A LITERATURE REVIEW OF PARENTAL GRIEF RESULTING FROM CHILD SUICIDE: A CASE FOR THE PROFOUND SEVERITY OF MATERNAL GRIEF

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This literature review is dedicated to my grandfather Howard Laidlaw (d. 1982) and my older brother Christopher Howard Moore (d. 2017) who lost their lives to suicide after long fought battles against depression. This is also dedicated to my mother Catherine Moore-Boyd and her dear friend Susan Yeager Jordan who lost her son Joshua Jordan in the same fashion (d. 2017). Two grieving mothers were then brought together by tradgedy, soon to become dear friends to lean on one another during the lifelong grief of the same unimaginable loss - the death of a child by suicide.

To my father Paul Moore, despite the pain, your strength for our family has been immeasurable. You have always been larger than life in my eyes and you are by far the best papa in the entire world. To my step father James Boyd, even though you didn't have to, you have loved me through every phase of my life and have selflessly helped parent me for almost 20 years. Thank you and I love you. To my sister and brother in law Jessie and Tyler Dubois, your love for me has been selfless and unconditional. I wouldn't have been able to get through any of this without you.

To my grandfather Howard, my brother Christopher and Susan's son Joshua, rest easy. May your pain have subsided and your hearts be at ease. And of course, this goes out to every grieving mother who has somehow managed to survive each waking day since the loss of their child. There is no greater strength paired with no greater greater pain.

"*If love could have saved you, you would have lived forever*."

-David Ellsworth

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Losing a child is undoubtedly a beyond painful experience, and losing a son or daughter because he or she chose to take his own life is arguably unthinkable. How is the experience of a mother bereaved by suicide unique from the experience of other family members, specifically of the father? Although past research indicates the grief and mental health outcomes of bereaved individuals varies based on their relationship to the suicide victim, and that bereaved parents experience the highest levels of distress, the experience of mothers versus fathers has yet to be studied (Kawashima, & Kawano, 2017). The present literature review seeks to gather the available information addressing this gap in the understanding of parental bereavement and grief, and spark additional research in this area that may help to inform post-intervention therapeutic techniques for suicide-bereaved parents.

First, an overview of recent suicide statistics is reported, illustrating the severity of the need to understand all types of suicide-bereavement. Sociocultural views of suicide, the primary theories of grief and bereavement, and how suicide affects the family unit are then outlined to provide the foundational knowledge to interpret research findings later discussed. The body of the literature review then addresses parental grief as a whole, followed by maternal and paternal grief individually, in attempts to elucidate the profound severity of maternal grief in particular (Farnsworth & Allen, 1996). This review does not argue that the grief experienced by fathers is not equally as profound, but that

the process must be differentiated from that of mothers so that counselors may be better able to address their different needs.

Overview of Suicide & Statistics

The Center for Disease Control and Prevention (CDC, 2018) identifies suicide as part of a broader class of behavior called *self-directed violence*, which refers to behavior directed at oneself that intentionally results in injury or the potential for injury. Suicide is a result of self-directed lethal behavior (CDC, 2018). Illustrating the seriousness of this issue, according to data reported by the CDC (2018), suicide was the 10th leading cause of death for all ages in 2013. There were 41,149 suicides in 2013 in the United States which equates to one every 13 minutes. Suicide is often the result of multiple comorbid disorders, such as depression and addiction. In 2010, 33.4% of suicide victims tested positive for alcohol, 23.8% for antidepressants, and 20.0% for opiates, which included heroin and prescription painkillers. In 2013, suicide resulted in an estimated $51 billion in combined medical and work loss costs, demonstrating both the practical and humanitarian importance of this epidemic.

The Substance Abuse and Mental Health Services Administration reported that more than 8 million adults reported having serious thoughts of suicide in the past year, 2.5 million reported making a suicide plan in the past year, and 1.1 million reported a suicide attempt in the past year (Piscopo, Lipari, Cooney, & Glasheenm, 2016). A report conducted by the Center for Disease Control and Prevention (2016) compared suicide mortality rates spanning from year 1999 to 2014. It was noted that between 1986 and 1999 there was a consistent decline in suicides, but over the following 15 years, a steady

incline was observed. Given this incline in suicide prevalence, an investigation into the factors involved that leads someone to that decision is warranted, as is an examination of how suicide affects the surviving loved ones.

Gender disparities. Although males consistently have been found to take their own lives at nearly four times the rate of females, representing 77.9% of all suicides, females are more likely than males to have suicidal thoughts (Piscopo et al., 2016). Still, according to the same data, suicide is the seventh leading cause of death for males, and fourteenth among females. One factor involved in this gender disparity may be due to the fact that males are more likely to choose a highly lethal form of suicide (e.g., firearms), compared to females who typically choose a less lethal form of suicide (e.g., drugs).

Suicide prevalence & age. Based on data collected and reported by Piscopo et al. (2016) for the Substance Abuse and Mental Health Services Administration, suicide prevalence is highest among adults that are 18-to-25 years of age, followed by adults aged 26-to-29 years, then by adults 50 years or older. Suicide is the third leading cause of death among persons aged 10-14 years of age, the second among persons aged 15-34 years, the fourth among persons aged 35-44 years, the fifth among persons aged 45-54 years, the eighth among person 55-64 years, and the seventeenth among persons 65 years and older.

While the percentages of adults 26-years-old and older who report having suicidal thoughts or a suicide plan, or who do commit suicide appears to be holding relatively steady in the last decade, these percentages are slowly rising among those 18-to-25 years old. Suicidal ideation may begin early in development, particularly during the adolescent

years. A total of 17.0% of U.S. high school students in grades 9-to-12 reported having seriously considered attempting suicide in the past year; 16.5% reported having made a plan about how they would attempt, 8.0% actually attempted suicide, with 2.7% making an attempt which then required medical attention (Piscopo et al., 2016). As tragic as these statistics are, considering that young people are particularly vulnerable, with the highest risk for suicide and suicidal tendencies, the parents of those young people are at the highest risk for having to potentially cope with a loss of their child to suicide. How are these parents affected? How do they grieve?

Sociocultural Views of Suicide

The following is an overview of percentages of adults reporting experiencing suicidal thoughts in the U.S. based on racial/ethnic classification: 2.9% African/African American, 3.3% Asian, 3.6% Hispanic, 4.1% Caucasian/White, 2.6% native Hawaiians/other Pacific Islanders, 4.8% Native American/Alaskan Native, 7.9% multiracial (Piscopo et al., 2016). These differences in percentages between those with various racial or ethnic backgrounds suggests the importance of sociocultural factors involved in suicidal behavior. Moreover, differences in suicide ideation have been well-documented in cross-cultural studies (e.g., Eshun, 2003). Contextual influences, ranging from discrepancies in funding of governmental prevention programs to differences in the community's attitude toward suicide, cannot be ignored when examining suicidal behaviors and how those behaviors may affect loved ones.

The psychological processes (i.e., mental illness) involved in suicidal behaviors occur within a particular social and cultural context, which may serve to promote

vulnerability or perhaps resiliency. Some theorists, such as Durkheim (1951; 1897), assert that given the regularity, predictability, and consistent prevalence of suicide across societies and throughout history, suicide is a *social fact*. A social fact is essentially any social phenomenon that exerts an external effect on the individual within that society. Under Durkheim's (1951/1897) philosophical perspective, suicide is not the result of individual psychology or mental illness, but rather a result of poor social regulation that fails to align individual and collective goals. For example, suicide is more common in times of economic hardship, when there are high rates of job loss and unemployment (Chang, Stuckler, Yip, & Gunnell, 2013).

Social cohesion therefore helps to restrain suicide, and evidence for this can be seen by the protective effects community (Morris, 2007) and religion (Cook, 2014) may exert on individuals. A study conducted by Kleiman and Liu (2014) found in a sample of over 20,000 participants, that individuals who reported frequently attending religious services were significantly less likely to succumb to suicide compared to those who attended less often. One could argue this result has more to do with the religious teachings on suicide, as opposed to the benefit of feeling connected to others within a religion. Nevertheless, *both* individual and sociocultural factors carry importance in suicidal behavior (Hoven, Mandell, & Bertolote, 2010), and also in how surviving loved ones of suicide victims experience the loss (Cottle, 2000).

Continuing from sociological perspective on suicide, the present literature review, being an analysis of parental grief and suicide-bereavement resulting from the suicide of a child, is specifically concerned with societal attitudes toward the parents of a suicide

victim. These attitudes may be powerful forces in how a family, and particularly the parents, react to and grieve their child's suicide. Although several research tools, such as the Suicide Opinion Questionnaire and the Suicide-Attitude Questionnaire (see Range et al., 1999), have been developed to measure these attitudes, both contain substantial limitations and do not sufficiently examine attitudes specifically pertaining to the domain of the family, or parents of suicide victims. Lester and Akande (1994) and Eshun (2003) examined the role of negative suicide attitudes in predicting suicidal ideation within a particular culture. However, it remains unclear if a lower prevalence of suicidal behaviors in cultures holding negative attitudes surrounding suicide is because the society as a whole disapproves of suicide regardless of circumstance, or is a result of underreporting to avoid stigma. Social stigma and suicide, specifically in regards the grieving parents of the suicide victim, will be discussed in later sections.

How Suicide Affects Others: Bereavement, Grief, and Mourning

To be bereaved is to be deprived of something of value, typically due to the death of a loved one (Warren, 1981). Grief makes up the psychological components of bereavement and these feelings are evoked by loss, especially when a close loved one dies. Mourning is the act and manner of expressing grief, which can be culturally sculpted in numerous ways. Although bereavement, grief, and mourning are individualized concepts, there are several theories that seek to identify commonalities experienced amongst those who grieve, and ultimately identify the typical path of grieving for the bereaved tends to be (see Burglass, 2010 for review). The field of

bereavement and grieving has transformed over time with earlier theories and models being replaced with ones which are more modern and empirical based.

Relevant theories of grief. The first major theoretical conceptualization of grief dates back to Freud (1917), with his work *Mourning and Melancholia*. Mourning, as Freud describes, takes place in the conscious mind and occurs when someone grieves over the loss of a specific tangible "love object." Mourning is a healthy and natural process, but can manifest itself into pathological melancholia if the bereaved does not effectively go through the grieving process. In this state, the individual does not feel complete separation from the "love object" and remains connected to the deceased in unhealthy ways. Effective grieving, according to Freud, entails breaking the connection with the deceased through three discrete tasks: (1) freeing the bereaved from bondage to the deceased; (2) readjustment to new life circumstances without the deceased; and (3) building of new relationships. Freud (1917) proposes that failure to work through these stages compromises the process of grief and recovery, causing the bereaved to become more susceptible to mental and physical illness. Freud stressed the importance of moving on as quickly as possible to return to a normal level of functioning, however doing so may have potentially detrimental effects to the surviving loved one's well-being later on and progressive theories now reject decathecting from the deceased loved one (see Klass, Silverman, & Nickmann, 1996).

After Freud's (1917) work, the field of grief and bereavement remained practically untouched for decades until Kubler-Ross (1969) introduced the "5 Stages of Grief," which is still considered a valuable framework by professionals today. However,

this particular model lacks the support of empirical evidence and is not derived from any type of theoretical principles (Stroebe, Schut, & Boerner, 2017). Also, this particular model was about confronting one's own death, not mourning another person. Akin to Freud's (1917) theoretical perspectives on mourning, these stage-type theories have not shown to offer much value to our understanding of the grieving process overall (see Burglass, 2010; Stroebe, Schut, & Boerner, 2017). Stage theories are appealing to health care professionals and society alike for various reasons. For instance, they offer a clear cut, linear navigation through an extremely complex process such as grief. The problem with this model though, is that stage theories fail to address the complexity of the experience of grief and the different trajectories it may take. Early stage theories began losing popularity due to their rigidness and inability to address the different concepts associated with grief from various types of losses, such as parental grief resulting from child suicide. Less restrictive theories of grief, mourning, and bereavement are more informative, practical, and reflective of the actual process experienced by the bereaved.

Bowlby, being famous for his work on Attachment Theory (see Bretherton, 1992), postulated that four phases of mourning are tied to the attachment phenomena, carrying the purpose of regaining proximity to the lost loved one (Bowlby, 1961; 1973; 1982). Though his proposed theory of grieving is also a stage-model, his integration of attachment theory is of critical importance when considering the impact that the loss of a child has on primary caregivers. Attachment theory has been widely studied and accepted within the field of psychology, and therefore the strength of the caregiver-child attachment must be considered while evaluating the effects of the unique loss of the child

to suicide. Bowlby (1973) claimed the grief following a death of a loved one depends on the attachment system that was formed throughout development. Bowlby considered child grief in response to the death of the primary caregiver, though the formed attachment and bond would surely shape the grieving and mourning of the primary caregiver in the case of child death as well.

Worden (1991) proposed the "Four Tasks of Mourning," that rejects the notion of stages and is conceptually more fluid, with an eventual goal of withdrawing the emotional energy towards the deceased and relocating said energy to another relationship. Although this theory took a slight side-step away from the traditional stage theories, its scope is still heavily constrained, and does not account for persistent, complicated, or unresolved grief. Analyzing one's grief requires the use of an appropriate theory that accounts for the psychological and social processes of grief, and does not pathologize healthy grieving behavior. The popular narrative of grief theories only began to shift when Stroebe and Schut (1999) introduced the dual process model of coping with bereavement. This dynamic model integrated and improved upon many traditional theories, and asserts that an individual has to cope with loss-oriented (i.e., accepting the death experience) and restoration-oriented (i.e., building new relationships, moving forward) factors. An individual may oscillate between the two, experiencing a wide range of negative emotions (e.g., shock, despair, anger, guilt, mitigation, etc.). The dual process model of coping is now considered *the* grief theory, primarily for its ability to account for the uniqueness of each individual's situation, gender differences, and cultural differences (see Rothaupt & Becker, 2007). Bereavement theory, formulated based on empirical data,

also notes the importance of restoration, or personal growth, following a loss (Hogan, Morse, & Tason, 1996).

Though these aforementioned theories are useful when considering the grieving process of an individual, they are not sufficient when considering uniqueness of losses involving a child (of any age) or suicide. Losing someone to suicide naturally evokes different types of grief among surviving loved ones. For example, a parent who loses their child to suicide may experience disenfranchised grief, which results when that grief is not truly socially recognized by others (Doka, 2002; 2008). Parents must work through processes of grieving, bereavement, and mourning in a social world, where there is potential to face judgment or ridicule from others who may consider them to be failure as parents.

Additionally, the prevailing traditional grief theories emphasize breaking the bond with the deceased as the essential goal. However, based on both anecdotal and empirical evidence from a 10-year study, Klass and colleagues (1996) identified the importance of continuing bonds for bereaved parents. Parents grieve in a healthy fashion by maintaining a sense of connection with their child through memorials and holding onto his or her belongings, for example (Riches & Dawson, 1998). Oftentimes parents do these types of behaviors because they desire to give meaning to their deceased child's shortened life. If a child is deceased due to suicide, however, the social reputation of the parents is altered and the death is stigmatized; this type of mourning may then be discouraged by their community or religion. Or, parents may impose a sense of shame on themselves due to the perceived judgement.

Suicide & its Impact on the Family System

As discussed, losing a loved one who purposefully and intentionally chose to take his or her own life uniquely affects the surviving family (see Cerel, Jordan, & Duberstein, 2008 for review). The bereaved family is faced with the seemingly impossible task of attempting to adjust the structure of the family system to a new homeostasis (Jackson, 1968, as cited in Bowlby-West, 1983). This task is not only difficult because of the pain of the loss, but also because the death disrupts the family's dynamics while each member attempts to work through the wide-range of emotions associated with bereavement and grieving. Bowlby-West (1983) describes displacement of feelings, enmeshment of family members, promotion of family secrecy, and restructuring of family roles as just some of the homeostatic adjustments that take may place. The added complexity of these processes that result from a family suicide rather than accidental or natural death is sometimes too tremendous, leading to the fracturing of the family system (Ratnarajah, Maple, & Minichiello, 2014).

Considering family systems theory (Cottle, 2000) a suicide can have utterly traumatizing effects on the psychology of each individual family member, which consequently has the potential to lead to the fracturing of the family system (Brende & Goldsmith, 1991; Murphy, Johnson, Chung, & Beaton, 2003), and the occurrence of potential abuse or violence. A preexisting unstable family system is also a common risk factor in the case of many suicide victims (Strickland, Walsh, & Cooper, 2006; Qin, Agerbo, & Mortensen, 2003), and thus an already broken family becomes further fractured. Moreover, after the occurrence of a suicide, familial risk of suicide increases

jointly; children of suicide victims risk doubles, especially if the child is young at the time (Garssen, Deerenberg, Mackenbach, Kerkhof, & Kunst, 2011).

Parental Grief & Child Suicide

Although the loss of a child impacts the family system as a whole, parental grief is noted by experts in the field as the most profound and overwhelming type of grief, especially maternal grief (Rando, 1986). Parents are never truly prepared for this type of unexpected loss, as it is seen as unnatural for a child to die before his or her parents (Davies, 2004). Work comparing the intensity of reactions to various types of familial losses have found the loss of child is paired with grief far more extreme than grief resulting from the loss of a parent or spouse (Sanders, 1988). Moreover, feelings of extreme guilt and helplessness can result from the suicide of a child due to the parents feeling as if they failed in the role of being a protective primary caregiver (Gilbert, 1997; Miles & Demi, 1992).

While the overall death rate of children has dramatically decreased in modern times, child and adolescent suicide rates have quadrupled since the 1950's (Wingfield, Petit, & Klempner, 1999). Considering the strongly formed attachment bond between the primary caregiver and child (Bowlby, 1961; Bowlby, 1973; Bowlby, 1982), it unfortunately is not surprising that parents report thinking of the violent death of their child daily for more than four years after the event (Murphy, Johnson, & Lohan, 2003a). Long-lasting adverse mental health and social outcomes result from suicide-bereaved parents, and this particular group of individuals are more likely to have preexisting vulnerabilities (Bolton et al., 2013).

Though the emotional pain experienced by a parent grieving after his or her child commits suicide is unimaginable, parents bereaved by other forms of violent death (e.g., suicide or homicide) experience relatively similar negative outcomes (Murphy, Johnson, & Lohan, 2003a; Murphy, Johnson, Wu, Fan, & Lohan, 2003). Although "time heals all wounds" is a classic cliché, these longitudinal studies found the largest predictor of improved stress levels and lessening of PTSD symptoms in the parent participants was time. However, in this period of grief when emotional and mental health is highly disrupted, researchers have also identified physical, health-related effects resulting from the death of a child (Murphy, Lohan, Braun, Johnson, Cain, & Beaton, 1999). Compared to controls, bereaved parents were found to have significantly higher mortality rates, presumably resulting from the death of their child (Li, Precht, Mortensen, & Olson, 2003). Parents reported experiencing the most intense reactions shortly after the death of their child, and this coincided with higher mortality rates from unnatural causes (e.g., accidents, suicide).

Robust individual differences in parents' coping abilities have also been found; other previous research has found those who have previously endured human loss or are better adept at emotional regulation cope better with the loss of their child (Znoj & Keller, 2002). Maladaptive coping strategies, such as repression, in response to the violent death of a child are also associated with poor health outcomes, mental distress, and PTSD symptoms (Murphy, Lohan et al., 1999). This phenomenon should be further studied considering the ineffectiveness of presently available coping strategies for parents

(Murphy, Johnson, Lohan, 2003b). Differences in mortality rates of bereaved mothers and fathers are discussed in later sections.

As discussed, the stress resulting from parental bereavement has been associated with poorer overall health outcomes, and this association is even stronger when the cause of death was unexpected, such as in the case of suicide (Song, Floyd, Seltzer, Greenberg, & Hong, 2010). Marital closeness of the parent dyad was significantly associated with better health outcomes, though, emphasizing the importance of a family support system throughout the grieving process. A study examining the PTSD symptoms of parents following the violent death of a child found the only significant predictor of reduced symptoms, other than gender, to be perceived social support (Murphy, Johnson, Chung, & Beaton, 2003). This social support from family and friends is most important in the first year following the death of a child, as suicidal ideation, feelings of loneliness, and depression levels are often highest at this time (Murphy, Tapper, Johnson & Lohan, 2003; Stroebe, Stroebe, & Abakoumkin, 2005).

Qualitative studies examining the experience of parents bereaved by child suicide have found that the death evoked such severe grief symptoms that parents eventually come to construct some kind of meaning from the event. These particular grief responses are complex and have been overlooked by much of the previous literature which did not consider examining both negative *and* positive outcomes. Akin to posttraumatic growth after a loss (Calhoun, Tedeschi, Cann, & Hanks, 2010), parents may gain new insight through these sense-making processes. By 5 years after the child's death, the majority of parents (57%) report having found meaning in the death (Murphy, Johnson, & Lohan,

2003c). Finding some kind of abstract meaning in the senselessness of a child's death also predicted lower grief severity (Keesee, Currier, & Neimeyer, 2008). There are two main avenues a parent may take to make meaning after their child's death: cognitive mastery and renewed purpose (Wheeler, 2001). In the former, the parent tries to make sense out of the incoherent situation, and answer the general question of "why?" Whereas in the latter, the parent reinvests him or herself into a new purpose in light of losing their full purpose as a mother or father. As Wheeler (2001) argues, parent bereavement after the death of a child is actually a crisis of meaning, and consequently these meaning making practices are crucial throughout the grieving process.

The previously discussed literature found the reactions of parents to their child's death to be relatively similar among various causes of death, however, how can a mother or father make meaning of his or her child's death in the case of suicide? The unique types of grief and feelings of guilt resulting from child suicide undoubtedly adds an additional obstacle to the grieving process. Miles and Demi (1992) found that more suicide-bereaved parents report guilt as the most distressing aspect of their grief, compared to parents who lost a child to chronic illness or an accident. The current body of literature fails to thoroughly examine these distinctions in grief reactions, likely because of difficulty studying parents in this situation.

Maternal grief. Substantial theoretical, empirical, and anecdotal case evidence exists demonstrating the profound severity of grief following the loss of a son or daughter experienced particularly by mothers. Though minimal research has specifically investigated exactly *how* maternal grief differs from paternal grief, findings from

empirical studies and theoretical perspectives converge to provide some insight. To understand the differential experience of mothers bereaved by her child's suicide, first the experience of motherhood itself must be understood.

Defining motherhood. Mothers do not only serve an essential role in the lives of their offspring, but they often also hold a critical responsibility of transmitting culture, and this culture in turn shapes maternal expectations placed upon them (Barlow & Chapin, 2010). These expectations are typically idealized in virtually all cultures, coinciding with a vast array of prescribed guidelines of what a mother should and should not do. The goals of "good mothers" are to protect their children, while being nurturing, patient, and kind. The scope of motherhood is much larger than that of traditional fatherhood; unequal domestic responsibly, familial responsibility and demands leads to frequent scapegoating of mothers who are seen as "failing" to provide for their children (Maher, Fraser, & Lindsay, 2010).

Contrastingly, on the individual level, mothers generally describe having a child as a life-changing journey (Miller & Tina, 2005). According to Athan and Miller (2005), new mothers feel as though they have been born again themselves, with a newfound meaning and purpose. Akin to other highly emotional experiences that spark personal growth, the challenges and joys reported by mothers provides an opportunity for spiritual transformation. Qualitative interviews conducted by the researchers found women do not just adopt the role of motherhood, but also the role of a heroine. Being that motherhood is such a high-pressure and substantial undertaking, the presence of child-rearing support lowers the risk for dysfunction in parenting (Athan & Miller, 2005). From an

evolutionary perspective, cooperative parenting and support (i.e., alloparenting) amongst mothers was essential under ancestral conditions, and thus is still useful today (Hrdy, 2009).

The importance of social support does not negate the significance of the quality of attachment formed between mother and child (Bretherton, 1992). For decades, attachment theory was only considered in the context of mothers, largely ignoring the role of fathers in attachment based on Trivers' (1972) parental investment theory. Considering the biological necessity of mothers in childbirth and nursing that is not experienced by fathers, mothers are often referred to as *the* primary caregiver. Regardless of the level of parental involvement, previous work has suggested the importance of the gender of the parent. Even fathers maintaining the role of primary caregiver were found to behave more similarly to secondary caregivers, remaining less likely than mothers to engage with and tend to the infant (Lamb, Frodi, Hwang, Frodi, & Steinberg, 1982). Additionally, Kreuder (1996) found through videotaping parent-infant dyads fathers engaged in less interactions in the area of care and nurturance, and more in the area of play, compared to mothers.

Though these gender differences in parenting roles and styles are likely primarily the result of culturally guided norms and socialization experiences, they serve to forge the quality of the relationship between parent and child. The uniqueness of the bonds forged between mothers and their children and the motherhood experience would consequently lead to a unique type of grief given the loss of the child.

Empirical Support. As previously discussed, no literature to date investigates the specific differences in grief and bereavement of mothers and fathers following the death or suicide of a child. Past research assessing the reactions of parents bereaved after their child's death has identified consistent disparities in the severity of grief reactions and coping mechanisms though, indicating the remarkability of maternal grief. For all types of violent death, mothers report higher levels of grief compared to fathers (Keesee, Currier, & Neimeyer, 2008). Keesee and colleagues (2008) also found the grief of both parents is significantly heightened in cases of sudden violent death (e.g., suicide, homicide), compared to nonviolent death (e.g., natural illness). Many of the findings to be reported regarding sex differences and paternal grief do not exclusively consider violent deaths or suicide; the anticipated grief reactions would then be expected to even higher for parents of individuals who fall victim to suicide.

Studies that have explicitly examined parents' reactions to adolescent suicide or suicide attempts have found both immediate and long-term gender differences between maternal and paternal reactions. A study interviewing parents following their adolescents' suicide attempt found mothers and fathers experience a very different host of emotions in reaction to the situation (Wagner, Aiken, Mullaley, & Tobin, 2000), that reflected Bowlby's (1973) attachment theory. Though both parents reported increased positive concern for the adolescent, mothers were more likely than fathers to experience sadness, caring, and anxiety. Unlike fathers who primarily reported feeling hostile, mothers were mindful to not verbalize their negative emotions to avoid upsetting the adolescent further. Mothers were most likely to provide support and less likely to express

feelings of hostility in the case of highly lethal attempts, making the high-risk attempt actually a facilitative attachment behavior.

Longitudinal research suggests mothers of suicide victims are at an increased risk for the occurrence of depression, compared to both fathers and siblings, three years following the suicide (Brent, Moritz, Bridge, Perper, & Canobbio, 1996). Though preexisting depressions levels may differ between males and females, and younger siblings and older siblings, mothers were also more likely to experience recurrences of depressive symptomatology. Additionally, the psychological distress caused by a death of a child is associated with increased mortality in mothers from both natural and unnatural causes (Li, Precht, Mortensen, & Olsen, 2003). This association is even stronger in the case of sudden or violent deaths, such as suicide. Li and colleagues (2003) found bereavement was associated with long-term natural mortality due to illness (e.g., cardiovascular disease, cancer) for the mothers, because of stress, a weak immune system, or poor health behaviors such as smoking or consuming alcohol. An increased risk of unnatural causes of death, such as suicide or accidents, would presumably be a result of mothers intense grief reactions and subsequent depression (Murphy, Tapper, Johnson, & Lohan, 2003).

Similar to how the tragic death of a child increases the risk of parental suicidal (and non-suicidal) death, having children actually may actually provide protective effects against suicide. Qin and Mortensen (2003) found parental status (i.e., having children) to be associated with lower suicide risk. The effects were stronger for women than men, and even greater if the child is young. These findings align well with attachment theory

(Bowlby, 1973), emphasizing the importance of the role of the mother, especially early in life when the child is most reliant. The primary and critical role of mothers in their child's development is further illustrated by the findings of Garssen and colleagues (2011), which suggested the suicide of a mother is most predictive of offspring suicide. Moreover, this increased suicide risk is especially strong if the mother committed suicide at a young age, when the child is most reliant and requiring the most care. Mothers appear to be most affected by the suicide of their child and children appear to be most affected by the suicide of their mothers, demonstrating the remarkable strength of the bond between mother and child, and also the unique severity of the grief that the follows child suicide.

The body of research conducted by Murphy and colleagues provides a comprehensive examination of the experiences of parents bereaved by the violent death of a child. The research team has identified differences of bereaved parents based on parental role for: change in mental distress over time (Murphy, Das Gupta et al., 1999), health and health care utilization (Murphy, Lohan, Braun, Johnson, Cain, & Beaton, 1997), coping strategies (Murphy, Johnson, & Lohan, 2003b), and PTSD symptoms (Murphy, Braun, Tillery, Cain, Johnson, & Beaton, 1999; Murphy, Johnson, Chung, & Beaton, 2003). Mothers tend to experience a stronger mental distress reaction to the violent death of their child initially, compared to fathers. However, mental distress appears to persist longer in fathers, perhaps because fathers engaged in maladaptive repressive coping strategies. Compared to the general population, bereaved mothers also tended to experience worsened mental distress symptoms overall. In coping with this

distress, various strategies used by bereaved parents were found to be less effective for mothers compared to fathers.

As mentioned, Murphy and colleagues (1999; 2003) found the PTSD symptoms following the violent death of a child tend to be greater in severity and duration for mothers compared to fathers. In both studies conducted, mothers were approximately three times more likely than fathers to meet DSM diagnostic criteria for PTSD. Although the notion that death by suicide results in the worst outcomes for parents has been dispelled (Murphy, Johnson, & Lohan, 2003a), parents whose children fell victim to suicide or homicide, as opposed to illness or accident, experience significantly more panic behavior (Hogan, Greenfield, & Schmidt, 2001). However, specifically in the case of homicide, parents reported more feelings of blame and anger. Similar to other traumatic experiences though, posttraumatic growth can often result, and is an important part of the healing process according the prevailing bereavement theories (Hogan, Morse, & Tason, 1996; Stroebe & Schut, 1999).

Martinčeková and Klatt (2017) conducted a study consisting of semi-structured interviews investigating the factors involved in posttraumatic growth resulting from maternal grief. Results revealed the importance of forgiveness in decreasing grief symptomology and promoting posttraumatic growth. In other words, lack of forgiveness (with oneself, partner, God, family, friends) promotes anger, creating a barrier for bereaved mothers that prevents them from moving on. Establishment of a symbolic ongoing bond with the deceased child was a major way that all of the mothers found some solace in their loss, although this process was complicated for the mother whose

pre-loss bond with her child was most conflicted. To accomplish this goal, mothers must be able to cope with the extensively complex negative emotions brought on by the suicide of their child. With forgiveness being key, self-blame and blaming others (particularly the mother, as the typical primary caregiver) for "missing something" and not noticing the warning signs (e.g., lack of eye-contact, depressed mood, destructive behavior) prior to the suicide is a major obstacle in addressing parental grief. The great role of social stigma in differentiating the parental grieving processes is later discussed.

In addition to gender differences in coping with child bereavement, individual differences in the ability of parents to engage in positive and productive meaning-making processes have been empirically reported. Similar to how motherhood (and fatherhood) is an opportunity for a spiritual growth, grieving from the bereavement of motherhood by child suicide appears to require an equally transformative experience of finding meaning in the tragedy. Parents who refuse to find some sort of meaning, or have extreme difficulty doing so, report worse long-term mental and physical health outcomes (Murphy, Johnson, & Lohan, 2003b; 2003c). This may be a particularly difficult task for mothers, especially those with low self-esteem, who were found to cope less successfully compared to fathers and parents with higher self-esteem. Mothers with low self-esteem were also more apt to engage in poor coping strategies (e.g., repression) that predicted higher PTSD symptoms (Murphy, Johnson, & Lohan, 2003b).

Given the importance of successfully coping with the suicide of one's child in eventually accomplishing resolution through identifying a meaning or purpose, it is essential to understand what factors lead one parent to healthy coping with the loss and

another to persistently suffer mentally and psychically. These factors may be contextual (e.g., perception of social support, sociocultural influences) or dispositional, relating to the individual personality characteristics and abilities of the parents. A study conducted examining the latter relationship found high levels of optimism and the use of active coping strategies were associated with less intense and complicated grief reactions (Riley, LaMontagne, Hepworth, & Murphy, 2007). Furthermore, coping strategies, such as seeking social support and positive reframing, were found to predict personal growth. Findings from Znoj and Keller (2002) likewise suggested bereaved parents' ability to regulate their highly intense emotions, essentially coping, is positively related to personal growth once they adapted to the loss. These findings directly align with the widely-accepted dual process model of coping with bereavement (Stroebe & Schut, 1999).

Experiencing any loss produces various emotions that may even conflict with one another, and in the unique case of maternal grief, these emotions may be so intense and complex that they become problematic obstacles in the grieving process. Jealousy, envy, shame, and guilt resulting from losing an offspring due to miscarriage or later death are problematic social emotions found to commonly typify maternal grief (Barr & Cacciatore, 2008). Guilt in particular results when a mother feels she has failed at being a "good mother." Mothers are still seen as the parent that cares for the children and provides for the majority of the family's needs within the home, despite it being now common that both parents work outside of the home (Alanne, Laitinen, Soderlund, & Paavilainen., 2011). Anxious uncertainty thus results from the pressure associated with

meeting this ideal standard of motherhood (Miller, 2005). Societal expectations can unconsciously shape mothers self-perceptions, which then in turn influence the grieving process following child bereavement.

The Role of Social Stigma. Being that the scope of motherhood differs in numerous ways from that of fatherhood (Miller & Tina, 2005), so does the social stigma attached to maternal versus paternal suicide-bereavement and grief. In numerous ways, culture and tradition teach each family member the socially acceptable and unacceptable reactions to bereavement (Bowlby-West, 1983). Moreover, considering the aforementioned importance of social supports, sociocultural context may help or hinder processes of grief and bereavement. Calhoun, Selby and Faulstich (1980) found evidence of the stigmatization of parental suicide-bereavement. Participants were asked to respond to newspaper reports of a child's death caused by illness versus a child's death caused by suicide, and results revealed that the parents were less likable and blamed more for the child's death in the case of suicide. Negative societal reactions, whether perceived or real, thus become an additional stressor for bereaved parents. Seeing that the expectations placed on mothers exceed those placed on fathers (Alanne et al., 2011), this external stressor would be even more challenging.

Surveys dispersed by Feigelman, Gorman and Jordan (2009) directly to bereaved parents participating in support groups identified the harmful effects of stigmatization following the death of a child. Negative responses from others and resulting difficulty maintaining interpersonal relationships with family and non-kin predicted increased grief difficulties, depression, and suicidal ideation. Unfortunately, mothers, more so than

fathers, tend to be the recipients of the negative effects of stigma. Even in cases of parents committing murder-suicide of their children and then themselves, fathers' actions are rationalized and they are still perceived as exemplary in their fatherhood roles (Nikunen, 2006). Contrastingly, mothers are frequently represented as cold-blooded killers in the media. The occurrence of parental murder-suicides is much more frequent in the case of fathers to the point of social desensitization. Society differentially reacts to mothers, as committing such a heinous act is seen as against their nature.

The gender norms that shape the socially prescribed parenting roles clearly contribute to different forms of stigma following a child's suicide, which in turn carry consequences and obstacles in the grieving process. Mothers, being the source of life and primary care, can be perceived as failures considering their child chose to take his or her own life. How can suicide-bereaved mothers healthily cope and work through the loss of their child when their grief is disenfranchised and invalidated by others?

Paternal grief. The remarkability of maternal grief in no way disregards or minimizes that of fathers bereaved by their child's suicide. The gender differences described in the parental roles are just that - different, and not necessarily unequal. Furthermore, gender differences do not imply biology, but rather are a result of natural enculturation and socialization processes (West & Zimmerman, 1987). However, due to limited access and low response rates of suicide-bereaved fathers, many researchers have noted the difficulty involved in studying this population (e.g., Brent et al., 1996; Keesee, Currier, & Neinmeyer, 2008; Wagner et al., 2000).

Parke and Stearns (1993) discuss the disparate parental roles, suggesting mothers tend to provide the majority of nurturing and care required in child rearing. Fatherhood is thus conceptualized very differently than motherhood. From birth, fathers interact differently with their children compared to mothers (Kreuder, 1996; Lamb et al., 1982). To understand paternal grief following child-bereavement from suicide, and how it differs from maternal grief, this difference in the parental roles throughout the child's life must be recognized and appreciated. The mother-child versus the father-child relationship may drastically differ, consequently resulting in different feelings of bereavement and grief processes.

Compared to mothers, fathers report significantly lower levels of grief following the violent death of their child (Keesee, Currier, & Neimeyer, 2008). However, it must be noted that fathers' grief reactions were still very severe, just not as severe as that of mothers.. Fathers also report experiencing different emotional reactions following the suicide attempt of their child; unlike mothers, fathers felt more hostile and angry than anxious (Wagner et al., 2000). Wagner and colleagues (2000) go on to discuss the validity of these findings, noting that fathers may be reluctant to admit emotions such as anxiety and fear because of cultural standards of masculinity. As with all of the findings documenting grief differences between parental roles, the origin of these observed differences cannot be assumed.

In regards to the long-term effects of parental grief following suicide-bereavement on overall well-being, depressive symptoms are found to recur less frequently in fathers compared to mothers (Brent et al., 1996). Similarly, Li et al. (2003) documented that only

maternal child bereavement results in significant increases mortality rates. Bereaved fathers only appeared to have an increased risk of unnatural death immediately after the loss of the child. Another study with a smaller sample of fathers, however, found bereaved fathers' health to actually worsen over time and bereaved mothers' heath to improve (Murphy, Lohan et al., 1999). In this sample, this finding was due to the higher likelihood of mothers to utilize healthcare and engage in health-protective behaviors compared to fathers.

Additional longitudinal analyses by Murphy, Das Gupta and colleagues (1999) have discovered that although the grief symptoms of fathers associated with child bereavement are lower compared to that of mothers overall, the severity of symptoms of mental distress follow a very different timeline. While mothers reported consistent decreases of mental distress across the three post-death assessments (4 months, 12 months, 24 months), fathers' mental distress levels slightly increased, likely because fathers were also found to frequently engage in repressive coping strategies. Later work additionally discovered the use of active and effective coping strategies was only effective at reducing mental distress and PTSD symptoms in fathers, not mothers (Murphy, Johnson, & Lohan, 2003c). This particular finding may be due to mothers having more severe and persistent PTSD symptoms compared to fathers after the violent death of a child (Murphy, Braun et al. 1999; Murphy, Johnson, Chung, & Beaton, 2003), making coping that much more onerous.

Both the grieving process and potential posttraumatic growth involved in paternal grief is not nearly as understood as maternal grief. Is it just as vital for fathers to engage

in meaning-making processes to reach resolution following child bereavement from suicide? And if so, do fathers and mothers find meaning in the tragedy the same way? Some research suggests the utilization of religion and support groups aids finding meaning, and bereaved mothers are more likely to use and benefit from these resources than fathers (Feigelman, Cerel, McIntosh, Brent, & Gutin, 2018; Murphy, Lohan et al., 1999). Since bereaved fathers engage in more repressive coping strategies compared to mothers (Murphy, Das Gupta et al., 1999), personal growth may present a more difficult task for fathers (Riley et al., 2007). The dual process model of coping with bereavement (Stroebe & Schut, 1999) should be specifically considered in the context of maternal and paternal grief resulting from child suicide-bereavement.

The above-mentioned reluctance of fathers in reporting particular emotions, such as fear and anxiety, is a result of the unconscious (or sometimes conscious) influence of societal expectations of masculinity (Wagner et al., 2000). Thus, in addition to the general stigmatization associated with suicide bereavement (Calhoun, Selby, & Faulstich, 1980; Feigelman, Gorman, & Jordan, 2009), fathers may feel socially pressured to conceal or dismiss their feelings. Both obstacles contribute to problems during the grieving process. On the other hand, because fathers are frequently seen as the secondary caregiver (Lamb et al., 1982) and are not held to the same idealized standard as mothers (Maher, Fraser, & Lindsay, 2010), suicide-bereaved fathers may not experience as much social scrutiny and ridicule (Nikunen, 2006)

Evidently, fathers do report less intense child-bereavement grief reactions compared to mothers overall. However, there appear to be numerous discrete challenges

experienced in paternal versus maternal grief. The present literature review focused on the experience of mothers, given the profound severity of maternal grief, but even more work is necessary specifically examining paternal bereavement and grief processes to begin to fill the literary knowledge gaps.

Non-Scientific Account of Parental Grief as a Result of Child Suicide

Given that little literature pertaining to grief and bereavement utilizes both qualitative and quantitative methods to inform theoretical perspectives, the following section is devoted to reviewing the available essays and other non-scholarly literary accounts of parental grief resulting from the death of a child. These anecdotal accounts are examined through various theoretical lenses discussed earlier. Much of the referenced work accounts for the emotional reactions initially experienced by parents, the lasting effects of the child suicide, and how parents develop mechanisms to cope with the unexpected and tragic loss.

Maternal Grief Example. Lesa Jackson, a nurse and mother, lost her teenage son to suicide (Riley, 2017). After the death of her son's father, Lesa's son struggled with severe depression, even though he appeared to be happy and doing well at school. In wake of the unexpected tragic loss, Lesa said to herself, "I don't know why, I don't know what." Feeling the deep regret of not taking her son's situation more seriously, Lesa now devotes much of her life to spreading a message to parents to take time to carefully listen to your children's feelings and reach out to mental health professionals when needed. It is especially important for parents to continuously check in with their children throughout the vulnerable adolescent period.

Although Lesa was an educated nurse and did everything she knew to do to address her son's mental health problems, the loss left her and her daughter with endless questions and overwhelmingly severe grief. In coping with her son's suicide, she discovered a newfound purpose of educating other parents about what signs of suicidal ideation to look for, and how to address the warning signs in prevention. Lesa's experience maps directly on the dual process model of coping with bereavement (Stroebe & Schut, 1996); the pain of wanting to know "why" is part of loss-oriented grief, and the meaning and purpose she derived from the loss is restoration-oriented grief. Lesa's experience of meaning making falls into the theme *becoming more altruistic*, according to Murphy and colleagues (2003b) prominent themes of meaning making. Grieving in the situation of suicide bereavement is unavoidable, especially as a mother when that unique attachment bond is lost (Bowlby, 1973), but constructing some type of meaning may help.

Paternal Grief Example. At the age of 13, Ryan Halligan chose to take his own life and hung himself after being the victim of horrid incidents of cyberbullying and in school (Erb, 2008). Ryan was bullied his entire life for having learning and motor disabilities, and when he disclosed to a friend he received a rectal exam at a doctor visit, the bullying became homophobic and relentless. John Halligan, a former IBM engineer and Ryan's father, was unable to forgive himself for not being able to prevent his son's suicide, as he and his wife Kelly only became aware of the severity of the bullying after Ryan's death. Through the dreadful grief, however, John found a greater calling to take action and lobby in Vermont for legislation preventing cyberbullying and suicide

prevention. Just six months after Ryan's death, the Vermont Bully Prevention bill (ACT 117) and another bill mandating suicide prevention education in public schools (ACT 114) were passed.

Even in wake of severe grief from Ryan's suicide, John was outspoken in the media and public school districts. Perhaps it was beneficial to the grieving process of Ryan's parents that they found out exactly why Ryan chose to take his life, and were able to better cope with the loss by addressing the issue legislatively. This particular meaning making process most closely falls into the theme of *seeking justice* (Murphy, Johnson, & Lohan, 2003b). John and Kelly were able to cope by maintaining their continuing bond (Klass, Silverman, & Nickmann, 1996) with Ryan by spearheading the passage of critical legislation and by awareness of suicide in adolescents.

Clinical Interventions for Parents

Providing effective clinical and therapeutic interventions for parents afflicted with the loss of their child to suicide is imperative. Interventions based on scientific evidence demonstrating effectiveness are discussed in this penultimate section. Interventions should not be based on traditional theories (e.g., Kubler-Ross model, Worden model) given their lack of empirical support. Modern theories of grief (e.g., dual processing model, continuing bonds), which have been supported by research studies (see Davies, 2004), should instead serve to inform clinical practice. Moreover, considering the individual uniqueness of a parental suicide-bereavement, selected interventions should be optimally designed to the specifics of these situations.

Anecdotal accounts help to substantiate empirical data suggesting successful interventions focus on creating a positive interpretation of the event, i.e., meaning making processes (Ratnarajah, Maple, & Minichiello, 2014). These processes include acts such as restorative telling in support groups and memorializing the deceased child's story as a means to help others. A study conducted by Murphy, Johnson, & Lohan (2003b) assessed the effectiveness of various coping strategies used by bereaved parents at the first year and fifth year following the death of their child. The self-esteem of the parent proved to be the best predictor of mental health outcomes, and so clinicians can assess and attempt to raise a parent's self-esteem in therapy. However, the utilized coping strategies failed to improve PTSD symptoms of parents.

Experimental studies testing the effectiveness of interventions for mothers after the death of their child generally find little support; their level of grief and coping abilities tend to remain unaffected (Raitio, Kaunonen, & Aho, 2015). Perceived social support appears to be the only consistent factor associated with improved symptoms, personal growth, and meaning making practices (Murphy et al., 2002; Murphy, Tapper, Johnson, & Lohan, 2003; Stroebe, Stroebe, & Abakoumkin, 2005). A potentially useful intervention must thus incorporate the inclusion of family, friends, and health professionals to facilitate the grieving process. Others may help the mother (or father) accept the death and begin to move forward while maintaining continuing bonds with the deceased child (Klass, Silverman, & Nickmann, 1996; Stroebe & Schut, 1999). Providing social support for individuals bereaved by suicide, as opposed to other causes of death, is even more critical when considering the attached negative social stigma of suicide

(Calhoun, Selby, & Faulstich, 1980) that may lead outsiders to view the grief of suicide-bereaved parents as invalid (Doka, 2002; 2008).

Based on empirical findings, the most universally effective interventions for parental suicide-bereavement and grief include journaling about the experience (Esterling, L'Abate, Murray, Pennebaker, 1999; Pennebaker, Colder, & Sharp, 1990) and support groups (Hatton & Valente, 1981; Murphy, Johnson, Lohan, & Tapper, 2002). Those who attend parent bereavement support groups, compared to those who do not, are four times more likely to engage in meaning making of their child's death, and deriving meaning significantly predicted lower levels of grief (Murphy, Johnson, & Lohan, 2003c). These types of activities specifically help the bereaved parent maintain the continuing bond with his or her child (Klass, Silverman, & Nickmann, 1996). Interventions may also be most successful if specifically attuned to the common gender differences in the grieving processes of bereaved mothers versus fathers. However, minimal research is currently available to inform empirically-based interventions and counseling practices that uniquely address the different needs of grieving mothers versus fathers.

Conclusion

While it appears that the major obstacles in the grieving processes of fathers are societal expectations of masculinity - leading fathers to repress their emotions and underutilize beneficial resources - mothers are burdened with remarkably severe psychological reactions in comparison and disproportionate social stigma overall. With this understanding, interventions designed to address maternal grief resulting from

suicide-bereavement must sufficiently address the loss itself, in addition to feelings of self-blame and failure as the exemplary primary caregiver. While fathers may similarly experience these emotions, external influences of social stigma and expectations may not continuously serve to promote them as frequently (Miller & Tina, 2005).

The current literature review aimed to integrate the theoretical and empirical literature surrounding parental grief resulting from child suicide, and in doing so, identified substantial gaps in researchers' and clinicians' understanding of the differential grieving processes of mothers and fathers. Although some past researchers have suggested addressing this gap in future research, no one has yet to do so. Virtually all of the reviewed literature either exclusively considers mothers, or fails to differentiate between the grieving process of mothers and fathers. A substantial amount of the cited work is also dated, warranting further research using both quantitative and qualitative methodology examining the differences between paternal and maternal grief following child suicide.

Examining suicide-bereaved mothers versus fathers directly, is it the role of social stigma that accounts for gender disparities in the grieving process? Or rather, does the parental role and relationship per se lead to the profoundly severe grief experienced by particularly mothers? Do mothers and fathers later engage in different meaning making practices that may also account for their distinct experiences? The results of this future work may be used to inform intervention practices, and to educate bereaved parents of suicide victims about the common grief reactions they may experience, which can then serve to help normalize their complex and intense emotions. Promoting feelings of

connectedness to other suicide-bereaved parents through this education may be even more essential for mothers, who may subsequently become ostracized as maternal figures. For counselors to be able to accurately address the unimaginable grief reactions and the social stigma experienced by suicide-bereaved mothers in particular, researchers must first identify the inner psychological and social complexities involved in their bereavement experiences.

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