents to help cope with the impact of suicide on their lives. The emotional turmoil described included rapid mood swings, experiencing many emotions simultaneously, and feelings of anger towards the victim, themselves, the mental health system and health professionals. Apathy, irritability, sadness, and personal thoughts of suicide were described along with sleep disturbances and fatigue. Alterations in social experiences included not wanting to share emotions, and limited interactions with family members. Conserving energy, and limiting the amount of pain experienced by temporarily insulating themselves from the harsh reality of death were described as efforts to cope.

There are several reports by concerned health professionals discussing the impact that a child's suicide has on parents, indicating the interest the mental health community has in understanding their experiences (Gyulay, 1989; Hiegal & Hipple, 1988; Ojanlatva, Hammer, & Mohr, 1987). The authors agreed that parents of a child suicide victim experienced an intensity of various emotions ranging from guilt and depression, to anger and relief. Parents suffered the same feelings of guilt, anger, pain, and sadness that other

mourners suffered, but can also experience intense feelings of rejection that can last for years. Gyulay (1989) discussed how the “anticipated suicide” of a child caused preparatory grieving in parents. Anger, guilt, and relief are identified similarly by Ojantlava, Hammer, and Mohr (1987). However, other emotions such as, blame, shock, numbness, denial, and shame were also identified and discussed, including parents having suicidal thoughts due to feelings of worthlessness.

A mother’s and a nurses’s viewpoint concerning the death of a child by suicide is found in an article by Hoffman (1987). Her motivation for writing this article was to open a window of understanding into the complexity of emotions a mother experiences which include grief, anger, shock, and numbness. She described fear for her other children as a dominant emotion following the suicide of her son. This identification of fear for the victim’s siblings was not mentioned in the research on parents of child suicide victims, nor in reports from health professionals. This gives credence and support to the statement made by Van Dongen (1990) that individuals are the most valid source of information concerning an experience.

Overall, these articles provide understanding and insight into the parental experience after the suicidal death of a child. Parents undergo responses and emotions similar to other mourners, plus a variety of other emotions unique to this experience. Health care professionals are assisted in helping these parents cope effectively with this stress by this knowledge and insight.

Summary of the Literature Review

Despite the plethora of parental risk factors touted as having significance for adolescent suicide attempts, no single factor has been identified as the cause for adolescent suicidal behaviors or attempts. The factors operating in the causation of adolescent suicidal behaviours and suicide attempts are complex. Attribution of parental responsibility appears to be unjustified, and therefore settling on one line of investigation is divisive. Family problems such as parental rearing styles, family conflict, and family disturbances have been cited as risk factors yet there is no consensus nor firm evidence. Data on the effect of parental separation and divorce are also non-conclusive due to contradictory findings and study limitations. However, data from studies on parental behavior, specifically the quality of child care as a significant risk factor, show more conclusive evidence. There is growing interest in the role fathers play in adolescent suicidal behaviour. A systematic attempt needs to occur in future research to assess concurrently the influence of paternal and maternal care. The identification of parental risk factors for adolescent suicide behaviour has been hampered by limitations of the studies and contradictory findings.

Research has been conducted into the effects of a child's suicide on the parents and offers insight into the unique grieving and bereavement process. Comparisons to other groups of bereaved parents have taken place in order to investigate similarities and differences. Unfortunately, research on the parental experience of living with a suicidal

child has not kept pace, therefore limiting health professionals' insight and knowledge.

Interest by health care professionals on the burden experienced by parents living with a mentally ill child was reflected in the research conducted since deinstitutionalization. Similar interest was generated through studies on families' emotional burden, unsatisfactory experiences with the mental health system, and a need for family support and education. Current articles focusing on family burden, promoted the need for increased phenomenological research into the perspective of individual family members.

Only one current study investigated the experience of adolescent suicide from the parents' perspective (Wager, Aiken, Mullaley, & Tobin, 2000). These researchers acknowledged the lack of knowledge and insight that health care professionals have about the impact of adolescents' suicidal behaviours on individual family members. This study recommends continued research in this area emphasizing the benefits such research would have for parents of a suicidal adolescent.

CHAPTER 3: METHODOLOGICAL APPROACH AND METHODS

This phenomenological study is designed to describe the meaning and significance of what life is like for a group of mothers in Newfoundland living with an adolescent exhibiting suicidal behaviours. Two sections constitute this chapter. The first section presents phenomenological research as a methodology and as a mode of inquiry described by van Manen (1997). The second section includes an overview of the methods and steps used in the research process to investigate the experience of mothers living with an adolescent child exhibiting suicidal behaviours.

Methodological Approach

Phenomenological research

Phenomenology is both a dynamic philosophy and an investigative methodology. It is a philosophy of the personal and of the individual, which is pursued against the background of an understanding of the whole, the communal, and the social (van Manen, 1997). As a research method it is a rigorous, critical, systematic investigation of phenomenon with an approach that is inductive and descriptive in design (Streubert & Carpenter, 1995). Researching topics central to the life experience makes phenomenology a suitable method important to nursing practice (Beck, 1994).

Phenomenology as described by van Manen (1997) is an approach to qualitative

research that is both descriptive and interpretive. Research of this nature must begin in the world of the lived experience or, “the original, pre-reflective attitude” (van Manen, 1997, p.7). The aim of phenomenology is to explicate the meaning of human phenomenon, and to understand the lived structures of meanings of everyday experience. Phenomenology seeks to question and understand what a particular experience is like for a person from the perspective of the person experiencing it. Since knowledge speaks through lived experience, phenomenology asks the simple question: What is it like to have a certain experience?

Phenomenological descriptions aim at elucidating lived experience. These descriptions are construed in such a fashion that the nature and significance of the experience is able to be grasped. Phenomenology can suggest different ways of looking at a phenomenon or reveal dimensions of meaning not before considered. Through the lens of the researcher, the essence or the true meaning of the lived experience is described (Streubert & Carpenter, 1995). An essence is “that what makes a thing what it is and without which it would not be what it is” (van Manen, 1997, p. 177). The aim of phenomenology is to transform this lived experience into “a textual expression of the essence in such a way that the effect of the text is at once a reflective re-living of something meaningful” (p. 26). This insight into the essence involves a process of reflectively appropriating, clarifying, and making explicit the structures of meaning of the lived experience.

One of the core concepts of phenomenology is “intentionality.” van Manen (1997)

describes this as the way an individual is connected to the world. Every thought or action is directed toward some object, either physical or ideal, although we are not conscious of our intentionality as experience. It is in retrospect that we discover this basic characteristic of consciousness. It is only by being conscious that we are related to the world. The principle of intentionality facilitates the researcher's questioning of the way a person is able to experience the world as a human being.

“Reduction,” a core concept in phenomenology, involves the researcher's need to overcome subjective feelings, previous experiences, theories, or scientific concepts that would prevent the researcher coming to terms with the experience as it has been lived (van Manen, 1997). This process is called “bracketing,” but according to van Manen, complete reduction is impossible. He suggests that holding our presuppositions and assumptions at bay and exposing them as barriers to an understanding, rather than forgetting or ignoring what is already known, helps in assisting the researcher come to terms with personal assumptions. The researcher therefore, needs to work consciously and vigorously at reduction throughout the study.

van Manen (1997) describes phenomenological research as consisting of six different activities that form a dynamic interplay within human science research. First, the researcher must choose a phenomenon of interest, and be committed to a study of that phenomenon. The second activity is investigation of the phenomenon as it is experienced, rather than how it may be conceptualized. The third activity is an attempt to grasp what gives the experience being investigated its special significance. It is a way of making

explicit the structure of meaning of the lived experience. This takes the form of reflecting on essential themes within the phenomenon. The fourth activity is an attempt to capture in textual form, through the interplay of thought and language, the experience as it has been lived. The fifth activity is the maintenance of a strong and oriented relation, so as not to become distracted from the purpose of the research. The final activity is to balance the research context by considering the parts and their contribution to the description of the experience in its entirety.

Methods

Methods, according to van Manen (1997), are paths that lead toward a clearing where the nature of a phenomenon can be revealed. It is the mode of inquiry, the particular way which allows the researcher to gain an understanding into the nature of the phenomenon. In the current study, data were analyzed following interviews with six mothers living with an adolescent exhibiting suicidal behaviours. This section describes the inclusion criteria for participant selection, methods of participant selection, ethical considerations, interview procedures, data collection and procedure, interview technique, data analysis, and credibility.

Participants

Participants in this study were mothers living with an adolescent exhibiting suicidal behaviours. The inclusion criteria required that: (1) the adolescent was medically diagnosed with a mental illness by a pediatric psychiatrist, and had exhibited suicidal behaviours such as suicidal ideation, suicidal gestures, or a suicide attempt; (2) the adolescent was between the ages of twelve to sixteen years; (3) the mother was living with the adolescent for a period of one year or longer and; (4) the mother was fluent in English. Rationale for these criteria was based on the following assumptions: (1) this ensured capturing the phenomenon of interest; (2) after their sixteenth birthday, the adolescent is referred into the adult mental health care system; (3) living with the adolescent for a period of one year or longer provided sufficient time for the mother to give insight and meaning into the experience; (4) the participants understood and spoke English since it is the language of the researcher. This reduced the possibility of any confusion or misunderstanding of information being conveyed during the interview process.

Selection of participants

Purposeful sampling is used most commonly in phenomenological research (Streubert & Carpenter, 1995). Individuals are selected for the research study based on their particular knowledge of the phenomenon. In phenomenological studies, the size of the sample depends on the amount of relevant data. Roberts and Burke (1989) stated that “the exact number of participants often cannot be determined in advance because the

researcher will continue until the meanings are clear” (p. 226). The sample size of six participants was considered appropriate since a study of this nature involves a large volume of narrative data (Morse & Field, 1995; Sandelowski, 1995).

The six mothers involved in the study were identified with the assistance of several pediatric psychiatrists at the Janeway Child Health Center, St. John’s, Newfoundland. The adolescents and their mothers were actively participating in family therapy on an out-patient basis with a pediatric psychiatrist. The prospective participants were contacted by telephone by the pediatric psychiatrist to ascertain their interest in taking part in the study. For those who agreed, their names and telephone numbers were released to the researcher who then contacted them by telephone, briefly explained the study, and if they were willing, invited them to participate and arranged a convenient time and place for the interview.

Ethical considerations

Permission to conduct the study was granted by the Human Investigation Committee of the Health Science Center, Memorial University of Newfoundland (see Appendix A). All the necessary steps were taken to ensure that the rights of the participants were recognized and protected. At the start of the interview the following information was thoroughly explained to the participants: the purpose of the study; data collection procedures; the type of data to be collected, such as the mother’s thoughts and feelings about the experience; the approximate time required from the participant; and the

choice to withdraw from the study at any time. Signed and witnessed consent was then obtained from the participant, including permission to tape the interview. All participants were given adequate time to read the consent form and to ask questions (see Appendix B).

The mothers were informed of measures to ensure their anonymity. Codes would be used for identifying the tape recordings and transcriptions, rather than the use of names. Each taped interview would be erased after transcription and the transcription secured in a locked cabinet. The participants were informed that their experiences would be described in a manner that identification of the information source would be impossible. As well, all identifying information would be destroyed once data collection was completed.

All the participants were informed of the potential benefits from participating in the study. They were informed how it was anticipated that the information provided by them would enhance health professionals' knowledge and understanding of their experience, and aid in the development of an increased sensitivity to their needs. The mothers were told how some people find it helpful to express their thoughts and feelings about a personal experience, appreciating someone listening to their story. Kavanagh and Ayres (1998) described the benefits of participating in qualitative interviews which include catharsis, self-acknowledgment, empowerment, and healing.

The participants were also informed that there was a degree of risk for emotional upset due to the sensitive nature of the interview. Kavanagh and Ayres (1998) report on the inherently uncertain nature of the research interview, as it allows for the personal expression of one's experience. Some parents are more vulnerable to risk because of their

limited ability to use coping strategies during particularly sensitive points in the interview. Being sensitive to this, assurance was given to the mother that if she should become upset while revealing personal feelings, support would be given, and the interview stopped or delayed at her request.

The psychiatrists were aware of the mothers' participation in the research study and the potential risk to create emotional upset, and agreed to be available to the mothers should they want to discuss their feelings. Kavangh and Ayres (1998) recommend that the investigator have a mechanism for following up on the participant's response to the interview, for example a subsequent interview or phone call. In follow-up conversations, each participant reiterated how good they felt telling their side of the experience to a non-judgmental person. At all times I was cognizant of the sensitive nature of the interview and its subsequent potential emotional distress, and utilized strategies to minimize as much as possible the risk for each participant. In this way the psychological well-being of each mother was protected.

Data collection

Data were collected by the use of unstructured interviews, audio-taped and conducted at a time and place convenient for the participant. All interviews were conducted in the researcher's home, and lasted approximately two to three hours. The interview was not structured with a list of developed questions, however, questions were developed to help me facilitate the interviews (see Appendix C). These questions were

broad, open-ended and designed to avoid influencing the mothers' answers in any way. At the beginning of the interview I informed the mother that I was interested in obtaining her thoughts and feelings about what life was like for her living with an adolescent showing suicidal behaviours. I assured the mother that there were no right or wrong responses. I requested her to tell me about the experience in her own words. I began the interview by asking, "What is a typical day like for you?"

I listened quietly and patiently, using prompts and reflective techniques only if I required elaboration on a specific comment. Silence throughout the interview was used as a further attempt at reflection by the mothers. During the interview several mothers cried briefly while describing certain events and their reactions and emotions, and I gave support and showed empathy. The tape recorder was turned off as necessary to take short breaks due to the sensitive and tiring nature of the interview topic. The session ended when all the mothers had exhausted descriptions of the experience, and no new information emerged.

In order to augment the interviews, I listened to the tape-recorded interviews and wrote my observations regarding non-verbal behaviour, and any areas needing clarification. For example, while listening to the tape recordings I recorded what the mother was doing, and her facial expressions, during silent intervals in the conversations. These notes were transcribed and analyzed along with the interview data.

Data analysis

Within one day following the interviews, the tape-recorded interviews were labeled and transcribed verbatim by the researcher. Transcribing the interviews personally allowed me to become fully immersed in the data, and obtain an initial impression of the context of the conversations. I then began to read and reread the transcriptions as the tape-recorded conversations played, to ensure accuracy of the transcriptions, and also to get a sense of the whole of the experiences.

The specific approach used to begin data analysis was van Manen's (1997) selective or highlighting approach. The text was read and reread, and specific statements appearing to say something to me about the experience were highlighted. I took each of these highlighted statements and attempted to capture them in writing. As the data analysis continued, I identified themes from the transcriptions. Several meetings followed with my research advisor as we discussed the emerging themes. I attempted at all times to remain oriented to the fundamental question of the study, and not to become side-tracked by indulging in speculation. I always attempted to balance the content by considering parts along with the whole, thereby settling for no less than the true meaning of the phenomenon as described by the mothers. van Manen suggests continuously measuring both the researcher's textual reflections, and the participants' descriptions, against the whole.

After the summary of themes was completed, the mothers were contacted to verify whether the themes truly reflected their experiences. All agreed that my interpretation

adequately reflected their lived experiences. After several more meetings with my research advisor, the themes were refined. The thematic statements that emerged were used in developing the text. I endeavored to be exact by aiming for interpretive description, fully describing the details of what it is like for a mother living with a suicidal adolescent. Writing and rewriting is the “untiring effort to author a sensitive grasp of the phenomenon” (van Manen, 1997, p.132). Finally the essence or true meaning of the experience was captured and described in text.

Credibility

Credibility in qualitative research is measured by how well the researcher reports the perspectives of the informants (Morse & Field, 1995). A qualitative research study is credible when the people having the experience being studied recognize it as their own (van Manen, 1997).

To ensure credibility of this research study I undertook the following measures: (1) the research committee selected for this study consisted of nurse researchers proficient in phenomenological methodology and possessing a sound knowledge on the subject area; (2) my interviewing skills were discussed with my research advisor before the start of the interviews. Suggestions for improvement were made by my research advisor after reading the initial interview transcription, and improvements were made for the subsequent interviews; (3) close collaboration with the research committee aided in the discovery and refinement of meanings embedded in the texts. This assisted me in gaining a deeper

understanding of the experiences and in extrapolating messages and meanings; (4) collaboration with the participants as the themes emerged verified that the themes truly reflected their experiences.

I attempted to control any researcher bias in several ways. Before the start of the research study I discussed with my research advisor any preconceived ideas or biases I might have had concerning the mother's role in adolescent suicide. From then on, I consciously used bracketing, suspending my personal beliefs and biases, in order to study the essential meaning structures. van Manen (1997) suggests that presuppositions and assumptions persistently creep back into the researcher's reflections, and trying to forget them is impossible. Being cognizant of this, I attempted to hold these assumptions at bay, understanding that exposing them as barriers would help me come to terms with these assumptions. Frequent consultations with my research advisor were helpful in keeping me focused on the research question guiding the study.

CHAPTER 4: FINDINGS

The findings are presented according to the major themes which were identified from the data analysis. Section one is a description of the participants' characteristics; section two is a presentation of the thematic statements, with descriptive and interpretive material; and section three is a discussion of the essence of the experience.

Participants' Characteristics

Six mothers, ranging in age from thirty-two to forty-five years participated in this study. The educational level varied from a high school diploma to a university degree. All of the mothers were married; one for the second time. All of the fathers were living in the home. Five out of the six mothers worked outside of the home. Several mothers attended a support group for parents living with mentally ill children.

The ages of the adolescents exhibiting suicidal behaviours ranged from thirteen to sixteen years. Five of the adolescents were girls; one a boy¹. All of the adolescents were the biological children of the mothers. There were one to three siblings living in the homes. The number of suicide attempts made by the adolescents varied from one to five.

¹ In the text, "she" will be used for the adolescents so as not to identify the lone boy.

Thematic Analysis

Following the thematic analysis, six themes were identified. These themes assisted me to move toward a rich and deep understanding of what life is like for these mothers who were living with an adolescent exhibiting suicidal behaviours. All the themes have equal importance and special significance, and are not presented in order of priority.

The thematic statements which emerged from the analysis are:

- 1) Failure as a good mother: “Where did I go wrong?”
- 2) The ultimate rejection: “Is dying more attractive than living with your mother?”
- 3) Alone in the struggle: “You really have to live through it to know.”
- 4) Helplessness and powerlessness in the struggle: “It’s out of my control.”
- 5) Cautious parenting: “It’s like walking on eggshells.”
- 6) Keeping an emotional distance: “I won’t get dependent on your company.”

Failure as a good mother: “Where did I go wrong?”

All the mothers expressed the belief that they had failed at motherhood. Their narratives reverberated with blame, self-recrimination and a sense of total failure. This guilt stemmed from the belief that their own child wanted to die because of something they had done wrong or omitted to do. One mother stated:

What did we do wrong? I shouldn't even say "we". My husband is away half the time. I'm the mother with the kids so obviously I did something wrong!! Not him. It was me!! I went back over everything I had ever said or did to that child. I was convinced I had done something wrong. Nobody else, just me.

One mother described how she asked her adolescent where she failed in raising her, where she had gone wrong in her parenting. She questioned the times she had fought with her daughter and wondered if that was the cause of her suicide attempt. Another mother expressed her horror at missing the warning signs her daughter had shown and described her guilt in not taking her to hospital sooner. She felt her daughter had gone too long without medical help and this delay contributed to her suicide attempt.

The mothers' narratives all contained similarities in how confused and inadequate they felt in their ability to be a proper mother. This led them to doubt and distrust their normal parenting skills. One mother really felt she had been a good mother before her child's suicide attempt but now believed she could not have been.

Insecurities extended into their whole lives and their interactions with others. They no longer trusted their judgments or their decision-making skills. Many mothers felt as this mother did:

It changes your whole focus, your way of thinking, the way you do things, the way you interact with people, the whole thing. I am very unsure of anything or anyone. I can't make a decision anymore. I don't trust myself anymore to make a decision.

One mother described her feelings of incompetence about giving advice on parenting to her friends raising teenagers, due to what she described as, “the mess I’ve made.”

Because of feelings of incompetence and low self-confidence, she advised her friends to do the exact opposite of what she was doing with her daughter, in order to be a good and proper parent:

One of my friends approached me and asked what did I do when my daughter was caught smoking? I said, “I can’t tell you what to do. Obviously nothing I’ve done has worked. Do the opposite, not what I did because it might have the same effect.”

This blame and feelings of being an incompetent and “bad” mother, led them to search for an explanation as to why their adolescent attempted suicide, with no satisfactory answers. One mother revealed her constant search for answers: “There’s no explanation good enough for me. So what do you do? You sit down and think, why did she try to end her life one morning?” Another mother explained her relentless search for a satisfactory answer as “a movie that keeps playing over and over in my mind that I’m never going to be able to turn off.”

In their descriptions of self-blame, many mothers expressed the need to become the “perfect mother”; one who does not make mistakes or miss vital clues precipitating a suicide attempt. One mother revealed this intense need as she stated:

Sometimes I felt I had to become the perfect mother who couldn't make mistakes. Because I feel in some way like I've failed, I've become harder on myself. Until you feel like you've failed your child in some way, can you actually understand what it's like to live with it.

The women tried to be good mothers despite what was happening. All the mothers' narratives contained similar accounts of the amount of time and effort they had invested in seeking help for their children. This included countless medical appointments, drives to group meetings and therapy sessions, visits to hospitals during admissions, family counseling appointments, and even court appointments. One mother talked about the journal she has kept for years recording all the places, people, appointments and so on, in order to have written proof for herself of how she tried to help her daughter in case she died. Overall, a deep sense of personal blame and guilt for their adolescents' suicidal behaviours were expressed by all the mothers throughout the narratives, causing them to feel failure as a good mother. The ultimate cause for the suicidal behaviours was something they did wrong or failed to do.

The ultimate rejection: "Is dying more attractive than living with your mother?"

Prevalent throughout all the mothers' narratives were feelings of rejection and betrayal by their child. The mothers felt that by trying to reject life, their child was ultimately rejecting them. All the mothers found this difficult to verbalize and many cried openly as they discussed living every day with this intense feeling of not being wanted by their child. One mother stated, "Is dying more attractive than living with your own

mother; being put into the ground to rot? What am I ..the plague?" The feelings of rejection were so strong in one mother she described being unable to give her daughter a hug while in hospital after a suicide attempt. Many of the mothers expressed anger and sadness, coupled with confusion, as they questioned over and over why their child would want to die. This mother's description showed these mixed emotions:

I couldn't look at my daughter without crying. I'd think, " Oh God I'm so happy to have you, so happy you didn't die." And then I'd think, "You little brat!" She has everything in her life she could want... to do this to me! ... to do this to us!... to the family!

Many of the mothers believed the adolescent was throwing life back at them for something they did or did not do. Several mothers recounted minor incidents that appeared to precipitate the suicide attempt. One mother described an incident surrounding her daughter being caught drinking at a sleep-over. She was grounded and no longer allowed to sleep there again. Immediately, she took an overdose of pills. The mother recounted how angry she felt, wanting to shake and choke her daughter after the suicide attempt. One mother's story captured this feeling of the adolescent "getting back" at her:

This day my daughter wanted to go to the mall to get a pair of sandals. I told her she was not getting the sandals until the summer, but she argued saying she wanted them now. We went home and nothing more was said. The next morning she asked me again, "Mom I'm not getting those sandals now am I?" I replied that it was too early. After we had all left the house (she was leaving after us), she became so mad she kicked a hole in her bedroom wall. She knew she would be grounded for it, so she wrote us a letter, saying to take care of her cat. Then she

overdosed on pills.

These feelings of rejection were difficult to understand, given what the mothers had tried to do for their children. One mother talked about the piano and voice lessons her daughter had taken. Another mother related how her daughter as a child was smart in school, talented in singing, played a musical instrument, and had the best clothes. She described how she had gone without, in order to give to her daughter. This mother expressed feelings similar to all the mothers as she angrily stated, "I carried her for nine months. I looked after her to the best of my ability. I gave her the best care I could. I took it so personally. Why was she doing this to me?"

The honesty expressed by the mothers in describing their feelings of rejection extended into several of them quietly admitting they had wished on occasion that their child had never been born. One mother stated:

I even said to my husband " If only we had stopped at one... if only she had never been born. Imagine if we never had her? Wouldn't things be great? Wouldn't life be wonderful?" You are saying this and thinking what kind of mother am I? I hate my child so I must be the worst mother.

Another mother's description of her feelings of rejection showed her desire to bring an end to the struggle and regain some type of a normal life. She described her intense emotions dealing with years of suicidal behaviors and attempts with her daughter:

I love her and I hate her. I said once that life would be easier if she died. And I meant it at the time. It would bring some finality to what is happening. I could close the door and move on.

The feelings of rejection were so strong that several mothers expressed that they wanted to die before their own child ended her life. One mother begged God in her journal to let her die in her sleep. Another mother recounted her horror because she was thinking a lot about death as a consequence of so much “death talk” from her child.

This was the most brutal aspect of the adolescent’s rejection; the mothers contemplation of suicide herself. During their darkest moments, these mothers longed for an end to the pain through either their child’s death, or their own. The mothers lived daily with feelings of failure in caring properly for their children. This caused grief and despair accompanied at times with thoughts of their own death being an easier stressor than living without their own children.

Alone in the struggle: “You really have to live through it to know.”

All the mothers described feelings of loneliness and a sense of isolation from the rest of the world. These feelings originated from several sources including family, friends, and even health professionals. One mother felt that she was not part of anything anymore. Another mother described her isolation as feeling like a steel drum with nothing in it. All the mothers felt that in order to understand the experience you had to be living it. Even when they knew that other people cared and were concerned they still felt alone. They

realized that most people do not understand what they are experiencing and therefore cannot help them. One participant stated, "Caring and understanding are two different emotions. You can care but you mightn't understand."

Remarks from mothers of healthy adolescents substantiated this sense of isolation. A remark from another parent to this mother validated these feelings. "What is she? Some kind of spoiled brat? She just wants to be number one." Often the suicidal behaviours or attempt were regarded as a stunt, a stupid action of a child that would stop when the adolescent grew up. The adolescent was just deliberately misbehaving in the hopes of getting attention or the adolescent should just "snap out of this adolescent silliness."

The mothers' narratives contained descriptions of isolation from their spouses. The mothers felt that this experience had negatively affected their relationships with their husbands. It had not brought them closer but rather had caused a bridge to form in their relationships. One mother explained how she and her husband had excellent communication before the adolescent's illness, but not since. He wanted to help her and begged her to let him but she told him he couldn't. She really was unsure why she could not communicate her feelings to him. Another mother described that even though her husband was an excellent, caring parent, she was distant from him. He was not the mother and therefore he was not experiencing what she was as the mother. She stated:

I can't explain it but I say to him, "Leave me alone!" Ever since this happened it's not the same. I can't say what it is. I feel like I'm the only one allowed to yell at her. I'm her mother. You're not!

Many mothers described how coping with their adolescents took so much of their time and effort, little else was left to give to their husbands and their relationships. This had affected their marriages in negative ways and many did not have the desire or energy to try and make it better. One mother expressed sadness about her deteriorating marriage but did not feel it was as important or deserved as much attention, as her child deserved.

The isolation was not only felt from their husbands but included other family members such as, grandparents, aunts, and in-laws. Many extended family members displayed a tremendous lack of understanding about the adolescent's illness. This was also the case for family members who were in the health profession. One mother reported:

My biggest disappointments were two close family members. One will be a doctor soon and the other is a nurse. I got responses like, "I'd like to kill her," and "How can you live through this?"

Many family members did not hesitate to express their lack of understanding and even anger towards the adolescent. Others chose to ignore the suicidal behaviors as if they never happened. The mothers experienced a stigma surrounding the suicidal behaviours from family members such as grandparents who displayed an ignorance about it, often ignoring it as if it never happened. One mother called it a "taboo topic". The suicidal behaviours and what they might represent were viewed as a shameful thing to happen in the family. Many mothers felt the uneasiness and discomfort in others when the

adolescent was brought up in conversation. One mother wondered why this was. "With any other illness there's an ease with which you talk about it. But when the diagnosis is depression or suicide, it becomes so difficult." This mother's description showed how her extended family viewed the illness:

The family doesn't want to talk about it. They think it's shameful. When my daughter first went into hospital I phoned her grandparents to let them know, but there was a stigma attached to it. The whole family was ashamed of her. They don't want to hear about it, or talk about it, so I feel isolated, completely cut off from that group. They don't even want to try to understand.

Other family crises were viewed with more empathy and even importance, than the illness and suicide attempts by the adolescent. This caused the mothers to feel frustration and sometimes resentment. Many mothers felt forgotten and ignored by their families because the actions by the adolescent were seen as silly or as attention-seeking behavior. One mother described it as becoming solely "her problem," ignored and forgotten by everyone else. Another mother described how she emotionally withdrew, as family members continued to ignore the situation with her adolescent. She learned to become quiet as her sense of isolation grew. This mother's account echoed the sentiments of other mothers:

My father was in hospital and everyone was phoning. I was concerned about my Dad too. Yet I had this child who took pills a month before and nobody mentions it. I could have lost my daughter! There was real disappointment there. Where's the compassion for my daughter?

The mothers' feelings of isolation extended outside their own families to include professionals such as, teachers, nurses, and social workers. The mothers felt at times a greater sense of dismay because they had assumed that professionals, especially health care professionals, were knowledgeable about the illness and its affect on the family. Unfortunately, this was not the case. The mothers often felt they were shown a lack of understanding about the illness and their feelings. One mother described her experience at the hospital when she brought her daughter into the emergency department after an overdose. She was ignored by the nurses and had to approach them to receive any help as her daughter was incoherent. She expressed a great deal of disappointment towards the nursing profession during her interview. Yet another mother cried as she described her experience at a parent-teacher interview:

I went to a parent-teacher interview for my other daughter. The teachers knew my daughter and her problem. All of the teachers, save one didn't ask about her. I saved this teacher for last who I knew would ask about her. I cried when she did ask because to all the others it was like she didn't exist.

One mother's encounter with a parent who was a social worker illustrated this lack of understanding and knowledge and the ignorance shown by many. She related how this parent told her that her daughter must be the worst disappointment to her and how she must be ashamed of her.

Before the onset of the adolescent's illness, the mothers felt connected to their friends who were also raising teenagers. They had a lot in common, could easily talk to

each other, gave advice to each other and shared stories, feelings and advice about raising children. But now they felt they did not have anything in common with their friends who were unable to relate to what they were going through. Their child's illness had created a chasm between them. They felt that it was impossible for their friends to understand their changed lives. The normal worries of motherhood no longer concerned them, as they struggled daily with the stressors of their adolescent. They felt disconnected from other mothers now, like they were struggling by themselves. Most mothers described feeling separated from friends as they realized they could not relate to their lives anymore. The following commentary by one mother captured the sentiments of all the mothers:

They have meaningless little stories. "Suzie only got 75% on a test!" And I'm thinking, "Big deal! So what! Has she slit her wrists lately?" Compared to what I'm living with, it wouldn't rock my boat. I've probably been up all night at the hospital, putting ice-packs on my eyes before I go into work, and they tell me the stupidest little stories. I can't listen to them.

Another mother spoke about how she found herself constantly comparing her life to other mothers' lives while working and shopping thinking, "Do I have the only daughter who's gone crazy on me?"

Several mothers expressed their irritation and lack of tolerance towards their friends as they talked about their teenagers and honestly admitted their feelings of jealousy and envy. This irritation and jealousy was evident in one mother's description of her

thoughts during conversations with her friends:

I see my friends worrying about something and I think, "Big deal! Who cares? Get a life!" My friend's son wanted to dye his hair and she was going nuts, and I said to her, "Give it up." I was very jealous of a lot of people, especially those bragging about their perfect teenagers. How come mine couldn't be doing okay? Listening to them you wanted to say, "Oh put a sock in it!"

All the mothers felt that the only people who truly understood their emotions and what it was like to live with these adolescents, were other mothers experiencing similar situations. They needed validation for their feelings and they received this validation from other mothers. They could rid themselves of some of the guilty feelings, receive acceptance for the negative emotions, and decrease their feelings of isolation. They also received comfort from them and strength to continue. One mother described her difficulty verbalizing her intense emotions and the comfort she received when other mothers described similar emotions. For that moment she felt less alone.

Helplessness and powerlessness in the struggle: "It's out of my control."

Feelings of helplessness and powerlessness prevailed throughout the mothers' narratives. These feelings originated from many sources, all contributing to a complete lack of ability to control the direction their lives were taking. The mothers described how this illness and the suicidal behaviours were controlling and dominating their families' lives. The adolescents had become the focus in the families, to the exclusion of the other

members' needs and problems. One mother stated, "She's the focus and everyone else gets left behind in the dust. You are just following her!"

The mothers discussed how the amount of attention they gave the adolescent placed a great strain on the family, including the other children. This investiture had become the dominant feature in the mothers' lives. The adolescent was the focus of the family; everything and everyone revolved around her. One mother described how she felt torn between her children, almost like she had to choose between them or take sides. She did not feel free to love them all equally because her daughter took up most of her attention and time. She stated, "There was nothing in place for my other children. They were stuck in the middle; so was the whole family. You can't give them what they deserve because you are too wrapped up."

Another source of the mothers' helplessness and powerlessness stemmed from a loss of control over the occurrence of the suicide behaviours or attempt. All the mothers described ruminating over ways to stop any further recurrence of the suicidal behaviours and attempts, yet to no avail. The mothers described what their adolescents were like as young children, talked about their natural mothering skills, and how well they had looked after their children. One mother talked about how she tended to her daughter's cuts and bruises as a young child and how she helped her with issues in her life as she got older. But with this experience she felt helpless to make it go away, or to make it better. One mother described her helplessness:

You don't want them to die! If I can keep her alive somewhere down the road she'll find a bit of peace. But she takes it out of my control and there's not a thing I can do. It's an empty feeling... total emptiness.

Several mothers expressed anger about the helplessness they felt while seeking help for their adolescents in the mental health care system. They entered the health care system having faith in it, but felt it had let them down. These negative experiences added to the powerlessness they were feeling. One mother described her experience:

The doctors were telling me not to worry, that she was only looking for attention but I had this child who was seeing the walls bleed! I waited and she got progressively worse. I felt so helpless... at their mercy. I had too much faith in the system. Sometimes I think I know more than they do. Let me tell you, there's not help anywhere.

Another mother discussed how she had given her daughter's psychiatrist all the suicide notes her daughter had written but he kept saying her daughter was only looking for attention, trying to manipulate her. He did not take her seriously until her daughter overdosed. She explained how this experience left her frightened with the realization that she was ultimately responsible for her daughter's welfare because she no longer trusted the medical profession.

All the mothers felt a deep need to find an explanation or reason for the suicidal behaviours and attempts. They agonizingly searched for an explanation, however none was found. One mother described endlessly questioning her daughter as to why she suddenly made a suicide attempt one morning after her mother's refusal to buy her a pair

of sandals. Her daughter could provide no answer for her behaviour, leaving the mother feeling helpless. Several narratives echoed with similar accounts of years of searching for answers, only to be left with increased feelings of despair, helplessness, and powerlessness. This mother's description showed her quest for an explanation:

Right now I'm telling myself it's her grandfather who we think might have committed suicide. It's genetic and had nothing to do with her upbringing. There's something faulty there in the brain... a genetic defect. I wish someone could tell me that! "Look what we found, a faulty gene. It's supposed to be this shape, but it's that shape." I feel so helpless that no one can tell me.

All the narratives reverberated with descriptions of a wide range of intense emotions, accompanied by a powerlessness to control these emotions. One mother stated, "There are bombs going off around me, and inside me, that I have no control over! You're standing there in the middle with everything exploding around you." Yet another mother said she was a mental robot with no control over her mixed emotions, causing her to cry at the silliest things such as a commercial on the television. The least little thing could cause her to overreact. She attempted to control these unpredictable emotions but described a complete helplessness in doing so.

Overall, a sense of helplessness and powerlessness was prevalent in all the mothers' narratives. The adolescent's suicidal behaviours were dominating and controlling their lives and all members of the family. No matter in what direction they turned, they experienced an overwhelming powerlessness to prevent another suicide attempt or suicidal behaviours. They floundered in a sea of uncertainty. They lived in a

whirlwind of intense and swiftly changing emotions that they felt helpless to control: love and hate; anger and compassion; crippling anxiety and numbness.

Cautious parenting: “It’s like walking on eggshells.”

Another theme prevalent throughout the mothers’ stories was cautious parenting. The narratives described an uneasiness and a hesitation in parenting the adolescent since the manifestation of the suicidal behaviours. This cautiousness was controlled and tempered by fear. Uneasiness and hesitation were the trademarks of their new parenting. One mother, describing her fear said, “I’m never at rest. It’s like a monkey on my back, clinging on, clawing into me.” This fear controlled the mothers and gave them no rest. It was the fear of triggering a repeated suicide attempt. They were afraid they would say the wrong word or commit the wrong action and become the cause of another attempted suicide, or exhibition of suicidal behaviours. The mothers were unsure and confused what this word or action was and therefore, had become extremely cautious in their interactions with their adolescent. One mother related how she constantly waited for something to happen and realized that one little thing could trigger an event. She gave examples of possible triggering events she called “bad days,” such as her daughter having a fight, doing poorly on a school test, or arguing with a sibling. She lived in a state of confusion and fear, not knowing what the triggering incident might be. One mother stated that her caution in parenting stemmed from the fear that her child would not come to her if she felt suicidal, even though they had made a contract that she would. She felt that if she upset

her in any way, the adolescent would not keep her end of the bargain.

Another mother described her fear of being close to her child because of a possible successful suicide and the subsequent hurt she would feel. She had been deeply hurt many times in the past. She felt that her child had no intention of staying with her and was afraid to get close to her and trust her again for fear of betrayal. Another mother similarly described the change and cautiousness in her parenting as being due to a complete lack of trust in her daughter. Her daughter had repeatedly promised that she would not attempt suicide again, yet had made four attempts. Her ability to trust her daughter had been erased. She cried as she described how much she missed her daughter and the bond they once shared however, she had decided not to become dependent on her company because she felt her daughter was trying to run away from her.

Yet another mother expressed the deepest fear a mother can feel; the possible death of her child. She described her fear as “lying deep down in my bones and always in the back of my mind.” Her caution in parenting was rooted in her fear of knowing a remission doesn’t last. She is always afraid to say her adolescent is fine because she knows deep down in her heart it will not last. She has lived for many years on this see-saw and is trying to prepare for the worst:

When I get up and I'm washed and dressed I say "Okay, now I'm washed and dressed if anything happens. If they come to the door I'm clean." I think that every single day of my life. It's always there.

For many mothers this fear has caused them to overcompensate with their

adolescents. This was evident as one mother described her life with her adolescent as “walking on eggshells.” She gave in to her adolescent for everything, not feeling she should argue with her, afraid of the possible negative consequences. She described how she did not know whether she should discipline her daughter anymore so instead, had become very lenient with her.

While some mothers were more lenient, others overreacted. One mother revealed her ability to panic quickly over minor events or at the slightest hint of something amiss, in contrast to her husband who was much calmer, not wanting their daughter to control them. She described pacing her room one evening, waiting for her daughter to call as she was late returning home. She screamed at her daughter upon her return because of the extreme anxiety she had felt.

Another aspect of this cautious parenting was described by the mothers as a need to constantly check on the safety and whereabouts of the adolescent and look for clues or signs of something amiss. They expressed a constant uneasiness and worry, making a relaxed time impossible. One mother described it as a preoccupation, finding it very difficult to concentrate on other peoples’ conversations in a group. For many mothers this interfered with their ability to work, eat, and sleep.

The mothers ‘kept watch’ over the adolescents, listening and looking for anything out of place or any indication of trouble. They needed to constantly check on their child; it became almost a paranoia. For many, all pills and dangerous items such as guns, were removed from their homes. Phone calls were made routinely to check on their

adolescent's safety. Several mothers described this 'vigil' being dominant at night. One mother echoed the actions of many of the mothers as she described pacing in front of her child's bedroom at night, listening for sounds of regular breathing. She then went in to say goodnight, pretending to want a kiss, but actually checking to ensure her child was safe. All the mothers described having disturbed sleep, waiting for the child to make a whimper, signaling impending trouble.

One mother's description of her typical day exemplified this cautious parenting and preoccupation with the safety of her child:

Let me describe a typical day. I tiptoe in her room and watch the clothes, looking at the blankets to see if they're moving up and down. Okay, wipe my brow; she's breathing. Then I check the pill bottles. I take them all from her and give her the ones she needs, one at a time. I count the pills. And then I go on to work and wait for nine-thirty to come so I can phone and see if she answers the phone. If the answering machine cuts in I panic and watch the clock again; maybe she's sleeping. Then I call again and finally she answers the phone and there's some relief. Depending on what kind of day she's having, I'll probably go home at lunchtime and do the same thing. Sometimes I take all the pills and I hide them. I put them in my purse and take them to work with me. So I'm going around with a purse full of pills.

Overall, whether the mothers expected too much or too little from their children, the common thread was an alteration in the parenting program. They were hesitant and very cautious in all their interactions with the adolescent for fear of another suicide attempt or suicidal behaviours. Some mothers became more lenient; some overreacted and panicked at the slightest hint of something amiss. All described a constant need to

check on the safety of their children, hoping to prevent the occurrence of another suicide attempt if they detected anything unusual.

Keeping an emotional distance: “I won’t get dependent on your company.”

A prevalent theme woven throughout the narratives involved the mothers keeping an emotional distance from their suicidal adolescents. They all expressed a negative change in their relationships since the onset of the suicidal behaviours and suicide attempts. One mother stated, “I’ll never abandon her, physically I won’t. But emotionally there’s a distance.”

All the mothers’ stories reverberated with uneasiness, as they waited for disaster to strike again. No matter how well the adolescent was doing, they always felt something could and would go wrong. They lived in terrible anticipation for the blow of another suicidal attempt. Trust in their adolescents was shattered with an inability to welcome its return, because they had been burned emotionally too many times before. All the mothers agreed that due to this permanent break in trust, the bond once shared between their child and themselves had shattered, causing the mothers to retreat emotionally from their adolescents. One mother talked about her complete loss of trust in her adolescent because of the repeated promises she had made to never engage again in the suicidal behaviours and attempts. Unfortunately, her daughter had attempted suicide four times, always promising it was the last time. One mother stated:

I can't reach out and take it back. And in a way I'm afraid to. I'll get it back and she'll pull another stunt and I'll hurt twice as much. So I say, I won't get dependent on your company. You keep trying to run away!

Several mothers discussed their need to maintain this distance between themselves and their child because of a knowledge that their child might one day die from a suicide attempt. The mothers' voices while filled with pain, also portrayed a degree of resignation towards the possibility of this event. One mother discussed her terrible fear surrounding the possibility of a successful attempt by her daughter someday down the road. The description of her need to keep a distance between her and her daughter was evident as she stated, "You need to take the pain away, for yourself. Every story doesn't have a happy ending. You don't think everything will turn out all right."

Other mother explained how this need to have an emotional distance between themselves and their child had extended into thoughts of life without the child. One mother told of the conversation she and her husband had concerning how easy their lives would be without this child. At times she regretted ever giving birth to her child. Another mother spoke about loving, yet intensely hating her daughter at times, and how she had confessed to a family relative her thoughts on how easier her life would be if her daughter died. She felt it would bring some closure; she could close the door and move on. Admitting these horrific feelings had caused her to move emotionally away from her daughter, fearful her daughter would know her feelings. Even though she was feeling a desire to finally end the struggle, no matter how, she wanted to hide her feelings from her daughter.

For all these mothers, the emotional distance they felt was predicated on a lack of trust. They felt they have been betrayed once too often and the trust now is eroded. Ultimately however, it is a self-defense against the possibility of the next suicide attempt being the final successful one; it is a type of anticipatory preparation. If the adolescent should succeed, they have already distanced themselves from the adolescent in preparation for the rest of their lives spent without them.

Summary

The mother felt a deep sense of failure, blame, and guilt for their adolescents' suicidal behaviours and attempts. Their reasoning was, if they had been a better mother this never would have happened to their children. The mothers also felt that their children's suicidal behaviours were a way of expressing their children's rejection of them.

Due to feelings of failure, guilt, and blame the mothers doubted and distrusted their ability to parent properly and became hesitant and cautious in their parenting. They lived constantly with the fear that the next suicide attempt would be successful. They did not know what event in the normal course of a day may trigger the beginning of the self-destructive behaviours. They have no past parenting experience to help them with their present parenting. They floundered in knowing how to relate to their adolescents, how to talk to them, how to effectively discipline them, and how to properly guide them into adulthood. They felt a lack of trust in their adolescents due to the repetition of suicidal

behaviours. At times they overcompensated with their adolescents or were too lenient, not wanting to precipitate a confrontation or argument.

The adolescents became the primary and dominant focus of their worlds. They worried constantly about the adolescents' safety, resulting in an inability to relax or feel peaceful away from their children. Their work and sleep became affected. Their relationships with other family members and friends were all strained as much of their thoughts, energy, and time were focused exclusively on their children.

Negative feelings by the mothers were compounded by the fact they felt alone. The feelings of isolation were from spouses, family members, close friends, and mothers of healthy adolescents. As the mothers began to experience the stigma surrounding suicide and the accompanying callous and hurtful comments, their feelings of isolation mounted. Lack of understanding and knowledge from others including health care professionals, and the stigma associated with suicide contributed to the isolation, until they felt that this problem was theirs and theirs alone.

As the struggle continued with little ease or help, a sense of powerlessness and helplessness set in. The adolescent had become the focus in the family with the adolescent's problems dominating and dwarfing all others. They felt helpless to control and stop this ripple effect. They felt powerless to stop the cycle of self-destructive behaviours and agonizingly searched for an explanation. They felt battered by emotions they felt they could not control.

The emotional turmoil and pain they were experiencing was at times so intense,

they felt a need to retreat from the source; their own children. They felt they had to emotionally distance themselves from their suicidal adolescent as a means of self-preservation. The adolescent's desire to die was so persistent that they periodically felt their children's death would be an easier stressor than living constantly with the self-destructive behaviours and suicide attempts. As their struggles continued, they felt a great sense of helplessness and powerlessness and also grief and loss.

The Essence

The essence of this experience was captured as multiple loss and unresolved grief. The mothers were living and feeling a loss of peace, a loss of normalcy, a loss of hope, a loss of the child they had, and finally a loss of themselves. The essential meaning of all these profound losses was a type of grief, unique to this experience.

The narratives described a significant loss of peace; a constant uneasiness and fear. This loss of security and peace controlled their lives and their interactions with others. They yearned for its return and reminisced about the happiness, security, and safety they once felt. They feel it would be better if they had never known what peace felt like because the difference now was unbearable. One mother's description of the peace she had lost is reflective of all the mothers' stories:

I'd love to have peace back. Sometimes I try to force it. I know I'll have it when I die but I want it when I'm alive... it's a lovely feeling. If I didn't know the difference it would be grand. I'd be ignorant to it; how good it feels to be at peace with yourself.

The mothers experienced a loss of normalcy. Their lives underwent a profound change, a fracturing in every way. Normal life was lost and they were confused about what was normal anymore. Their thoughts, actions, and interactions with others all underwent a change. They distrusted themselves to make decisions because of the fear of making another wrong one and its negative consequences. Yet, they experienced a need to become “the perfect mother,” while at the same time feeling as if they were the worst. This caused terrible confusion in their decision-making.

A loss was felt for the child they once knew. This child was lost to them and replaced by a stranger they had to get to know. To some mothers the entire child was lost; to others, a part of the child was lost. The mothers constantly questioned where the child they raised and cared for was gone. The bond between the mothers and their children was broken, with a sense of resignation towards its permanency. The mothers clung to memories and pictures in their minds of the sweet children they had brought into the world, who they lovingly cared for, mended their hurts, and soothed their childhood problems. They longed to have this child back because this child's life held so much promise and opportunity.

Another loss they felt was a loss of hope: hope for an ending to the self-destructive behaviours; hope for a return of their happy former lives; hope for a bright and prosperous future for their child and themselves. One mother's description captured how

she was experiencing this loss:

Even though she seems fine now, I still think she 's not what she should have been. Whatever she could have been without this disease, she never will be. I still feel there 's something lost. I guess it 's not what you hoped for your child. Right now she 's still a lost soul.

Accompanying these multiple losses was a loss of part of who they were and valued the most; a good mother and a good person. Yet, because of their feelings of failure as a good mother and person, many mothers expressed not wanting to return to what they were. The mothers spent a great deal of their lives covering up these negative feelings and even pretended they did not exist, but always the emotions returned. One mother poignantly remarked, "It doesn't last and then you have to come home to yourself." They did not feel positive about the direction their lives were taking, instead felt stalled and stationary in the place their child occupied.

Grieving and mourning occurred due to this multitude of overwhelming losses. They grieved the loss of the child they once knew and the suffering they saw with the child. They grieved the death of the hopes and dreams they and the child had, for the future. They grieved for the happiness, peace, and security they once had and the normal life they were living. One mother stated:

I don't think a mother can go through this and be like she was ever again. I see my child the way she was before. I think we're grieving for that. Maybe we grieve for that time we lost. Life should have been better than what it was.

The grief was constantly recurring and rarely resolved. With a physical death, there is an absolute end. But with this experience the person is always present and there are glimpses of the child they once knew. It was a constant reminder of what could or should have been and this was wrenching. Several mothers described the depth of this suffering by admitting they have had thoughts about life being easier without the child in it. It would be less stress to actually bury their child, than have to think about their child's death. They have imagined their lives if they had never become pregnant with this child how much better it would have been. These confessions were immediately accompanied by the mothers expressing how it only proved what dreadful mothers they were because no decent and good mother would ever have these thoughts, let alone verbalize them.

A mother's role includes giving life to her child, caring for her child, and maintaining that child's life. Other deaths are perceived as out of the mother's control but suicide seems preventable; an unutterable waste. The desire for a child to die seems so worthy of blame by the mothers. These bereaved mothers do not receive the comforts that society provides for death. There is no funeral, no condolences, no gathering of family and friends. The cycle is never-ending and painful. Recoveries give relief, but are tinged with a sense of foreboding. With a relapse, the grieving process starts all over again. And always there is the fear that it may be permanent this time.

CHAPTER 5: DISCUSSION

This chapter relates the findings of the study to the literature on parents and suicidal adolescents, parents of adolescent suicide victims, and parents living with a mentally ill child. Similarities to findings from research studies and reports by health professionals are discussed. Findings from this study contribute to the underdeveloped knowledge base in the area of the maternal experience of living with an adolescent exhibiting suicidal behaviours.

The literature on parents living with a mentally ill child discusses generally the emotional impact on parents and the resultant psychological distress (Hatfield, 1987; Parker, 1993). Reactions include shock, denial, panic, guilt, sadness, loss, and grief. Wagner, Aiken, Mullaley, and Tobin (2000) reported on the severity and complexity of maternal emotions associated with living with a suicidal adolescent.

The findings from the current study on the emotional turmoil experienced by mothers contributes to a deeper understanding of this experience. Clawson (1996) described the family as the buffer that absorbs the stressors experienced by its members. These mothers absorb the stressors in this family crisis and appear to have become the prime buffer, experiencing a battery of complex, confusing, and painful emotions. These include failure, helplessness, powerlessness, isolation, rejection, guilt, self-recrimination, loss, unresolved grief, and emotional detachment. Struggling to come to terms with these emotions, and finding ways to cope with their complexity and intensity, were evident throughout the mothers' narratives. The mothers were confused about how they could

feel such intense love and caring, coupled with anger and often emotional detachment.

Failure and rejection

Failure as a good mother coupled with the ultimate rejection as a mother were two findings in this study. Feelings of blame, vulnerability, and parental failure are discussed in the literature on parents living with a mentally ill child and parents of an adolescent suicide victim (Gyulay, 1989; Hales & Hales, 1995; Ojanlatva, Hammer & Mohr, 1987; Wager, Aiken, Mullaley, & Tobin, 2000).

The mothers felt they had failed in the most essential way a mother can; maintaining the life of her child. They felt the adolescent was retaliating against them through their attempted suicides. Since they gave the child life and by rejecting this life, the child was ultimately rejecting them. The current study demonstrates what effect these profound feelings have on the mother. There is an intense desire for relief from the emotional pain and chronic family stress, even to the point of occasionally wishing that this child had never been born or thinking life would be easier without the adolescent. These feelings were related to a desire to want to end the struggle and regain some control over their lives.

The literature on parents of an adolescent suicide victim discusses a similar effect. Gyulay (1989) and Ojanlatva, Hammer, and Mohr (1987) described how parents often desire for relief from the multiple problems of living with a suicidal adolescent and sometimes feel that death would be an easier burden, compared to their suffering.

Cautious parenting

Findings from this study demonstrate how mothers changed their approach to parenting to a more cautious one so as not to trigger further suicidal actions on the part of their children. This hesitation and caution in the mothers' parenting is predicated on failure, rejection, and fear. The fear felt by family members is described in a general way in the literature on parents living with a mentally ill child (Hales & Hales, 1995; Parker, 1993). The literature on parents of an adolescent suicide victim also mentions briefly the fear parents felt before the actual suicide death of their child (Gyulay, 1989; Hoffman, 1987).

While the fear experienced by parents of mentally ill children and parents of suicidal adolescents is addressed in the literature, this study uncovered how living with this fear causes a caution and hesitation in parenting. The mothers in this study described being fearful of a closeness to their adolescents because of a possible successful suicide attempt and the subsequent hurt and pain. This caused the mothers to become cautious and hesitant in their interactions with their adolescent due to lack of trust. In the recent study by Wagner, Aiken, Mullaley, and Tobin (2000) mothers reported being careful about what they said to their adolescent who had made a suicide attempt because they wished to avoid upsetting their adolescents for fear it would provoke further suicidal behaviours.

Helplessness and powerlessness

Another finding was helplessness and powerlessness in terms of the greater family dynamic. Descriptions of helplessness and powerlessness are found in the literature on parents living with a mentally ill child (Hales & Hales, 1995; Parker, 1993). These feelings of helplessness and powerlessness were described by the mothers in the current study. The adolescent had become the focus of the whole family, dominating all the family members' lives. Many mothers felt helpless to halt or alleviate the immense strain placed on all family members. While the mothers recognized this tragic development, overwhelming concern for the suicidal child dictated that she was powerless to stop the family disintegration and the unfortunate cycle continued.

The current study uncovered another source of helplessness and powerlessness. These mothers expressed an inability to find answers for why this has happened to their children. This resulted in agonizing questioning and searching for answers. No discussion of this was found in the literature on families living with mentally ill children or parents living with a suicidal child. Only in the literature on parents of an adolescent suicide victim was reference made to agonizing questioning (Van Dongen, 1990). This finding of agonizing questioning causing helplessness and powerlessness is similar to the parental experience after the suicidal death of a child and points to the significant similarities in both life events.

Loneliness and isolation

Another finding in this study was loneliness and isolation experienced from several sources. Isolation experienced by parents is mentioned with limited discussion in the literature on parents living with a mentally ill child (Seguin, Lesage, & Kielly, 1995; Van Dongen, 1990). This isolation is related to the stigma surrounding mental illness and society's readiness to blame the family for the mental illness. These feelings are confirmed when mental health professionals seem to blame or exclude the family. These parents do not receive the comfort from friends and society in general that they desperately need. (Hales & Hales, 1995; Parker, 1993).

This stigma was similarly reported by the mothers in the current study and therefore adds support to the lingering existence of this prejudice. Remarks from and interactions with others such as family members, friends, and social acquaintances, demonstrated to the mothers the lack of knowledge and understanding others have of this experience. These experiences compounded the mothers' sense of isolation. Another source of the stigma also came from mental health professionals. The mothers had expected health professionals to be educated, understanding, and compassionate. Unfortunately, the opposite was reported.

An alteration in socialization is discussed in the study by Van Dongen (1990). These alterations included the parents not wanting to share their emotions and limiting their interactions with family members. The isolation described by the mothers in the current study is very similar to this alteration in socialization found by Van Dongen. However, this study uncovered the depth and sources of the isolation. The narratives

described a loneliness in the mothers' feelings and in their changed lives. This isolation from the rest of the world was closely related to the guilt they felt and the stigma they encountered. The mothers also experienced a lack of trust with the adolescents and felt isolated from them because they often could not offer an explanation for their actions.

Emotional distancing

A significant finding involved the mothers keeping an emotional distance from their adolescents to avoid further pain. This emotional distancing used as a coping mechanism, is mentioned briefly in the literature (Ojanlatva, Hammer, & Mohr, 1987; Wagner, Aiken, Mullaley, & Tobin, 2000). References to emotional distancing are discussed in a more comprehensive way in the literature on parents of an adolescent suicide victim (Gyulay, 1997; Van Dongen, 1990). These authors discussed the frozen emotional state of parents after the death of their suicidal adolescent, used as a protective defense against the chilling reality of death.

The emotional detachment and distancing was described by the mothers in the current study in a much more in-depth manner and offered a clearer insight and understanding about this reaction. The mothers needed to temporarily shut down emotionally, to distance themselves from the pain, to escape from the constant stress. There was no way to physically distance themselves from their responsibilities, so instead they used emotional distancing as a self-protective strategy, as a temporary reprieve. The mothers insulated themselves from the relentless pain they felt and the terrible anticipation of the possible death of their children.

The essence: loss and grief

Loss and grief is mentioned in the literature concerning parents living with a mentally ill child but little insight is gained into the depth and nature of this loss and grief (Hales & Hales, 1995; Hatfield, 1987; Parker, 1993). The literature on parents of an adolescent suicide victim discusses the loss and grief of parents in a more in-depth manner, offering an understanding of the uniqueness of the grief experienced by these parents (Bailey, Kral, & Dunham, 1999; Seguin, Lesage, & Kielly, 1999). Gyulay (1989) described the preparatory grief of families living with a suicidal child that develops over months to years. This anticipatory grief is different from the family anticipating the death of a terminally ill child because a terminal illness is out of everyone's control, even the most sophisticated medical technology and science.

The multiple losses described by the mothers in the current study are not reported or described in the literature. The mothers felt a loss of peace, a loss of normalcy, a loss of hope, a loss of the child they had, and a loss of parts of themselves they valued the most. These mothers experienced a fracturing of their normal lives including a loss of normal thoughts, actions, and interactions with others including their children. A striking loss for the child they had before the onset of the suicidal behaviours was experienced. The mothers clung to memories of the former child and yearned for the return of the child they had. Along with this loss was a loss of hope, for a return to the way the family was, for an ending to the self-destructive behaviours, for a happy future for themselves and their family but especially for their child. A profound loss experienced was a loss of part of themselves they valued the most, the good mother and person.

A mourning occurred due to the multitude of these overwhelming losses. They grieved for the normal life they had, one filled with happiness, security, and peace. They grieved for the suffering they see in their child and the loss of the happy, normal child they knew and loved. They also grieved for the death of the hopes and expectations both they and the child had, for the child's future. The mothers yearned for a return of the child they had known. The mothers whose adolescents had made several suicide attempts admitted that life became harder with each successive attempt, because the anticipation of death became more pronounced. Each attempt seemed to signify the adolescent's increased desire for death. These mothers lived with constant anticipatory grief, a preparation for the inevitable death.

The grief described by the mothers in the current study has similar qualities to the grief described in the literature on parents of an adolescent suicide victim, particularly the preparatory grieving described by Gyulay (1989). The parents of an adolescent suicide victim have lived for so long anticipating and even preparing for the death of their child, that they experience a unique type of grief. The findings from the current study demonstrate that the mother's grief experienced during the years living with the adolescent exhibiting suicidal behaviours, is remarkably similar to the grief experienced by parents after the suicide death of their child. Current research investigating the grief experienced by parents of an adolescent suicide victim addresses two important areas: the uniqueness of the bereavement process; and the multi-dimensional aspects of this grief. The findings on maternal grieving from this study similarly demonstrate the uniqueness of this grief. This study therefore, contributes to a comprehensive insight and understanding about this

preparatory grief.

Summary

There is a considerable lack of knowledge and understanding about the maternal experience of living with a suicidal adolescent. The findings from this study significantly demonstrate that these mothers are experiencing a level of suffering and stress not well recognized or understood by nurses and other health care professionals.

The findings of emotional turmoil, failure and rejection, helplessness and powerlessness, and isolation associated with stigma are mentioned in the literature focusing on parents living with a mentally ill child and parents of an adolescent suicide victim. The findings of emotional turmoil, failure and rejection support similar findings in the study by Wagner, Aiken, Mullaley, and Tobin (2000) investigating parents' emotional and behavioural responses to a suicidal adolescent. However, several significant findings uncovered in this study add important data to the underdeveloped knowledge base about the maternal experience of living with an adolescent exhibiting suicidal behaviours.

The emotional turmoil these mothers experienced resulted in a spontaneous show of emotions and also rapid emotional changes. The failure and rejection experienced by the mothers caused them to want to end the pain and struggle and regain control over their lives, even to the point of occasionally thinking that the death of the child would be easier than living with the suicide attempts. The fear they constantly lived with caused a change, a hesitation, and a caution in their parenting. Changes occurred in normal

parenting styles and in communication between the mothers and their suicidal adolescents.

From the outside looking in, these mothers could appear uncommunicative, hesitant, and untrustworthy towards their children. They could also appear emotionally distant, frozen, or detached from their adolescents. This should not be viewed as failure on the mother's part to show care and concern for her child. Instead, this emotional distancing and detachment was a self-protective mechanism used as the mothers searched for coping strategies.

The helplessness and powerlessness experienced by these mothers was generated from vulnerability, a loss of control, fear for the adolescent's safety, and agonizing questioning. Their intense feelings of being alone in this struggle had many sources other than the stigma of suicide. All together, they promoted in the mothers acute feelings of isolation from the rest of the world.

The multiple losses experienced by the mothers caused a unique type of unresolved grief. Similarities exist between this grief and the grief experienced by parents after the suicide death of an adolescent particularly concerning its uniqueness and multi-dimensional aspects. However, the findings from this study combined to describe the loss and grief of these mothers as unique; not replicated by any other life experience. These grieving mothers did not receive the normal comforts that society provides for tragedy. Little comfort and support was provided to them however, their grief was just as deep and painful as any mother would experience when she thinks about the possibility of her child dying. The horror and preparatory grief was just as real, just as poignant. Unfortunately, the mothers' suffering was compounded by her guilt, blame, and society's lingering

stigma, that yes, she was the cause of this preventable tragedy.

**CHAPTER 6: IMPLICATIONS FOR FUTURE NURSING EDUCATION,
PRACTICE, AND RESEARCH,
LIMITATIONS AND SUMMARY**

The findings of this phenomenological study have significant implications for nursing education, practice, and research, due to the present lack of knowledge and understanding concerning the maternal experience of living with an adolescent exhibiting suicidal behaviours. The dearth of nursing research into the experience limits a clear and sensitive understanding of what life is like for these mothers. There are some limitations to the research and the chapter begins with these.

Limitations

Phenomenological research attempts to capture the unique experiences of an individual. While every attempt was made to do just that, I recognize in presenting themes that captured the experiences of these mothers as they lived daily with an adolescent who exhibited suicidal behaviours, I may suggest more similarities among these mothers than actually existed. A limitation of the study may be a risk of presenting this experience in a universal manner.

A second limitation is that these mothers had lived for varying lengths of time with the suicidal behaviours and some could reflect on this experience more fully than others. In addition, some mothers could talk more comfortably about or describe these experiences more fully. Some of the mothers were in a support group so the extent to

which their experiences were more shared, than personal or unique, would be difficult to ascertain. The interpretations could be examined with that in mind.

We know that experiences are bound by time and space, as well as other conceptual factors, so it is important to emphasize these mothers' experiences are limited by the fact that they lived in a particular geographical area.

Nursing education and practice

At present, nursing education in the area of adolescent suicide primarily focuses on the care of the adolescent. Nursing has increased its knowledge base over the past several decades in therapeutic communication, management, and interventions with the adolescent exhibiting suicidal behaviours. Knowledge and understanding of the parental experience of life after the suicide of an adolescent also has increased due to research in this area. However, understanding of the experience of living with a suicidal adolescent from the perspective of family members intimately involved, like the mother, has not kept pace. "Most health professionals have been taught about mental health and about families, but many do not understand families experiencing mental illness" (Spaniol, Zipple, & Lockwood, 1992, p. 341). Currently, there is a lack of knowledge and understanding concerning the impact of adolescent suicidal behaviours on the mother.

Families play a vital and intrinsic role in the health and well being of a suicidal adolescent. As deinstitutionalization has proceeded, families of the mentally ill have become "the institution of choice" (Parker, 1993, p.19). But in most cases, coping with a suicidal adolescent is totally outside the experience of families. The findings of this study

demonstrate how mothers living with suicidal adolescents desperately need help from educated, knowledgeable, and compassionate health professionals. Mothers, often assuming the primary responsibility for the care and well-being of these adolescents, deserve the equivalent respect, openness, and acceptance that any mother of a child with a potentially fatal illness would receive.

Being committed to quality family-centered care, nurses are in a pivotal position to help these mothers. If nurses are to prove effective in helping the mother, then they must achieve a comprehensive knowledge and understanding of the mother's perspective and the impact of the experience on her. Knowledge and understanding gained from listening to the mother and viewing the experience from her eyes, will greatly enable nurses and other health professionals to more effectively meet her needs. The nurse could assist these mothers and their families to work out some of the difficulties that the mothers in the study experienced. For example, promoting marriage counseling and working on conflict resolution with all family members might greatly facilitate a more healthy atmosphere in the family and help reduce some of the mother's feelings of guilt and powerlessness.

These mothers are a unique group with individualized needs requiring nursing interventions tailored to meet these needs. The magnitude and complexity of the emotional problems experienced by the mother is underestimated and not clearly understood by the mental health community. Nurses need to recognize the emotional turmoil mothers experience and provide validation and acceptance of these emotions. The mothers have a need to know that they are not alone in this crisis. An increased sensitivity

by nurses towards the complexity of emotions experienced by the mothers, would significantly help in reducing the isolation felt. Nurses' support for these mothers is especially important because they often lack support from family members, friends, and society. Support groups for mothers in a similar situation may also provide a source of help. The stigma surrounding suicide places these mothers in a vulnerable and isolated world. Nurses can help reduce the stigma associated with suicidal behaviour and mental illness. This could be accomplished through education both of the public and health professionals. Nurses can promote public awareness campaigns in schools and society in general. In instances where they know of individual difficulties and where confidentiality would not be violated, they could take part in conferences involving the adolescent, parents, and teachers so more positive attitudes could be promoted.

A window of understanding must be opened upon this maternal experience. Future education for nurses in the area of adolescent suicide must include the impact of this crisis on the mother's life. Only in this way can nurses become competently educated in a holistic, family-centered approach.

Nursing research

The findings in the present study are a beginning to an increased understanding about the maternal experience of living with a suicidal adolescent. However, further research is urgently needed to further our understanding of the distress these women experience and what interventions may help them with their identified problems.

Some studies that could be conducted with this group of women is on the support

systems these women have and how they develop resiliency in a situation such as this. Further research is also required into the long term psychological and physical effects on the mothers' health and what measures could be put into place to lessen the negative effects. Focus group research with mothers of these adolescents and mothers with adolescents who have mental illnesses without suicidal behaviours, may identify weaknesses in the health system as a support for these parents.

The current study raises other issues about the family, fathers, and other siblings. Research is needed into the effects on the family and the relationships within the family. A similar study is suggested into fathers' and siblings' experiences. While the mothers feel they are the main cause of their suicidal adolescents' problems, we do not know how other family members feel. Nor do we know if the other family members are subject to the same type of stigma and isolation these mothers reported.

Finally, research into the attitudes toward adolescents of health professionals, teachers, and the general public could help to measure how big a problem stigma towards this mental health problem is and form the basis of a public health campaign to improve support to women, their families, and the adolescent.

Summary of the Study

At present little is known about the maternal experience of living with a suicidal adolescent. This phenomenological study investigated the question: What is life like for mothers living with an adolescent exhibiting suicidal behaviours? Six mothers living with

a suicidal adolescent participated in one unstructured interview and described their individual experience. After the data was analyzed using van Manen's (1997) mode of inquiry, six themes were revealed and the essence of the maternal experience was captured.

The findings of this study demonstrate the emotional turmoil and significant impact this experience has on mothers and their need for understanding and compassion from nurses and others in the health care community. Failure, rejection, isolation, helplessness, powerlessness, cautious parenting, and emotional distancing encompass the maternal experience. The mothers' stories paint a picture of suffering due to multiple loss and unresolved grief.

The need for compassionate understanding and care is vital for the well-being of these mothers. Nurses occupy a pivotal and important position in family-centered care. Therefore, with a greater understanding of the maternal experience, nurses can become effective in supporting and helping these mothers. Further research into the problems of families including mothers of suicidal adolescents, could help prevent some of the negative effects that these people experience.

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APPENDIX A: HUMAN INVESTIGATION COMMITTEE CONSENT



Memorial

University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

1999 03 18

Reference #99.26

Ms. Margaret A. Torraville
33 Shea Street
St. John's, NF
A1B 1Y2

Dear Ms. Torraville:

This will acknowledge receipt of your correspondence dated **March 1, 1999** wherein you clarify issues and provide a revised consent form for the research study entitled "**Adolescent Suicidal Behaviors: A Phenomenological Study of Mothers' Experiences**".

At a meeting held on **March 11, 1999**, the Human Investigation Committee granted full approval of the research study and revised consent form.

I wish you success with your study.

Sincerely,

~~H.B. Younghusband, PhD~~
Chairman
Human Investigation Committee

HBVjglc

C Dr. K.M.W. Keough, Vice-President (Research)
Dr. R. Williams, Vice-President, Medical Affairs, HCC
Dr. S. Solberg, Supervisor



APPENDIX B: CONSENT TO PARTICIPATE IN NURSING RESEARCH

FACULTY OF MEDICINE - MEMORIAL UNIVERSITY OF NEWFOUNDLAND
AND
HEALTH CARE CORPORATION OF ST. JOHN'S

Consent to Participate in Health Research

TITLE: Adolescent Suicide Behaviors: A Phenomenological Study of Mothers' Experiences.

INVESTIGATOR(S): Margaret Ann Torraville, R.N. B.N. Telephone 753-4382
School of Nursing

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time without affecting your normal treatment.

Information obtained from you or about you during this study, which could identify you, will be kept confidential by the investigator. The investigator will be available during the study at all times should you have any problems or questions about the study.

1. Purpose of study:

The purpose of this study is to gain a greater understanding of what living with an adolescent exhibiting suicidal behaviors is like for mothers. It is anticipated that the results of this study will enhance health professionals knowledge, understanding and sensitivity about the mothers experience.

2. Description of procedures and tests:

You are being asked to participate in one interview, conducted at a location and time convenient for you. The interview will last approximately sixty to ninety minutes. If clarification is needed, a follow-up interview will be requested, within two months of the initial interview. The interview will be audiotaped with your permission. Your interview will be transcribed word for word. Your experience will be described in a manner that identification of the information source will be impossible. All identifying information will be destroyed once the study is complete. You may request a summary of the study findings upon completion of the study.

3. Duration of participant's involvement:

Your involvement includes one sixty to ninety minute interview, with the possibility of a

follow-up interview, if any clarification is needed. The investigator will contact you by telephone after the interview, to ascertain your perception of the data; specifically whether you believe the description to be representative of your experience.

4. Possible risks, discomforts, or inconveniences:

Some individuals may find it upsetting to talk about their experience due to the sensitive nature of the conversation. You may stop or delay the interview at any time and support offered to you.

5. Benefits which the participant may receive:

You may not benefit directly by participating in this study. However, your involvement may provide useful information to enhance health professionals' knowledge, understanding and sensitivity about the mother's experience living with an adolescent exhibiting suicidal behaviors.

7. Liability statement.

Your signature indicates your consent and that you have understood the information regarding the research study. In no way does this waive your legal rights nor release the investigators or involved agencies from their legal and professional responsibilities

Signature:

Date:

Participant Initials

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APPENDIX C: UNSTRUCTURED INTERVIEW GUIDE

Unstructured Interview Guide

I am interested in what life is like for you living with your child who shows suicidal behaviours.

You can share any thoughts or feelings you have. I would like you to tell me about the experience in your own words, your own feelings.

Please feel free to talk about whatever you feel.

(Questions to facilitate the interview)

1. What is a typical day like for you?
2. What are your feelings towards your child when he or she makes a suicidal gesture or attempt?
3. What are your feelings towards your child after the gesture or attempt?
4. Do these threats, gestures or attempts change the way you feel about yourself or your child?
5. Do you feel your life has changed since your child's first suicidal behaviour? If yes, how has it changed?

