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EMPIRICAL STUDIES

Qualitative inquiry into the experience of suicide loss, aftereffects and coping strategies of suicide-bereaved Greek-speaking parents in Cyprus

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ABSTRACT

Purpose: Studies on suicide-bereaved parents are scarce in South European and Eastern Mediterranean countries. We explored the experiences of Greek-speaking suicide-bereaved parents in Cyprus, with emphasis on the interpretations of their child's suicide, its aftereffects and their coping strategies.

Methods: A qualitative methodology based on inductive content analysis of the interviews of ten mothers and two fathers was applied.

Results: The participants described their efforts to make sense of the senseless, reporting numerous interpretations of their child's suicide. Some participants had achieved to move on by trying to keep the remaining family together. Others felt detached from their social network. The different coping strategies and support systems described, reflected participants' efforts to escape from obsessive, enduring and deeply traumatizing thoughts about their child's suicide. The analysis mirrored participants' ultimate desire to find existential relief and serenity through the management of distressing reminders of their child's suicide, and alleviate the burden of their own negative self-judgement and the criticism of others. They sought physical and emotional comfort in the inner realm of their psyche, through spiritual and psychological coping processes.

Conclusion: Further exploration is suggested about intervention planning aiming to strengthen effective coping strategies and external supportive resources in mourning parents.

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KEYWORDS
Loss and grief; child and adolescents; coping; qualitative; suicide

Introduction

Suicide-bereaved parents are among those with the highest risk of experiencing physical and mental health problems (Bolton et al., 2013; Erlangsen et al., 2017; Pitman et al., 2014, 2018; Spiwak et al., 2020). Although the death of a child by suicide has been linked with an increased risk of experiencing prolonged or complicated grief by bereaved parents (Kersting et al., 2011), there is substantial lack of qualitative data on their experiences (Ross et al., 2018). Prolonged grief is described as a continuous yearning for the deceased or obsession with the deceased that is accompanied by excruciating emotional suffering (World Health Organization, 2016). Complicated grief is deemed as a particularly severe type of grieving that lasts longer than usual, transcends cultural and societal conventions and seriously impairs the daily functioning of the bereaved (Zisook & Reynolds, 2017).

Previous studies in suicide-bereaved parents have described the death of a child as a highly traumatizing experience, followed by depressive and post-traumatic stress symptoms such as sleep disorders (nightmares, insomnia), cognitive problems, numbness, self-harm and suicidal behaviour (Li et al., 2019; Morris et al., 2019; Sugrue et al., 2014; Zisook & Reynolds, 2017). Severe suffering and sorrow, intense pain, anger, fear, and deaths by suicide have been also reported in this population (Entilli et al., 2021; Li et al., 2019; Morris et al., 2019; Ross et al., 2018; Shields et al., 2019). Feeling responsible for the child's suicide, self-criticism, and guilt along with social stigmatization and social isolation have been revealed as core experiences in suicide-bereaved parents (Kawashima & Kawano, 2017; Maple et al., 2010; Shields et al., 2019; Wainwright et al., 2020). Furthermore, complicated grief has been described as mainly associated with the survivors' interpretation of their loved ones' intention to end their life (Jordan, 2020). Other data on suicide-bereaved parents underline the occurrence of existential and spiritual implications such as loss of faith and belief, transformation of world view and changing priorities setting (Entilli et al., 2021; Ross et al., 2018; Sugrue et al., 2014).

Differences in suicide-bereaved parents compared to other bereaved parent groups have been shown. Specifically, suicide-bereaved parents are more likely to manifest mental health problems than grieving parents who lost their child to a car accident (Bolton et al., 2013), and suicide-bereaved mothers are at greater risk for psychological, physical and mental

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ramifications than mothers who lost their child to other causes (Pitman et al., 2014). Previous data also highlight cultural differences in bereavement patterns and coping among groups of bereaved parents (Jordan & McIntosh, 2011). Pitman et al., (2018) have shown cultural variations regarding the interpretation of stigma following sudden death. Blame and concealment of death seem to be more evident in Eastern and Southern European cultures compared to the British (Pitman et al., 2018). Since stigma and self-blame have been associated with a complicated grieving process, studies from Mediterranean countries focused on suicide-bereaved parents' coping will hopefully add to the existing literature (Jordan, 2020). Overall, as previous qualitative and quantitative studies on suicide-bereaved parents and their grieving process have mainly been conducted in Northern and Central European countries, the USA, and Asia, Mediterranean and Southern European populations represent an understudied group on this topic (Coulter & Mooney, 2018; Harwood et al., 2002; Houck, 2007; McMenamy et al., 2008; Wojtkowiak et al., 2012).

Nonetheless, data has shown that suicide-bereaved parents gradually develop strategies to cope with their unexpected and shocking loss. At the same time, exploratory research applied to qualitative studies examining the experiences of suicide-bereaved parents revealed a serious gap in the suicide-related literature. Specifically, only 16 qualitative studies were identified between 2006 and 2022 addressing suicide-bereaved family members, which included mixed samples of spouses, parent, siblings, and children of the deceased (Barnes, 2006; Begley & Quayle, 2007; Dutra et al., 2018; Entilli et al., 2021; Hybholt et al., 2020; Kawashima & Kawano, 2017; Lee et al., 2017, 2019; Lindqvist et al., 2008; Maple et al., 2010; Ross et al., 2018; Shields et al., 2019; Spillane et al., 2018; Sugrue et al., 2014; Tzeng et al., 2010; Wainwright et al., 2020). Of the 16 studies, only seven were conducted solely on suicide-bereaved parents (Entilli et al., 2021; Kawashima & Kawano, 2017; Maple et al., 2010; Ross et al., 2018; Shields et al., 2019; Sugrue et al., 2014; Wainwright et al., 2020), and only a few focused on parents' coping strategies, their effort to manage the aftereffects of suicide and the process of healing (Entilli et al., 2021; Maple et al., 2010; Ross et al., 2018). Both adaptive and dysfunctional strategies of suicide-bereaved parents members were addressed in these studies. The most common adaptive strategy described was the effort to be occupied and maintain a routine such as gardening and walking as well as helping others in need (Lee et al., 2019; Ross et al., 2018; Spillane et al., 2018). Avoidance of suicide topics and alcohol use was also documented (Entilli et al., 2021; Maple et al., 2010; Ross et al., 2018; Spillane et al., 2018). However, as these data come from particular cultural contexts, i.e., Australia, Ireland and S. Korea, the need for in-depth exploration of the coping mechanisms applied by suicide-bereaved parents in various other countries becomes apparent.

Overall, studies on the degree to which parents' coping mechanisms in different social contexts are associated with adaptive rehabilitation will allow for new culturally specific interventions to be developed and already applied interventions to be revised and enhanced. Following the increase of suicides in the last 40 years, suicide remains the second leading cause of death among people aged 15–29 (Centers for Disease Control and Prevention, 2020; Organisation for Economic Co-operation and Development, 2020; World Health Organization, 2018) resulting in a rise in the number of suicide-bereaved parents (Bolton et al., 2013; Erlangsen et al., 2017; Pitman et al., 2014). Bearing in mind the limited data on the experiences of suicide-bereaved parents, new studies are expected to expand existing knowledge on the subject. Under this scope, the aim of the present study was to explore the experiences of Greek-speaking Cypriot parents whose child died by suicide, with focus on a) their interpretations of the incidence, b) the impact of suicide on them and their immediate family, and c) the healing strategies and supportive systems used to cope with their loss.

Materials & methods

Design

A qualitative methodology, based on a conventional approach to content analysis and an inductive category development was used, as applied in nursing research (Karanikola, 2019). The objective of inductive category development is to conceptually extend an already described phenomenon, or a theoretical framework for which scientific literature is limited (Graneheim et al., 2017). Considering the existing limited qualitative data on suicide-bereaved parents' experiences (Entilli et al., 2021; Kawashima & Kawano, 2017; Maple et al., 2010; Ross et al., 2018; Shields et al., 2019; Sugrue et al., 2014; Wainwright et al., 2020), this method was appraised as more suitable for the present study. The target population was parents who had experienced the death of their child by suicide. The consolidated criteria for reporting qualitative research (COREQ) checklist for qualitative studies was used to guide the reporting of the present findings (Supplementary Table S1) (Tong et al., 2007).

Setting & sampling

Regarding the context of the Republic of Cyprus, it is worth mentioning that there is no official personal data registration for those who die by suicide making it impossible to formally contact their parents. Moreover, there are no suicide-bereaved parents support groups within state or private mental health services, and unofficial self-help groups for this population are scarce or non-existent. Thus, in order to gain access to the entire target population and attract the most participants possible, both public and private mental health services were informed about the aim and procedures of the study through a formal communication process. Consequently, participants' recruitment partially took place in collaboration with the mental health services used by suicide-bereaved parents or by the deceased. However, a precise estimation of the number of relevant service users was not possible due to the aforementioned lack of a formal registry of suicide-bereaved relatives.

Aiming to attract participants from diverse backgrounds, the study was also posted on social media (Facebook, twitter), groups and pages related to mental health services and medical topics, as well as in the press and in scientific events. The participants were also advised to introduce the study to their peers. Thus, through this open call and snowball technique the purposive sampling of eligible participants was expanded.

Data collection

Those willing to participate in the study voluntarily contacted the main author (RZ) in order to be informed on the purpose and procedures of the study. Upon their consent to participate, a meeting was set with the main author (RZ) so as to be assessed on the degree to which they met the following inclusion criteria for the study: (a) being a mother or a father to the deceased by suicide; (b) full understanding of the aim and procedures of the study; (c) written informed consent to participate in the study; (d) adequate ability to communicate their experiences with the researcher; (e) ability to reflect on and process the suicide-loss experience. There was no time-specific inclusion criterion regarding the time since suicide.

The sample size was determined at 12 individuals based on the theoretical and data saturation criteria during the simultaneous analysis and data collection (Morse, 2015). Specifically, the recruitment of new participants was finalized when no more novel themes were arising according to data analysis. At that time all study advertisements and participants' recruitment strategies ended. Since all those who contacted the researchers fulfilled the inclusion criteria, they were all included in the final sample (response rate 100%). There were no dropouts from the study. Half of the participants ($n = 7$) were referred to the research team by a member of their therapeutic team. Two participants were recruited through social media. The rest of the sample ($n = 3$) was introduced to the study by their peers.

Data collection (July 2017-August 2019) was conducted by RZ, MK (trained clinical interviewers with advanced clinical and qualitative research qualifications) through personal interviews with the participants using open-ended questions. Two interviews, ranging from 1 to 3 hours and 3–6 months intervals, were conducted with each participant. The aim of the second interview was to confirm and enrich the data which had been collected and analysed in the first interview. Moreover, in the second interview the researcher had the chance to select additional data on ambiguous issues which had emerged after the first analysis. Depending on the preference of the suicide survivors, all interviews were conducted at their homes. Data collection was achieved through the following guide, which was developed according to relevant literature (Zavrou et al., 2022): (1) How do you feel talking to me about the suicide of your child? What do you think about the suicide? Have there been any changes in your life since the time of the suicide? If yes, can you give me an example? (2) Can you describe the impact of the suicide on you and your family as a whole? (3) How have you been coping with the changes in your life following your child's suicide? (4) Is there anything else that you would like to discuss?

In order to highlight the profile of the participants, a set of demographic data were collected at the beginning of the first interview, along with data regarding the suicide of the participants' child. These data were collected according to relevant literature on socio-demographic related differences of grief response (Andriessen et al., 2017; Feigelman et al., 2019, 2019). A data sheet was developed for this purpose, and these data are presented in Table I.

Ethical issues

All procedures contributing to this research comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The study was approved by the National Bioethics Committee in the country in which the study took place (File number: EEBK/2017/03). All demographic data recorded and presented herein were drawn from a population of 1,000,000 making it impossible to identify any participant.

The participants were informed both orally and in written form about the purpose, process and

Table I. Demographic variables of the participants and their child who completed a suicide.

A. Demographic characteristics of the child who completed a suicide.						*B. Demographic characteristics of the participants*					
Participant	Sex	Age (years)	Method of suicide	Place of suicide	Number of siblings	Sex	Age (years)	Marital status	Years away from suicide	Religion	Occupation
1.	Male	34	Hanging	Home	None	Female	63	Widow	15 years	Chr. Orthodox	Retired
2.	Male	22	Hanging	Home	None	Female	45	Divorced	4 years	Chr. Orthodox	Private sector employee
3.	Female	16	Drugs ingestion	Home	One	Female	62	Married	19 years	Agnostic	State sector employee
4.	Male	23	Leap into space	Near	One	Female	59	Widow	5 years	Chr. Orthodox	Unemployed
5.	Male	23	Self-shot	Home	Two	Female	54	Divorced	3 years	Chr. Orthodox	Unemployed
6.	Male	23	Leap into space	Near	One	Male	62	Widow	5 years	Chr. Orthodox	Retired
7.	Male	30	Drugs ingestion	Home	One	Female	59	Divorced	12 years	Chr. Orthodox	Private sector employee
8.	Male	28	Leap into space	Near home	Two	Female	60	Widow	5 years	Chr. Orthodox	Retired
9.	Male	40	Poisoning	Home	Two	Female	63	Widow	16 years	Chr. Orthodox	Retired
10.	Male	28	Self-shot	Near home	One	Female	56	Married	7 years	Chr. Orthodox	Private sector employee
11.	Male	23	Hanging	Home	Two	Female	55	Married	8 years	Chr. Orthodox	Unemployed
12.	Male	23	Hanging	Home	Two	Male	59	Married	8 years	Chr. Orthodox	Unemployed

confidentiality terms of the study, and were reassured that no data that could identify their identity would be reported at any point of the inquiry. All interviews were recorded with the participants' permission. At each phase of the study, they confirmed their consent to participate in the next phase. Finally, all participants were provided with a list of all public mental health services, highlighting the clinicians who were affiliated with the team to provide support to any participant in need. The fact that most survivors thought the interview was therapeutic allayed our worries.

Data analysis

Each researcher (RZ, AK, MK) analysed each interview independently. Following the research questions of the study, participants' feelings, experiences, interpretations and perceptions regarding (a) their child's suicide, (b) the impact of suicide on them and their family, and (c) their coping strategies and support were highlighted in different colours (initial codes). In order to institute how initial codes would be identified, "interpretation of the suicide" was determined as the participants' thoughts, feelings, emotions and behaviours which followed their child's suicide; "impact of suicide" was defined as the interpersonal and intra-personal (cognitive, emotional, spiritual, behavioural, and physiological) changes which were experienced by the participants after their child's suicide; "strategies to cope with the loss" were defined as those mechanisms applied by the participants to manage the impact of suicide on them; "supportive systems" were described as those sources used by the participants to cope with the impact of suicide on them and/or their families (Feeney & Collins, 2015; Jantzen, 2021; Stanisławski, 2019). Through teamwork, code groups were established reflecting the participants' common interpretations, descriptions and perceptions. This process allowed for categories and themes to emerge. At this stage, descriptive definitions of each category, themes and codes were developed to establish a criterion of data selection to each category and theme. Thus, formulation of initial categories and themes out of the data and according to the definitions provided took place. Since the inductive approach was applied, this formulation did not follow any particular theoretical framework. Next, levels of abstraction were identified to reflect further relevant codes, categories and themes according to the same frameworks. Revision of categories, themes and codes was made after each interview. Thus, the process of subduction of previous categories and formulation of new categories and themes was ongoing (Hsieh & Shannon, 2005; Mayring, 2023; Thomas, 2006).

Additionally, code groups and categories allowed for data and thematic saturation to be achieved. Data saturation criterion was partially attained based on the heterogeneity of the sample, in relation to participants' demographics (sex, marital status, age, etc.) and suicide-related variables i.e., time away from the suicide, means of suicide, etc.) (Table I) (Morse, 2015). The heterogeneity yielded a multi-dimensional description of the phenomenon by the participants resulting in a variety of perspectives and experiences. Thematic saturation was determined by the frequency by which a theme re-occurred; Due to poor evidence on the accepted frequency to determine thematic saturation (Morse, 2015), the research team decided that each category would be considered as saturated if it was included in the 80% of the transcripts (Bryman, 2012). This not only supported the inclusion of the themes in the results, but it also indirectly revealed themes, rarely addressed by the participants to be investigated either in the first or the second interview. This partially ensured that there was nothing new to the data.

The process of confirming the rigour and trustworthiness of the study was based on the evaluation of the degree to which all nine of Munhall's criteria of research rigour were applied successfully (Supplementary Table S2) (Karanikola, 2019).

Results

The participants described their effort to make sense of the senseless, giving ground to numerous interpretations of their child's suicide. Specifically, suicide was described as the result of either a mental disorder, Divine Will or even a conscious choice. The participants also provided vivid descriptions about the impact of suicide in a personal, familial and social level. There were participants who had achieved to move on with their lives by trying either to keep the remaining family together or empower themselves through the process of meaning-making. Others were still struggling to cope with their loss feeling detached from their social network.

Although numerous coping strategies and support systems were described, their activation reflected the participants' effort to escape from their repetitive, enduring, distressful thoughts and obsessive, disturbing images about their child's suicide which were utterly traumatizing to them. Accordingly, intense social stigmatization kept the participants away from social interactions, in an effort to protect themselves from the threat of criticism. Self-stigma and grieving sorrowful memories were also addressed in the participants need to achieve deliberation from the guilt and the pain of loss regarding their child's suicide. Coping strategies were adapted in the hope of subsequently experiencing spiritual, psychological and physical comfort.

Table II. Presentation of the research questions and the results of the present analysis in terms of the identified themes, categories and codes. The core theme is also presented.

Research questions	Themes	Categories	Codes
Interpretation of the suicide event	Making sense of the senseless	1. Eternal feelings of guilt	1.Guilt & self-blame
		2. The perpetual quest for liability	2. Responsibility attribution
Aftereffects of suicide (positive & negative)	Defeated by the traumatizing experience or empowerment: The bipolar phenomenon of offspring suicide bereavement	1. Impact on family structure & attitudes	1. Decreased quality of communication between the parents and the rest of the family members, and in the couple
			2. Accusations among family members
			3. Distress in siblings
		2.Impact on social attitudes	1. Difficulty in engaging in social activities & maintaining social relationships
			2. Factors associated with interpersonal/ social aftereffects
			– Social stigma
			– Lack of empathy
			–Inner need for being withdrawn
Coping Strategies & Support	The struggle to escape from the repetitive distressing thoughts & obsessive, hurtful images of the child's suicide		1. Activation of internal sources of strength & self-support.
			2.Being physically occupied & becoming exhausted
			3. Mind as an effective therapeutic means
		1.Construing the power of acceptance	1. Acceptance
		2.The healing effect of supporting others	1. Supporting vulnerable family members
			2.Supporting others in need & give charity
		3. External Sources of Support: The role of the core family, social network and church.	1. Members of the core family
			2.Social network (colleagues, neighbours)
			3.Church
Core theme	*Finding existential relief and serenity, an inner cozy and safe space to be, through the management of the distressing reminders of the child's suicide, also liberated from negative self- judgement and that of others.*		

Based on the above, the essence of the present analysis mirrors the participants' ultimate desire to find existential relief and serenity through meaning making of their child's suicide, the management of its distressing reminders, as well as alleviate the burden of their own negative self- judgement and that of others. They sought physical and emotional comfort, ***a cozy and safe space to be,*** in the inner realm of their psyche, through spiritual and psychological coping processes.

The themes and categories identified in the study, also presented in Table II, are described as follows:

Making sense of the senseless

Suicide was described as an incomprehensible incident, as the participants could not find any good reason why it occurred. Searching for the cause of the event seemed to give rise to numerous "whys", obsessively trapping the participants in a vicious cycle of a torturing, constant pain: *"I'm constantly asking myself 'why'. And the pain gets even worse because I don't know why he's gone." (P7)* or *"Why; I wonder why. [...] Why did this happen to us?"(P12).*

The participants tried to make sense of the suicide through a continuous effort to give meaning to it mainly driven by their painful emotions and feelings, as well as their need for peace of mind. In their effort to give meaning to the event, some of the parents developed the perception that their child's suicide was fate: *"[...] it just happened to be us [...]" (P3)*, or Divine Will: *"I feel that my son is an angel. God wanted him [...] Maybe I'm thinking this way to feel a bit better. (P5)*"; while others described it as a form of punishment: *'[...] people say that the greatest punishment for man is to bury your own child.' (P6)*. Other participants believed that their child made a conscious choice: *'[...] he probably wanted to go for his own reasons, which in his mind were the right ones.' (P2)*; while for others, suicide was the result of a possible mental disorder: *" [...] this happened because of his mind."(P12)*. Most importantly, all the participants described their child's suicide as an enduring, traumatizing event: *"You may talk, eat or drink, but the thorn is a thorn." (P8).*

Eternal feelings of guilt

Whichever the cause of suicide, almost all the participants were wondering if they could have done something to prevent the tragedy, a process which resulted in blaming themselves. There were participants who felt that, as parents, they had failed their child, while others described that they did not do enough to prevent their child's suicide. The experience of guilt was timeless, manifested through all the dimensions of time: past, present and future: *"I felt like it was my fault. I felt sorry, and I still feel sorry." (P8).*

The perpetual quest for liability

When the participants thought they had done nothing wrong, they were trying to find out who

or what else could have been responsible for their child's suicide. They placed the blame on other family members, even God Himself: *"I feel that a great deal of responsibility falls on his dad [. . .] sometimes I even blame God for letting my son do this." (P5)*. Others accused the healthcare professionals who did not diagnose that their child was suicidal or knew about it and did nothing*: "[. . .] the psychiatrist was not that good [. . .] my son managed to manipulate him [. . .]" (P2)*. Bureaucracy issues and flawed healthcare systems were also held accountable: *"This system (inpatient mental health services) was totally dysfunctional" (P6)*. Bullying and victimization were considered by some participants as crucial factors associated with the suicide: *"Her peers (bullies) pushed her to end her life." (P3)*.

Defeated by the traumatizing experience or empowered: the bipolar phenomenon of offspring suicide bereavement

On the one end, despite the time that had elapsed since their child's suicide, many participants were still struggling to move on with their lives, as they clearly described the emotional, psychological, physical and social impact of suicide and its consequences, on a personal, familial and interpersonal level. Specifically, the main emotions expressed were deep grief, intense and enduring pain, sadness and anger: *"I can't stand this pain. Pain is pain. Like the first day. After 7 years it is the same." (P7)*. Almost all the participants did not want to express their painful feelings to other family members, so as not to impose or put any more strains on them, which in turn burdened them all the more: *"We try not to show them (other family members) our feelings [. . .] That's why we're sad."(P12)*. Even long after the suicide, the participants described that they had still been struggling to go back to their usual way of living; they described that it was impossible for them to return to their daily habits, without having to face the "emptiness" in their life's routine: *"He used to come in the kitchen asking me to cook something for him or whatever . . . Now I get up and everything is empty. I see emptiness."(P4)*. Thoughts about their child were constantly on the participants' minds, whether it was morning or evening. However, these were more intense at night-time: *"[. . .] I can't sleep at night [. . .] you have all the time this 'why' in your mind." (P5)*. Loss of life's perspective was also described by the participants, who seemed to be drowning in pain, unable to make plans or to set goals for the future. They were trying hard to focus on the present: *"I lost my most precious thing, my son [. . .] that's why I don't want to look back. I only live for the present, nor do I look ahead, into the future, because I'm afraid it's going to be brutal too." (P2)*.

Interestingly, on the other end, there were participants who had gained introspection by transforming their worldview, altering the way they perceived themselves and their lives and changing priorities: *"I face things more realistically now." (P8)*. Similarly, the participants emphasized the need to support and protect their other children or other vulnerable family members, a process which had an empowering effect on them by promoting self-growth: *"I had to support my husband, to support the entire family [. . .] That made me a very strong individual, a realistic and powerful individual." (P3)*.

Impact on family structure & attitudes

The participants highlighted mainly negative changes in family dynamics and attitudes. Decreased quality of communication between the parents and the rest of the family members, as well as in the couples, was reported. They, specifically, described the need expressed by the rest of the family members to avoid discussions about the tragic incident: *"We rarely talk about it. We try not to [. . .] If I mention it to my children, they become disturbed. If I open my mouth about this, they tell me 'Don't do it." (P8)*. Consequently, unwillingness to discuss the suicide among family members was negatively influencing the quality of communication either between the couple or among the parents and the rest of the family: *"We couldn't even talk about it with my husband." (P2)*. Additionally, it was shown that an already problematic relationship between the couple usually ended after the child's suicide: *"[. . .] we had problems with my husband [. . .] today I'm divorced." (P2)*. Yet, others described a strengthening of the relationship with their husband or wife: "*We have come closer [. . .] to support each other" (P3)*.

There were, also, cases where family relations were disturbed due to accusations between parents or parents and children regarding their child's suicide. Sometimes, the mother blamed the father: *"[. . .] But I feel that his dad had a great deal of responsibility for my son to do that (suicide)" (P5);* while other times siblings considered their parents responsible for the suicide: *"When my son talks to his father, he tells him 'It is your fault that my brother killed himself'." (P4)*.

Furthermore, there were descriptions revealing adaptation difficulties in siblings who had survived the suicide of their brother or sister. There were siblings who couldn't stand being around photos or personal belongings of the dead child: *"My second daughter had an aggressive attitude towards anything that concerned my older daughter (the deceased). Any photo of hers I had, she would go and turn it upside down." (P3);* while others asked their parents to keep

memorabilia of the deceased around in order to feel close to their dead brother or sister or keep her/his memory alive: *"I have a lot of his clothes in the closet, my youngest son wants to wear them." (P11).*

Impact on social attitudes

The participants described a difficulty in engaging in social activities or even maintaining social relationships. They felt an inner need to stay away from the social network either because of adverse attitudes towards them or due to lack of genuine interest, even from members of the extended family. Specifically, the participants delineated that their child's suicide was a unique and private experience, therefore difficult to externalize and share with others. They, also, believed that the others were incapable of understanding their thoughts and emotions: *"I can't hang out with others [. . .] I feel they don't understand me, they don't feel me." (P5)*. Lack of empathy and sensitivity regarding their loss was also described as an important obstacle to interacting with others, developing and maintaining social relationships*: "I used to hang out with colleagues from work [. . .] Until I heard 'Why are you crying for a drug addict? Isn't it better that he's gone?' [. . .] So, I stopped talking."(P7)*. Most importantly, the participants underlined their hesitation to share their thoughts and experiences with others not only because they believed they would not be confronted with sufficient empathy, but also because they feared they would be negatively criticized: *"I used to go to the coffee shop [. . .] and once I overheard them saying 'instead of helping their son they abandoned him, hung himself; so, I stopped going out."(P12)*. Overall, almost all the participants emphasized adverse attitudes associated with the suicide of their child, such as stigma and criticism, within their wider social network. Experiencing the judgement of others was described as the central factor linked to withdrawal from social relations, interactions and community activities.

The struggle to escape from the repetitive distressing thoughts and obsessive, hurtful images of the child's suicide

In response to the traumatizing experience of the suicide and the subsequent impact in their lives, the participants described a variety of coping strategies. As they reported, self-motivation was mostly derived from their need to empower themselves through cognitive and behavioural strategies. They would either activate internal resources of strength and self-healing or accept external resources of support, mainly from members of their core family and, to a lesser degree, from their social context, due to stigma or lack of empathy.

Interestingly, the participants described their struggle to construct meaning about their child's suicide in their efforts to seek relief from the pain of loss: "*God wanted him (the deceased) [. . .] when I go to church, I feel calm (P5)*. Moreover, they clearly described their battle to get rid of their own torturing thoughts by recruiting several coping strategies: *"I try to empty my mind [. . .]" (P9)*. Almost all the participants underlined their effort to physically occupy themselves, even to the point of exhaustion. Physical fatigue was described as a means to cope with the hurtful reality of the child's suicide, particularly, to escape from the repetitive, painful thoughts that surround it. Although a behavioural strategy, this had a twofold healing effect, on both cognitive and behavioural level. Not only did it help participants to escape from their haunting thoughts during the day but also, by getting exhausted, they were able to sleep at night: *"You pray that your day is very busy and tiring, so that you won't have time to sit and think until late, and no chance to have insomnia."(P1)*. On the other hand, there were participants who stated their need to get medication to control disturbing thoughts, but mainly to be able to sleep: *"I can't sleep at night. I must take the pill to sleep." (P5)*.

An additional behavioural coping strategy described was the necessity to be in contact with nature: *"I found my way out . . . be in the quiet, in the woods" (P9)*. The participants described that gardening, going into the woods, as well as going to the shore and even swimming had a therapeutic effect on them, helping them to forget, relax, or find solace: *"Working in the garden, with the flowers, makes you forget somehow." (P4)*. Noteworthily, the participants mentioned that through gardening and contact with the soil they felt that they were in close proximity to their dead child: *"I work with the soil in the garden because I feel that I'm close to my son."(P5)*. Cemetery was also described as the place to be connected to the deceased: *'I go to the cemetery every day. If I don't go once, I think that my son will get sad.' (P10);* it also seemed to provide them with a cozy place to externalize emotional burden: *My only way out was going to the cemetery and cry" (P3)*; most of all, it seemed to offer them the therapeutic opportunity to do things for their dead child: *"I feel good by doing things over the grave." (P5). In contrast*, others described their struggle to control their distressing thoughts and images by keeping away from familiar places, including their own home, even leaving their own country especially during holidays, in an effort to sustain themselves: *"I prefer during holidays to be away from home, out of town, out of the country. To be away because things keep coming up constantly." (P1).*

Lastly but most importantly, the mind was described as an effective therapeutic means: *"I had to put my mind to work" (P1)*, even in order to quit

medication: "*I have quit medication because I know that the 'medicine' is in your mind" (P7)*. Playing or watching mind games, such as chess, also seemed to be effective in keeping the mind away from disturbing thoughts, as described by a male participant: *"There is only one thing that I watch and relax [. . .] being focused on chess." (P6)*.

Overall, the participants, very clearly, described their effort to build upon self-motivation in order to support themselves. For instance, a participant used self-monitoring techniques to support herself: *"[. . .] to see if I was getting better or worse, I was saying out loud my feelings while recording them. After some time, I played the recordings back to see if I got worse, and I felt that in time the sobbing and heartbreak were fading away. And I said to myself that I was ok." (P2)*.

Construing the power of acceptance

The participants emphasized that peace of mind was achieved through acceptance: "*If you do not accept it, you can't move forward easily" (P3);* rationalization also proved a strong tool as they described different patterns of interpretation to help them accept their child's suicide. One participant described the suicide as an incidence which resulted from his/her son's conscious choice: *"I have accepted it [. . .] Because he was always doing the right thing. [. . .] he probably wanted to go for his own reasons" (P2)*. Another participant described suicide as a predestined twist of fate which had to be accepted: *"It wasn't meant to be for this kid to live with us any longer, so it happened. [. . .] I have admitted it to myself. I have accepted it." (P3)*. Overall, the participants' cognitive process to understand, interpret and make sense of their child's suicide was described as dynamic and incessant. Most importantly, it was revealed that when this process was followed by a worldview transformation in terms of priority changes, acceptance of their kid's suicide was to some degree expedited, forming an adaptive coping strategy. This process facilitated personal-growth, empowerment and self-motivation in parents.

The healing effect of supporting others

The presence of other family members who survived the kid's suicide, e.g., siblings of the deceased or grandchildren of the bereaved parents seemed to work as a buffer against the adverse feelings and the enduring pain experienced by the participants: *"You can't give up. You must try for the rest of the family. Not only for yourself, but for the others as well [. . .] You must show strength, that you cope with it."(P6)*. Bereaved parents' effort to provide support, care and protection to other family members who survived the suicide was described as an effective strategy to cope with their loss, and mainly a crucial motive to continue with their lives: *"What keeps me so far is my grandchild and my daughter." (P7)*. In the effort to support and protect other family members pretending that nothing wrong was going on was also adopted: *"In the house I was pretending that nothing was wrong" (P3)*; a coping strategy which despite the anticipated positive effect on others, seemed to burden the participants: *"There were several times that I said to myself 'I am too tired to pretend I am O.K." (P7)*.

The participants, also, described their need, desire and satisfaction to offer their support to people outside the family, to give to charity, and even establish a foundation in the child's memory: *"I intend to establish a foundation for scholarships after my son's name." (P2)*. By being supportive towards others, they were motivated to be active and experience positive feelings: *"I want to give help to those in need. It satisfies me." (P10)*. Overall, the participants reported that keeping themselves occupied and their mind busy by supporting others was a prerequisite to continue with their lives: "*What gives me the strength to live and do things is to establish a foundation to help children." (P2)*.

External Sources of Support: The role of the core family, social network and church

Additionally, the participants reported on the important role of external sources of support. The participants who received support from a health professional reported that they were dissatisfied with the quality of care provided to them. They reported that the interventions were not effective, but most importantly that they experienced lack of empathy from them: *"The psychologist was staring at me like I was from a different planet." (P2)*. As a result, they didn't express their feelings and thoughts to the therapists freely. The participants, also, referred to the support from the social network, mainly colleagues: *"When I went back to work my colleagues supported me." (P2)*. Others, although to a lesser extent, mentioned the support they received from neighbours: *"Somehow the neighbours support us." (P4)*.

However, when the participants experienced criticism or lack of empathy and genuine interest from their social network, they avoided opening up or getting in touch with them: *"I can't hang out with others, not even with my sisters [. . .] whatever they ask, whatever they say is just to say something. Nothing more." (P5)*. In contrast, the majority of the participants emphasized the importance and the healing effect of support from the members of the core family: *"Somehow, supporting each other, my husband and I, we managed to get over it in a way." (P4)*.

Overall, the participants clearly described their traumatizing experiences regarding their child's suicide and revealed the significance of the process and its elements towards acceptance and healing. Their obsessive, distressing thoughts and feelings underpinned recurring, traumatizing reminders of the event or flashbacks of their child's life moments which in turn triggered the need to adopt effective coping strategies and accept supportive systems in order to deliberate themselves from the torment.

Discussion

The present study reported data on parents' experiences regarding their child's suicide, revealing patterns of coping through the aftermath of the distressing incident. The participants' ongoing effort to understand the aching void brought about by their child's suicide and their struggle to survive it and alleviate guilt and stigma was revealed as the basis of their ending up adopting coping strategies, thus verifying the traumatizing nature of their experience.

Overall, the participants' ultimate desire for existential relief and serenity, through the management of the distressing reminders of their child's suicide, and liberated from the burden of their own negative self- judgement and that of others was identified as the cornerstone of the present findings. Consequently, based on the results of the present analysis, helping this vulnerable population to experience spiritual, psychological and physical comfort is suggested to be the essence of the supportive services provided to them. Additional emphasis on alleviating the impact of the stigma and criticism whether of the self or that of others proves imperative.

Supportive measures to help deliberate the parents from the distressing reminders of their child's suicide during the suicide-related meaning making process are of great significance. Meaning making, as a cognitive coping strategy, refers to how people understand, interpret, and make sense of life events (Park & Folkman, 1997). The meaning making theories support that this process motivates individuals, and provides them with a framework to understand and give meaning to their life's experience (Park & Folkman, 1997). For some participants the meaning-making process was contextualized by their religious beliefs, already described in the literature (Neimeyer et al., 2006). Specifically, strong faith seemed to help the participants make sense of their loss, while various spiritual and religious practices offered them the means to find comfort and relief during bereavement. In more detail, the participants were frequently left with a persistent and tormenting "why", and in their attempt to give meaning to the shocking event, they interpreted the suicide as an act of divine will, which seemed to buffer the pain and help them cope with feelings of guilt. Apparently, the present results are in line with other studies which supported that religion and spirituality might buffer the impact of suicide bereavement (Castelli Dransart, 2018; Čepulienė et al., 2021). Therefore, a deeper understanding of the works and influence of spirituality during suicide bereavement may provide, through future studies, data for the development of effective practices for mental health professionals who support suicide-bereaved individuals.

Furthermore, the participants herein, were constantly struggling to move on with their lives, clearly describing the impact of their child's suicide on a personal, interpersonal, familial and social level. This disintegrating sequence of life on suicide bereaved parents has also been previously reported (Dutra et al., 2018; Spillane et al., 2018). Additionally, the participants recounted the social stigma against them and their dead child following the suicide, a finding previously described as suffering the judgement of society (Dutra et al., 2018). This experience was intense enough to keep the participants herein away from social interactions, in order to protect themselves and the memory of their dead child from the threat of criticism. They also longed to deliberate themselves from the painful guilt they themselves carried for their child's suicide. Therefore, serious steps should be taken to enhance the public's mental health literacy on the medical and social reasons behind a child's suicide in the hope of earnestly contributing to the de-stigmatization of the suicide-bereaved parents as being incompetent, inadequate and guilty.

The participants also described their effort to primarily protect and support the vulnerable members of their family; this was perceived not only as an adaptive coping strategy, but mostly as an essential motive to sustain their existence and continue with everyday living. Previous studies have described the suicide-bereaved family members' need to strengthen bonds with one another or with friends (Barnes, 2006; Begley & Quayle, 2007; Dutra et al., 2018; Lee et al., 2017, 2019; Lindqvist et al., 2008; Spillane et al., 2018; Tzeng et al., 2010) and the bereaved mothers' need to maintain their motherhood role (Shields et al., 2019) as crucial coping strategies. Thus, interventions to facilitate bereaved parents to engage in strategies to effectively support their family members should be recommended. Immediate referral and link of suicide-bereaved family members to mental health services, with special attention to the vulnerable members, e.g., siblings, may, also, moderate the impact of the suicide on bereaved parents.

Some of the participants did not have any other children, they were divorced, or widowed; encouraging these bereaved parents to engage in suicide preventive activities, or even activism, may also be valuable. Some examples of activism may include efforts towards (a) establishing advanced mental health services for suicide-loss survivors; (b) enhancing the public's mental health literacy regarding youth suicide and its prevention; (c) facilitating other suicide-bereaved parents to express themselves, share their experiences with the public, contact others with similar experiences, participate in self-help groups and use mental health services for grief-specific counselling when needed (Cruwys et al., 2018; Pitman et al., 2018; Shields et al., 2019). Indeed, not only do suicide-bereaved survivors constitute the main target group for postvention, but they also comprise a competent active force behind a number of effective suicide prevention organizations, such as the

Suicide Prevention Action Network in the USA, or the Media Award for Responsible Portrayal of Suicide in Belgium and the Lifekeeper Memory Quilt in Australia (Andriessen & Krysinska, 2012).

The participants, also, emphasized the effectiveness of their personal healing processes, both on a cognitive and behavioural level. Further studies on the factors associated with one's ability to activate his or her inner healing strategies may be suggested. Further research on the effectiveness of supporting interventions on both personal and familial level incorporating the patterns of coping addressed herein is also proposed.

A child's suicide was described by the participants as an exceptionally traumatizing event for the entire family and an incomprehensible act in terms of the motive, confirming previous data (Lee et al., 2019; Lindqvist et al., 2008), where, in addition, the main explanation given for suicide relies on serious mental health problems (Lee et al., 2019; Ross et al., 2018). Moreover, according to existing literature, youth suicide is described as an unexpected incidence which disturbs family dynamics and leaves the bereaved family members perplexed about the factors associated with it (Correa et al., 2014; Figueiredo et al., 2015). Similarly, the participants herein, described inability to comprehend the motives behind their child's suicide, while the absence of a note bewildered the participants even more. Interventions to enhance effective communication patterns, empathy and acceptance between adolescents or young adults and their parents are proposed; especially in families which survived the suicide of a close relative (Ferrey et al., 2016).

Noteworthily, this study is amongst the very few qualitative studies shedding critical light on suicide-bereaved parents' experience (Adams et al., 2019; Kawashima & Kawano, 2017; Ross et al., 2018; Shields et al., 2019; Sugrue et al., 2014). Specifically, the majority of relevant studies come from North European and Asian countries, while the present study is the first, to the best to our knowledge, to present this phenomenon within the cultural background of a South European-East Mediterranean country. The present study owes its strength to the perceptions and powerful experiences of suicide-bereaved parents revealed for the first time within this cultural context and thus adds new and important information to the existing literature on the subject. Additionally, since the present findings are based on both theoretical and data saturation they may be considered as representative of the target population and its socio-cultural context from which they were drawn, i.e., Greek-speaking suicide-bereaved parents in Cyprus. However, one may comment on the relatively low number of the study participants. The sample size herein may be attributed to social stigma that follows youth suicide which may hinder family members from revealing the true cause of their child's death. Additionally, lack of suicide registry in the state where the study took place makes the suicide-bereaved parents inaccessible to investigators; however, since the size of the present sample was based on data and theoretical saturation the rigour of the study is supported. Most importantly, since the aim of qualitative studies is to explore the subjective interpretation of the living experience of individuals and further unveil their perceptions and meanings of the experienced phenomena through their lifeworld stories, generalizability of findings to various contexts as stemming from a large sample size is not a relevant objective (Stanisławski, 2019). Instead, the focus is on describing the particular context in which phenomena occur through findings characterized by rigour and transparency according to relevant and advanced criteria as described in the methods section. Moreover, the present study, although indirectly, is among the few which provide data on the implications of suicide on bereaved siblings. Despite the evidence on the implications of chronic illness (e.g., cystic fibrosis, cancer) on siblings (Milo et al., 2021; Snaman et al., 2020); there is a lack of studies focused on suicide-bereaved siblings. Thus, according to the present findings future studies on the subject are needed.

Finally, the present sample lacks a balanced gender distribution mostly attributed to the fact that most of the female participants were either widows or divorced, resulting in underestimation of the burden experienced by male bereaved parents. It should also be clarified that by English not being the mother tongue of the researchers it may have influenced the accuracy of transferring data from the participants' native language to the presentation herein. However, it is worth noting that, aiming to eliminate this type of bias, the translation of quotes was performed by a bilingual research associate (AK).

Conclusion

In response to the traumatizing experience of losing a child to suicide, the participants described their efforts to feel empowered by activating cognitive, meaning making and behavioural self-healing processes, as well as embracing external sources of support mainly from the members of the core family. Finding existential relief and serenity through spiritual, psychological and physical endeavour, ultimately relieved from internal or external judgement and the distressing reminders of their child's suicide, was the participants' paramount desire. Further exploration of the phenomenon is suggested with emphasis on newly developed interventions aimed at strengthening supportive resources in suicide-mourning parents. Finally, de-stigmatization and relief from other suicide-related traumatizing consequences in the post-suicide period need to be addressed by clinicians.

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Authors' contributions

RZ, MK developed the study design, the research questions, collected the data, and drafted the manuscript. RZ, AK, MK analysed the data. RZ, AC, EP, AK, MK contributed to the interpretation of the results and critically revised the final manuscript. All authors read and approved the final manuscript.

Ethics approval statement

The protocol of this study has been approved by the Cyprus National Committee of Bioethics (File number: ΕΕΒΚ/ΕΠ/2017/03).

Data availability statement

The participants in this study did not consent to have their complete transcripts made publicly available after data analysis, as containing personal information for which they could be identified. Despite the anonymization of the interview transcripts, there is always danger of breach of confidence. Therefore, the data underlying the results presented in the study are only available internally, and interested parties are advised to contact the corresponding author. Finally, the authors attest that the manuscripts have the information needed to support the findings of the study.

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