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WOMEN'S EXPERIENCE OF GRIEF AFTER SUICIDE

A THEORY OF GRIEF INTEGRATION

By

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled, "Women's Experience of Grief: A Theory of Grief Integration" submitted by Lois L. Sapsford in partial fulfillment of the requirements for the degree of Master of Social Work.

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ABSTRACT

The focus of this study is on women's experience of grief after the suicide of a family member. The time elapsed since the suicide ranged from three to seventeen years. The purpose of the study was to develop a theoretical understanding of the process of the long term grief experience of women surviving a family member's suicide.

The qualitative method of grounded theory was followed as outlined by Glaser and Strauss (1967; Glaser, 1978; Strauss, 1987). Analysis was guided by the constant comparative methodology of Glaser and Strauss (1967; Glaser, 1978; Strauss, 1987, Field and Morse, 1985; Chenitz and Swanson, 1986 and Bogdan and Biklen, 1982).

Literature reviewed by the researcher included: 1) general bereavement research and clinical findings, 2) suicide bereavement research and clinical findings, and 3) women's psychological development research and clinical findings.

The interpretations of the study are presented in a three phase conceptual model which describes the process of women's grief experience after the suicide of a family member. The basic social process is described as the experience of Grief Integration. The model describes the

sequence of women's grief as it emerged within the study. The model does not suggest that the stages are experienced in strict linear fashion, but rather points to the re-experiencing of the stages comprising a cycle of development, with each repetition bringing the woman to a new level of integration. The interpretations of the study are then compared to the literature reviewed.

Implications for further research based on the study are presented. Recommendations from the study toward application of the model are presented in the form of suggestions to the clinician who works with this defined population.

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DEDICATION

This study is dedicated to my co-researchers: ANNA, BETTY, CONNIE and DEBBIE. Your courage in sharing your stories, your tears and your wisdom with me creates the essence of this research study. I thank-you for allowing me into your lives and for your contribution to our furthered understanding of your experience.

TABLE OF CONTENTS

LIST OF FIGURES

CHAPTER ONE

THE RESEARCH QUESTION

Introduction

Each suicide directly affects six people resulting in 750,000 people being touched by suicide each year in the United States (Shneidman, 1969). Health and Welfare Canada (1987) concluded that 40,000 to 50,000 Canadians are affected by suicide each year. Suicide and its effects on others is a major mental health problem.

Recent research has come to focus on surviving family members of suicide. Shneidmam (1972) introduced three levels of help that should be provided to suicidal persons and those connected to them: 1) prevention (before the act), 2) intervention (during the crisis period) and 3) postvention (after the fact) (McIntosh, 1986). Shneidman states that of the three levels, "postvention probably represents the largest problem and presents the greatest area for potential aid" (p.x.). It is to add to our knowledge base of the experience of surviving a suicide that the present study was undertaken.

The Evolution of the Question

The original purpose of this research study was to generate explanatory theory regarding the process and outcome of bereavement of families who had experienced loss through suicide. The qualitative methodology of grounded theory was chosen to identify, describe and provide a

theoretical analysis of the grief process of these families. The chosen time period consisted of a minimum of two years after the suicide of a family member.

The researcher does not enter a research study with a fixed or select sampling regime (Glaser, 1978). Remaining consistent with this concept from theoretical sampling:

> the researcher can make shifts of plan and emphasis early in the research process so that the data gathered reflects what is occurring in the field rather than speculation about what cannot or should have been observed. He can follow his emerging theoretical sensitivity. (p.38).

Glaser further indicates that the sample which a researcher has access to might alter upon entry into the field. The research must remain flexible to the emerging sample rather than fixed to a commitment of a pre-conceived hypotheses or select sample.

Entry into the research field of this study required sensitivity and flexibility. The range of participants' names provided by the referring agency was composed of adult women, identified in a dominant caretaker role in their families. The potential participants expressed that the experience to be told was that of women's experience of grief after a suicide in their immediate family.

The data were collected by the use of detailed personal descriptions of the individual experience of grief after the suicide. The role that the larger social network has had and

continues to have on the grief process was discussed in context.

The qualitative research methodology of Grounded Theory (Glaser & Strauss, 1967; Glaser, 1978; Strauss, 1987) was employed to identify, describe and provide a theoretical analysis of the process of women's experience of grief after suicide. The research question that evolved is: "What has been your experience of grief after the suicide of your _____ (family member)?"

Background

The researcher's clinical background in working with suicide survivors and the literature addressing this subject have been investigated as "data" to be considered. The research question that was developed was: "What is the experience and process of grief on a long term basis following the suicide death of a family member?"

The impetus for this study emanates from this writer's clinical experience while in the position of Suicide Bereavement Co-ordinator, with the Suicide Bereavement Program, Canadian Mental Health Association, Calgary, Alberta, working with families bereaved by the suicidal death of a family member. During this counselling experience a number of questions continued to be raised regarding the long term grief process. This study was initiated to begin to address such questions as:

- is there a completion of the grief process as outlined in research findings on normal grief?
- are there different long term patterns of those who are grieving the loss of a family member by suicide as compared to other deaths?
- do such families perceive an end stage to their grief?
- what is the long term impact of the suicide on the family system?
- how do social networks influence the long term outcome of bereavement?

During the researcher's clinical experience there was a noticeable overriding concern expressed by clients for their families' future...How will I live through this?... and if I do, what can I expect for me and my family in five years from now? Lukas and Seiden (1987) quote a survivor addressing this concern:

> It's the hardest thing I've ever had to live through. I'll go for a couple of days, and then I'm back to where I was before, and I wonder what its going to be like in five years. Someone I know who's experienced a suicide told me that the pain eventually gets a little more numb, but I don't know. It just has to be the hardest thing to go through. It's like my own personal holocaust (p.53).

The suicide bereavement literature has a short forty-year history consisting of clinical observation, comparative research and case study materials. In 1953, Lindemann and Greer proposed that survivors of suicide are likely to get

stuck in their grieving and go on for years in a state of cold isolation. Further writings in this area focused on the radically different bereavement of suicide survivors (Cain, 1972; Lindemann & Greer, 1972; Calhoun, Selby & King, 1976) as compared to other bereavement experiences. Only recently has research begun to challenge this point of view in the shift toward describing the similarities of suicide grief as compared to other forms of bereavement (Barrett & Scott, 1989; McIntosh & Wrobleski, 1988; Demi, 1984).

Research has recently been conducted on the individual reaction to suicide and the social reaction to the suicide survivor. In the few research studies which exist in this area, most studies focus on the short term outcome, the period immediately after the suicide and up to one year following the death. The research to date has assisted in the development of awareness of the needs of survivors immediately following a suicide, and in the creation of specialized programs aimed at providing postvention to survivors immediately after the suicidal death of a family member. Shneidman (1972) developed the term "postvention" as the appropriate helpful acts that come after the event of suicide to assist survivors in their grief.

There remains a paucity of suicide bereavement research addressing: 1) the experience and impact of the loss upon individual family members, 2) the experience's impact upon the family system, and 3) the process and outcome of grief

beyond the first year. This research contributes to the professional knowledge base relating to grief after suicide and the subsequent clinical needs of the survivor.

Significance of the Study

As mentioned previously, it has been estimated that each suicide directly affects six people resulting in 750,000 people being touched by suicide each year in the United States (Shneidman, 1969). Forty thousand to fifty thousand Canadians are reported as affected by a suicidal death each year (Health and Welfare Canada, 1987). This figure needs to be taken into account with the existing research often describing a "qualitatively different" experience for suicide survivors (Winch & Letofsky, 1981). The research indicates that those who are bereaved by suicide are themselves at a higher risk for suicide (Cain & Fast, 1972; Griffin & Felsenthal, 1983). This adds to the need for further research in the area of understanding the experience and process of suicide grief.

The information generated by this study has direct implications for the practice of social work with this specific population. The information generated by this study may be used: 1) to provide clinicians with a deeper understanding of the long term grief process of suicide survivors 2) to assist clinicians in continued development of programs aimed specifically at assisting this population,

both immediately and on a long term basis after a suicide; 3) to assist researchers to further the knowledge base in this grief area; and 4) to provide suicide survivors themselves an opportunity to have their experience compared to that of others for the purpose of possible confirmation.

The American Association of Suicidology (1989), and McIntosh (1986) have supported the need for research development addressing the: 1) "process and outcome of bereavement beyond the first year" and 2) "the impact on the family system" in the experience of suicide bereavement. Findings from this study will enhance understanding of the experience and process of grief after suicide beyond the first year of the suicide.

Definitions

For the purpose of this study, **suicide** is defined from the Webster's New World Dictionary (1982), as: the act of killing oneself intentionally (p.1424). Participants are family members who believe and state openly that the death was an act of suicide by the deceased.

In the study, **Suicide Survivor** is used interchangeably with **Survivor.** Both terms are defined as family members who remain after a person commits suicide.

The definitions provided by Rando (1988) were adopted in defining the terms of **grief** and **bereavement.**

Grief is defined as " the process of experiencing the psychological, social, and physical reactions to your perception of loss" (p.11). Grief is defined as a

continuing development, involving changes over time to psychological, social and physical reactions...thus a process. The loss examined in the study relates to the death of a family member by suicide, after a minimum of two years prior to the research.

Bereavement is defined as "the state of having suffered a loss. To be bereaved means that you have suffered a loss" (p.12). The study examines the state of bereavement of family members who have suffered a loss due to suicide.

Organization of the Thesis

This first chapter has served to introduce the reader to the mental health concern of suicide bereavement. The present study has been introduced and placed within context and significance in this area. The major definitions have been defined as utilized throughout the study.

Chapter Two provides a preliminary review of the literature that is consistent with the grounded theory method of inquiry (Glaser, 1978). In Chapter Three, the research methodology is further developed. Chapter Four introduces the participants, and provides the conceptual model depicting their experience of grief after suicide. Literature relevant to the interpretations of the study are then compared. In Chapter Five, the researcher provides an overview of the research process and discusses the need for further research. Suggestions for clinical implementation, as supported in discussions of the application of theory by Glaser and Strauss (1967), is presented based on the conceptual model.

CHAPTER TWO

REVIEW OF THE LITERATURE

Approach to the Literature

Glaser & Strauss (1967), in their early writings, advocated moving into the interview or observation phase of the research with as few preconceived notions as possible, thus allowing the researcher to "discover" the point of view of the respondent. Based on this premise, they advocated that a literature review take place only after the data had been collected, analyzed and summarized, and then compared with existing literature. Strauss (1987) indicates a shift in this thinking by suggesting that the literature is approached initially "not for specific ideas or for a scholarly knowledge, but for authors' perspectives and ways of looking at social phenomena, which can help to sensitize one to theoretical issues" (Strauss, 1987, p.300). This shift in thinking supports that " a critical review of sources that led to the selection of the problem to be studied at this exploratory level should be provided, although this literature may be largely conceptual rather than data-based...thus providing the framework for examining the complex human situations" (Germain, 1986, p.150).

Chenitz and Swanson (1986) supported by Strauss (1987) provide a comprehensive approach in their description of the purpose of a review of the literature in a grounded theory research design. Chenitz and Swanson advocate that the literature is always "approached as data in the form of written documents" to be approached with a "cautious and sceptical" (p.44) attitude by the researcher. The literature is initially examined to identify the "scope, range, intent and type of research that has been done" (p.44) in the area. This examination also assists in the development of the study's purpose and significance. Since grounded theory is advocated for use in areas where little or no research exists, the discussion of the literature helps to assess the importance and appropriateness of such a method of research.

Chenitz and Swanson encourage a complete initial literature review to assist in establishing the study's purpose, and to place it in the context of what has been done previously in the area. The literature is seen as data, not facts or truths on which to base the proposed grounded study. Subsequent and ongoing reviewing of the literature is an essential component of this methodology. As the grounded theorist begins to identify emerging codes within the data, the literature is again examined for the purpose of supporting the emerging categories and thus serving as more "data" with which to saturate or contrast a

category. Finally, as the study is completed, the literature is once again reviewed, for the purpose of presenting the grounded knowledge from the study in the context of other work carried out in the area. Due to the mid phase use of the literature review, the final writing may include references to the literature in support of or in contrast to the emerging theory. It is by following the method of inquiry as outlined by Chenitz and Swanson (1986) that the following literature review has been undertaken.

Literature Overview

Two main bodies of knowledge were reviewed in the initial phase of this study; the general bereavement literature, and that which pertains specifically to suicide bereavement. The general bereavement literature has been examined to provide a grounding and exposure to the research, processes and theories hypothesized historically and to date within this field of learning. The vast quantity of bereavement research, as indicated by Raphael's 1983 survey of this topic which included more than four hundred published works, indicate that one cannot over-simplify the phenomenon of bereavement.

A more exhaustive literature review specific to the area of suicide bereavement included a total of forty-five sources regarding the bereavement effects on individuals within family surviving members after a suicide. These

writings were sorted initially by research methodology employed. The clinical observations and case studies were found in the work of: (Boudreau, 1983; Buksbazen, 1976; Cain & Fast, 1966; Cantor, 1975; Chaudhry-Fryer, 1982; Doyle, 1975; Hajal, 1977; Leblhuber, Schony, Fischer, Sommereder & Kienbacher, 1981; McBride-Valente & Hatton, 1981; Mueller, 1984; Rudestam, 1977; Rynearson, 1981; Shepherd & Barraclough, 1976; Schuyler, 1973; Whitis, 1968; Calhoun, Selby & Walton, 1985; Demi, 1984; Canto, 1981; Demi & Miles, 1988).

Quantitative research studies examined included: (Andress & Corey, 1978; Bernhardt & Praeger, 1983; Cain & Fast, 1966; Calhoun, Selby & Gribble, 1979; Shepherd & Barraclough, 1976).

Qualitative research studies employing various qualitative methodologies consisted of: (Dodson, 1983; Dunn & Morrish-Vinders, 1987; Lukas & Seiden, 1987; McIntosh & Wrobleski, 1988; Richard & Letofsky, 1985; Solomon, 1981; Todd, 1980; Wrobleski & McIntosh, 1987).

Reviews of the research studies and clinical findings were presented by: (Foglia, 1984; Bergson, 1982; Calhoun, Selby & Abernathy, 1984; Calhoun, Selby & Selby, 1982; Clark & Stokes, 1985; Dunne, McIntosh & Dunne-Maxim, 1987; Hewett, 1980; McIntosh, 1986; Rando, 1988; Rosenfeld & Prupas, 1984; Schneidman, 1973; Van Dongen, 1988; Winch & Letofsky, 1981; Worden, 1982).

The same body of literature was also sorted according to whether it addressed **short term outcome** (up to one year after the suicide), **intermediate outcome** (one to two years after the suicide), or **long term outcome** (two years plus after the suicide). Of the sources; twenty addressed short term outcome, thirteen addressed intermediate outcome, and a total of twelve addressed long term outcome of the suicide survivor in some way.

The literature reviewed was examined by incorporating an intrapersonal and interpersonal perspective when possible. The review was organized within a conceptual framework that attempted to place the existing literature into three domains. The literature was found to be inconsistent with its treatment of the various aspects of bereavement. Some theorists described stages; others used the terms of components and phenomenon of grief. A number of different conceptual categories were used to describe the symptoms of grief consistently from an intrapersonal focus. To expand the focus to include the interpersonal experiences of those studied, as well as the intrapersonal effects, the researcher developed the three following domains. The three domains were modified from a previous grounded research study (Wolfe, 1989) and encompass the literature from an intrapersonal and interpersonal perspective. The identified domains are composed of:

1. Domain of the Self
2. Familial Domain
3. Social Domain.

This conceptualization reflects the direction of the present study to begin to understand the long term experience and process of suicide related grief for the survivor. The framework takes into account the survivor experience and the impact of the environment surrounding the individual. (see **Figure 1**).

The general bereavement literature was reviewed initially to discuss the data presented within this body of literature for further comparison to the suicide bereavement literature.

General Bereavement Literature

> No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing.
>
> At other times it feels like being mildly drunk, or concussed. There is a sort of invisible blanket between the world and me. I find it hard to take in what anyone says. Or perhaps, hard to want to take it in. It is so uninteresting. Yet I want the others to be about me. I dread the moments when the house is empty. If only they would talk to one another and not to me (C.S. Lewis, 1961).

In 1961, faced with the death of his wife, C.S. Lewis gave us one of the first self descriptions of the process of grief in his work - A Grief Observed. Until this time

bereavement theories had been postulated largely from clinical observations as clinicians watched and learned from their clients' grief.

Bowlby's attachment theory (1980) has been widely used in providing a basis for much of the grief research and knowledge development to date. Bowlby's theory has provided a way of conceptualizing the human response of developing strong affectional bonds as a life long process. Subsequently when these emotional bonds are broken by some form of loss, the emotional response of grief occurs (Bowlby, 1980).

Bereavement theories, as developed over the past forty years, have varied greatly in describing the length of the grieving process. Lindemann (1944) reported that acute grief reactions should be completed within six to ten weeks of the death of a loved one. Clayton, Desmarais & Winokur (1968) supported this claim by reporting improvement of grief symptoms for 81 percent of their sample within six to ten weeks. However, research and clinical observations within the past fifteen years have indicated that the grieving process is still continuing well into the second year of bereavement (Mawson, Marks, Ram, & Stern, 1981: Parkes & Brown, 1972; Frantz, 1984; Worden, 1982). Shneidman (1985), discusses the human grief process as a finite process which takes about a year, however he goes on to state that "the figurative sands of secondary grief stay

on the beaches of our psyches all the remainder of our lives" (p. 52). Shneidman does not attempt to define his use of the term 'secondary grief'. On the other end of the continuum there are the conclusions brought out by the U.S. Committee for the Study of Health Consequences of the Stress of Bereavement (1984), which indicate that the pain of bereavement may continue for a lifetime.

A more general agreement exists within the literature with regards to the **phases of the grieving process.** The experience of grief has been classified in several different forms (Kubler-Ross, 1969; Bowlby, 1980; Parkes, 1985; Hardt, 1978; Shneidman, 1985; Worden, 1982; Rando, 1988). It is a matter of choice as to which classification to use, as they all classify basically the same information and pattern of grieving using varying titles and numbers of stages to describe this same pattern. For the purpose of this review, Worden's (1982) description of the four "tasks of mourning" will be examined to provide the basis for general bereavement phases.

The Four Tasks of Mourning:

Task I: To accept the Reality of the Loss

The first task of grieving is to come full face with the reality that the person is dead, and will not return. This task is outlined as including such aspects as: searching for the deceased,

denial of the loss or the importance of the loss, and refusal to believe in death as irreversible. Usually, shock is associated with this phase of grief.

Task II: To experience the Pain of Grief

"It is necessary for the bereaved person to go through the pain of grief in order to get the grief work done" (p.13). The pain of grief is described as including: anger, sadness, pre-occupation with the deceased, and guilt over behaviour prior to the death. Physical symptoms of normal grief have been reported by Lindemann (1944), Parkes (1965), Clayton, Desmarais & Winokur (1979), and Worden (1982), as including: loss of appetite, shortness of breath, heart palpitations, headaches, numbness, chest and digestive illness, altered sexual interest, anxiety attacks and sleep disturbances. Worden (1982) describes that the avoidance of this task can often be seen in the form of an individual cutting off their feelings and denying any pain. However, as Bowlby (1980) describes, "sooner or later, some of those who avoid all conscious grieving, break down -- usually with some form of depression"(p.158).

Task III: To Adjust to an Environment in Which the Deceased is Missing

Both Parkes & Weiss (1983) and Worden (1982) describe that a survivor is usually not aware of all the roles played by the deceased until after the loss occurs. Therefore this task "usually emerges around three months after the loss" (Worden,p. 14) and consists of a time of realization of all the changes in one's life due to the loss of one person. Common to this task is often the fear of other losses in one's life, often seen in the form of overprotective parenting of remaining family members.

Task IV: To Withdraw Emotional Energy and Reinvest It in Another Relationship

Worden describes the fourth and final task as the emotional withdrawal from the deceased person, so the same emotional energy can be reinvested in other relationships. This is described as the most difficult task to complete. To complete this task the person must deal with issues of loss, trust and loyalty.

Worden (1982), provides a benchmark for completed grief as being "when the person is able to think of the deceased without pain...(and)...when a person can reinvest his or her emotions back into life and in the living" (p.16). Although

no general consensus has been found as to the "normal" grieving period, the sources of literature that have addressed this issue within the past ten years agree that it is essential to continue to study the process of bereavement to increase the knowledge base in the area of a normal grieving time. It is important to strive to "understand how long the normal grieving process takes so that we don't put intentional or unintentional pressure on grieving parents to recover sooner than it is realistic to expect that they can" (Frantz, 1984, p.13). The recent grief literature to date generally agrees on the process and length of bereavement being directly related to a number of factors which influence the outcome. These factors are often categorized into three areas (Rando, 1988; Worden, 1982; Parkes & Weiss, 1983;):

A. Psychological Factors:

- the meaning of the relationship (Raphael, 1983);
- individual coping skills;
- past experience with loss; and
- age (Clayton,Desmarais, & Winokur, 1968; Marris, 1974).

B. Social Factors:

- cultural norms (Rosenblatt, Walsh & Jackson, 1976);
- gender role socialization (Rando, 1988; Glick, Weiss & Parkes, 1974); and
- family/social support (Maddison & Walker, 1967).

C. Physiological Factors:

- nutrition;
- physical health (Rando, 1988); and
- drugs and sedatives (Parkes & Weiss, 1983).

One source within this body of literature stands alone in it's findings regarding the long term effects of grief. McClowry, Davies, May, Kulenkamp and Martinson, (1987), completed a qualitative study on families seven to nine years after the death of a child to cancer. Their findings indicate that, unlike the majority of the literature, these families continue to experience the pain of grief and loss up to seven to nine years later. They also depart from the majority of the sources in their description of three distinct patterns of grieving, with only one of these patterns involving a 'resolving' or 'getting over it' phase. The three phases include:

1. Getting over it
2. Filling the emptiness
3. The empty space phenomenon

The empty space phenomenon is key to McClowry's et al. emerging theory, as it discusses a pattern of experiencing an empty space as part of the long term grief process and that families are seen to: a) fill it with something else, b) get over or resolve it, or c) maintain the space. This study begins to offer a potential wider lens with which to view the long term process of grief.

The suicide bereavement literature is reviewed next, organized according to the three-domain conceptual model noted previously as adapted from Wolfe (1989). This conceptualization reflects the expansion of effects from those of the individual to including the effects from the social and familial environment of the survivor. (see **Figure 1**).

Figure 1

Suicide Bereavement Literature

Conceptual Framework

1. **DOMAIN OF THE SELF**
   - A. Mental Health
     1. self esteem
     2. emotional
     3. psychological
     4. behaviourial
   - B. Physical Health

2. **FAMILIAL DOMAIN**
   - A. Relationships with family of origin
   - B. Relationships with present family
   - C. Parenting Relationship
   - D. Couple Relationship

3. **SOCIAL DOMAIN**
   - A. Sense of isolation
   - B. Stigmatization

Domain of the Self

Shneidman, in his book On the Nature of Suicide (1969), stated:

> I believe that the person who commits suicide puts his psychological skeleton in the survivor's emotional closet...he sentences the survivor to deal with many negative feelings and, more, to be obsessed with thoughts regarding his own actual or possible role in having precipitated the suicidal act or having failed to abort it. It can be a heavy load (p. 22).

This statement, based on clinical observation sets the pace for much of the subsequent literature which addresses the survivor's grief following a suicide.

A. Mental Health

The **Domain of the Self** is the category most addressed in the literature. Within this domain, **mental health** is given extensive coverage by examining survivor grief predominately on a short term basis. The issue of survivor **self esteem** is addressed by Parkes (1975), who contrasted spouses who had long and short term preparation times prior to the death. He concluded that reactions of self reproach for not taking good enough care of the spouse; anger at self; and thoughts of suicide were more prominent particularly among suicide survivors.

Mueller (1984) supports these observations in her self report after her husband's suicidal death. She stated that following the suicide she depended upon friends to care for

her, since "they had confidence in me when I had absolutely none in myself. My self-esteem was so low at this point I felt incapable of making even the slightest decision" (p.4).

The death is seen as abandonment (Menninger, 1938), and the survivor often interprets this as a punishment for something he/she has done wrong. The punishment is the death of the person and therefore the survivor feels responsible for the death, thus leading to feelings of guilt and low self worth (Buksbazen, 1976; Schuyler, 1973;). Herzog and Resnik (1969) concluded from a two year follow up study of parents surviving an adolescent suicide, that these parents experienced a long-lasting guilt about the death of their child which continued to influence individual self esteem and family functioning. Studies by Henslin (1972) and Glick et. al. (1974) compared the incidence of guilt as reported by suicide survivors and natural death survivors and found that 52% of the sample of survivors of suicidal death experienced guilt, while only 36% of the widows of accidental and natural deaths experienced guilt. However, a longer term comparison completed by Shepherd and Barraclough (1974) found no significant differences in the two groups with respect to mortality or remarriage rates, four to six years after the death. They argue that these indicators show no differences in self esteem in the long term outcome. McIntosh and Kelly (1988), in a comparative study, support this claim in revealing greater similarities than

differences in the grief of suicide and non-suicide survivors of death. "No group differences were found in the degree to which guilt was felt or the proportion of suicide vs. other survivors who expressed guilt of any kind" (p.90). Demi's study (1984) contradicts these findings in reporting suicide survivors exhibiting more guilt and resentment, subsequently affecting self esteem of the survivors. She does however conclude, based on the entirety of her findings, that "suicide survivors were not at greater risk than non-suicide survivors for poor bereavement outcome" (p.91).

Survivors of suicide are reportedly at high risk for **emotional distress** during the short and intermediate bereavement period (Whitis, 1968; Rando, 1984; Calhoun, Selby, & Faulstich, 1980; Solomon, 1981). The literature is, however, not consistent on this point. Until recently, clinical observation and case studies made up the majority of the literature. Recently the claims of quantifiable and qualifiable differences of grief after suicide have been challenged by studies which compare the grief responses of suicide, accidental and natural deaths. In the studies of emotional impact on widows bereaved by these modes of death, Stone (1972) found suicide widows to have more emotional problems than widows bereaved by other modes. However, Demi (1978); Shepherd & Barraclough (1974); and Silverman (1972) found no differences in emotional outcome in these groups.

In studies relating to parental survivors, Owen,Fulton and Markusen (1978); Rando (1984); Saunders (1981); and Videka-Sherman (1982),indicate that the death of a child can lead to short and long term emotional disturbances. In the area of parental suicide survivors, Herzog and Resnik (1969) would agree with the short and long term emotional disturbance. Demi and Miles (1988) report findings from a study comparing and measuring emotional and physical distress in suicide and non suicide parental survivors. They report (of a sample of 59 suicide survivors, 61 accidental or chronic disease death survivors) that survivors of suicide report no greater emotional distress and no more physical health problems than parents of children who died of accidents and chronic disease. The study reported a mean time of 19 months after the death of the child.

The **psychological** and **behavioral** aftermath of suicide has been reported by most of the clinical and case studies. The psychological implications have been reported as including the affective reaction of relief (Rudestam, 1977; Wallace, 1973). Sheskin and Wallace (1976) also found in a comparative study that there were no differences in the experience of relief between suicide widows and natural death widows. Anger is reported (Rudestam, 1977; Schuyler, 1973; Shepherd and Barraclough, 1976;) as another consistent reaction in the suicide bereavement process. Wallace (1973)

related anger as existing in both suicide and non-suicide bereavement, and indicated the essential differences related more to the emotional investment of each widow in her relationship with her husband, and not directly tied to the mode of death. Wrobleski and McIntosh (1987) reported in an exploratory study that "the persons toward whom anger was felt were most typically the deceased or the deceased and others," (p.140) and that anger decreased with time (mean time after bereavement = 3.4 years). They also noted a connection with the angriest survivors tending to be the most guilty-feeling survivors.

Denial of the suicide-nature of a death appears quite frequently in the literature in the short term assessment of the survivor. Rudestam (1977) reported that the feeling of disbelief and denial persisted in suicide survivors up to and beyond six months.

Depression also appears as a significant part of the psychological aftermath (Rudestam, 1977; Herzog and Resnik, 1969; Demi and Miles, 1988). The literature addressing depression in survivors of suicide spans the time frame after the suicide from only months to five years after the death. This, coupled with unspecified definitions of the experience of depression in each case, results in limited interpretation on this point. Rynearson (1981) addresses the existential dilemma raised for the survivor of suicide from his own personal account. He discusses depression in the

sense of hopelessness and despair as usually internalized by the bereaved, "who finds his own personal definition and future orientation to some degree altered...an involuntary tendency to question the validity of future values, commitments, and relationships" (p.85).

This period of depression often leads to a period of considering suicide as an option to ending the pain and often to thoughts of joining the dead individual. According to Cain (1966), suicide survivors have a statistically greater risk of committing suicide than other members of society. Research in this area is lacking, and this hypothesis relies heavily on clinical observation for its basis. This writer's clinical experience is consistent with this observation. Based on program statistics kept for a year and a half period, just under 75% of the clients experienced some suicidal ideation following the suicide. Wrobleski and McIntosh (1987) report that of a sample of 159 individual survivors of suicide studied, 48% indicated "thoughts of own suicide" (p.140) as a part of their bereavement.

It has been hypothesized by Calhoun, Selby & Selby (1982) that behavioral changes such as sleep disturbances, change in smoking patterns, use of tranquilizers and/or alcohol,changes in appetite, sexual difficulties and crying spells, may be seen at a higher magnitude and more persistent in the suicide-bereaved as compared to the non-

suicide survivor. The majority of the literature in this area is again comprised of case study and research investigating the behavioral changes within the first year of bereavement.

B. Physical Health

A great deal has been written in the general bereavement literature relating to the physical health problems of the bereaved. Suicide bereavement literature has for the most part accepted that a similar situation exists for the survivor of suicide. Lukas and Seiden (1987) indicate that within the first six months following a suicide, almost every survivor goes to their family physician for treatment of a physical symptom such as crying spells, inability to sleep, fear of being alone, migraines, ulcers, heart pains, or exhaustion. Wrobleski and McIntosh (1987) reported that within a sample of 159 survivors, with a mean time since the death of 3.4 years, 90% reported concentration difficulties, 87% sleeping difficulties, 55% panic attacks, 48% headaches, 41% stomach aches, and 41% reported back aches as part of their grief. They conclude that, "while it cannot be said with certainty that the levels of these problems were particularly higher among suicide survivors than survivors of other causes...one expects that these problems may exist to a lesser degree in the grief process associated with other causes of death"

(p.142). A comparative study, completed by Demi and Miles (1988), disagrees with this hypothesis and reports that "the hypotheses that suicide bereaved parents would report greater emotional distress and more physical health problems than parents of children who died of accidents and chronic disease were not supported" (p.297) in their study. Both groups of parents in the study reported an increase in health problems and an increased use of drugs.

Familial Domain

The clinical observations within the literature discuss, only briefly, the impact of the suicide on the family interaction and relationships. The effect on the parents' interaction with their **family of origin** after a child's suicide has not been addressed in the literature to date. From a systems perspective of family interaction, it is asserted that: the family of origin's pattern of grieving, experience with loss, support structures and perceived involvement with the family of the suicide, would all be factors in understanding the impact their involvement would have on the resulting grief process.

The influence of the suicide on the **relationships within the existing family** has been addressed by only a handful of clinical articles. Suicide bereavement is not just an intrapersonal process but involves the family and larger social system. For a more complete understanding of

the impact of suicide on these systems, investigation is warranted. Hajal (1977), Whitis (1968) and Mueller (1984) present the only clinical reviews addressing the impact and treatment of the family system after a suicide. Mueller (1984) describes her family after the suicide of her husband as a family unit that disintegrated. Whitis (1968) and Hajal (1977) describe the family system after the suicide (short-term... within a year after the suicide) as a family in which there was no leadership, with parents abdicating that role. The families are described as "overwhelmed by hostility, recriminations, blame, phobias, psychosomatic disorders, depression and guilt" (Whitis, 1968,p.162). The two case studies presented describe dysfunctional communication within the family, with the characteristics of denial, hostility and withdrawal from family interaction the norm in the period after the suicide. Whitis describes the emotional climate in the home as one of "cold war" (p.162). The therapy plan, for each of these described families, was to promote and enhance the grief work within a family therapy approach, as first defined by Paul and Grosser (1965) as "operational mourning."

Augenbraun and Nueringer (1972) found that quite frequently scapegoats are sought within the family after a suicide. Hewett (1980) supports this claim in describing the "Games Families Play" after suicide. Based on clinical observation, he lists these to include: scapegoating,

keeping an impossible secret, the survival myth, circle the wagons, King/Queen of the mountain, the silent treatment, who loved/was loved the most, let's grieve forever, halo and pitchfork, and let's head for the hills.

Todd (1980) completed a qualitative study investigating the bereavement of sibling survivors of suicide. She found "the siblings and their families experienced significant stress in their lives before and after the suicide" (p.186), and that the family interaction following the suicide was closely tied to the eventual resolution or prolonged grief of the siblings. Although this study does not concentrate on the interactive process of the family, it does point to the need for developing research to address this important aspect of bereavement following a suicide.

Rudestam (1977) completed the only research study to address the family interaction directly after a suicide. Rudestam's study concluded that seven months after the suicide of a family member, "family relationships were frequently strengthened" (p.162). Of the respondents, 11 remarked that the family atmosphere had become closer, and only one said that the atmosphere was worse. Of respondents with children, 10 indicated closer relationships, and eight indicated more concern about their children as a result of the suicide. The fact that this study is based on a non-clinical sample as opposed to the documented case studies, may explain in part the difference in findings. Rudestam,

points to a limitation within his study in stating that " increased family harmony is a phenomenon of short duration and that noticeable interpersonal difficulties (may) ensue considerably after the 6-month grief interval" (p.170).

Statements have been made within the grief literature that the work of mourning is best experienced as a family (Van Dongen, 1988). However, the noticeable lack of research in this area must be addressed in order to fully validate and expand this claim.

The effects on the **parenting and couple** relationship after a suicide have again been documented largely through case studies. Rudestam's (1977) study stands alone in addressing the impact on the parenting and couple relationship. He concludes that "the occurrence of a suicide in the family does not routinely create acknowledged difficulties in the marital relationship" (p.168). In this study of a non clinical sample, no respondents claimed to have worse communications in their marriage than before the death. Two couples reported improved communications.
The lack of research in this area again points to the importance of developing research studies which focus attention on the process of grief from an intrapersonal and interpersonal perspective, thus incorporating the larger systemic view and its impact and role in the grief process.

Social Domain

"Bereavement is a lonely and **isolating** experience regardless of cause of death" (Sheskin & Wallace, 1976, p.235). Survivors of suicide are likely to experience a sense of shame and experience the **stigma** of suicide (Cain, 1972; Shneidman & Farberow, 1970; Ginsburg, 1971; Buksbazen, 1976; Fisher, Barnett, & Collins, 1976; Hajal, 1977; Hewett, 1980, Worden 1982). Using a simulated research design Calhoun, Selby and Gribble (1979) present a study which investigated others' reactions to the survivors of suicide. The general purpose of these studies was to approach members of the community and obtain their responses to written descriptions of fictitious survivors and situations. Calhoun, Selby and Walton (1985) created a second simulated design, this time testing reactions of others to the surviving spouse of an individual who commits suicide. In both investigations Calhoun et.al. reported the spouse and family of a suicide were viewed as being more to blame for the death, as having had a greater chance of preventing the death, and feeling a greater sense of shame around the death. He concludes that "the family faces not only the stress created by the loss of a family member, but the family must also deal with the reactions of others who learn of the nature of the death" (1979,p.571). In yet another simulated design, Calhoun, Selby & Faulstich (1980), concluded that the parents of a fictitious suicide of a

child were rated as less likeable and blamed more for the death of the child. It has been hypothesized on the basis of these and clinical case studies that the negative social reactions to the survivors may enhance the psychological stress of suicide bereavement.

Sheskin and Wallace (1976), in their comparison of suicidal deaths and deaths from other causes, report that loneliness and isolation are part of any type of grief, regardless of the method of death. The lack of social support, however, was significantly more difficult when the death was by suicide. Survivors of suicide reported feeling isolated and stigmatized by friends.

The hypothesis of greater feelings of isolation and stigmatization for the survivor of suicide is supported by the majority of the literature. McIntosh and Kelly (1988) however, conducted a comparison study which failed to differentiate suicide survivors from survivors of other causes. McIntosh and Kelly report that suicide and accidental death survivors showed similarities with respect to stigma, shock and a desire to understand "why" after the death. By several measures, however, accidental-death grief was found to be the most severe in this study, leading the researchers to conclude that little evidence exists to support statements in the literature that suicide is a markedly different or worse grief experience compared to other causes of death.

Summary

The suicide bereavement literature has a short forty year history in addressing the experiences and needs of those left to grieve after the suicide of a family member. To date, the literature offers some generalizations that have formed the basis of involvement with the survivors in offering postvention services. Shneidman (1973) developed the term postvention as defining: "those appropriate and helpful acts that come after the dire event itself" (p.413); the dire event being suicide.

Within the last decade the body of literature in this area has addressed itself to exemplifying the similarities of suicide bereavement to other forms of losses. This indicates a shift away from the thinking of suicide bereavement as a radically different process as was advocated in the early 1970s (Cain, 1972; Lindemann & Greer, 1953, Calhoun, Selby & King, 1976; Schuyler, 1973).

The suicide bereavement literature has consisted mainly of clinical observation, case studies and comparative research, and has only recently begun to develop a body of research literature to assist in our understanding of this phenomenon. The research literature has focused almost exclusively on the suicide survivors' experience immediately - up to two years after the suicide (Demi, 1984; Calhoun, Selby & Selby, 1982; Rudestam, 1977). This essential body of research has assisted in providing the professional knowledge base and subsequent treatment approaches to

addressing the needs of survivors following a suicide. More recently, research is beginning to study survivors' reactions from a more long-term perspective (Barrett & Scott, 1989; Todd, 1980; Dunn & Morrish-Vinders, 1987; McIntosh & Wrobleski, 1988; Demi, 1984). These studies have brought into question some of the previously held beliefs of the unique aspects of suicide grief (stigma, intensity of guilt, isolation, and unresolved grief potential). The study of suicide bereavement remains a complex nidus as the research continues to raise as many questions as it attempts to answer.

The direction for further research in this area was recently discussed at the 1989 American Association of Suicidology Annual Meeting. The panel members consisting of Drs. Dunne, Pfeffer, Farberow and Rudestam concluded that extensive future study needed to include: "risk factors of adverse consequences to survivors (lack of social support, stigma,etc); the impact of loss upon all family members; the process and outcome of bereavement beyond the first year; and the impact on the family system" (AASW Newsletter, 4,2, 1989, p.9). This is supported by the present literature review which identifies the paucity of literature regarding the "process and outcome of bereavement beyond the first year, and the impact within the family system."

In the following chapter the research methodology of grounded theory is further developed, and discussed as to its application within the study.

CHAPTER THREE

RESEARCH METHODOLOGY AND PROCESS

Grounded Theory

This study, exploring the long term grief process after suicide, employed a qualitative research design based on the grounded theory methodology developed by Glaser and Strauss (1967), Glaser (1978), Strauss (1987). This method is appropriate for research when the area to be studied has undergone little empirical study and requires an exploratory method (Glaser & Strauss, 1967). The study of the long term experience of grief after suicide has undergone very little empirical or theoretical study, is complex, sensitive and concerned with process and interaction. These characteristics noted lend themselves to a qualitative research design (Chenitz & Swanson, 1986).

Suicide bereavement research which has utilized qualitative methodology includes: Todd's (1980) qualitative study of the long term experience of sibling survivors of suicide and Dunn and Morrish-Vidners (1987) exploratory study of the psychological and social experience of suicide survivors between one and five years after the suicide. Dunn and Morrish-Vinders (1987) advocate for the continued use of the qualitative research methodology in the study of suicide bereavement. They indicate its strength in enabling

"controlled observation, systematic comparisons, and a focus on select problem areas" (p:181).

Through the use of grounded theory methodology, this study provides a theoretical analysis of women's experience of grief after suicide, with an actual time frame of three to seventeen years after the suicide. The study became focused on women's experience based on the sample availability, as was referred to in Chapter One: Evolution of the Question.

The minimum period of two years after the suicide was selected since the majority of the literature addresses the bereavement issues within the first year of the death, and thus has provides us with a theory on this immediate grief experience. Hence, an exploratory analysis of the process following the first two years of the suicide was appropriate.

Grounded theory is a comprehensive, systematic research method, originating from the qualitative sociology and cultural anthropology research fields. It is based on the assumption that the social organization of the world is integrated and that the task of the grounded theorist is its discovery (Glaser & Strauss, 1967). Chenitz and Swanson (1987) have defined grounded theory as:

> a highly systematic research approach for the collection and analysis of qualitative data for the purpose of generating explanatory theory that furthers the understanding of social and psychological phenomena. The objective of grounded theory is the development of theory that

> explains basic patterns common in social life...it describes a method to study fundamental patterns known as basic social-psychological processes which account for variation in interaction around a phenomenon or problem (p.3).

Meanings and **processes** are therefore the subject of inquiry, rather than the prevalence of particular problems, issues or responses.

Theoretical Framework

There are two theoretical underpinnings that together develop the overall framework of this study. The epistemology of the symbolic interactionists and the constructivist paradigm combine to provide the framework for this study, as will be discussed.

Grounded theory research is directed at theory development, therefore there is no need to develop operationalized statements from any theoretical premise. Grounded theory is based within the theoretical orientation of symbolic interactionism (Mead, 1934; Blumer, 1969). It is concerned with the study of how people define the meaning of their reality and how they then act in response to their beliefs (Chenitz & Swanson, 1986). Blumer (1969) advanced the symbolic interactionist theory by distinguishing three basic premises on which it rests:

1. "human beings act toward things on the basis of the meanings that the things have for them" (p.2).

2. "meaning of such things is derived from, or arises out of the social interaction that one has with one's fellows" (p.2).
3. "these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters" (p.2).

Symbolic interactionists view human behaviour as a result of process (Chenitz & Swanson, 1986), and thus are consistent with the grounded theory methodology in attempting to discover that process. The grounded theory researcher must examine the human behaviour in interaction and must attempt to understand the behaviour as the participants understand it. Blumer (1969) discusses the researcher from a symbolic interactionist perspective as having to attempt to "take the role of other" (p.39), being both a participant in the world and an observer of the participants in that world (Chenitz & Swanson, 1986).

The second theoretical framework which guides this research study is the constructivist point of view. The constructivist point of view is adhered to by the researcher in acknowledging the active role the researcher plays in creating observed data. The constructivist point of view postulates that reality is constructed by living persons through the process of relationship (McNamee, 1988). The constructivist point of view is supported by the symbolic

interactionist statement of the researcher as both participant and observer. As symbolic interactionist point out, it is through our individual senses that we perceive our reality, and the constructivist adds to this with the belief that it is through our connectedness and relationships to others that we perceive meaning. The quest for knowledge is therefore a matter of representing a shared experience. The knowledge discovered in the course of the interviews will therefore tell about the nature of the conversation and relationship with the researcher and the participants, as well as about the experience of the survivor. McNamee (1988), describes the constructivist approach to research as a process of bringing forth certain phenomena rather than the process of the discovery of the truth, and insists that the researcher/observer must always be included in the process.

It is from a combined symbolic interactionist-constructivist point of view that this research was approached.

Participants

The participants for this study were accessed primarily through the Suicide Bereavement Program, operated by the Canadian Mental Health Association, Calgary, Alberta. The Co-ordinator of the Suicide Bereavement Program made initial contacts to possible participants outlining the research

request. Only names of individuals or families who had agreed to be contacted were given to the researcher. One participant presented herself to the researcher requesting to be part of the study. This participant had not previously obtained services from any counselling agency following the suicide in her family. Participants are therefore a mixed clinical and non-clinical sample, with the clinical sample having had at least one contact with the referring counselling program after the suicide. The participants fit the criteria of having experienced an immediate family member's suicide at least two years prior, and were not presently receiving counselling from the Suicide Bereavement Program, or any other counselling program.

Initially ten names were received from the counselling agency. Following the framework of theoretical sampling, and Morse's (1989) discussion of "primary selection," the potential participants were contacted by the researcher to further describe the research process and to assess the appropriate first participant. Two men and three women chose to not be involved in the research. Reasons for non-involvement included participants re-entery to a counselling program and thus not meeting the outlined requirements of the research, and personal re-evaluation of their involvement in the research at this time.

The remaining participants consisted of women surviving a family suicide. The consent to participate was an

individual decision and there was no pressure from the researcher for participation.

The formal letter of request to C.M.H.A. is found in Appendix A. See Appendix B for C.M.H.A. letter of conditional approval of the research.

Interview Procedure

The "unstructured formal interview" (as defined by Chenitz & Swanson, 1986) was used as the primary data collection means for this study. One initial interview ranging from two and a half to three hours took place involving each participant.

The unstructured interview is defined by Chenitz & Swanson (1986) as an intensive, in-depth and qualitative interview which obtained information in the respondent's own words, gained a description of the situation and elicited details.

An interview guide was initially developed to provide a basic framework and working map for exploration into this area. The guide development is considered as a starting point in the interviewing process, or as Lofland and Lofland (1984) describes it, a "guided conversation" (p.59). Glaser and Strauss (1967) and Lofland and Lofland support the notion that the interview guide is not rigidly adhered to by the interviewer, and is likely to be altered throughout the course of the interviews and study. The interview guide was

developed from a combination of clinical experience and examination of the literature. It included questions addressing the experience of surviving the suicide from an individual, familial and social context (see Appendix D). The interview guide was pilot tested on two female survivors of suicide known to the researcher from previous counselling experience. The pilot test was used to assess the applicability and completeness of the interview guide. The responses from the pilot test have not been included within the interpretations. The interviews (in the research) did not involve strict application of the guide but rather used it to ensure common questions were addressed in each interview and included a retrospective and current discussion of the grief process experienced.

Interviews were conducted by the researcher and occurred simultaneously with the analysis phase of the research, in accordance with the notion of theoretical sampling procedures outlined by Glaser & Strauss (1967). In grounded theory, the initial sample is determined to examine the phenomenon where it is found to exist, then data collection is guided by the strategy of theoretical sampling (Chenitz & Swanson, 1986). Theoretical sampling is the process of data collection "whereby the analyst jointly collects, codes and analyzes his data and decides what data to collect next...in order to develop his theory as it emerges" (Glaser & Strauss, 1967). The data collection is

therefore controlled by the emerging theory, "The basic question in theoretical sampling...is: what groups or subgroups does one turn to next in data collection? And for what theoretical purpose?" (Glaser & Strauss, 1967, p.47). Bogdan and Biklen (1982) describe the sampling procedure as "choosing particular subjects to include because they are believed to facilitate the expansion of the developing theory" (p.67). This method was employed as careful selection was made with the addition of each participant interviewed. This selection continued until the point of saturation. (Glaser, 1978). The qualitative principles of purposeful sampling is described by Morse (1989) as:

> selecting the best informant who is able to meet the informational needs of the study and of selecting a "good" informant ... one who is articulate, reflective, and willing to share with the interviewer (p.117).

Based on the principles of qualitative purposeful sampling, the number of participants was not set prior to the data collection and analysis phase. The principle of purposeful (theoretical) sampling and the phenomenon of saturation is described as calling forth the "variation within the phenomena or concept rather than to convey the weighting, the proportions, or the statistical significance of different responses" (Morse, 1989, p.130). Saturation is achieved "when in coding and analyzing both no new properties emerge and the same properties continually emerge as one goes through the full extent of the data" (Glaser,

1978, p.53). The distinguishing feature in theoretical or purposeful sampling is that "Data are collected until no new information is obtained" (Field & Morse, 1985, p. 94). The qualitative principles of purposeful (theoretical) sampling were employed until saturation was achieved.

Data Analysis Process

The constant comparative method of analysis as developed by Glaser and Strauss (1967) was used to analyze the data collected within the study. In this method, data collection and analysis occur simultaneously, resulting in the generation of theory based on the data in which that theory is grounded. (Strauss, 1987). The constant comparative method of grounded theory therefore involves systematic and intensive analysis of the data "often sentence by sentence, or phrase by phrase of the field notes, interviews, or other document; by constant comparison, data are extensively collected and coded" (Strauss, 1987, p.22).

Utilizing the constant comparative analysis methodology, all data were audio taped and then transcribed. All interviews were listened to the day following the interview and "audio coding" of the interviews occurred. Audio coding is a term created by the researcher to depict the act of utilizing the constant comparative method of eliciting substantive codes from the act of listening to the

data. Strauss (1987) supports the continued use of audio data throughout the process: "you **must** (notice the italics!) listen to the tapes intensely, and more than once...listening as well as transcribing is essential for full and varied analysis" (p.267).

Glaser (1978) refers to the act of coding as "fracturing the data" according to conceptual categories to allow for comparison. Glaser (1978) distinguishes between the two types of codes: substantive and theoretical:

> Substantive codes conceptualize the empirical substance of the area of research.
>
> Theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory. (Glaser, 1978, p.55).

Immediately after transcription, the information was again "coded with substantive codes that reflect the substance of what the people said" (Chenitz & Swanson, 1986, p.8). These codes were then compared initially with the substantive codes created through the process of audio coding. The substantive codes were then compared to other codes developed within this set and later with other data collected. Similar codes were clustered together, thus collapsing some existing codes to form more inclusive categories, or theoretical codes which conceptualize how substantive codes relate to each other.

Throughout the data collection and coding phase, interview notes or field notes were also completed by the

researcher following every interview, recording subjective impressions and observations about the interview process. This information was also coded using the same comparison method. The researcher's interpretation of the analysis process is consistent with Charmaz's (1983) interpretation of the grounded theory method. Charmaz differs with Glaser and Strauss's (1967) implication that the data speaks for itself. Charmaz interprets that the codes developed directly reflect the questions posed by the researcher, thus including the researcher's "commitments, interests, expertise, and personal histories" (p.112) in the analysis process. Charmaz's interpretation is in agreement with the constructivist viewpoint as previously discussed.

The concept of theoretical sampling at this point, in the generating process, involved eliciting codes from the raw data and using the codes to further direct data collection. This process was assisted by the researcher's generating memos in relation to the emerging codes. The memos are analytic notes which attempt to define a) the boundaries of a code, b) the empirical criteria on which the code rests, c) the conditions under which it emerges, d) the theoretical connections and significance to both the data and major theoretical themes in the data (Glaser, 1978).

The next step in this process involved the emergence of the core categories or basic social process (Glaser, 1978). The core category must: a) be central to as many other

categories as possible, b) re-occur frequently in the data, c) relate meaningfully and easily to other categories, and d) have "carry through" qualities in terms of relevance and explanatory capabilities. The emergence of core categories is the beginning phase of the generation of theory and subsequently should direct the theoretical sampling, coding and memo writing from that point on. As a result of this developing conceptual awareness, more process oriented questions were incorporated into each subsequent interview. Each interview remained consistent in the original question posed to the participants, being: What has been your experience of grief related to the suicide of your___ (family member)?

Theoretical sampling continued until the core categories were saturated. That is, "no new data and no additions are added to the category and one overriding core category can explain the relationship between all of the others" (Chenitz & Swanson, 1986, p.8). Glaser (1978) discusses that within the process of saturation, the "amount of time for data-collection can perhaps be shortened without sacrificing the richness of the data, which sacrifice, paradoxically, can occur through dilution when the researcher gathers endless voluminous notes unfettered by theoretical sampling" (p.40).

During this process the researcher also developed theoretical memos, which resulted in greater conceptual

detail and integration of the theory, a process referred to as densification by Glaser and Strauss, (1967). It was through the sorting and re-sorting of the memos that the basis for a preliminary draft of the theory was provided. Throughout this process the concepts of **fit, work, relevance** and **modifiability** were applied to the emerging theory as directed by Glaser (1978).

The concept of **fit** reflects the researcher's commitment to the data (Glaser, 1978), giving the data priority over and above any pre-existing concepts, thoughts or hypotheses. The theoretical constructs must be seen as arising out of the data, not being imposed from outside the data. Always the researcher looked for pathways from the theoretical constructs emerging, back to the data.

The concept of **work** examines the researcher's commitment to explanation, prediction, and interpretation (Glaser, 1978). The findings must be at a higher level of abstraction than the actual description in order to "work." The past, present and future must be observed as interpreted and predicted in order for the emerging theory to work.

Glaser(1978) defines the concept of **relevance** as the researcher's commitment to the findings remaining true to the concerns of the participants rather than to a pre-determined reason for the study. The broad question which began every interview ensures that the participant had

opportunity to take the researcher where she needed to go to hear the experience.

The concept of **modifiability** discusses the commitment of viewing the interpretations as part of an ongoing process, a snapshot rather than a fixed piece of work. The interpretations of this research are offered as just that, a first step in developing an understanding of women's long-term experience of grief after suicide. "And since a theory is modifiable, changes in relevant variables can be accounted for by way of modifications" (Hutchison, 1986,p.117).

In attempting to assess the work and fit of the research, the preliminary model of the emerging theory was presented to the participants. May (1986) describes this process as part of an evaluation of the theory as she states: "The theory should explain clearly what the subjects...take for granted as true in their social world" (p.153). Reason and Rowan (1981) describe: "one of the most characteristic things about good research... is that it goes back to the subjects with the tentative results, and refines them in the light of the subjects' reactions" (p.248). Morse (1989) discusses this technique in terms of confirming:

> The last method of ensuring that the data are complete and all parameters of the experience are described is to confirm the findings with the participants. This may be done individually; although, if conducted in a group setting, the resulting dialogue between participants comparing

> their experiences with each other assists in removing interviewer bias and confirms the accuracy of the researcher's interpretation. (p.126)

The participants requested to meet as a group to meet the other participants and hear the interpretations together. This group meeting was facilitated by the researcher. The process then consisted of the participants unanimously supporting the interpretations, suggesting some changes in wording, emphasis and model construction. The group meeting was an extremely useful step in assuring the fit of the theory to the data, the lived experience. The accuracy of the researcher's interpretations was confirmed.

The literature pertaining to suicide grief was again reviewed for its fit or possible contradiction to the emerging theory. The literature pertaining to women's psychology was also reviewed at this time for the same confirmation, elaboration or disagreement of the emerging model.

The interpretations were again returned to the participants in the form of the initial draft of Chapter Four of the thesis. Each participant was asked again to assess the model description for fit and for appropriate and accurate use of their own words in describing the conceptual model presented. The participants confirmed to the researcher that they experienced validation of their experience by reading the interpretation chapter. One participant related crying as she read the chapter, because:

"it was so accurate, it felt so good to be confirmed and to hear other voices expressing the same feelings I have experienced."

Writing-up the theory is seen as the final stage of the generating process in grounded theory. The writing has been done throughout the study in the form of memos. These memos have been sorted and re-sorted as to the intention of presenting an integrated, rich analysis of the theory of the core category. The power of the theory resides in the generation of concepts, not description (Glaser & Strauss, 1967) Thus the most central property of grounded theory is that it is transcending, it focuses on the conceptual and organization of the emerging ideas rather than simply describing masses of data. The written product now consists of an integrated, substantive theory of the identified basic social process of "Integration", as it describes the process of women's experience of grief after suicide.

Evidence and Credibility (Validity and Reliability)

Validity and reliability are important issues in evaluating any research findings. Charmaz (1983) and Chenitz and Swanson (1986) discuss the differences in qualitative and quantitative research and their use of these measures.

Chenitz and Swanson (1986) introduce the term **"evidence"** as replacement of "validity" in terms of

qualitative research. Kirk and Miller (1986) argue that qualitative studies have inherently good validity or evidence. The data are grounded by the very nature of the data collection, and intrinsically possess a certain kind of validity not ordinarily possessed by non-qualitative methods. A good validity check using grounded theory is to ask for the participants feedback on the proposed theory after analysis and ask if their experience is described in the theory, or is their experience evidence of the theory (Field & Morse, 1985). This validity check has been implemented within the research as described in the previous section.

The constructivist approach to research replaces the term validity with that of **"responsibility"**, thus indicating the researcher's responsibility to represent the participant's experience.

The internal validity of this research is addressed by asking the question: Are the research interpretations useful or meaningful? This question replaces the quantitative definition of internal validity as a matter of generalizability. The usefulness and meaningfulness of the research is exemplified in this research by the confirmation of the survivors' experience. This usefulness will be explored from an application basis in the final chapter.

Reliability refers to the extent to which a measurement procedure yields the same answer, however and wherever it is

carried out (Kirk & Miller, 1986). Since grounded research is derived from an interactive process, no two analyses will be exactly the same. Chenitz and Swanson (1986) argue that a more appropriate question to ask of grounded theory is: "If I apply this theory to a similar situation, will it work, that is allow me to interpret, understand, and predict phenomena?" (p.13). Chenitz and Swanson advocate that the answer to this reliability or "**credibility**" question would be "yes", stating further that the test for the reliability of theory is through the use of that theory and its applicability to similar settings. Therefore reliability in qualitative research answers more the question of dependability of the method. The procedures of the method of grounded theory can be repeated in reliable accuracy, therefore the methodology is reliable.

The constructivist approach to research advocate the use of the term "**coherence**" in place of reliability, which is similar to the use of the term "credibility" as advocated by Chenitz and Swanson(1986). Both terms address what is coherent and credible for the observer as well as for the participant.

Field and Morse (1985) acknowledge their indebtedness to Homans's (1955) outline of six variables that he suggests should be used to evaluate the adequacy of qualitative research. The six variables are outlined as: "time, place, social circumstance, language, intimacy and consensus"

(p.117). The criterion of time is discussed as the researcher "spending sufficient time in the setting to enable adequate contact ... and establish rapport with the informants" (p.118). The criterion of place is discussed in terms of the closer the researcher is to the people studied the more accurate the interpretations will be. Social circumstance refers to the "variety of reported situations in which the behaviour is observed" (p. 118). The criterion of language refers to the researcher's familiarity with the language of the participant. The conclusion drawn is that the more familiar the researcher with the "language of the participants the greater the accuracy of the interpretations" (p.118). Intimacy is described in similar terms, in that the greater the degree of intimacy established between researcher and participant, the more accurate the interpretations of the data. The final criterion of consensus indicates that the " more the observer confirms the expressed meaning of the informants, with other informants the greater the accuracy of the interpretations" (p.118).

The interviews for the research were set up to allow all the time the participant required fully discuss their experience. The place was established based on the comfort of the participant, with interviews taking place in the researcher's home or in a comfortable office space. All data was collected by use of a audio coded interview, thus

the social circumstance was limited initially. The researcher's past counselling role with suicide survivors increased the familiarity of the researcher to the language, and lent itself to the accuracy of the interpretations. Similarly, the degree of intimacy established with participants was directly related to the researcher's comfort in the discussion of suicide and grief because of past counselling experiences. The criterion for consensus was addressed by returning the interpretations to the participants for their direct input. Further issues of consensus are addressed in the suggestions for application of the interpretations, as outlined in Chapter Five.

This qualitative study will refer to the question of validity and reliability in terms of **evidence** and **credibility** of the data and of the analysis process.

Ethical Considerations

Because of the nature of this study, ethical considerations were seen as particularly important. The main ethical consideration in this study was the risk of the research interview generating issues not yet addressed by the participants. In addressing this concern, all participants were informed of this possibility at the outset, with the opportunity to decline involvement. If they chose to participate, arrangements had been made to access the Suicide Bereavement Program, C.M.H.A. counselling

services, (see Appendix A and B), or other appropriate counselling services to provide follow-up to the participants as required. No such services were required. Due to the researcher's extensive background in clinical counselling with this population, efforts were made to ensure any debriefing necessary had taken place prior to the interview ending.

Informed consent forms were reviewed with each participant at the start of the taping interview to ensure that consent was given knowingly and freely; see Appendix C for example consent form. Reference had also been made to address participation of minors within the study, however based on the sample this was not utilized.

With respect to confidentiality, participants were informed that the audio tapes were to be transcribed by a Faculty of Social Work support staff member, (as supported by Field & Morse, 1985; Bogden & Biklen, 1982) and that all personal identifiers would be removed and replaced by codes known only to the researcher. The transcriber's adherence to ethical and confidentiality standards were addressed by the researcher prior to any transcribing being completed. The audio tapes have had all personal identifiers removed and have been kept in a secure locked place known only to the researcher throughout the process. The master code list has also been kept under lock and key. The tapes and code list will be destroyed following the completion of the thesis

defence. The confidentiality of information has met the standards according to the Canadian Association of Social Workers, Code of Ethics (1983).

This final written draft of the thesis ensures anonymity to the participants, even in cases where their "own words" are used to illustrate the study's theoretical interpretations.

Each participant will be given a complete copy of the research interpretations upon completion of the defense of the thesis.

The proposal for this research was submitted to the Faculty of Social Work Ethics Committee, and also to the Conjoint Areas Ethics Committee. Approval from both committees is found in Appendix E and F respectively.

CHAPTER FOUR

WOMEN'S EXPERIENCE OF GRIEF AFTER SUICIDE

Introduction

The findings in this study are presented in the form of a Conceptual Framework as defined by Field and Morse (1985) as "a theoretical model developed to show relationships between constructs... often used in qualitative research" (p.137). The conceptual framework describes the process that women in a caretaking role within their families go through upon the suicide of a family member. The conceptual framework identifies three phases, including four seemingly sequential stages within the second phase of the model. These distinctions have been made as key characteristics as this process emerged in such sequential order. The conceptual model describes the sequence of women's grief that emerged within the parameters of the research. The model does not suggest that the stages are experienced in a strictly linear fashion, but rather that the movement through the process seems to occur in the sequence given. This research points to a process of re-experiencing the stages. This comprises a cycle of development, with each repetition bringing the woman to a new level of integration. An understanding of repetitive phases indicates that the model should not be seen as a finite process but rather a

cyclical process leading to deeper and new levels of self and integration within each women's experience.

The model represents a composite picture in time of the descriptions of four women's experience of grief after a family member's suicide death. The uniqueness of each individual must be stressed, each experiencing her own process. The model represents the themes that emerged in their stories as heard by the researcher.

The participants allowed the researcher into their lives at a very real and intimate level through the descriptive interviews of their experience of grief. It is in acknowledging this relationship and the uniqueness of their stories that the initial section of this chapter is written. It is presented in an informal style that best reflects the humanness of the individuals and introduces the reader to more than a conceptual model formed from "data". The conceptual model is used to describe the process of grief as it emerged, following the brief introductions of these four courageous women.

Suransky (1982) supports the informal style of "hovering low" over the experience by way of introduction, when she writes:

> Theory must always "hover low" over its grounded actions, over the concreteness of every day experience played out in specific contexts. The immediacy...gives us access to the conceptual world beyond which our subjects inhabit but which becomes vacant, devoid of meaning, if divorced from the site and realm of experience and action....

> ... those who begin their enquiries with facts will never arrive at essences. The "fact gathering" psychology...produces a fragmented perception of reality precisely because the aim is to gather isolated data from isolated parts of the organism... such facts, documented and "verified" will never be more than facts among other facts, facts closed in on themselves, not permitting a grasp of the totality of the human gestalt and resulting in "focalistic vision" that prevents a genuine transforming action on reality. (p. 36-37).

Remaining true to the Constructivist theoretical underpinning, and following Suransky's (1982) direction, the participants, as individuals will be introduced to the reader. Necessary steps have been taken to ensure participants identities are protected, while allowing the unique characteristics to come forth.

Introduction of the Participants

Anna

Anna is a 30 year old professional woman raised in a small prairie town in a family of five. Anna's family is made up of: her mother and father, now in their 60s and 70s respectively; her oldest brother in his 30s; her deceased brother who died just over three years ago by suicide; and herself ... the youngest in the family.

Anna presents as an intelligent, caring woman who takes great interest and care in all her relationships. She credits her upbringing by a warm, caring family for her own approach to living. Anna describes her relationship with her mother as:

> We have a really close relationship and she was one person I could always be open with. And she could be open with me, so we were and still are very grateful for one another.

Anna refers to her mother as having characteristics of a "Jewish Mama." She describes her as a "real mother" when discussing her ability to care for her family and to be often the "spokesperson for the marriage."

Anna describes her father as very caring in "a very German way." This is indicated by his "protectiveness" of the family and lack of ability to verbalize a lot of his feeling. She has learned to recognize his gestures of initiating a family car ride as his way of reaching out to the family.

> My father, I think being a man, from that era - ...was fairly protective and was - well, would minimize stuff. ...And I am open with him but it is difficult for him to really open up.

Anna's oldest brother, (as she consciously continues to refer to him), is described as "estranged from his emotional state" when referring to it being "hard for him to talk about how he is feeling."

Anna relates being close to both her brothers growing up as children, however being particularly close to "Ned," her now deceased brother. In describing that relationship she states:

> We were always very close. We were - we just liked one another's personalities - a real connection between the two of us.

Anna relates that this very close relationship began to change approximately two years prior to her brother's death with his diagnosis of "paranoid schizophrenia" and his at times violent and disturbed behaviour.

> So the relationship really started to change because of the illness and I found more that I was becoming a caretaker ...there was a distance thing. And at times when he was really suicidal, or homicidal, I had to really withdraw and move to protect my family. And there were times when I think he needed me and I wouldn't make myself available. There were times when I did avoid him because I wasn't sure if he had guns in his place....if there's anyone that could have helped him, it would have been me.

Anna's self description of caretaker within her family system and within her relationship with her brother are key in her subsequent grief process. These will be drawn out throughout the conceptual process description.

Anna remembers experiencing a "sixth sense as to something being wrong" on the day her brother committed suicide. She found herself avoiding answering her phone at work and avoiding returning home on this day certain that the telephone was delivering a sad message, "I found myself becoming just more and more saddened,...and defensive and wanting to protect myself and my time." Finally the news could be forestalled no longer...

> And I thought, that one I'm not answering, absolutely not, and it rang and rang and rang, and this time there were over 15 rings, and I thought, something's wrong, somebody's really persistent.

> And of course, that was the phone call from my father, and he was really upset and he explained to me that I needed to come home as soon as possible. Uh, that Ned had killed himself, that they had found him that afternoon....and so that really marks the beginning of my reaction to his death...
>
> ...and - God, what was it like - it was horrible!

Betty

Betty, age 42, presents as a petite woman with a sense of warmth and caring that emits upon first meeting her. Betty has spirit about her that not only allows, but encourages, an open honest relationship within moments of meeting. She opens her mouth to speak and the faint English accent adds a special quality of sincerity to her story.

Betty describes her childhood as one of uncertainty and pain.

> There's three children in our family - I'm the baby and my brother was three years older than me, and we have a half-sister who is four years older than me so she's one year older than my brother. We're all born and raised in England, came over on the boat when I was eight years old so he would have been 11 and she was 12.
>
> ...not a very happy childhood. Mom and Dad used to fight a lot - we used to separate a lot - every other weekend we always had to decide who we had to go with.

Betty describes an estranged relationship between her parents and herself. The lack of stability and consistent caring were key in her mind to the development of her relationship with her brother as one of "it was Bob and I against the world." Betty relates time spent in orphanages

when neither parents were able to keep herself or her brother,and the coming to Canada at a young age with English accents, as two key factors in the drawing together of the relationship between herself and her brother. "So I think my brother took a big place of my father. You know, he was everything to me...and again it was Bob and I against the world."

Betty describes an adolescence of "getting into trouble" with her brother, with alcohol playing a big part in their development. In their early adult lives, Betty and Bob's lives continued to intertwine. Betty relates having a child at a young age and the subsequent marriage to the father of the child. Bob continued his increasing involvement with alcohol. Betty and Bob maintained close contact with one another. Bob remained in contact with his parents during this time, while Betty continued to be estranged from them. Bob was diagnosed as "manic depressive" in his early twenties, and made numerous suicide threats and attempts at this time in his life. Bob came to live with Betty for a while after her separation from her husband, and she remembers drugs and alcohol becoming key features in both of their lives.

Betty remembers with fear an evening where Bob requested of her to make a suicide pact with him:

> I got really scared and I think after that, that was when I went back to my husband ...I know now I did that to escape from Bob because I didn't know what else to do. I couldn't help him and I guess

> I didn't want to die with him and I probably would have if I'd stayed. So I left.

Betty returned to Europe with her husband, and relates the memories of receiving word of her brother's suicide a year later:

> I guess we'd been in Europe about a year and I got really sick one day. I was just laying in the bed, it was really dark, and I just wanted the curtains closed. It must have been a couple of days I was like that until finally, my husband, came home with the padre and said ...(pause)...
>
> ...your brother's dead. But it happened three days ago, and my parents had already cremated him, and he was gone.

Betty relates a life of running, denial, and escaping into a world of drugs for the following 15 years after her brother's suicide. Betty describes this period of her life as "absolutely blocking it (the suicide). I just wouldn't allow it in." Sixteen years later, when Betty "allowed" herself to face her grief, in her search for information around his death she recalls being met by an attitude from professionals that in 16 years her grief shouldn't be important or somehow real:

> And I remember being really - I was so angry at them. I thought - it's got nothing to do with whether it's been 16 years ago. It wasn't 16 years ago - that's just the date. It actually happened last month, you know. And that's what was happening. That's exactly - it did happen last month!
>
> ...I had nightmares - crying and crying.

Connie

Connie, age 36, introduces herself within her family context with:

> I have one brother left, but we're not even close...and I'm not my Dad's little baby anymore because he's not there and I'm not - never was my Mom's little baby... she's my little baby, sort of. So I feel old that way.

Connie grew up as the youngest sibling and only girl within her family in an urban centre in the western prairies. Connie had four older brothers, with the eldest dying at a young age. Of the remaining sibling, the eldest is alive to date and is not in contact with Connie, and Mike and David have both committed suicide - Mike approximately ten years ago, and David just over three years ago.

Both of Connie's parents were alcoholics and separated numerous times while she was a child. This created an atmosphere of the kids against the parents. Connie has fond memories of being her Dad's "little girl" and his insuring no harm came her way. However, this was often at the expense of her brothers, whom she cared for deeply. Connie discussed physical and mental abuse that her brothers received at the hands of her father and mother. In their middle childhood years they lived mainly with their father as their mother's alcoholism took her away from the family on drinking binges for months at a time. Connie's father died approximately six years ago, and Connie's mother now

resides in a senior's home where Connie takes a key role in her care with mixed feelings,

> Sometimes when I go see her I still get those feelings, like, I hate her because she's still alive and she's the sweet little old lady in the old folk's home now.

Connie has developed adult diabetes which has kept her from maintaining a job for the past two years. However, she feels she is learning to live with it. Connie's first brother to commit suicide had become diabetic a couple of years before his suicide and had become very depressed and underwent as Connie describes, a "whole personality change." Connie describes her relationship with Mike being "my closest family connection." Connie was informed by her father of her brother Mike's suicide:

> And then I got a phone call from my father one day that he had shot himself in the middle of the night and it was - I guess - shock, you know, for the whole two weeks.

Seven years later, Connie recalls a conversation with her brother David just prior to his suicide:

> We'd been talking about Mike committing suicide and David was saying that he was going to commit suicide and I remember saying to him one night just before he left - you know, he said to me, nobody has any right to tell anybody else that they have to live and I said yes, I realize that but God, you know, if you do this too - like, I've lost Mike and...it was just like - Oh God, No, like that couldn't happen twice, but it did.

Connie remembers her initial reaction as one of:

> It made me think of it more...for awhile there I thought that maybe I had to, too, for some reason.

Debbie

Debbie, a 39 year old woman, and mother of two pre-teen daughters, talks about wanting to use her experience of her husband's suicide just over three years ago, to help others deal with the pain of grief.

Debbie retraces a history of a close relationship with her husband of 12 years, with his binge-drinking being the only major concern in their relationship. Three years prior to her husband's suicide they experienced the death of his mother and sister, a physical move from a mountain town to a small rural prairie town, and numerous job changes for her husband. Gary, Debbie's husband, experienced episodes of depression and paranoia during the two years prior to his death and was medically treated for this depression. Gary made at least one suicide attempt through the use of an overdose.

Debbie recalls Gary "not being himself," with depression and lethargy being a way of life for him in the last year of his life. Debbie discusses the change in relationship which occurred from one of mutual caring-for, to one of her assuming sole caretaking roles for her husband and children. "I felt more like his mother, I didn't feel like a wife anymore." It is with remarkably-detailed memory that Debbie relates the last three years of her family's life prior to her husband's death.

On the night, just prior to Gary's suicide, Debbie relates an incident of Gary requesting she read to him:

> I just thought he really needs a mother right now, so we sat on the couch and he had his head on my lap and I read to him...that night Gary was up all night pacing and smoking...and in the morning he came into the bedroom and said Debbie I bet you $500 Dr._____ killed mom and dad and____ killed my niece. And I thought Oh God it's all back again!

Debbie continues to describe moment by moment with word perfect accuracy the final hours of her husband's life. His life ended after she had left the house to attempt to call his doctor as she was very concerned for his safety. Debbie returned to the family home to discover his body:

> I called his name and looked in the kitchen and bedroom and then I went downstairs, he was laying down on the floor and I thought his head was smashed in, I thought he smashed his head in with something...(cries)... and his eye was gone, you could see the brains...(cries)... there was no blood. ...I ran outside and screamed for help!...(cries).
>
> ...How can I tell my kids that their Dad is gone?

This experience is important to be included in the research at this time as it reminds the reader of the horror and trauma from which this grief-experience takes its beginnings. Horror is a fact of suicide-grief that cannot be overlooked. The theory of Grief Integration as it emerged from the experiences of these four women will now be presented.

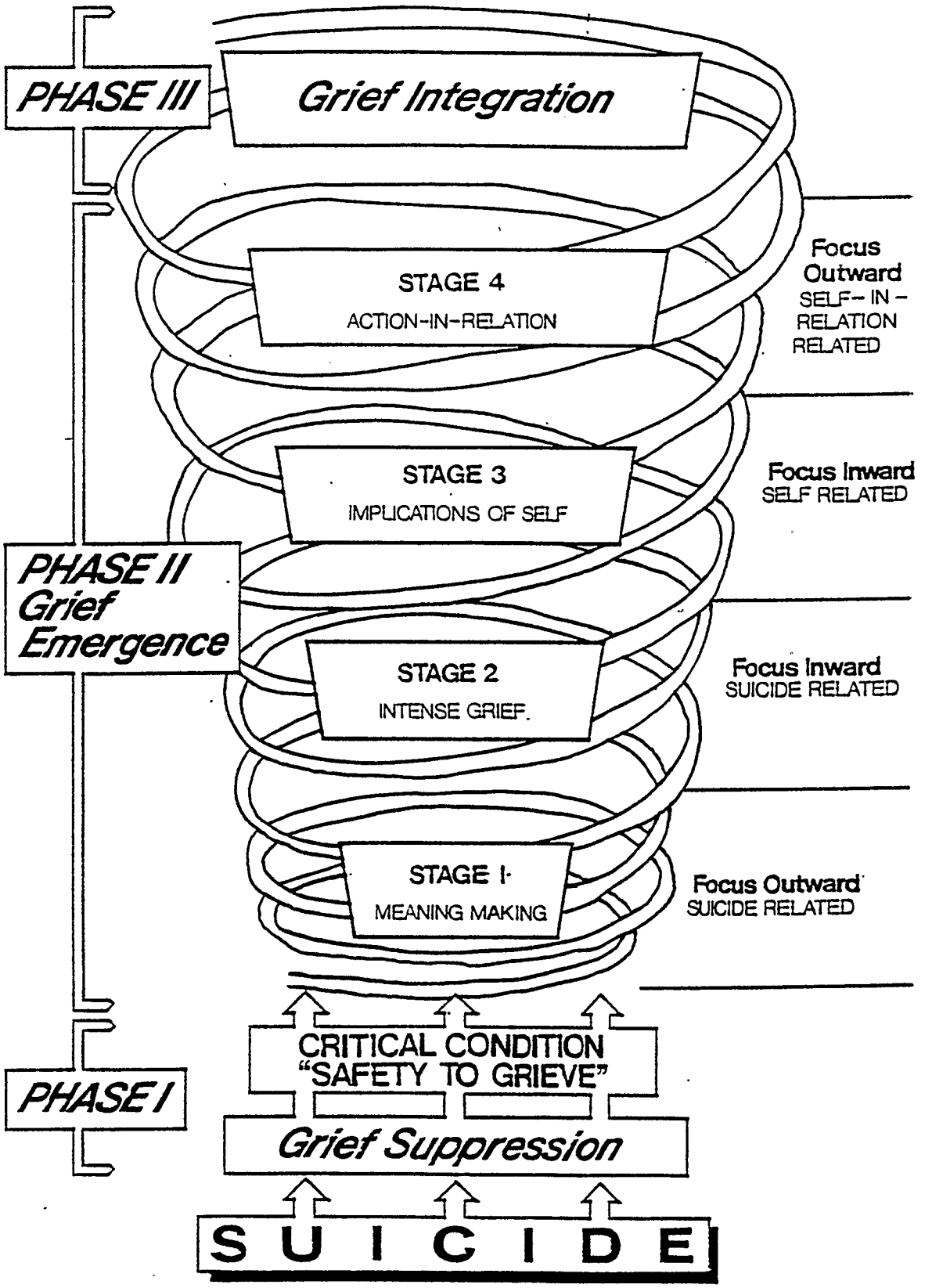
Grief Integration
A Theoretical Model

The findings are presented in the form of a conceptual-theoretical model as graphically presented in Figure 2. It is composed of three phases: Phase I: Grief Suppression, Phase II: Grief Emergence and Phase III: Grief Integration. The common thread or basic social process (Glaser, 1978) in this model is that the process of grief is characterized by a move toward **integration.** The past, present and future are integrated, maintaining and re-creating the connection or the relationship with the suicide victim. It is this emphasis on **connection** which has allowed for an **integration** of their grief, or as Kaplan & Klein (1989) describe it, as continued "action - in - relation" to their relationship with the dead person. It requires a **change in action**, not an emotional withdrawal from the relationship.

The findings draw upon "in vivo" concepts (generally spoken in participants' language) as well as "heuristic" concepts (generally language applied by the researcher at a conceptual level) (Glaser, 1978). Wherever possible the participants' own words are used and defined as to their particular meaning. The interpretations are illustrated when possible by direct quotes from the transcripts in order to "ground" the theoretical concepts in the data from which it emerged. "A good qualitative paper is well-documented with description taken from the data to illustrate and substantiate the assertions made" (Bogdan & Biklen, 1982, p. 177).

Figure 2

CONCEPTUAL MODEL



Summary of Model Characteristics

Phase I - Grief Suppression

Characteristics:

1. Caretaking
2. Replacement
3. Running/Escaping

Critical Condition - Safety to Grieve

Safety is a necessary condition to facilitate the movement of the survivor to Phase II.

Phase II - Grief Emergence

Stage 1: Meaning Making

Focus: Outward / Suicide Related

Characteristics:

- Searching
- Need for Information
- Spiritual Questioning
- Social Stigma

Stage 2: Intense Grief

Focus: Inward / Suicide Related

Characteristics:

- Guilt
- Anger
- Sadness
- Fear
- Shame
- Unpredictability
- Pre-occupation w/deceased
- Physical health problems

Stage 3: Implications of Self

Focus: Inward / Self Related

Characteristics:

- Abandonment
- Identity Loss
- Connectedness
- Dreams
- Presence felt
- Family Re-constellation
- Social expectations

Stage 4: Action in Relation

Focus: Outward / Self-in-Relation Related

Characteristics:

- Completing picture of the deceased
- Re-creating existing relationships
- Authenticity
- Self empathy
- Permission

Phase III - Grief Integration

Characteristics:

- Grief residing with the survivor
- Altered quality/frequency/duration of grief
- Re-creation of relationship with deceased
- Rituals of connection
- Dreams as connection
- Replacing the suicide as most important memory

Phase I - Grief Suppression

The Suppression Phase was entered into by all participants upon news of the suicide. In the scope of the research three main characteristics were observed as suppression experiences. These were not identified as stages within this phase as they are all defined as serving the same function of suppressing the grief related to the death from being openly thought about. They are seen as separate characteristics that do not all need to be experienced in order to move to the Grief Emergence Phase. There is a **critical condition** identified as **"Safety"** which needs to be met in order for the movement from this phase to the next to occur. The condition of Safety will be discussed following the identification and discussion of the three characteristics.

1). Caretaking is identified as a woman's experience of this phase. Three of the women discussed how, at this time, their key function as caretaker within their family moved them immediately to a position of "pushing aside" their grief to facilitate the caring of others pain. Anna describes her conscious movement into this role fulfilment:

> my role in the family was always that of the family therapist, and so that kicked in very naturally at that time. So my sadness and my - the hurt - and the guilt - I think that got pushed to the side somewhat and I was more concerned about how do I help my parents make sense of this. How do I try and be a good daughter and get them

> to find some way here that they're not going to go under also.

The caretaking role can be a deliberate move, based on past positions within the family, and can also serve the function of escaping as "it was easier to view other people's grief rather than really get into it myself."

Connie found herself in the caretaking role by way of abdication on the part of her parents as indicated: "When David died she [mother] wasn't drinking anymore and all she said to me was that well - I'm too old now so you're going to have to handle this. And that was it." This role becomes the focus at this time and the experience of "not having time to think about yourself" and always putting others needs ahead of your own was a comfortable and familiar position for these women.

Debbie's position of mother of two children after her husband's suicide also required the caretaking of others prior to looking at her own grief, "when I realized I had to tell my kids, I got myself together and put their needs and grief first before my own."

2) Replacement of the person who has committed suicide can also be a feature within this phase. This experience is often coupled with denial of the death, but is evident in the research that the two need not always be connected. Debbie "started going out with a man really soon after Gary died. When I think about it now I think some of it was out of anger," and continues on to discuss how she was not

denying her husband's suicide, but rather denying the importance of the event by becoming a new person in a new relationship. It was not until she was able to end this new relationship that she could allow herself to experience the pain of her grief.

> I was trying to live separate lives - a life of having this boyfriend and this new relationship and have lost a husband, and this other one, and trying to sort of run away from it all and cover it over as though I'm fine.

Betty experienced her unconscious attempts to replace her brother in her life by seeking relationships with men who physically resembled her brother:

> I met this guy who was into dope, but he was - he looked like he was lots of fun and happy-go-lucky, and again, he reminded me of my brother... I wanted to replace him, recapture him.

Betty describes this time as a time of denial of the significance of her brother's death when she states: "still... absolutely blocking it, yes. I just wouldn't allow it in." It is in reference to this blocking that she discusses her many attempts to replace the relationship with her brother with a facsimile.

3) Running/Escaping are seen as connected and evident during the suppression of grief. Running relates to physically moving in attempts to "get away from" the pain or keep the pain suppressed, "and I ran away again"; while escaping is used as a more internal escape by the use of mood modifying substances. Two of the women discuss the use of alcohol and street and over-the-counter drugs in attempts

to "escape the experience." In both of these women's experience, depression and suicide attempts were the end result of this phase:

> But when things weren't going well, and even the drugs weren't covering it anymore, I flipped out. I became really depressed. I was getting suicidal...it was just like a vicious circle. I couldn't even get away. The drugs just weren't doing it and it was horrible. I hit rock bottom, I guess.

The experiences within these three areas of this phase have the similarities of denial of the meaning of the loss and eventual depression as common threads throughout. This phase was not seen as pathological in grief in this study, but rather a necessary step toward the emergence phase of grief.

The passage within this phase is not time bound but rather there is a sense of "readiness to grieve" or "safety to grieve" that is necessary to have in place prior to moving from this phase. The **critical condition** of **"Safety"** can be defined as the individual having some sense of control over her/his life and/or some sense of security of self and other's preservation. This safety can be found in the security and support of a family system as in Anna's experience, and in assessing that the others will survive and it is permissable to begin one's own grief. Anna felt support within her family system to allow her to face her own grief only after their safety was ensured. If the family support system is absent, then it becomes imperative

to have a supportive social support in place before moving into the emergence phase. Only when Betty returned to school and developed a sense of self-success and found a spiritual support group and tested them as to their ability to support her was she "interested/able/willing to ask questions of her brother's suicide" and thus "open Pandora's Box" to her grief. Connie found the necessary support in a social group only after caretaking duties were fulfilled. Debbie discusses this safety as occurring as a result of breaking the "replacement relationship" and realizing that she could find support in her children and self when looking at her grief. The common thread of safety is observed by the nurturance and caring by self and others which allows movement from this phase of suppression to the set of stages identified within the Emergence phase.

Phase II - Grief Emergence

The Emergence Phase is composed of four stages which take the individual on a journey of emerging as defined as: "to develop or evolve as something new, improved development" (Webster's, 1982). Stages are defined as "degrees in a process of development, growth or change" (Webster's, 1982), therefore are seen as interrelated and not occurring in a strict linear fashion. The stages are presented in the order as they emerged within the data,

however there is overlap and interdependency inherent within them. The stages are not mutually exclusive. It is important to discuss each stage in a separate context initially to facilitate the observation of the fine distinctions within their evolving form, and to draw relational connections between each progressive stage. A key distinguishing feature between the identified stages is that of focus as it relates to the individual griever.

Stage 1. Meaning Making------Outward/Suicide Focus

Stage 2. Intense Grief------Inward/Suicide Focus

Stage 3. Implications of Self------Inward/Self Focus

Stage 4. Action in Relation------Outward/Self in Relation Focus

Stage 1. Meaning Making

The **focus** of this stage is predominately on the **act of suicide** itself. This is a very **active** stage with the survivor focusing on following-up leads, clues, reading, and general information-seeking activities to help her understand or "make sense" of the fact that someone very close to her has taken his own life. The energy at this stage is directed **outward** as a result of "searching" behaviors taken on by survivor. The searching can take the form of talking to others close to the deceased in search of clues or hypotheses as to "why" he chose death, and "why" he chose now? The search to find "the answer" in a single cause form is ever present during this stage. The survivors

talked about knowing that there was not a single cause, however finding their energy going toward searching for that one "missing piece" that could be the answer.

When a mental illness diagnosis had been made, as with three of the suicide victims in the study (paranoid-schizophrenia, manic-depressive and depression), the survivors found themselves immediately blaming the disease as the cause, however their search did not stop there. They all became compelled to read, and learn every aspect about the diagnosis and this process inevitably brought up more questions and unanswered questions surrounding the suicide.

> There was the reality that he was sick. It's different than somebody who loses their job and decides to kill themselves. I mean paranoid - I think he did a noble battle with that illness for as long as he could.

Debbie recalls "every time I ever found an article on depression or something, I read it" and that the more she learned, the more she wanted to know, to try and "make sense" of why he would choose death.

As she was living out of the country at the time of his suicide, Betty's searching included intimate details of the last days and weeks of her brother's life. She discovered that 15 years after the suicide when she "opened Pandora's Box of her grief" what surfaced first was her need to know, her need to make sense of the desperate condition that would have led him to suicide. She recalls searching through vital statistics for the missing pieces:

> And so she called back next week or something and she said - I've got something. Are you ready? ... Oh go ahead tell me! Holy shit! Oh God! (Cries)...She gave me the gruesome details. How he'd shot himself...and then she told me how there was a sawed off shotgun beside him and he'd had some liquor in his body...and I just couldn't take it all in...I began crying!

Fifteen years after her brother's suicide Betty needed the missing pieces to begin feeling the grief. Not only did she need the details of the suicide, but she also found herself drawn to make connections with people who may have known him or been in his life before his death.

> I'd got his address of the last place he'd been, and it took me probably about a month before I could finally just drive by it. And then about another month before I could finally stop and I knocked at the door and there was nobody there. So about another month passed before I finally managed to contact who was there and it turned out that the guy who owns the house now had bought it from the other people - had no idea where they had gone. What I wanted to know then was - did you know him, did he leave anything behind?

What becomes so evident is the survivor's need for information. Any information that adds a piece to the puzzle may be used by the survivor toward making sense or making meaning of the suicide. The meaning making facilitates moving into the stage of intense grief.

> I don't know if you get over it - but making sense of what - you know - the illness - what that must do to people, what it must have done to him.

Another characteristic of this stage is the **spiritual** questioning that begins to take place for survivors. Old spiritual beliefs about heaven and hell are questioned, and the very basis of their beliefs is challenged. This

experience can either be one of questioning and discarding their beliefs or can be one of drawing upon their spiritual beliefs to bring them closer to their grief. It is the questioning of long held beliefs that is the focus of this stage.

> I was into - I was thinking about (him) a lot. Trying to deal with some of it. I sort of go into my spiritual side of - you know, where do you go after this? Where did he go? Is he okay? What happened to him? And there was so much stuff that people go - oh God, he committed suicide - easy way out - oh, he's going to hell now and he's going to pay for that.

Betty's experience of questioning her spiritual beliefs at this stage also brings forward another characteristic of this stage: the **social stigma** attached to suicide. At this stage, the stigma is experienced as real and powerful to the survivor. Survivors may find themselves defending the act of suicide to others as a result of others blindly condemning the person. The women expressed a need to be allowed to question at this stage and experienced the social pain of a suicide survivor, when met with others' condemnation without question.

> They're lovely people but it was - the stigma attached to suicide - I mean, I didn't realize how significant that was, or the meaning that people attach to it, and the assumptions they make about the family until I'd gone through it...I felt like I had the mark of Cain on me...and I knew that - okay - this is part of what's going to go on.

Anna's experience of the "significance" of the stigma indicates the role of the social experience as intertwined

and connected to the individual's grief experience. Anna responded at this stage to her experience by:

> I found that made me even more protective, especially around people that I hadn't seen for awhile, and I made a decision that if they're going to ask a lot of questions, I'm not going to say a great deal.

Anna refers to her conscious reaction to the stigma and negative social experience as one of "editing" information and "editing" carefully her grief around others.

Connie's experience of having two brothers brought with it the social stigma of being perceived as coming from a family of inherited suicide:

> a lot of people do - are very ignorant of, you know - like your brother shot himself so I suppose you're going to now too. And I suppose your whole family has suicide, they think it's a disease or something...and I think sometimes they think - like maybe it's catchy or something.

Betty discusses her experience of being "shut down" by the social expectations of others, being compounded in her situation of experiencing readiness to grieve 15 years after the suicide. She very eloquently puts the time condition into perspective when she states her reaction to this social expectation:

> And there were not a lot of people I could talk to about this because it happened so long ago, and I got the same old - you know - after a year you're supposed to let it go - 17 years - what's the matter with you?

Once again the stigma of being somehow "not healthy" in her grief, or being denied her searching and attempts at making meaning for herself of her brother's suicide is experienced.

It is within this stage that the reality of the suicide comes into focus for the survivor. Through the searching, questioning and adding information about the suicide, the survivor is able to create as complete a picture as possible about the actual act of the suicide. This stage is therefore focused on the act of the suicide and on the deceased and is essential in order to move on to the next stage of Intense grief, in which the focus moves inward.

Stage 2. Intense Grief

The **focus** of this stage remains within the **act of the suicide**, as in Stage 1. This stage however is differentiated by the experience being turned **inward**, allowing the survivor to experience the **internal** pain of grief. The survivor during this stage becomes involved with their pain as it relates to the suicide. This stage is **characterized** by feelings of **guilt, anger, sadness, fear, shame, unpredictability, idolization and pre-occupation with the deceased, and physical health problems.** It is within this stage that the survivors seem at highest risk of suicide themselves.

"Not knowing what to expect from yourself on a day to day basis" characterized this stage for Anna.

> ...I'd get angry and think - why would you do this? Why would you cash in?
>
> ...At times, really feeling overwhelmed that I wasn't a good sister to him.

> ...and so I felt really guilty because I think that he was just excruciatingly lonely, felt really, really abandoned, and I just wasn't there for him.
>
> ...and really questioning what could I have done to stabilize him.
>
> ...Sadness - the sadness - I guess the - missing him. Yeah. It's like that desire to have him back as normal - as my normal brother.
>
> ...That would be the major emotion or whatever you want to call it - that longing.
>
> ...What I found is not wanting to kill myself because of that but I found that afterwards, my stress level was just nonexistent or really low...I would find myself getting really overwhelmed - really, really easily and I would think - well - I don't have to put up with this shit...maybe I'll just check out...really being self indulgent with my anger and thinking - you know - I'll just kill myself.

Betty describes the internal emotional pain of this stage, again as one of being overwhelmed by her emotions:

> ...there was a time when I could never stop crying, I mean, I could never stop. I just couldn't stop.
>
> ...I had nightmares, crying and crying!
>
> ...and then I was getting caught up in the whole loneliness, you know, what he was feeling at that time and god - it must have been hell.
>
> ...I get scared of that (own suicide) because I have a lot of - we look alike - we have a lot of character similarities - you know.
>
> ...I isolated myself. And I stopped growing.

Connie talks about the differences and similarities in her grief at this stage for her two brothers with whom she had very different relationships:

> ...I don't think David really felt that I really cared about him as much as I did about Mike. We weren't as close...but I still cared about him just as much and then it was just - it was just like - Oh God, No, like that couldn't happen twice, but it did. And I felt really guilty about that.
>
> ...when you havn't seen someone for about a year, it's different than when you've just seen them.
>
> ...I have got to the point where I have thought about suicide and I took a bunch of pills one night.
>
> ...I would find myself thinking and pardon my language, but I think - Oh you assholes, you went and did that...I'd think of a lot of their bad points so maybe I can justify them doing that...I was just looking for something to blame it on.

The fear of others killing themselves and fear of other family members developing similar health problems was an additional key feature to Debbie's experience of this stage of her grief:

> ...For about three months, I couldn't go anywhere by myself. I couldn't go in the dark at night...and I was so afraid of somebody else killing themselves, about my kids killing themselves!
>
> ...I'd have myself and the kids to the doctor at the slightest sign of anything.
>
> ...lots of times I'd get really pissed off. And I just say - why did you do that, why would you do that to us?
>
> ...I blamed the doctor for not paying enough attention, and I blamed myself for not paying enough attention.
>
> ...I felt like they (other family members) blame me.
>
> ...I think that I idolized him after he died.

The identified characteristics of this stage can be found in each survivor's own unique experience of Intense Grief. The focus is noticeably on the suicide victim and on the intense pain associated with the act of his taking his own life. Betty's description of this stage being like the "opening of Pandora's box" speaks to the intense internal pain experienced in the survivor's grief at this time.

Stage 3. Implications of Self

The **internal** emotional experience is maintained at this stage of the grief experience, however the **focus** now shifts from being focused on the suicide, to a focus on the **self** and the **implications** of the suicide on the individual.

Characteristic of entry to this stage is the feeling of **abandonment** and **loss of identity** in the absence of the deceased. The survivor begins to focus on the relationship with the deceased and the awareness of the deep sense of **connectedness** that she experienced in that relationship. There is often a sense of fear of identity-loss with this awareness, as the woman identifies her "self" within the relationship. Her sense of failure in this relationship forces her to question her self and her perceived strengths. "I felt that I could have done more...maybe I could have prevented the death... because if anyone could have helped him it would have been me." She becomes at a loss as to which qualities of herself she will be able to maintain

without this relationship, and which (if any) she must lose with the death of the individual. Because her sense of selfhood is intertwined with her relationships, the loss of a key relationship causes a loss of her self. This becomes a questioning and frightening stage in her grief experience. **Dreams** of the deceased and the sense of **feeling his presence** are also characteristic within this time of self-searching. One woman described the dreams of the deceased as "a comforting connection to him" while the rest of the world was telling her to move on. Once again this stage is connected with a higher risk of suicidal thinking on behalf of the survivor, as she struggles with her identity, her grief experience and the often contrasting message presented by her social world.

Betty describes this overwhelming sense of loss-of-self as she struggled with the loss of this key relationship:

> I think what happened was - I really had become invisible. I really didn't know who I was because Bob (her brother) was - he was who I could check out who I was. He made my identity. It was him I relied on. When he was gone, there was nobody - there was nobody there!

Betty's identification being tied to her relatedness and connectedness is key at this stage. When a relationship is changed through the violent act of suicide, the woman also becomes uncertain of other relationships in her life, and begins to question her self-identity in those other relationships as well. As the self identity is questioned within relationships, some women moved to distance

themselves from all relationships and experienced an overwhelming sense of isolation, aloneness and furthered sense of identity loss.

> I have tended to keep more of my emotional experiences to myself, or have been very selective about who I let in on that.
>
> I was very insecure, very, very, insecure. No self-esteem. Still needed (a) man to make me happy. Always thought it was my fault that things weren't working out
>
> I mean my trust of people is just virtually, was virtually nil. How can you trust them? They're just going to go away anyway. If you get close, they're going to leave you. Or they're going to ask so much of you.

Connie describes her sense of abandonment and loss of identity, which she understands only after she has become involved in another relationship that provides her with her sense of who she is:

> I think it's easier for me now that I'm with somebody because it's taken my mind off of it a lot. And it makes me feel now like I can go on, that I have something to look forward to. Whereas before, when I was alone, I just felt like there was nothing at all for me.

For Debbie, the experience of sharing children together with her husband became a focus for her sense of "who am I now that I am a mother without a father:"

> When they do something good, you think he would be so proud of them, and they do something really rotten and you think he should be here to deal with this too.

Debbie describes her immediate involvement in another relationship after her husband's death as a way of running from facing the question of "who am I now." She states

having to begin to see herself in a different way than how she defined herself in her marriage. The question of could she still "be" outside of that relationship was a constant challenge for her during this stage:

> I had to focus on myself. Before it was, you were a wife and you were a mother and you never had time to know how you feel or why you feel.

A feature of identifying the self within the relationship was also evident in Anna's experience. Anna describes her relationship with her brother as: "We just liked one another's personalities, a real connection between us." During this stage of her grief, Anna was surprised to experience what she describes as "an incredible fear of developing the illness myself." The trigger for her fear occurred when she reached the age that her brother was at his death:

> For whatever reasons, when I turned ___ I became terrified for the first two weeks...it was because this was the year he died...I just thought I'm going to go crazy this year.

Anna was struggling with her sense of identity as she saw it connected to her relationship with her brother. In a sibling relationship, this seems to go to a level of the possibility of inherited qualities and characteristics, as well as the qualities of being in relation with others as a way of developing self. As your self is developed within key sibling relationships from your birth, the struggle becomes one of who am I without being in relation to that person?

Another **characteristic** within this stage is that of **family re-constellation.** Anna describes her and her family struggle as they gather for family functions as a family of five with only four members.

> For his birthday...I made him a cake and put four candles on it to represent the family and where his was, I put this dove. That's how I remember his birthday, the beginning of his life,and I think it's really important that we remember the beginning of his life.

Anna's description also points to the **healing activities** that are characteristic of the next stage, that of acknowledging his physical absence, while coming to some personal understanding of his ever present connection in her life.

Debbie discusses her emerging struggles with re-defining her family after her husband's suicide:

> You can't have a family again. You can't have the father of your kids. No one is ever going to be the father of your kids.

The realization that the person will never be replaced and that this is not a goal in grief is very real during this stage. All women in this study at this stage, describe their anger toward others who attempted to encourage them to begin to "let go" or "find another husband" as if he could be replaced.

The **social experience** of the women in the study was consistent also at this stage of their grief. They all relate experiences of being pushed to "let go of him," "get on with your life," "put it behind you," "finish your

grieving and get on with it." For all the women comments from others, indicating these goals in grief, had the effect of the survivors themselves choosing to cut off from these possible social supports. These expectations of grief were not at all an experience within their own grief and, upon hearing such advice, the decision was made that this person did not understand their grief and therefore was not only not helpful to them, but invoked anger and rage.

> You know, it was done and let's sort of leave it. But I couldn't, and when I hear somebody say that, I usually run. And my way is, I either - I cut them out of my life or actually move. Well, I don't move anymore but I tend to unplug my phone and cut everybody off.
>
> It pisses me off. Damn right. What do you mean, let him go - shit. I can't let him go - he's my brother!

Connie relates her struggle through this period of identity and connection, as not only being cut off from social supports due to their "false expectations" for her grief, but also, as she turned to the literature for support, she was met with the same "lack of really understanding" her experience:

> ...Something is wrong with you. You go through all these steps in this order and - like that grief book makes me sick. The one that tells you what - how you're going to be feeling like this for a month and then you're going to be mad for a month and then you're going to be blah, blah for a month, and then it's going to be over.

It is during this period of grief that the survivors wanted to be heard. They express wanting others to be able to hear how important it is for them to remember and

maintain the relationship or connection with the deceased. Anna expressed this need in her comment "Why aren't you able to hear my grief when my brother died?" as expressed to friends who could not "hear" her grief, but wanted to impose their expectations or just not be available to her. It is an attempt on the part of the survivors to integrate the grief experience into other relationships in their life.

The survivors are able to move fully into the next stage of this process (again the overlap inherent within these stages must be stressed) at a time when they are able to accept that they do not need to give up qualities of their selves that were developed in relationship. Their task becomes to accept these relational-qualities as part of their identity and strive to maintain connection with the deceased in a new way.

Stage 4. Action in Relation

The fourth stage of the Emergence Phase is **characterized** by a **focus** that is now turned **outward** and becomes very **active** in "doing" activities as part of the grief process. The woman experiences a **self-in-relation** focus during this stage. The self-in-relation focus not only extends to the relationship with the deceased but is carried through to activities with other living relationships.

A prominent **characteristic** of this stage is actively **"completing the picture of the deceased."** It seems important at this stage to be able to expand the knowledge that the survivor had as to who the deceased was in other aspects of his life. In other words, who was he outside of our relationship? This task is necessary for some women to move from idolization to realization of their influence being only one influence in his life.

> I think that I idolized him and sometimes I have to stop and think about other parts of him too.

Anna describes her "private purge" activity as a way of becoming involved in her brother's other life - his art work:

> What's been central for me in my healing from Ned's suicide, has been being involved in his art...and I just love it... that has been one of the most healing activities I could do - is talking to the different editors of magazines, pulling together portfolios...and I just went through this whole, sort of private little purge. I found photographs in there of just him and his friends.

Betty relates her process of re-connecting with some forgotten memories and searching for the more complete picture of her brother at this time:

> that's what we had together was our humour. Rather than be macabre and really think of all this sadness and everything Bob was - which was a part - I mean, that's what I sort of dealt with for the last few months, I guess, when I think of Bob - is all that. And I sort of had forgotten the other side...so I went back to my friend (who had been her brother's girlfriend) and I went - tell me about Bob (her brother). Was he happy? And she said well she saw him in a totally different light. She said he was very different

> with me. We used to talk - and I said - what did you talk about? Just tell me. Well, it wasn't anything. No! No! - tell me, like, what - tell me one little thing. Did you talk about a rock as you walked - tell me!

Completing the picture of the deceased allows the survivor to begin to establish a qualitatively different relationship with the deceased, to see him in a "different light." Each woman had different techniques for completing this picture: Anna immersed herself into his art work to understand the other aspects of him, Betty sought other people who knew him for information, Connie experienced difficulty with this stage, as she had few people available who knew her brothers. This remains an issue today for Connie in her relationship with her mother. Connie is unable to discuss her brothers with her mother, as her only remaining family link. Debbie also struggles with this issue, in that she has experienced a "cutting off" from her husband's siblings with whom she would like to be able to exchange information about him. She experiences this cutting off as a blaming directed toward her, and has yet to decide how to approach this subject. Debbie has however attempted to "re-visit" her memories of her husband with her daughters by embarking on a summer vacation that took them back to his favourite places, and their honeymoon tracks:

> And that was a really hard holiday because we went there on our honeymoon and Gary had lived there, and a lot of the places that we went - I tried to remember what he had told me about different places. And some of it was really nice and some

> of it I really spent a lot of time crying, but we spent a lot of time laughing too.

Another **characteristic** of this stage is the **re-creating of existing relationships.** Each of the survivors experienced an **authenticity** about themselves and the relationships they chose to maintain or create at this time. There are relationships that are not maintained due to the other not being able to be with the survivor's process, as discussed previously. Anna describes the authenticity within her family at this phase of development:

> there's some really good things that have happened with the family. We were always really close. But I think there's more acceptance of one another's differences, of our weaknesses. We take more of an interest in one another...we pay more attention to one another.

In the areas of her personal relationships Anna describes herself as:

> My friendships are very precious to me and I experience their meaning in a different way since Ned (brother) died. I pay more attention to people, I listen more. I take more of an interest, I think, in people and what they're about.

Authenticity with others is a theme also heard from Betty, in her attempts to not only re-define her relationship with her brother, but also efforts made to re-define her relationship with her estranged mother:

> We actually travelled last year out to see my sister and my mom and that was really an incredible breakthrough. Because I saw who they were and I think I've always wanted mom to be a mom to me. Be there for me and she can't be...I saw who they were, you know. Mom's very - she's going to die and she's really sick. And I tried -

> I sat right in front of her and I looked right in her eyes and said Mom, I can help you because I've been dealing so much with this lately...and she just cut me off and I just thought - she doesn't want to - there's nothing I can do...So I kind of let them go...I'm seeing that there's nothing I can do virtually. That I can't save them or rescue them, and they are certainly not going to be able to do that for me anymore. And I'm not going to get what I want from my mom, ever. I've got to get it from somewhere else.

Betty's experience of authenticity within her relationship with her mother, although painful, allowed her to re-define her expectations and her role in that relationship.

Connie experienced a sense of honesty in her relationships that was not there prior to the grief experience after her brothers suicide's:

> I don't judge anybody anymore and I think when people -my friends are depressed, I think I find more time to try and talk to them if they want to. To help them, and realize that they really are depressed.

Connie also relates a development in herself and her relationships as one of an enhanced sense of humour which she shares with others:

> I also found too that it really - I don't know, with me - and maybe this is kind of sick too - but it's given me a sense of humour.

Debbie discusses the developmental outcome for herself that the self and self-in-relation focus has provided her:

> I think even now that I've gotten to know myself better, probably within the last year, and I've had more time to focus on myself. Before it was,you were a wife and you were a mother and you never had time to know how you feel or why you feel.

Debbie has taken this new sense-of-self a step further in entering into an upgrading program at this time with the focus on developing a new career, one that fits her new sense-of-self.

During this stage another **characteristic** is that of giving themselves **permission** for the sadness of grief to be a continuing part of their grief, a permission toward **self empathy.** Anna describes the sadness and pain not as a constant state, but rather occurring at points in time:

> I can't say, like it's a constant state, it's more what I go through at points in time. The missing (him) is probably stronger with the passage of time, rather than reducing. But the missing him doesn't have to be the despairing kind of longing for him to be back like it was at the outset. The missing him now - what accompanies that is the understanding, more understanding of the illness, more understanding of why he made the choice to kill himself and - what he had to offer when he was here.

Anna's description of the "missing him" indicates the qualitatively different nature of this feeling, at this stage, as compared with previous stages. The activity of completing a picture of the deceased and re-defining the relationship allows for this qualitatively different experience.

Betty describes herself as "belligerent" in her approach to accepting sadness and anger as part of her ongoing grief experience:

> I said you know this is what's happening , but you know, I just want to be miserable (today). And somebody tried to rescue me later on...and said you look miserable - no, you look angry, or you

> look sad...and I thought to myself, I was sad but... it was more belligerent. I was feeling sort of angry and kind of miffed ...at life, just everything. I didn't want to smile, I wanted to be miserable, I really did...I've been in that before and there's been a lot more anger attached and a lot more not allowing. This time I really allowed myself. I really said, I'm really going to be this. That's who I am right now and that's who -and I'm just going to stay there right now.

The self-permission is developed at this stage, as a result of having undergone the developmental evolution of the previous stages, which forces the woman to identify her self in relation and to take "control" of her process.

Debbie supports Betty's feelings of "belligerence" with her definition of allowing the "whiney kid" to exist within herself:

> That's when I feel like a whiney kid, and I just want to whine and I can really understand when kids are whiney because I feel like that sometimes, just exactly.

During this stage, the women continued to make comment to the social pressure they experienced, to again "let go." Their acceptance of their periods of sadness, and continued discussion of the deceased's influence in their lives was interpreted as "pathological" and "sick" behaviour. All the women found ways to counteract this message. They found assurance within their new stronger sense of identity, and the need to listen first to their own experience, for the validation they sought. Betty describes the desire to be connected with other suicide survivors at this point as a way of adding more validation to her experience. Connie and

Debbie both became involved in survivor support groups for a period during their grief and related the benefit in having their continued connection to the deceased validated by the other survivors.

Phase III - Grief Integration

The Integration Phase is not to be seen as a finite stage in a linear process. The experience of the grief process, as interpreted in this research, is seen rather as a cyclical process with the process being re-experienced at various levels. Subsequently, Integration is seen as a continually evolving state within the woman's life.

The Phase of Integration is **characterized** by a number of threads of development which may be traced back through the previous stages. The key characteristic of this phase is the experience of **grief residing with** the survivor on an ongoing basis. Grief is not seen by the survivors as a finite experience, but rather a developmental process in which grief becomes a part of the lived experience.

Connie exemplifies this belief in her description of her grief at this time in her life:

> I guess mine (grief) is sort of like with me and travelling with me. I guess maybe more in my mind. And just - it's always there and it's coming in and out, in and out, and it will always be there. Sort of like - how - would you describe it - <u>like a circle around you</u>. A circle that everything is in that circle and it's in your mind, and sometimes it's not, and sometimes it's,

> like, farther outside of you - sometimes it's closer...like things sort of cling to you. Like little, maybe atoms, whipping around you.

Connie's graphic description of her grief "travelling with" her is an indication of the integration process which has taken place, her sense of identity and her continued connection with her deceased brothers as part of her life. Connie's strong sense of connection in her lived experience is echoed in her following statement:

> ...it's like it (grief) is a part of me. Everything is connected to me, everything that's ever happened is I guess.

The circular and developmental nature of her grief is expressed in her words:

> You know, I really think this (grief) could go on forever. Like, for years and years. And I think it should, I really do!

> I don't believe that you resolve, not with a suicide, I don't think you resolve that grief at all. I don't! I don't think I ever will. I think it goes through changes and I think it's daily changes - it's other things that happen in your life too.

It is stressed here that in Connie's identifying grief-after-suicide as integrated rather than resolved does not in any way indicate a tendency toward thinking of "unresolved" grief related to suicide. Rather it is identifying the goal of grief in a completely different language and process.

Anna discusses her experience of her grief "residing with" her:

> What's different is I don't feel the sense of horror. It doesn't feel so raw. You know, because I've lived with that for three years,

> almost three years, so it lives with me, resides with me easier.

Anna's grief is described as qualitatively different than it has been in the past phases of her experience. She continues with her expression of the respect she has integrated into her grief as a part of her life:

> I know there are going to be some days where that (grief) is going to be more intrusive. But I've made a decision that I will just live like that, and hopefully those days don't happen all that frequently. But when they do come, you know, I respect it rather than run from it.

Anna's developmental process of grief has brought her to a place where she is able to trust her experience and respect its validity in her life. She makes very vivid comments about her experience of the perceived social experience she continues to encounter during this phase. She is speaking here about someone's comment to her that it is time for her to let go of her brother:

> I've talked about this actually with another person, her stepson committed suicide and that just - we were talking a number of times about how that just doesn't make sense. How can you let go of somebody that you loved and has been precious and there's been rough patches, even if there was an illness or whatever. ...but letting go of the person, I mean, I'm not ever about to do that. He's very vivid in my memory. You know, as I said, he was a real lively spirit and I'm not going to let go of that. Because in many ways, he was very much a source of inspiration. And I don't want to let that go.

Once again the language of grief expressed by the social community was felt as not fitting the experience of grief that Anna claimed as her own.

Betty reacts to the question of, Is your grief ever finished and if so how have you experienced this?

> Is my grief over? Is it ever over? I mean, I'll always be sad he's not there. I'll always miss him. Is my grief over...No! it can't be until we end up together. I'll always miss him...and when friends say let him go, let him go. I can't. I can't. I don't want to!

Debbie discusses her long term experience of grief as a process of "living through it:"

> You don't get over it, you live through it , and you have to live through it. You have to experience it...
>
> I don't think it's always going to be as intense, and maybe you'll always have days when some little thing will trigger, and you'll feel really down. But then you'll also have other days when you're living, and days when you're happy. Like I've found there's days when I think, life is great. I really like life. I like being alive, and I don't feel guilty about that though. But then I also know that there's always going to be something that hurts inside. That you're always going to think, it's a real loss and it's a real waste, and always miss him.

Debbie's discussion of the intensity of the grief brings to light another **characteristic** of this phase. There is a change within the **quality/frequency/duration** of the intense sadness that is experienced at this phase. There is the common theme that the **intensity** of the sadness associated with grief remains the same, however, the **duration** is shortened, the **frequency** is lessened and the **experience** is qualitatively different based on the new relationship established. Connie states this very clearly:

> Oh, it's as intense - I don't do it as often but it's as intense and I think it is for a shorter

> period of time. Like, I don't cry for days now. It's maybe all night sometimes, still, but not to the point where I can't even go out of the house the next day.

It seems that there are **triggers** that will bring on these intense periods of sadness. They have been identified throughout the study as family birthdays, anniversaries, holidays (ie. Christmas), the anniversary of the suicide, and places, events, and symbols associated with the deceased. At this phase the survivor respects these triggers and is aware of the increased sadness that may be part of that occasion for them. Anna describes her yearly routine on her brother's birthday:

> On his birthday ... I got up in the morning and I was happy because I was remembering him and the good things. And, I thought it's a good thing I live by myself because people might think I was really not functioning that well. But I was sort of giddy and I said; Happy Birthday Ned. And then it started - I started to cry. And I was washing my face and it was like - maybe you'd better stop washing your face for now because I was crying (laughter). And it went on while I was getting ready. I mean not - for the first while it was fairly steady and just really sad, and then saying - well, it's okay.

Anna's comment relating to "people might think I was really not functioning that well" speaks to the social perception of appropriate grief that the survivor experiences. Anna stated that she would not relate this birthday experience to others because of the risk of being misunderstood and seen as experiencing "unresolved grief" by this reaction.

Connie discusses her ritual of spending Christmas alone as a time to re-connect with her memories and feelings of

her brothers. She experienced others wanting her to spend this time with their families, perceiving her ritual of being alone as unhealthy grief. She states trying their advice, however it just "didn't fit" for her.

> Yes, I look at photo albums. Play certain songs like certain songs about Mike. I have a tape that certain songs were played at his funeral off that tape and I like to listen to those songs now. When I listen to those songs now, it is exactly him. And at the time...I remember he loved those songs too...sometimes it makes me feel good, sometimes I'll sit there and cry for hours... you know, I'll look at pictures and just go over things in my mind that happened and stuff like that.

A common theme throughout this phase expressed by the women was the request to have their process and experience respected by others. Their own unique ways of maintaining their connection to the deceased were comforting and healthy for each of them. Some of the common **characteristic** ways that were expressed of maintaining connection were through the **rituals** as expressed by Connie's description of her Christmas. A ritual described by Anna was that of visiting the cairn where the ashes were kept on family birthdays and taking photographs to commemorate the occasion. **Dreams** were interpreted by the survivors as a comforting connection to the deceased and were welcomed at this phase.

Another strong theme in this phase is that of **replacing the suicide as the most important memory.** These women discussed that, as a result of their activities to come to a fuller picture of the deceased, they were able to integrate

this picture into their grief and his qualities and strengths in living replaced the suicide as the most prominent memory of him. Anna describes this process after having come together with a group of her brother's friends to reconstruct two sculptures of her brother's:

> It's like maintaining something of his and putting something that's his back together, and the most important thing in his life was art... and to be able to make that nice again is important for us. To have art become the most important memory rather than the suicide as the most important memory.

There remains an issue that all of the women in the study continue to struggle with as a result of their experience with suicide in their life. The issue of developing new trusting relationships with members of the opposite sex was addressed by all the women. Anna describes this as a "belief that things won't last":

> One of the things I find is it's really hard for me to be close to men... I find myself sometimes not really believing in things lasting. That's what it is. And I know where that comes from because I've wanted my relationship with Ned to last. I wanted it to outlive my parents.

With the very nature of suicide seen as someone making a conscious choice to end their involvement in the lives of these women, the issue of trust in developing lasting relationships is central. Connie expresses this in developing any new relationships as "it is really hard for me, yes to trust people." Debbie's experience in her husband's suicide evoked similar issues:

> Like I thought today about ever being married again and wondered if I would ever want to or if I ever could trust somebody. I think that's a really big thing.

The trust becomes an issue of trusting others in relationships and also a continuing issue of self trust. This issue of self-identity within and outside of relationships is a new characteristic still in a developmental stage for these women. Betty expresses this trust-of-self that is experienced as she discusses her evolving relationship with her young daughter:

> You know, she's so loving when she puts her little arms around me at night and she snuggles me in bed. She touches a part that I just didn't know existed. I didn't know I had any kind of goodness in me. Yes, I'd never felt that. Yes, and it makes me realize that, you know, this whole trust thing - I guess I have to reach and nurture this little child inside me, and jeez, it's really hard.

In this sense, the issue of trust is an ongoing struggle for the women involved in the study. This points to the evolving process of their grief after suicide, and reminds the reader that their process of grief is not over. The integrative process is inherently cyclical and developmental and each woman's definition of their integration at any given time will be in constant evolution. The issue of trust is best summed up in Anna's word's:

> I lost some people I loved the most, and I'm not going to give that to anyone else.

Comparison of Interpretations with Literature

In this section, the researcher compares the literature reviewed in the general bereavement and suicide bereavement literature with the interpretations of the research study. May (1986) supports that in the writing of grounded theory: "references from the literature may be used here (within the findings section) to enrich and show outside support for concepts or propositions in the scheme." (p.149).

Emphasis is placed on the suicide bereavement literature for any common hypothesis or validation of the findings. Discrepancies between the literature and the study are also addressed. As is consistent with the grounded theory methodology (Glaser, 1978), other literature that may confirm or add to the emerging theory of the study will be discussed and interwoven throughout.

Bereavement Literature Comparison

Every stage-model of general bereavement that was examined (Bowlby, 1980; Kubler-Ross, 1969; Worden, 1982; Parkes, 1985; Rando, 1988) postulated a final stage of adaptation which was consistently referred to as "resolution." These theories postulate three to six stage processes beginning with the acceptance of the death, and proceeding to a final stage of resolution, often described as withdrawal of energy from the dead to re-invest in the

living (Worden, 1982), acceptance (Kubler-Ross, 1969), reorganization (Bowlby, 1980) and resolving your grief (Rando, 1988). Since Worden's tasks were identified in the original literature review, comparison will be made between his definitions of this stage and the research findings. Rando's definition of her theory will also be addressed as to the similarities it holds with the findings.

Worden (1982) describes his four tasks of mourning as "essential that the grieving person accomplish these tasks before mourning can be completed." (p.10). The discussion of grief as a finite process differs from the findings of this study. Rather, grief is described by the women of this study as a "life-long process" and they have identified the term "resolution" as a word foreign to their experience. Worden's description of his fourth task is to "effect an emotional withdrawal from the deceased person so that this emotional energy can be reinvested in another relationship." (p.15). This notion of "withdrawal" is in contrast to the definition of integration given by the participants, as seen in Anna's words: "to resolve (to me) means that something is terminated...and I think about him every single day, and every day in some way. And so that letting go. I'm not going to let go of the image." Rather than seeing this finite stage as an emotional withdrawal, the women within the study describe it as "maintaining and re-creating the relationship" with the deceased. This shift in focus may

seem like a minor shift in language or nuance, however it calls forth a different expectation of the griever and demands a different interaction from a social and clinical perspective.

Gender specific research in the field of bereavement constitutes a very small area. Stroebe and Stroebe (1983) found that the first six months of bereavement is likely to be a particularly risky time for men and their own mortality, while the second year of bereavement is a more vulnerable time for women. A recent study by Zisook and Lyons (1990), indicate that "women were at higher risk than men for unresolved grief, especially in regard to the loss of mothers" (p.319). They conclude that:

> It is possible that women, tending to be more expressive and oriented to their own feelings, may be more apt to see themselves as having difficulty dealing with loss than are men (p. 319).

This is in contrast to the findings of the present study, as the women expressed experiencing their grief in different terms than resolution focused goals. The interpretations of the present study do not indicate pathology.

The present study finds support in Rando (1988) for this shift in focus from resolution to integration, by definition, while she continues to adhere to the language of "resolution." In her discussion of "what is necessary to resolve your grief" (225-240), she introduces such concepts as "Changing your emotional attachment and investment in your loved one," (p.230) and "the most crucial task in grief

is this change in relationship with the person who died...this means that there are some healthy ways to be connected to your loved one who has died" (p.231). The hypothesis of re-creating relationships with the deceased is supported in such statements. In her continued use of the language of resolution, however, Rando (1988) differs from the findings of this study as she indicates that resolution remains the goal of grief as expressed in the following statement:

> Each story told, each memory relived, each feeling expressed represents a tie to your loved one that you must process by remembering, feeling the emotions generated by it, and then letting it go. If you are dealing appropriately with your grief work, each time you do this you are getting more resolution of your grief (p. 249).

Rando's hypothesis becomes confusing by maintaining the language of resolution while incorporating the concept of integration. Rando (1988) defines resolution as:

> ...a relative term...grief is not usually resolved in the sense of being finished and completely settled forever. Certain aspects of the loss will be with you until you die, and there will be times when you experience brief upsurges of grief again. Rather the term indicates that the processes of grief have been addressed and completed as much as possible at a given point... and the loss has been integrated appropriately into the rest of your life (p.225).

Rando's discussion of the grief process is confirmed by the interpretations of this study, while her continued use of the resolution language confuses the reader as to the ultimate goal of grief. The language is of developmental process within a framework of linear finality.

Suicide Bereavement Literature Comparison

Without exception, the suicide bereavement literature approaches the phenomenon of bereavement based on a resolution model. The most recent comprehensive work in the area of suicide bereavement is that of Barrett (1989) in his book entitled Life After Suicide: The Survivor's Grief Experience. Barrett (1989) defines the grief process as being made up of a dual process of separation and reconstruction. His definitions of these processes are:

> Separation:... Initially, then the function of grief is to help the survivor detach emotionally from the deceased. If detachment does not occur, the survivor will cling both emotionally and psychologically to the deceased.
>
> Recovery:...the specific purpose of the reconstruction process is to redirect the survivor's emotional investment away from the decedent and toward new relationships (p.19).

Barrett does not cite references for his definitions, neither does he indicate how he arrived at such definitions. It is not clear if the findings discussed in his writing are based on clinical observations, research, case studies or literature reviews. Barrett's hypothesis of the process of grief differs from the interpretations of this study's three phase integration model. The widest discrepancy is in Barrett's hypothesis indicating that "only after emotional detachment from the decedent is accomplished can the task of recovery from grief be earnestly pursued" (p.106). Once again the hypotheses of recovery vs. integration, and emotional detachment vs. re-defining the relationship are

the key areas of difference within Barrett's (1989) work and this study.

This study reflects questions raised by Wortman and Silver (1989) in their review of the hypotheses of resolution and recovery as part of the grief experience. Several assumptions are reviewed reflecting beliefs concerning the grieving process. One belief examined is that of recovery and resolution as expected outcome following loss. Wortman and Silver (1989) maintain, based on their literature review, that:

> mistaken assumptions held about the process of coping with loss fail to acknowledge the variability that exists in response to loss, and may lead others to respond to those who have endured loss in ways that are unhelpful (p.349)

They maintain that "prevailing notions of recovery deserve reconsideration" (p.353). In this notion, Wortman and Silver (1989) offer perceived support for the use of an exploratory, grounded theory approach to the area of bereavement.

In a recent review of empirical evidence in the area of suicide bereavement, Van Der Wal (1990) presents a framework of tasks through which she attempts to examine the literature. The framework includes the language of "detachment of the deceased", as well as the language of "integration." Van Der Wal's "concept of integration refers to the end of the grief process" (p.158). In reviewing the

empirical evidence to date, in terms of integration, she concludes that:

> The studies discussed here do not give clear indications regarding the degree of integration...The lack of long-term research automatically results in a lack of information with regard to integration of the loss (p.158).

The appearance of the language of integration in association with suicide grief is new to the area. It is supported by the interpretations of the present study, and this study agrees with Van Der Wal's conclusion relating to the lack of long-term research in this area. The present study adds support to Van Der Wal's comment of her understanding of integration: "It has been said that death only ends a life; it does not end a relationship" (p.158).

It is difficult to make direct comparisons of specific research findings in the area of suicide bereavement, as no other research has approached the area from a non-theoretical basis. The majority of the studies as indicated in the initial review are comparison studies using methods for discovering similarities and frequency of symptoms of suicide survivors as compared to normal bereavement.

This study substantiates the findings of various investigations within the Intense Grief stage. Menninger (1938) supports the feelings of abandonment of the survivor. Buksbazen (1976) and Schuyler (1973) confirm the feelings of guilt and low self worth experienced during this stage. Demi and Miles (1988) support the existence of emotional and

physical distress occurring within this stage. Anger is upheld as a psychological reaction in the survivor by Rudestam (1977), Schuyler (1973), and Shepherd and Barraclough (1976). Related to anger, Wrobleski and McIntosh (1987) report in a qualitative study that "the persons toward whom anger was felt were most typically the deceased or the deceased and others" (p.140). This is also maintained in the current study.

Rynearson (1981) in his findings of the bereavement after suicide causing the survivor to enter an existential dilemma regarding future values, commitments, and relationships is substantiated by this study. This is located within the Emergence Phase, Stage 3 - Implications of Self, in the study.

Research that has concentrated on the prevalence of shame and the experience of the stigma of suicide (Cain, 1972; Shneidman and Farberow, 1970; Ginsburg, 1971; Buksbazen, 1976; Fisher,Barnett & Collins, 1976; Hajal, 1977; Hewett, 1980 and Worden, 1982) is also supported in the study's description of the experience of the stigma of suicide experienced throughout the process.

Due to the paucity of research addressing the experience of grief following suicide after the first year, there is little research that directly agrees or disagrees with the results presented here.

Psychology of Women Literature Comparison

The next body of literature to be introduced and compared is the growing body of literature addressing the specific psychology of women. The majority of this literature has been introduced as a result of a feminist philosophy of research. The feminist theorists began to realize that human development theories were grounded in men's experience, and then applied to women without question of fit. Some of the leading theorist in this area are found in the work of Gilligan (1982), the Stone Centre writings (Kaplan, 1984; Miller, 1988; Miller, 1986; Surrey, 1985; and Belenky, Clinchy, Goldberger & Tarule, 1986). The women's psychology literature was reviewed after completion of the data analysis phase, as the study had become a study of women's grief experience after suicide. It became imperative to review the women's developmental literature seeking to understand common threads that may exist to weave into the emerging theory.

Jean Baker Miller (1986) in the second edition of her book, Toward a New Psychology of Women, describes the overall attempt of her work as:

> to look toward a more accurate understanding of women's psychology as it arises out of women's life experience rather than as it has been perceived by those who do not have that experience (p.49).

Due to the fact that our psychological theories of the day have been developed based largely on men's experience within

our society, we have all tended to measure ourselves by men's standards and experiences. Men's interpretations of the world defines and directs us all by describing to us the so called human nature (Miller, 1982).

Gilligan (1982) found that when women's experience was closely studied, without attempting to force the observations into pre-set categories, there was an inner sense of connection to others emerging as a central organizing feature of women's development. Miller (1986) then hypothesized, based on similar experiences of women, that women's sense of self and worth is grounded in the ability to make and maintain relationships. Miller (1988) continued to postulate that most women find a sense of value if they experience all of their life activity as arising from a context of relationship and as leading on into a greater sense of connection. This opposes a sense of separation, as male based theories have postulated.

In Gilligan's (1982) theory of women's moral development, women progress from a lack of responsibility for self and others, through a stage of selfless responsibility for others, to a stage in which they can care for both themselves and others. Prior to these beginnings of women's psychological development, women were understood largely in terms of what they were missing when measured against a male paradigm. The main premise of the emerging women's developmental theory is, rather than autonomy and/or

separation being posited as the developmental path, "women's core self-structure, or their primary motivational thrust concerns growth within relationship, or what we call the "self-in-relation" (Kaplan, 1984, p.3). In this theory, connection with others is a key component of growth. The growth of the differentiated self is seen within the growth of one's relational capacities and relational networks. (Kaplan, 1984)

Recently, Conarton and Silverman (1988) have contributed to this growing body of literature in an attempt to describe a theory of Feminine Development Through the Life Cycle. Their theory postulates an eight phase developmental model consisting of:

Phase 1: Bonding
Phase 2: Orientation toward others
Phase 3: Cultural adaptation
Phase 4: Awakening and separation
Phase 5: The development of the feminine
Phase 6: Empowerment
Phase 7: Spiritual development
Phase 8: Integration

This model is based largely on the work of Gilligan (1982) and the Stone Centre authors previously quoted, and is another step forward in the attempts of creating a comprehensive framework to begin to understand women's experience.

The theories of women's psychology as presented by these researchers are supported by the themes emerging from the study of women's experience of grief after suicide. The concept of women's development taking place within a

relational context fits the experience of the women in the study. These women experienced a sense of self development within relationships and upon the suicide death of one such relationship, they discuss their experience of "loss of self." Miller (1982) describes this "loss of self" in her statement:

> One central feature is that women stay with, build on, and develop in a context of connections with others. Indeed, women's sense of self becomes very much organized around being able to make and then to maintain affiliations and relationships. Eventually, for many women the threat of disruption of connections is perceived not as just a loss of a relationship but as something closer to a total loss of self(p.83).

The notion of self-in-relation makes a shift in emphasis from separation to relationship as the basis for self experience and development for women, and this is corroborated in the study. Miller (1982) describes personal creativity of one's self for women as:

> a continuous process of bringing forth a changing vision of oneself, and of oneself in relation to the world. Out of this creation each person determines her/his next step and is motivated to take the next step. This vision must undergo repeated change and re-creation (p.111).

The women's experience of grief as a continuous process and one of change and re-creation of the relationship and subsequently of their sense of self, fits and adds confirmation to this emerging women's developmental theory. If women's experiences in our society is one of connection and growth within relationships, then it follows, that in the case of a loss of a relationship through a suicidal

death, there is a sense of loss of self, and a strong need to re-define the relationship with the deceased, rather than separating all energy from that relationship.

Surrey (1985) does not address this theory from a perspective of women's experience of death, however she states:

> I find that it makes a big difference to women if we can see the goal of change as that of changing relationships - and the images of ourselves in relationships - rather than becoming "alone" or "independent" (p.14).

She is validated by the interpretations of this study. The experience of the women in the study echoes this comment in their descriptions of changing their relationships with the deceased rather than ending them and subsequently isolating themselves. It is the common thread or theme of maintaining connectedness and relationship that the suicide survivors experienced in their relationship with the deceased.

The interpretations of the study also affirm a recent phenomenological study of women's inner strength, Rose (1990). Rose describes her interpretations in the form of nine emerging themes as part of the women's experience of inner strength. Her findings are described as:

> Inner strength was revealed by the participants of this study to have many interwoven and interconnected aspect. As such, it is a dynamic and complex phenomenon that transcends the sum of its parts. Existing within the meaning and essence of this phenomenon is a paradoxical coalescence of vulnerability with safety, tenacity with flexibility, resolution with ambiguity, movement with stillness, and emotion with logic. (p.61).

Rose discusses her creation of language to speak to the experience of the women in her study as the present day language did not encompass the meaning of the experience. She outlines the nine themes of women's inner strength as:

Quintessencing
Centering
Quiescencing
Apprehending intrication
Introspecting
Using Humor
Interrelating
Having Capacity
Embracing vulnerability

Many of the characteristics outlined within these themes are upheld with the conceptualization emerging from this study. The participants descriptions of "recognizing, becoming, accepting and being their real selves" (p.62), is echoed in the voices of the women of the present study.

CHAPTER FIVE

RESEARCHER'S PROCESS AND IMPLICATIONS

Introduction

The initial purpose of this chapter, is to review the conceptual model describing women's experience of grief after suicide. Next, a summary overview of the researcher's process will be provided. The necessity of the reflection on the research process as part of a qualitative study is described by McHutchion (1987):

> I believe in the power of the story, particularly when the story is heard and experienced with the informant on site. As it happens, I could not help becoming involved, even embroiled in the informant's process (p.313).

Wax (1952) concurs with the process of the researcher being part of the experience and therefore a necessary part of study. The chapter will continue to address limitations and implications for further research and to discuss application of the interpretations from a clinical social work perspective.

Women's Experience of Grief After Suicide

This grounded theory study presented the interpretations in the form of a conceptual model, outlining the process of grief for women after a suicide. The model consists of three phases: I. Grief Suppression , II. Grief Emergence and III. Grief Integration. The phase of Grief Emergence is composed of four stages: 1. Meaning Making,

2. Intense Grief, 3. Implications of Self and 4. Action in Relation. The basic social process is identified as Grief Integration. The emphasis is on connection and re-connection which requires a change in action, not an emotional withdrawal from the relationship.

Researcher's Process

> We are endeavouring to knock out of us all the pre-conceived ideas, emptying ourselves of everything except that nature is here in all its greatness, and we are here to gather it and understand it if only we will be clean enough, and humble enough to go to it willing to be taught and to receive it not as we think it should be, but as it is, and then to put down vigorously and truthfully that which we culled.

F.H. Varley gave us these words in 1914 as he described the Group of Seven and the task they had taken on as like minded artists in the early 1900s in Ontario, Canada. This task was to paint the nature that they were surrounded with in this new land, in a clean and pure way, putting aside their British taught "techniques." This challenge was met and the interpretations of such is captured forever in a permanent display at the McMichael Gallery in Ontario. The researcher suggests that it is the same process of "knocking out all the pre-conceived ideas," and emptying ourselves of everything that is occurring as a researcher enters into the qualitative research process, except the phenomenon under question. Further, the researcher suggests that it is essential to this process to: "be humble enough to go to it

willing to be taught and to receive it not as we think it should be, but as it is."

Reinharz (1981) provides a discussion of the impact of the qualitative research process on the researcher:

> each project (or cycle) is an integration of the researcher as person, investigating a particular research question (or problem), and using a certain method. Each element needs to be reviewed before the cycle begins again, to see if there has been change and growth. The researcher who has not learned something of personal value about him/herself, has not contributed to a fuller understanding of a definable issue, and has not refined further his/her current thinking on method, has not benefited completely from the cycle she/he has undergone (p.431).

The researcher's process of change and growth is seen as an important component of qualitative research. This "very personal and individual process" (Marshall, 1981, p.395) is therefore included as a part of the writing up phase.

The research premise in the study began from questions based on the researcher's clinical experience and perceived gap in the literature on this topic. The question related to "the process" of the "grief experience," and therefore the methodology of grounded theory fit the question. The question then remained broad enough and with enough flexibility to fully develop, based on sample availability and the experience that the collection and analysis brought to it. The flexible nature of the specified sample population was in keeping with Glaser's (1978) discussion of the concept of theoretical sensitivity in grounded theory methodology.

The purpose for the question was always maintained with the underlying question of "What can be learned about the long term experience of grief after suicide? How can the information gained assist clinicians in helping others in this life circumstance?"

The initial literature review served to provide the researcher with the scope, range, intent and type of the questioning that had been previously addressed in this area. (Chenitz, 1986). The effect was one of placing the research study into context. Chenitz's (1986) advice on approaching the literature as data, with a cautious and sceptical attitude, allowed the author to enter the data collection with a defined attitude toward discovery. Ongoing reviews and the final reviews of the literature served to assure that no data were overlooked and continued to place the emerging theory in context within the area under study.

The combined process of data collection and analysis which occurred was experienced as a circular process that did indeed build on itself. It was a constant struggle in the initial stages for the researcher to "trust the process" and allow the theory to emerge. The possibility of finding a common process inherent within the varied experiences seemed impossible. Marshall (1981) discusses her experience at this phase of the research as:

> So at this point there is an excitement that something is coming out of the data, but if anyone asks me I have no idea what, and will avoid being forced into saying! And at the same time there's

> a kind of fear that nothing is going to come out of the research and that I'm going to be left with a pile of tapes and nothing to say at the end (p.396).

Marshall concludes that these feelings of uncertainty are part of taking the risk of using a more open method; she encourages the researcher to "learn to live with these feelings, find them exciting rather than a problem" (p.396). The writer attempted to accept this advice at this phase.

With the support of a qualitative learning group, and a trusted mentor, this became a reality. Learning to live with these feelings led to the emergence of a core category and basic social process, which truly emerged from within the relational data collected. The importance of a supportive research support team is discussed by Reinharz (1981):

> the impact of a supportive, non-hierarchical research team on the ability of researchers to withstand public criticism and to tolerate the ambiguity of the concepts with which they dealt. Support counteracts the insidious obstacles of self-doubt, lack of faith, and the inability to persevere in the face of outside attack or lack of support (p.425-426).

The researcher's trust in the process of the methodology was further solidified by unsolicited comments made by the participants at the close of interviews indicating that they had felt genuinely "heard" and that the process of relating their experience had been helpful in their continued validation of their experience to themselves.

The experience of saturation of the core categories was at first perceived as disappointment in the sense that "this interview provided no new information", which was soon followed with the realization that this was the experience of saturation and thus time to stay with the data at an even more intense level.

As the emerging theory was brought to light, the researcher was continually drawn back to the methodology literature for validation of fit, work and relevance. Data were retraced through the ever changing model to ensure that the conceptual codes fit the data. The researcher was supported by Marshall (1981) at this phase, by her description of diagram development:

> I continually build up diagrams and arrows and spaces and schemes which for me are very much part of the conceptual development. I find that some survive the analysis, but others break down in time, perhaps they don't work out because there is some sort of tension in the data that I wasn't aware of. So diagrams that don't work help me understand and are almost as valuable as diagrams that do work (p.397).

The complete transcriptions were read and re-read to ensure that the theory worked. The test of relevance was realized precisely as described by Hutchinson (1986) as she describes:

> A quality theory must possess **relevance** related to the core variable and its ability to explain the ongoing social processes in the action scene. If the actors in the setting immediately recognize the researcher's constructs (**"Wow, that's it!"**), he can be confident that his theory possesses relevance. Relevance is dependent upon the researcher's theoretical sensitivity in enabling

> the BSP to emerge from the data without imposing his or her own preconceived notions or ideas (p.127).

Upon request by the participants, the researcher met with them as a group of co-researchers to discuss the interpretations. They truly fulfilled their role of co-researchers in their subsequent discussion and reworking of the model. Overall the expressed sentiment by the participants was one of **"Wow, this fits, this is it!"** The journey of reflection and self questioning within the analysis process had come full circle. The theory as it was conceptualized within the model "fit" their experience, and their experience "fit" within the theoretical model. The goal of illuminating the pattern or process of their experience had been achieved. With this validation of the credibility of the theoretical interpretation, came an overwhelming sense of trust and belief in the analysis methodology which had been employed. It had worked!

> But then there's the bit toward the very end when there's a kind of feeling that I **know** what it's all about and the structure of the data. It's a feeling of relief that I know that the data is worthwhile, that I've got something meaningful, and that I can write it, I can put it together (Marshall, 1981, p.398).

The researcher experienced the "writing up" phase as that of a facilitator or translator in which the interpretations wrote themselves. The experience was consistent with Marshall's (1981) description of: "this feeling at the end, this feeling of **knowing**, and it's very important to catch

this and write it down...writing it from me as the ultimate translator" (p.399).

The interpretations chapter was returned to the participants for further input and confirmation. The experience of confirmation and validation of the interpretations created a tremendous sense of intimacy between the participants and the researcher. The participants not only confirmed the findings, but continued to describe the impact of finally having their experience validated in print. Each related stories of personal strength that had been experienced as a result of reading the interpretations. It had truly been a joint research effort and both researcher and participants felt a sense of accomplishment.

Research Limitations and Implications

The interpretations, as presented, provide a starting point to the understanding of women's experience of grief after suicide. They have been presented in keeping with Bogdan and Biklen's (1982) comments:

> Writing up a qualitative study is really like doing a translation. You take what you have heard and seen and put it down on paper so that it makes sense to your readers as it made sense to you....you not only explain what you have seen or heard, but you must also convince the reader of the accuracy of your views (Bogdan & Biklen, 1982, p.176).

Part of the task of convincing the reader of the accuracy of the interpretations presented is to discuss the limitations

and implications for further research called forth as a result of the translation of the data.

The question of generalizability of research is often addressed in terms of limitations. Qualitative research does not think about generalizability in conventional terms as is indicated by Bogdan and Biklen (1982):

> Qualitative researchers are more interested in deriving universal statements of general social processes rather than statements of commonality between similar settings... The assumption is that human behaviour is not random or idiosyncratic. They therefore concern themselves not with the question of whether their findings are generalizable, but rather with the question of to which other settings and subjects they are generalizable (p.41).

The discussion of other settings and subjects that the interpretations may be experimented on clinically are included in the application discussion.

The sample size and characteristics imposed some limitations on the study. While there could be benefits in obtaining a larger sample, the process of saturation was achieved within the sample, and thus was sufficient to develop a conceptual model, which provides a starting point toward the understanding of grief after suicide.

Men's experience was not addressed due to sample restrictions; this turn of events however, allowed for a rich, dense analysis of women's experience, and thus speaks to the need for further research to explore men's experience.

The purpose of qualitative research is to elicit meaning: "generalizability is not the purpose of qualitative research but the purpose is rather to elicit meaning in a given situation and to develop reality-based theory" (Field & Morse, 1985, p.122). The purpose of qualitative research is important to the discussion of limitations.

There are a number of suggestions for extending the interpretations of the study to similar and varying groups. This study could be extended further by providing the interpretations to other women meeting the same criteria of bereavement. Their feedback and discussion would help elaborate, challenge or confirm the interpretations as they stand.

Another avenue of exploration would be to provide the same opportunity to clinicians with experience in working with this population, with a view of seeking their clinical impressions and discussion. These further explorations would contribute to refinement of the emergent theory.

This study could be extended also by the implementation of a grounded theory study which examined the experience of men's grief after suicide, fitting the similar criteria and methodology of the present study. Secondly, the interpretations of this study could be presented to men fitting the criteria, for their feedback and discussion as to fit and further refinement of the themes presented.

The goal of defining the study as "women's experience," is not to exclude men, but rather to report the gender bias of the research, based on the available sample. It is imperative that further research look specifically at both men's experience in isolation, and in comparison with women's experience, to come to a fuller understanding of the human experience of grief. Gender specific research will further answer the question of gender and its implications which may exist within our experience, based on our societal beliefs. One existing belief as expressed by Frantz (1984), is that of men's experience of grief as an inability to grieve:

> People who are unable to grieve, **particularly men** (emphasis added), often enter a seasonless world. They protect themselves from the pain of losing their child and in the process, cut off the joy of living...They're mildly depressed, they function, and live a fairly normal life, but something is missing, the ability to express of communicate deep feeling seems to be gone. (p.17).

There is a paucity of research addressing gender-related grief after suicide and non-suicide deaths. There are no attempts within this study to interpret any qualitative differences or similarities of men's experience of grief after suicide. Further research is required before any comparison can be drawn.

The researcher introduced the interpretations to two men in the process of proof reading the many drafts of this study. Both men made unsolicited comments to the researcher as to the fit of the model in their experience of non-

suicide related grief. No interpretations can be drawn from such comments; however it does speak toward the need for further qualitative research examining men's experience of grief.

This study also raises the question of the difference between suicide-related grief and non-suicide grief. This outlined experience of grief may be similar for women as a result of non suicide deaths in the family. This issue was not explored in this study, but such a comparison would be helpful in further clarifying the specific experience of suicide-related grief.

Application of Interpretations

Glaser and Strauss (1967) describe the application of grounded theory as "the theory's further test and validation" (p.244). The theory continues to evolve through a process of experimental application, and thus a continual re-definition of the theory. Glaser and Strauss discuss the "joint responsibility" of the reader with the researcher in determining if such interpretations are applicable in various settings. In the realm of clinical practice, this speaks to the joint responsibility of the reader and researcher in experimenting with the emergent theory, in various clinical settings, for the purpose of exploring its application, scope and usefulness.

The primary implication for practice, based on the interpretations of this study is the shift in focus from resolution to integration. The process of connection and re-connection leading toward integration, calls forth a different expectation of the griever and demands a different interaction from a social and clinical perspective. The basic social process of grief integration as characterized in this study allows the clinician to approach the bereaved woman with an altered expected outcome of grief. The language and expectations of grief as it exists today is challenged from this shift in focus from "resolution" to "integration."

In clinical application, rather than by encouraging and supporting activities of resolution, the clinician is encouraged to establish in counselling the context of incorporation and re-connection of the deceased within the living experience of that client. Another global application is toward establishing the context of "grief finding a place to be" with the client as an evolving part of their lives, rather than prescribing the "letting go" or "resolution" of a finite sense of grief.

Based on the themes presented within this study, the following suggestions have been compiled, to begin to examine the experimental application of the emergent theory in clinical practice. These suggestions are directed at the

clinician involved in a counselling relationship with a woman bereaved by suicide of a family member.

Phase I - Grief Suppression

At this phase it is suggested that the clinician take into consideration the possible purpose that the behaviours of caretaking, replacement and/or running/escaping may be serving within the life situation of the survivor. The assessment should check for the possibility of denial of the death, however is not to assume that the existence alone of any of the three behaviors mentioned above indicate denial. The **critical condition** of **safety** to grieve should be assessed with the client at this phase. If this critical condition is not met, the encouragement of grief emergence may prove harmful to the client. The clinician is able to assist the survivor to meet the safety concerns prior to pursuing the issues in the emergence phase.

This phase is not identified as pathological, but rather as part of the experience, and requires careful assessment re: the safety concern.

Phase II - Grief Emergence

Stage 1 - Meaning Making

It is suggested that if the client is assessed at this stage of the process, the clinician should be aware of the active **outward - suicide focus** of this stage. The survivor

is involved in active searches and is unable to consider the implication of the suicide to herself until she has exhausted her clues for information. The survivor may require the clinician to act as advocate in locating information during this stage.

Stage 2 - Intense Grief

The clinician's awareness of this stage as a time of high risk for suicide is necessary. The clinician must be honest in interactions with the survivor and discuss the risk of suicide openly. The **focus has shifted inward** although still primarily concentrating on the act of suicide itself. The participants in the study describe this time as being **unpredictable** and define the need of having a safe place to vent their sadness. The clinician may be instrumental in creating an atmosphere of safety, by scheduling appointments with flexibility, allowing time to attend to or be with the survivor until the wave of intense grief has subsided.

Stage 3 - Implications of Self

The **focus remains inward and has shifted to more of a context of self** at this stage. This internal developmental process may require the clinician to assist in the woman creating some quiet places in her life to allow this development. Journal writing may be encouraged to assist

the woman in this private developmental process. Appointments may be lengthened and spaced further apart, or left to the woman's request. This is not a time to abandon the client, as the sense of abandonment as a result of the suicide is real and the relationship with the clinician may be the only one where she is able to express her inner questions of self. The clinician's questioning at this time, directed to the client, regarding qualities of herself that came to be as a result of her relationship with the deceased, gives permission for those qualities to be ongoing in her life. Questions from the clinician regarding saying good-bye to the deceased as living, and reconnecting with him at this time are useful in giving permission for the continued relationship with the deceased. The clinician does not want to encourage "letting go" of the deceased, but rather encourage the woman to find her own meaningful way to re-connect. White (1989) discusses this re-connection from a family therapy perspective using the language of: "Saying Hullo Again: The incorporation of the lost relationship in the resolution of grief." (p.29). The suggestions given by the author would be to give permission for re-connection as a way of moving toward integration of the grief.

Stage 4 - Action in Relation

As the **focus begins to move outward, with a sense of self-in-relation**, the clinician can become instrumental in

assisting in the completion of the picture of the deceased, by way of supporting the woman's ideas and reaching-out efforts to this end. A new energy is found for developing relationships with an authenticity not formerly experienced. The clinician may provide a solid base for the woman as she experiments with her choices in living-relationships. This may be supported by the therapist in the establishment of a suicide survivors support group, as a forum to validate their experience and find others seeking authenticity.

The use of rituals can also be incorporated into counselling at this stage, while assisting the woman to make explicit her sense of renewed connection with the deceased. The rituals need be created and directed by the survivor, with the clinician acting in the role of supporter, facilitator or possibly as companion as the first steps of the ritual unfold.

Phase III - Grief Integration

The survivor may describe the grief as residing with her upon reaching this phase. The clinician's role continues to be one of giving permission for grief as a life-long evolving process. The woman may require the clinician's assistance in looking at new career choices, or "getting-a-life" as one participant put it. The issue of trust-in-relationships with men may continue to be an issue at this phase, and may need further personal exploration.

If the clinician is still involved with the survivor during this phase, it will become apparent that the woman continues to require a forum in which to discuss the deceased. It is stressed however that the quality of that relationship will be different.

The model itself may be experimented with in the clinical setting. The model may be presented to the survivor, at time of initial contact with the clinician, and used as a counselling tool to elicit feedback and discussion regarding the survivor's own experience of grief. The model provides, in this example, a working draft from which the survivor is encouraged to validate her own experience and to continue in the refinement of the model toward a theoretical understanding of the experience. In this way, it provides a framework for the clinician and client to enter into discussion and to decide on direction for the therapeutic relationship. If such experimentation occurs with the use of the model, the uniqueness of each woman's grief experience must be stressed and respected. The model is only useful to the extent that it is recognized as a part of the lived experience of the individual survivor. It is not to be implemented as the normative truth, but rather as a continually evolving, working theoretical model. Each survivor's experience and discussion of such, therefore, adds to the continual refinement of this emergent theory.

Victoria Alexander (1987), recounts her experience of "living through my mother's suicide," and describes her changing sense of self as:

> I am not the same person I was before my mother's death, not only because of her loss, but because suicide has become part of the vocabulary of my experience. It has a permanent place at the core of my life, and I am both more vulnerable and stronger for it. (p.117).

The conceptual model of Grief Integration presented here speaks to the process that is experienced in reaching that place within the woman's self where grief "has a permanent place at the core of her life."

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APPENDIX A

Sept. 7, 1989

Trish Cameron
Executive Director
Canadian Mental Health Association
201 - 723, 14 St. N.W.
Calgary, Alta.

Dear Ms. Cameron:

This letter is to request the assistance of the Canadian Mental Health Association, Calgary office, in a research study in the area of Suicide Bereavement. This research study is in partial fulfilment of the requirements for the degree of Master of Social Work. This thesis research is being supervised by Dr. Peggy Rodway, Faculty of Social Work, University of Calgary.

I am requesting the assistance of the C.M.H.A. operated Suicide Bereavement Program with respect to accessing the research participants from this program's client files.

This study is exploratory and qualitative in nature, utilizing the grounded theory methodology to identify, describe and provide a theoretical analysis of the bereavement process of families bereaved by suicide, a minimum of two years after the suicide. The impetus for this study emanates from this writers own clinical experience in the Suicide Bereavement Program. During this counselling experience a number of questions continued to be raised regarding the bereavement process after the first year, for family survivors of a suicide.

The research literature to date in this area consists primarily of clinical case studies, and has only recently begun to examine this phenomenon from a research basis. The research which does exist in this area has largely concentrated on the immediate bereavement process; from six weeks to one year after the suicide. While this research and clinical documentation has contributed to the professional knowledge base on grief after suicide and subsequent immediate treatment needs; there remains a paucity of research addressing a.) the long term adjustments to the suicide, and b.) the impact on the family system after a suicide. This research study will attempt to explore this phenomenon for the purpose of theory development.

REQUEST FOR ASSISTANCE:

For the purpose of this proposed research study, the request of C.M.H.A. would involve:

Suicide Bereavement Co-ordinator to:

1.) contact eight to ten past client families who fit the criteria of having had a family member commit suicide at least two years prior.
2.) inform the families of the research study and request their participation, ensuring full confidentiality.
3.) only names and phone numbers of consenting participants will be forwarded to this researcher. No file information will be necessary.
4.) the suicide bereavement program to agree to provide follow-up support counselling to families if requested by the families or if such a referral is deemed necessary by this researcher as a result of the research contact.

Researcher responsibilities:

1.) develop a participant consent form, outlining the research purpose and methodology, and ensuring full confidentiality to the participant families, the thesis will contain no personal identifiers.
2.) to meet with the participant families for an intensive qualitative interview (interview guide to be developed and available to C.M.H.A. prior to the study).
3.) to refer participants for follow-up support counselling to the Suicide Bereavement Program if the research interview has generated any unresolved issues for all or any family members.
4.) to provide participants and C.M.H.A. a written copy of the study findings upon completion of the research project.
5.) to acknowledge C.M.H.A.'s support in the written documentation of the research study.

This research study proposes to continue to develop knowledge in the area of suicide bereavement for the ultimate purpose of assisting in the ongoing development of comprehensive clinical programming for families bereaved by suicide. The American Association of Suicidology, addressed the need for continuing research in this area at the 1989 annual conference, in their statement that " extensive study is needed...to address: the

process and outcome of bereavement beyond the first year, and the impact on the family system." (Newslink, Vol.14, No.2. 1989). This proposed study will attempt to begin to address these questions regarding the process and experience of the family system, beyond the first year of the suicide; providing information essential in understanding and developing clinical resources to address the needs of the survivors of suicide.

Thank-you in advance for your agencies time necessary to consider this proposal. I have discussed this proposal with Marcia Rich, Direct Services Co-ordinator, C.M.H.A. prior to the writing of this formal request, and a copy of this letter will be sent to her. If you have any further questions regarding this study, please do not hesitate to contact myself directly or through Ms. Rich, whichever is most convenient for yourself. The full research proposal will be completed by September 30, 1989, for the University of Calgary Ethics committee approval at that time. I would appreciate your response prior to this date if possible to address any queries you may have and to include your response with the completed proposal at that time.

I look forward to working in conjunction with C.M.H.A. again, in endeavouring to continue to address the needs of the survivors of suicide and the continued betterment of service delivery to this population.

Thank-you for your consideration in this matter.

Yours sincerely,

Lois Sapsford B.S.W.
M.S.W. Candidate
University of Calgary

APPENDIX B

Our File: 1989/90-7-5

canadian mental health association
ALBERTA SOUTH CENTRAL REGION, 1988
201, 723 - 14 STREET, N.W.
CALGARY, ALBERTA
T2N 2A4
telephone (403) 283-7591
fax (403) 270-3066

September 13, 1989

Lois Sapsford, MSW Candidate,
2422 - 4th Avenue, N.W.,
Calgary, Alberta,
T2N 0P2

Dear Lois:

RE: RESEARCH STUDY IN THE AREA OF SUICIDE BEREAVEMENT

Thank you for your letter of September 7, 1989 requesting permission to conduct research on the above topic.

The Canadian Mental Health Association, Alberta South Central Region hereby provides approval for your request conditional on the following:

1) All criteria will be met as outlined on page two of your letter (copy attached).

2) You will provide us a copy of your finalized consent form for approval.

3) Your full research proposal has been approved by the Ethics Committee of the University of Calgary.

As you know the topic you have chosen is of interest to the organization and we appreciate the opportunity to assist you in your efforts. Best of luck in your undertaking. I look forward to your final report.

Yours truly,

CANADIAN MENTAL HEALTH ASSOCIATION
ALBERTA SOUTH CENTRAL REGION

Patricia (Trish) Cameron
Regional Director

PC/bb

APPENDIX C

STATEMENT OF INFORMED CONSENT

I give my consent to participate in a study exploring the long term bereavement process experienced by me and my family as a result of a family member having committed suicide. I understand that this study is to be undertaken by Lois Sapsford as partial fulfilment of the M.S.W. degree requirements at the University of Calgary.

I understand that by consenting to participate in this study, I will participate in a minimum of one family interview to discuss our experience, and in addition I may be requested to participate in one to two further interviews with the researcher individually or as a family for the purpose of confirming, modifying or adding to the researcher's understanding of this subject.

I understand that the interviews will be conducted by the researcher, and will be one and a half to two hours in length. The interviews will be arranged at a mutually agreed upon time and location as to assure confidentiality.

I understand that for the purpose of studying the information, all interviews will be audio-taped. I also understand that the audio-tapes will be transcribed by a Faculty of Social Work support staff member at the U. of C. The support staff member's adherence to ethical and confidentiality standards will have been addressed by the researcher. The researcher will ensure my confidentiality by ensuring no identifying marks are on the tapes, and that the tapes and master code list will be kept under lock and key, with access only to the researcher after transcription. I understand that the tapes will be erased upon completion of the research study.

I understand that I am free to withdraw from the study at any time.

I understand that I may initiate contact with the researcher by contacting the Suicide Bereavement Program, Canadian Mental Health, 283-7591. They will notify the researcher of my contact and she will return my call to me.

With respect to the thesis itself, I understand that the identity of all respondents will be protected. When quotes are to be used in the thesis, the researcher will ensure anonymity of myself and my family.

I have been informed of the possible counselling implications involved for myself and my family as a result of participating

in this study. I have been informed by the researcher, that the C.M.H.A. Suicide Bereavement counselling program will be made available to myself or any family member to deal with issues that may have arisen as a result of the discussion of our experience relating to the suicide. The researcher will make arrangements for alternate counselling services as required.

I have read and understand the nature of the research study and have had any questions answered to my satisfaction. I also understand that participating in it is voluntary and my own decision. I hereby agree to participate according to the conditions described.

_____ _____ _____

Participant's signature Date Phone Number

_____

_____

If you are under 18 years old, parental or guardian consent is also needed:

_____ has my consent to participate

Participant' name in the research project as described above.

_____ _____

Parent/Guardian signature Date

_____

_____

I would _____, would not _____, be interested in receiving a summary of the research findings upon completion of the research study.

Address: _____

_____

_____

_____

APPENDIX D

INTERVIEW GUIDE

A. BACKGROUND

1. Family Genogram
2. Who suicided?/ Date?
3. Method of suicide

B. DOMAIN OF SELF

1. Could you describe your relationship with the deceased and further describe your feelings about the loss?
2. Could you describe your process of grief - that which you have experienced to this time?
3. What emotions, feelings or ideas have been part of your grief and what is your experience of these to day?
4. Have your perceptions of yourself changed as a result of the suicide?
5. Could you describe any changes in your behaviour over the time since the suicide?
6. Could you discuss your physical health since the suicide?

C. FAMILIAL DOMAIN

1. Could you describe the impact and effects of the suicide on the family relationships?
2. How has grief been experienced as a family?
3. What would you consider the major issues involved for your family as you experienced this bereavement?
4. Could you describe the grief process as it occurred for the siblings, parents, spouses, and parent-siblings relationships?

5. What if anything had the biggest impact on how your family would grieve?

6. What has been your families experience with your respective families of origin as a result of the suicide? How has this changed?

7. Are you able to look ahead to the future as well as looking back?

8. Does the family continue to experience bereavement today, if so describe and discuss how this has changed?

9. Has this experience changed you or your family in any way. Could you describe these changes? Positive and/or negative changes?

10. Has experiencing a suicide changed your life view, or any family members?

11. Have any family members accomplished anything that you previously felt them incapable of?

D. SOCIAL DOMAIN

1. How have others outside of your family responded to your situation ?

2. Have your friendships been at all affected by the suicide... immediately following the suicide... as related to now?

3. Would you discuss your experience of others' responses to you and your family after the suicide and any changes up to now?

4. Have you attempted to access others for support? When...How?

5. How would you have wanted others' responses to be different?

6. Based on your grief experience, would you say that resolution has been part of your experience; if so what has been resolved? If not how would you describe the present situation for yourself and/or your family, and the process in reaching this place?

APPENDIX E

TO WHOM IT MAY CONCERN

I certify that the proposed thesis research by Lois Sapford, "The process of grief in the suicide bereaved family" has met the requirements for the conduct of ethics of research with human subjects, established by the University of Calgary.

C.R. Bagley

Oct 16, 1989

C.R. Bagley

Date:

Chair, Faculty of Social Work,
Ethics Committee

APPENDIX F

THE UNIVERSITY OF CALGARY

Certification Of Institutional Ethics Review

This is to certify that the Committee on the Ethics of Human Studies at The University of Calgary has examined and approved the research proposal:

Applicant: LOIS SAPSFORD, B.S.W.

Department: SOCIAL WORK - GRADUATE STUDIES (M.S.W)

Project Title: "THE PROCESS OF GRIEF IN THE SUICIDE BEREAVED FAMILY"

Sponsor (if applicable): _____

(the above information to be completed by the applicant)

H A C Ishiwan
Chair, Committee on the Ethics of Human Studies

16 Nov 89
Date

COPIES: 1. Sponsor 2. Chair Ethics Committee 3. Research Services 4. Applicant