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ORIGINAL RESEARCH

Experiences of parents whose sons or daughters have (had) attempted suicide

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Abstract

Aim. The aim of this exploratory study was to gain further insights into the experiences of parents of sons or daughters who have attempted suicide and how these parents respond to the increased psychosocial burden following the suicide attempt(s).

Background. Suicide is a major public health problem and relatives are understood as playing an important role in suicide prevention; however, suicide and suicidal behaviour affect the relatives' lives profoundly, both emotionally and socially, and the psychosocial impact on families is underresearched.

Design. Focus groups with parents of sons or daughters who have attempted suicide.

Methods. In January and February 2012, we interviewed two groups of parents recruited at a counselling programme for relatives of persons who have attempted suicide. The analysis combined a thematic analysis with a subsequent analysis of how the themes were negotiated in the conversational interactions. The findings were interpreted and discussed within an interactionist framework.

Findings. The participants in the study described their experiences as a double trauma, which included the trauma of the suicide attempt(s) and the subsequent psychosocial impact on the family's well-being. The pressure on the parents was intense and the fundamentally unpredictable character of suicide attempts was frequently emphasized.

Conclusion. Being the parent of a child who attempts suicide meant managing a life-threatening situation and the additional moral stigma. In part, the participants did this in the group by negotiating the character of the suicide attempt(s) and who was responsible.

Keywords: adolescence, attitudes to mental illness, family relations, focus groups, injuries, nursing, parental attitudes, psychosocial, qualitative studies, self-inflicted, suicide, support

Why is this research or review needed?

- Families can be a valuable resource in suicide prevention and postvention.
- Suicidal behaviour can have a destructive impact on families, but this impact is underresearched.

What are the three key findings?

- Parents of children who have attempted suicide describe the suicide attempt as a dramatic life-overthrowing and identity-defining event profoundly affecting the whole family.
- Parents of children who have attempted suicide do not delimit the trauma to the suicide attempt, but to their child's psychosocial problems and interpersonal behaviour.
- For the participants, the life-threatening character of a suicide attempt seemed to open new, socially legitimate opportunities for finding help and support and for generating social resources.

How should the findings be used to influence policy/practice/research/education?

- The study emphasizes a need for psychosocial postvention on those parents and families, who struggle coping with the impact of suicide attempt(s) and suicidal behaviour.
- Evidence-based suicide prevention and postvention should be part of standard nursing education as nurses encounter many families affected by suicidal behaviour.

Introduction

Suicide is a major public health problem. Drawing on data from the Global Burden of Disease 2000 database, World Health Organization (WHO) estimated that more than 800,000 people die from self-inflicted injury each year and that among those aged 15–44 years, self-inflicted injury was the 4th leading cause of death (Peden *et al.* 2002). Suicide is part of a larger problem concerning suicidal behaviour, which also includes suicidal ideation, communication of suicidal ideation and intent, planning suicide and suicide attempts. Suicide attempts are far more frequent than suicides and a person can attempt suicide multiple times. A suicide attempt is an important predictor for future suicide (Nordentoft 2007). It is suggested that a suicidal person intimately affects six other people (Shneidman 1969, Andriessen 2009) and suicidal behaviour is most often an event with serious repercussions affecting a multitude of people.

Not all suicides can be prevented, but many can. In 1999, WHO launched an initiative for the prevention of suicide (Krug *et al.* 2002). The initiative included not only an emphasis on identifying and eliminating factors that predict suicide but also an emphasis on providing psychosocial support to people who exhibit suicidal behaviour and to their relatives. The relatives were understood as playing an important role in the prevention of further suicidal behaviour; however, suicide and suicidal behaviour affect the relatives' lives profoundly, both emotionally and socially (Krug *et al.* 2002, Cerel *et al.* 2008). Finally, studies show an association between suicide and suicide in close family (Brent 2010, Hawton *et al.* 2012). A way to prevent the transmission of suicide and ease the suffering of suicide survivors, is postvention, which is the focused provision of help for people affected by suicide with the aim of reducing the after-effects (Shneidman 1975, Briggs 2008).

Background

A formal definition of what constitutes a suicide attempt is not simple. WHO defined parasuicide (suicide attempt) as a type of self-harm: 'an act with nonfatal outcome, where an individual deliberately initiates a non-habitual behaviour that, without intervention by others, will cause self-harm… and which is aimed at realizing changes which he/she desired via the actual or expected physical consequences.' (WHO 1986, p. 2). The definition emphasized the nonfatal outcome of the act and the person's deliberate intention to change his or her situation by means of the act. However, the definition was problematic for scientific classification because of the difficulties related to discerning/reconstructing a person's intentions behind an act (Krug *et al.* 2002, Hawton *et al.* 2012). One strategy has, therefore, been to ignore the issue of intention and the influential NICE guidelines on self-harm (National Collaborating Centre for Mental Health 2004, 2012) adopted a shorter and broader definition of self-harm (including suicide attempt): 'self-poisoning or self-injury, irrespective of the apparent purpose of the act'.

While categorizing suicide attempts as a type of self-harm has some scientific advantage, the category can be seen as problematic for lay people. This is because the term 'self-harm' minimizes the particular connotations of potential life-threatening danger and extreme recklessness commonly associated with a 'suicide attempt'. Finally, some types of dangerous self-harm or self-harm with strong suicidal intent are often articulated and treated as 'suicide attempt' by healthcare staff and other people in the immediate context. In this paper, we use the term 'sui-

cide attempt' to indicate a type of self-harm with a high level of potential lethality or danger regardless of the person's suicidal intention.

There are only a very limited number of articles reporting qualitative research into parents of sons or daughters who have attempted suicide. Torraville/Daly (Torraville 2000, Daly 2005) worked from within a phenomenological perspective and interviewed six mothers of adolescents who exhibited suicidal behaviour (ideation or gesture) or att-empted suicide. The essence of the mothers' experiences was 'multiple loss and unresolved grief', which encapsulated how the children's self-destructive behaviour created constantly recurring emotional turmoil and damaged the mothers' sense of self and hope for the future. The mothers grieved over their children's suffering, but they also expressed socially illegitimate feelings of anger and hate towards the children, who caused damage to the family's life. Rutherford interviewed four mothers of children who had had 'at least one significant suicide attempt' (2005, p. 20). Rutherford interpreted themes from the interviews from a psychodynamic perspective and described how the mothers continued to be emotionally traumatized even though the interviews took place one year after the suicide attempt. The mothers expressed feelings of fear and helplessness, but also anger and rage towards professionals and their ex-spouses, who were depicted as critical, dismissive and not understanding. Rutherford suggested that these latter feelings could also be interpreted as a way for the mothers to protect themselves from guilt and realistically reflecting on problems in their lives that may have contributed to the child's situation (Rutherford 2005).

We adopted an interactionist perspective on psychosocial responses to the burden caused by suicidal behaviour. The parents' interpretations of the personal and social meaning of their offspring's illness (suicidal behaviour) were based on their interactions when dealing with the situation. These meanings influenced the parents' cognitive and emotional coping strategies and their sense of identity and social status (Bury 1982, 1991).

The study

Aim

The aim of this exploratory study was to gain further insights into the experiences of parents of sons or daughters who have attempted suicide and how these parents respond to the increased psychosocial burden following the suicide attempt(s).

Design

The study was designed to use focus groups with parents of children who have attempted suicide. Focus groups in qualitative research are characterized by the production of conversational data through group interaction around topics supplied by a facilitating researcher (Morgan 1997, Halkier 2008). This approach is an appropriate way of exploring group meaning and norms (Bloor *et al.* 2001).

Sample

We recruited the focus group participants from among persons who took part in a support and counselling programme for relatives of persons who attempt suicide. The programme is run by a non-governmental organization, *Netværket for Selvmordsramte* (The network for the suicide struck: NEFOS). The programme has existed for five years in Southern Denmark and offers individual and group-based counselling to the relatives after suicide or suicide attempts.

All parents of children who had attempted suicide and who had participated in NEFOS group sessions in 2010 and 2011 were invited to participate in a focus group. Written invitations were sent out to 17 parents. Later, reminders were sent out to ensure a high level of turn-up at the focus groups. Two parents declined to participate for personal reasons and one parent did not participate because of an emergency immediately before the interview. The purposive sample (Patton 2002) included 14 parents.

Data collection

The focus groups took place in January and February 2012 on NEFOS' premises, where the counselling also took place.

Facilitation of the interviews

NB who is a trained and experienced research interviewer facilitated the focus groups and JC co-facilitated the groups and took field notes during the discussions. The facilitators had no prior knowledge of the participants and had no personal experience of being next of kin to a suicidal person.

The groups were started with a brief introduction to the study's purpose and a clarification of the ground rules of the session regarding time frames, mutual respect and confidentiality. The group interviews were focused by means of an open agenda. The agenda included six topics, which were developed on the basis of clinical experience: 1. The programme at NEFOS; 2. Communication with other children (in the family); 3. Stress and strain in everyday life;

4. Coping with difficult thoughts and feelings; 5. Communication with family, friends and colleagues/acquaintances; 6. Influences on the parents' relationship. The issues were introduced on plastic-coated notes (size A5) and the participants were asked to collaborate and arrange the notes in the order where they preferred to address the issues. This focusing technique had been planned to create transparency about the agenda and to engage the participants in a collaborative exercise right from the beginning. The groups were ended with a debriefing evaluation of the session. The level of facilitator involvement was deliberately low, because we were interested in how the participants negotiated the issues through the group conversations.

The focus groups were audio recorded. The recordings were transcribed by JC, who used transcription conventions that indicated basic conversational turn-taking. The accuracy of the transcriptions was checked by NB and by JC. The first focus group lasted 2 hours and 40 minutes; the second 2 hours and 30 minutes (both including a 10-minute break).

Ethics

The interview topic was highly sensitive (Lee 1993) and we organized our approach to protect the health and well-being of the participants. The high level of participation was most probably linked to participants' positive experiences at NEFOS. Trust and reciprocal relationships had been established prior to research and that could to some extent be interpreted as deceiving participants into the research-context, like a Trojan Horse (Fog 1994). If any participant felt distressed beyond what could be managed at the scheduled debriefing, a NEFOS councillor was on call. As it was, several of the participants expressed gratitude for the opportunity to, once more, talk about their experiences in a supportive environment.

In accordance with Danish legislation, we informed the National Committee on Health Research Ethics and the Danish Data Protection Agency about the study. All participants gave their consent to participate based on written and verbal information about the study. Data were handled confidentially and the data extracts presented in the following results section were anonymized to protect the participants' identity. NB translated the data extracts into English.

Data analysis

The analysis combined a thematic analysis with a subsequent analysis of how the themes were negotiated in the conversational interactions (Morgan 1997, Halkier 2010). First, we coded (Coffey & Atkinson 1996) the thematic content of the transcripts and identified four categories, which had some resemblance to the topics from our interview agenda: (1) Psychosocial strain and stress; (2) Effects on the parental relationship; (3) Effects on the family; (4) Effects on relationships with others. Second, we divided the transcripts according to the four categories and analysed the conversational turn-take structures and the topic-organization to identify how speakers presented and negotiated the conversational content (Hutchby & Wooffitt 1998). In the analyses, we identified two central themes across the preliminary four categories. These two themes concerned the participants' descriptions of emotional strain and how the strain affected their family. Third, we further explored and described the characteristics of the two themes through systematic comparisons of the thematic content and the two themes were linked to exemplary data extracts. Fourth, we re-examined the original audio recordings and the transcripts to determine whether the two themes and the data extracts represented a nuanced and balanced interpretation across the two interviews.

Results

There were six participants in the first group and nine participants in the second; by coincidence, one parent participated in both groups. In our sample, the median age of the participants' children at the time of the suicide attempt (s) was 15 years, ranging from 14–35 years; Table 1 gives a more detailed description of the sample and their offspring.

Emotional responses and stress

The participants had experienced the period before their child's suicide attempt(s) very differently. For the majority of the parents, the suicide attempt was the culmination of a prolonged period, often several years, where their child had suffered from psychological problems and exhibited highly disturbed behaviour, such as self-harm or eating disorders. These parents had struggled trying to help their children and to mobilize the appropriate health and social care services and felt powerless because of their inability to stabilize the child's deteriorating situation. Some of these children were formally diagnosed and had received treatment, whereas others had not. Some of these parents described the first suicide attempt as also being relieving, because they had feared a disastrous event for a long time; they hoped that hitting rock bottom could be an eye-opener for the child who might be more willing to accept help. For the minority of parents, the first suicide attempt had come with very short or no prior warning and they were shocked by their child's severe problems and lack of well-being.

Table 1 Description of the participants.

	Focus group 1						Focus group 2							
	#1	#2	#3	#4*	#5	#6	#1*	#2	#3	#4	#5	#6	#7	#8	#9
Characteristics of participant															
Gender	Female	Male	Female	Male	Male	Female	Male	Female	Female	Male	Female	Female	Female	Female	Male
Spouse participating in interview	#2	#1	No	No	#6	#5	#2	#1	No	#5	#4	No	No	#9	#8
Spouse participating in group-counselling programme	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes
Year of exit from programme	2010	2010	2010	2009	2010	2010	2009	2009	2011	2011	2011	2011	Still active	2011	2011
Characteristics of suicidal son/daughter†															
No. of suicide attempts	1		1	4–5	2		4–5		1	1		2	5	> 2	
Gender	Female		Female	Female	Female		Female		Female	Female		Female	Male	Male	
Age	14		14–15	15	15		15		20	<18		18	35	>18	
Suicide threats	Yes		Yes	Yes	?		Yes		Yes	Yes		Yes	No	Yes	
Psychiatric comorbidity	?		?	Cutting	?		Cutting		?	Borderline		Eating disorder	Schizo- affective disorder	Drug abuse	
Current suicidal behaviour	No		No	No	No		No		No	No		No	Yes	Yes	

*Same person participating in both groups.
†The participants were not explicitly asked about the characteristics of their suicidal child or about the suicide attempt(s), the information in this Table is extrapolated from the focus groups.

The participants described how the children's suicide attempt(s) and later suicidal behaviour threw them into a state of panic and horror. Some of the parents had found their child after a suicide attempt, whereas others had received news about the attempt from emergency healthcare staff. All participants described an all-consuming state of alarm as they fought to keep their child safe after a suicide attempt. This included numerous and lengthy telephone conversations with the child about their emotional distress, and physical intervening, such as standing guard, stopping suicidal behaviour and bringing the child to safety:

Participant #5, Group 1: Those six months, when Susan [his daughter]. When it was really at its worst. When she did the, I don't know, three, four five more or less whole-hearted suicide attempts. It was red alert 24 hours a day. I slept outside her door. Sometimes she ran off and I had to follow her. Over the fields, through the woods and up to the railway line. It was a nightmare. And she ran bloody fast, I couldn't keep up with her (laughs). It was just terrible and once I had to pull her out of the lake (…)

…

Participant #6: As you say, you slept outside her door. Just a telephone ringing, you [sighs heavily]. 'What now?' 'Where are we going now?' It was really hard.

The state of acute alarm was gradually succeeded by a period dominated by fear of a new suicide attempt. All participants described how fear would slowly ease off when the child was in a stable period, but that small reminders could trigger and reinvigorate the full and overwhelming feeling of fear. The most commonly described trigger was the sound of incoming telephone calls and text messages, which for many was associated with catastrophic or threatening news from or about their child. Most participants described long periods of continual ruminations and worries about the child:

Participant #2, Group 1: I think I've been like that for a long, long time, in that state. I've also thought that 'this is going really well' and 'now I'm not scared of anything anymore'. But this Monday she didn't come home. And she hadn't said she was going anywhere and time just passed. She is usually home at twenty to four and she still wasn't home by 8. And I couldn't get her on the phone and she hadn't got in touch, she hadn't said where she was or anything. Then it's back again. Oooh. My heart pounds and, then there was a perfectly natural explanation why she didn't come home, but it's there again. I can just feel all of it again.

All participants described how they had made supreme efforts to try to save and support their child after the suicide attempt and how these efforts had most often been futile and left them with all pervasive feelings of powerlessness.

All participants described discouraging setbacks, such as new attempts or renewed suicidal behaviour and broken agreements and promises. Both groups described hopelessness and anger towards the child, who was seen as partly responsible for setbacks and for corrupting all other family members' well-being. In the second group, the majority of participants described current or previous feelings of intense hate and blame towards the child and how they would give in to the child's threats about suicide:

Participant #4, group 2: But there's also that, that it can push you so far out, that something you love most in your whole life, that you can and I've been lying there, when I couldn't sleep and then, 'Well do it then for Christ's sake'. 'We might as well get it over with, mightn't we?' 'Also because I bet you're going to do it in 5 or 10 years anyway.' 'So you might just as well do it now, so I can get.' 'Why the hell should I spend ten years of my life trying to save you, if you can't?' Well, you just get pushed so far out, that you end up throwing in the towel, it's really amazing.

Most participants stated that they, in particular in the period immediately after the first suicide attempt, felt very guilty because they were responsible for bringing up their child. Later, most parents felt guilt towards other children in the family, which they believed had been neglected because of the massive focus on the suicidal child:

Participant #3, group 1: It's more the handling of the feelings of guilt and that kind of thing that I've found difficult (…) I felt so guilty, that it was my responsibility. It was me, who brought her into the world, me who formed her and it was me who let her down and it was more or less my fault that she got so far out as to trying suicide.

The participants described how they felt isolated after the suicide attempt, mainly because they were convinced that nobody would be able to understand the horrible event. Some participants felt uncomfortable sharing their story because they felt shame. The belief was that a child's suicide attempt would only happen in a sick family. Some parents were ashamed of their child's highly disturbed behaviour and that they were not able to stop it – even though they tried their utmost to do so:

Participant #3, group 2: We were so ashamed of it. It was on account of what she went through that people couldn't understand why she didn't just leave it all. [On top of threat of suicide, the daughter was in a violent relationship.] Or 'Why didn't we sound the alarm and fetch her home'? Or 'Why didn't my husband do something like that?' And then I say, 'Bloody hell man, of course we've done everything.' 'We've been down on our bended knees to the police and said, 'Do something'.' So we certainly reckoned we had done whatever we could…It was bloody hard to go and say to people. Because they couldn't understand that we didn't, that she didn't just go, that we didn't do anything. But in reality we did do everything, in our opinion, we did. I think it was terrible.

The pressure on the parents and families was intense and the fundamentally unpredictable character of suicide attempts was frequently emphasized. A participant described the parents as acting under the same level of psychological pressure as the children and two participants said that they had thought about committing suicide themselves because of the prolonged and unbearable pressure.

Double trauma: Effects on families and relationships

The participants described the fear of a repeat attempt making them hyper vigilant and attentive of the suicidal child. Many participants described being manipulated by their child, because of a combination of guilt and fear. Despite being aware that giving the suicidal child special privileges undermined the parents' fundamental values for upbringing and threatened to corrupt all relationships in the family, the parents found it very challenging and sometimes impossible to confront the child and, in time, to reclaim special privileges:

Participant #9, group 2: And then it affects the way you think you want to raise your children and what you want to teach them about life. Suddenly the foundation you have built on crumbles, because you always go round with a guilty conscience about doing something wrong. And suddenly you begin to be a pleaser, because you are frightened out of your wits that if you aren't a pleaser in this situation, when they begin to threaten you, if I face hard with hard, then it will be my fault if they kill themselves. So suddenly it slowly turns into a sort of downward spiral, where the one who threatens us who has sort of taken over and who decides what the rest of us may think and do and use in the upbringing. Because we carry a guilty conscience the whole time.

All participants were in long-term relationships and acknowledged that arguments and conflicts in the family were a threat that could easily lead to a divorce. Most participants described how the suicidal child would play the parents off against each other. This often happened if the child exclusively told one parent about his/her emotional stress, which meant that the parents generated completely different images of the child and felt different levels of strain. A further source of conflict was differences in the way the parents managed the situation. For instance, all the participants shared stereotype ideas about women needing to talk more about things than men and this could also trigger conflicts when women felt rejected and/or men felt intruded on. During the groups, several participants

confessed to being disloyal to their partner, simply trying to help their child the best they could. However, they would at the same time disregard explicit and implicit agreements with their partner, who would feel hurt and very angry:

Participant #5, group 1: In the beginning when there was a definite aim, keeping Susan [his daughter] alive. We really stuck together, there were no problems. A vacuum develops afterwards, where you realize that it is perhaps difficult to keep your balance right there. 'Who did what?' 'Did you say something wrong or?' 'I don't think you should have done that.' 'You shouldn't have let her go to that party', or something or other.

Participant #6: It's absolutely plain to see there's a test of the relationship there.

Participant #5: But it's the same again, those conflicts you have in all other families. There's just the unique difference that the consequences can be fatal, if you make a wrong decision.

Some participants described their other children as behaving similarly to themselves: sensitive and protective towards the suicidal child. Other participants described how siblings felt neglected because of the extra focus on the suicidal child, which often led to conflict with parents and with the suicidal child. According to the parents, some siblings explicitly stated that they hated the suicidal child and avoided having any connections. Some parents believed that some of the problems and illnesses the other children experienced had been caused by the damaged family dynamics and neglect:

Participant #3, group 1: I think that the brothers and sisters of such a child who is threatened by suicide become more protective and sensitive and have their antenna out. I have a daughter who's just turned eleven now, so she was 8 at that time, 7 or 8 years old, she is very aware of the older sister and she doesn't say anything directly. But I can feel that there's something there, that you have to take special care of Joan [the older sister].

Although participants had come to a greater understanding of the dynamics, fear, guilt and good intentions continued to generate conflict in the relationship. It was difficult to maintain a stable and giving relationship, because the child was always *in-between* the parents and a participant described her child's suicide attempts as a 'double-crisis' because of the secondary trauma and stress on family and marriage.

Discussion

Participants described themselves as severely emotionally and socially traumatized by their child's suicide attempt and as being caught up in a very disempowering situation, where the psychosocial effects of the son or daughter's suicidal behaviour threatened to corrupt all interpersonal relationships in the family. These findings were in line with previous research on parents of sons or daughters who attempt suicide (Torraville 2000, Daly 2005, Rutherford 2005).

The suicide attempts were highly 'disruptive' events (Bury 1982) in the families' lives and the group conversations contained numerous instances where the participants attempted to manage societal reactions and repair the disruption. The participants' accounts were focused on legitimizing their roles as morally adequate and responsible parents who should not be held responsible for their son or daughter's unhappiness and socially disturbing behaviour. Such emphasis on identity work was also described by Owen *et al.*, who analysed narratives of parents of sons who had committed suicide (Owen *et al.* 2012). In particular, the parents in Owen *et al.*'s study construed explanations of the son's reasons for committing suicide and thereby displaying anger and guilt and placing blame and exoneration (Owen *et al.* 2012). The parents in the present study were not as definitive in their explanations of the suicide attempts and negotiations of parental responsibility and blame were open and sometimes volatile. The on-going stress and the double trauma indicated that challenges to their parental roles and social status were evolvable and outside the parents' control.

The participants' experiences of parenting under the threat of the self-inflicted death of a son or a daughter were similar to parenting under other life-threatening conditions, such as a heart surgery where immediate survival and safeguarding are paramount (Rempel & Harrison 2007) and the more long-term management of caregiving-stress related to having a child with a chronic and life-limiting disease, such as congenital heart disease and cystic fibrosis (Moola 2012). Whereas these illnesses share the same level of life-threatening seriousness, they differ significantly with regard to the levels of imputed responsibility for the illness. One part of this issue was related to the participants' feelings of guilt, because they regarded themselves as being responsible for the child's situation. Another part of the issue was related to the participants' feelings of blame, anger and hate towards the child who was regarded as responsible for continual strategic manipulations of relationships in the family. In general, these latter feelings were not socially legitimate: parents are not expected to blame or hate their children for their illness-related behaviour. Finally, the parents felt ashamed by the situation. The child's disruptive behaviour and the suicide attempt were a moral stigma on the whole family, which the parents were expected to have sorted out

or prevented. Thus, suicide attempts and suicidal behaviour shared some basic resemblances with other life-threatening illnesses, but the participants had to cope with additional moral stigma and they did this in the group by negotiating the character of the illness and who was responsible for it.

The sons'/daughters' suicidal intent was not an explicit concern to the participants who were outcome oriented, in the sense that they regarded the life-threatening gravity of the suicide attempt as crucial. The suicide attempt was described as a dramatic life-overthrowing and identity-defining event profoundly affecting the whole family. More, the gravity of the suicide attempt could be seen as having a double meaning for the participants. It was the crux of the emotional and social trauma: the undeniable evidence of a family with a child with a severely disturbed behaviour and the source of profound emotional strain. At the same time, the sheer gravity of a life-threatening situation had the power to legitimize the participants' feelings and actions and it created new possibilities for coping with the situation. It assisted them in meeting other parents in spite of feelings of shame and embarrassment and with the help of a councillor, they learned to open a space for mutual support where they were able to share and discuss their attempts to manage the situation, to articulate socially illegitimate feelings and to confess wrongdoings.

Limitations

Several situational conditions influenced how the dataset was produced and, consequently, the findings. First, study participants were recruited after participating in individual and group-based counselling. During the counselling sessions, the parents were introduced to new ways of thinking about their situation. The parents adopted these new ways of thinking and they would emerge both explicitly and implicitly during the focus groups, e.g. 'If they really want to do it [commit suicide], there is nothing you can do to prevent it'. In other words, participants' experiences were framed by the counselling intervention.

Second, data were produced during group conversations where the facilitator involvement was deliberately low. We prioritized letting the participants themselves negotiate the conversational topics and interactions. This meant that the facilitators rarely interrupted to explore loose ends in individual participants' accounts and some of these open-ended issues remained unexplored. However, the participants seemed very open about their experiences even though some of the topics were very challenging. This was probably because they had good prior experiences of sharing from the group-counselling sessions.

Third, the size and group composition of the two groups differed. A larger proportion of the participants in the second focus group were still very emotionally affected by the suicide attempt(s) and by their children's disturbed behaviour. Additional longitudinal data from focus groups or from individual interviews are needed to confirm if there could be a psychosocial trajectory following the trauma caused by suicidal behaviour and to hypothesize on the key influences on such a trajectory.

Conclusion

The trauma of being the parent of a suicidal child was experienced as a double trauma. The double trauma stemmed from the effect of a suicide attempt on the entire family of the suicidal person. The parents were scared of a repeated suicide attempt and they would generally interpret the children's acts as 'suicide attempts' and not as 'self-harm'. Possibly, some of the parents more strongly linked the events with a deadly outcome than the sons/daughters and the councillors did. Further exploration and deeper insight into individuals' meaning(s) of self-harm and how it relates to family relationships might be helpful in minimizing the psychosocial burden (Hawton *et al.* 2012).

Suicidal behaviour aggregates in families and the findings emphasize a need for the nursing professionals to recognize the potential need for postvention/prevention for parents and families, who struggle coping with the impact of self-harm using more dangerous methods or with clear suicidal intent. Supportive family-orientated postvention could include psychosocial interventions including counselling and psychoeducation focused on recognizing warning signs, communicative skills and coping strategies.

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Conflict of interest

No conflict of interest has been declared by the author(s).

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/ethical_1author.html)]:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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