No Time to Say Goodbye:

the Personal Journeys of Whānau

Bereaved by Suicide

The experiences of four parents bereaved

by suicide.

A dissertation presented in partial fulfillment of the

requirements for the degree of Master of Social Work

Caroll Aupouri-Mclean

2013

ABSTRACT

Nominal literature exists concerning the experiences of Māori whānau bereaved by suicide. Māori are vastly denoted in the suicide mortality statistics. The sudden and unexpected loss of a whānau member to suicide is an overwhelming occurrence for peoples of various different ethnic and cultural milieus.

Informed by means of a Māori paradigm; Māori research procedures are merged alongside each other to become the keystones to this study. A Case Study approach to research was applied in conjunction with Māori methodologies and which also provided the researcher with the course to circumnavigate the research procedure. These four whānau who contributed to this research are the manawa or core of this study and in the course of sharing their stories, they proffer knowledge and describe experiences of their bereavement as a consequence of the suicide of their young adult child.

Different sources of evidence were gathered together and included participant interviews, researcher observations, and literature that documented the experiences of whānau bereaved by suicide. The four Māori whānau identified several iwi (tribal) connections and came from a variety of small rural communities, took part in the interviews. These participants experienced losing their young adult child to suicide within the last 9 years. The interviews were all audio taped, each transcribed and analysed thematically.

This research found, that whānau bereaved by suicide undergo various emotional responses. Shock, anger, denial, helplessness and guilt were some of the responses identified by the whānau. Coping in response to suicide entailed seeking and gaining support, psychological and social isolation as well as searching for reasons as to 'why' the suicide occurred. Self-blame or blaming others for the suicide were also imperative factors in how whānau coped in response to suicide.

ACKNOWLEDGEMENTS

Ko Horouta te waka

Ko Hikurangi te maunga

Ko Waiapu te awa

Ko Tu Au Au te Marae

Ko Ngati Rangi te me toku Hapu

Ko Ngati Porou me Te Arawa me Tuwharetoa toku Iwi

Ko Caroll Aupouri-Mclean ahau

I would like to acknowledge the various people who have shown me support throughout this journey in finishing my thesis.

To Fiona Te Momo, my supervisor, thank you for your guidance, support, and belief in me.

To all the whānau who participated in this study. It is with warmth I humbly am grateful to you for giving me the time and space into your lives. Letting me sit in your homes and listen to your stories of pain and anguish, of heartbreak and of resilience, and kaha.

To my own whānau, daughters, mother, and mokopuna, who believed in me. Your belief that I could accomplish the mahi gave me the kaha to see this through.

To my colleagues, who have been my sounding boards, and on-going support. I thank you for your valuable advice, willingness to listen, and encouragement to finish what I started.

Nga mihi aroha ki a koutou

TABLE OF CONTENTS

GLOSSARY

A

Awhi   to embrace

H

Hapu   sub tribe

Hui   a gathering or meeting

I

Iwi   tribe

K

Kai   food

Karanga   ritual call of welcome

Kaumatua   elder

Kaupapa   purpose, reason for meeting, Māori philosophy and practice

Kawa   natural order of things created by Te Atua

Korero   speak

Kuia   elderly female

M

Mana   prestige, authority, privilege, responsibility

Manawa   heart

Manaaki   to give, to share, hospitality

Mihi   greeting

P

Pōwhiri   ceremony of welcome

R

Rangatahi   youth

Rohe   boundary

T

Tapu   sacred, sacredness

Tautoko   support

Tikanga   behaviour, customs, habits, rituals, etiquette

W

Whakamomori   suicide

Whakapapa   genealogy

Whānau   family

Whānaungatanga   establishing family connections

CHAPTER ONE: INTRODUCTION

1.0 Introduction

"There are always two parties to a death;

The person who dies and the survivors who are left behind".

(Toynbee, 1968, p. 267)

In Aotearoa/New Zealand the suicide death of an individual may have an extensive, deep impact on Whānau, hapu, and society. It is vital to state that the fundamental social structure of Māori society encompasses Whānau, Hapū and Iwi and suicide impacts on these structures in the community. It is seen as a tragedy because of the loss that discontinues the whakakpapa.

There is a little information that discusses specifically the Māori people or their Whānau bereaved by suicide, or as suicide survivors. Beautrais (2005) and Barnes (2006) focus on the experiences of Western populations regarding suicide trauma. The difficulty in finding current literature on Whānau is extended to include a lack of study on bereaved Whānau. This makes any study on bereaved Whānau to be significant. In addition, an extremely overwhelming aftermath of a person taking their own life is the pain felt by survivors (Wong, Chan, & Beh, 2007) and without studies on this area the knowledge is unrecorded. Suicidal behaviour has a huge effect on others.

Suicide is an intentional action that leaves Whānau dealing with the loss of a loved person. This study unpacks this statement by investigating 'surviving the suicide of an adult child'. In particular it examines four parents that represent Whānau

bereaved by suicide. In collecting narratives of Whānau bereaved by suicide was a desire to explore the stories Whānau shared in the attempt to understand their response to the suicide and what helped them cope with the trauma. This study retells stories from Whānau who suffered bereavement as a result of a suicide that occurred in their Whānau. The participants are parents and make up four Whānau.

1.1 Terminology

The thesis will use various terminologies. To allow the reader an understanding of the position I take the following terms are explained. Also, Chapter Four Two and Four provide further information on the concepts and terminologies applied in this thesis.

1.1.1 Coping

The concept of coping speak of an individual's behavioural and intellectual efforts to master, manage or alter demands that are difficult or beyond his or her means (Lazarus and Folkman, 1984). These efforts can both be focussed on dealing with or changing the demands itself, problem-focused efforts, or directed at regulating the emotions generated by those demands like emotion-focused efforts. (Lazarus & Folkman, 1984; Lindsey & Yates, 2004).

1.1.2 Support needs

The concept of support needs refers to the requirements of individuals and families for specific acts that communicate caring. It validates their worth, feelings, or actions. It can also be a way to enable adaptive handling of problems due to the delivery of data, support and resources (Cutrona,1996).

1.2 Significance of the study

I am a Counsellor, Social Worker, and Educator. The research topic was shaped by my interests, as a Māori Counsellor, Social Worker, and Educator, whose professional background included working with Māori and their Whānau experiencing trauma in the health and social service sector. I was determined to approach the task from a realistic, 'grass-roots' point of view by ensuring the 'stories' and 'lived experiences' of bereaved Whānau have a place to be heard. In this research, I position myself as a Whānau member who has not survived the suicide of a family member. However, the four Whānau within the research identify as Māori, belonging within a Whānau, Hapū and Iwi context, and allows me to be a person that understands Whānau. I operate from a whakawhanaungatanga position to open a window for others to connect, learn, and experience the death of

a 'loved one' through suicide. This research was undertaken within a tertiary environment and is about completing an academic achievement and creating spaces for voices from Whānau to tell their personal stories. The research records the journeys of Whānau responding to and coping with the death of their loved one through suicide. Therefore, this research is of interest to those who wish to understand how others have responded to, and coped with trauma including, parents, Whānau, professionals and researchers.

Recording lived experiences is important in this research. Macey (2000) says, "an understanding of the lived experience of those bereaved by suicide and what it means to those who live it is needed to complement and complete the current scientific efforts of suicidology" (p. 298). The study I conducted is valuable because:

1. It addresses the lack of information on Māori, Whānau, and suicide.

2. Is developed from a basis that it is important for Māori ways of knowing and undertaking research with the best interest of Whānau.

3. It provides a forum for Whānau to share their experiences, have those experiences acknowledged, validated, and documented.

4. It facilitates a process of healing for Whānau affected by suicide.

5. It looks at the Treaty of Waitangi right for Māori to examine their own lives.

6. It provides an awareness of the kind of issues that unpaid and statutory organisations might contemplate while offering provision to people who are bereaved by suicide.

The overall aim of the research is threefold. The first is to examine Whānau stories of surviving the suicide of the adult child. The second is to explore the responses of Whānau to suicide of the adult child. Thirdly, to explore coping strategies that enable parents/family survive the impact of a suicide of relative.

1.2 Overview of chapters

Whānau understandings of death by suicide will be depicted throughout the subsequent chapters, by collecting all the information which will assist in understanding the phenomena. The thesis is divided into six chapters. The following information gives a brief overview of each chapter.

Chapter One introduces the research. It gives my personal rationale for conducting the research. It also provides a description of each Chapter. Chapter Two examines the literature pertinent to this research. It examines suicide, death, and other issues regarding Whānau.

Chapter Three explicates the methodology. It discloses the theoretical foundations which inform this study and provides some reasoning for the selection of approaches utilised. Chapter Four discusses the interviews with the Māori Whānau. Their perceptions, experiences, responses and ideas about coping with the death of their child through suicide, are reported as Case Studies.

Chapter Five intertwines the research by affording a discussion and explanation of the complete findings. An examination of the case study data and in what manner it links with the published literature is given. In Chapter Six the concluding

statements are made. Also, the Chapter revisits the research questions, findings, and gives some recommendations for future research.

1.4 Conclusion

Since there is a variety of literature about suicide the general information about experiences of Māori parents is rare. The endeavour of this research project is to examine whānau narratives of surviving a suicide death of their child. An aim of the research is to increase peoples understanding of the behaviour from parents grieving the loss of their child. Understanding the coping strategies that help parents survive suicide death is another objective of this project. It is anticipated that the thesis affords awareness into the phenomena and a better understanding of how parents are able to be supported in the loss and grief of their child. The six Chapters go a long way to provide answers to the aims of this project.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This Chapter reviews literature that relates to Māori experiences of bereavement and suicide. While there is considerable literature, nationally and internationally, concerning suicide, literature on Māori is not immense. Research recounting Māori and their experience of suicide in Aotearoa, from both an individual or family perspective, are deficient. The consequences of a death by suicide on those family members left behind, continues to be under conceptualized and inadequately comprehended. Kalischuk, Hayes & Grieving (2003); Beautrais (2005), Wong, Chan, Wincy & Beh (2007), Maple, Edwards, Plummer and Minichiello (2010) noted a growing appreciation of the necessity to better appreciate the reactions of those bereaved by suicide.

Suicide has being defined as "purposefully self-inflicted injury resulting in death" (Coupe, 2005, p. 45). Maple et al. (2009) explain suicide as the conscious deliberate action of ending one's own existence. Risks of suicidal behaviour are increased among people with mood disorders, anxiety disorders, substance abuse addictions, and antisocial behaviours. Other risk elements that have influenced the increased incidence of suicide include the exposure to trauma, life stresses, childhood adversity, family instability, unemployment, socioeconomic, and cultural factors (Beautrais, 2005).

An examination of the literature was carried out by means of the Massey University library catalogue and databases. The Index NZ; contained quality abstracts from journals and research that are not available anywhere else. The Social Science Indexes which include EPSCO and Proquest. These contain sociological and psychological journal articles. Newztext Plus has articles that reflect societal views on suicide. The National Bibliographic Database, Psychological Abstracts, PubMed, Social Sciences Index, Social Work Abstracts, and Sociological Abstracts are other data bases that were searched. Additional searches of the SPINZ (Suicides Prevention Information New Zealand) databases and Ministry of Health, Mental Health Commission's websites and Ministry of Social Development Information Centre database will be undertaken.

Material on Māori, Whānau, Indigenous, and minority groups that were grieving a suicide death was read. Other written information was carefully chosen on the basis of year of publication being under ten years old was preferred. Google searches were useful in tracing some specific literature. The themes are presented as subheadings followed by commentary. The themes are: 2.1 Suicide; 2.2 Bereaved; 2.3 Coping; 2.4 Grief; and 2.5 Frameworks. A conclusion ends the Chapter.

2.1 Suicide

Suicide is a major preventable public health issue (Cerel Padgett, Conwell, & Reed, 2009; Jordan and McIntosh, 2011; Said, 2008). For more than 30 years, international study and national policy proposals have endeavoured to curtail this phenomenon, by collecting beneficial information regarding those 'at risk' of suicide. However suicide remains to be the third-primary reason of fatality for

Māori (Collings and Beautrais, 2005). Moreover, suicide is reported as a main reason for of death in New Zealand, particularly avoidable deaths for the ages of 15-44 year olds (Ministry of Health, 1998). Significantly, in 2002, suicide caused more deaths than traffic fatalities (Ministry of Health, 2004). This current upsurge in suicide fatalities among Māori makes it essential to comprehend this phenomenon. Coupes (2005) epidemiology studies ascertained that rates for Māori increased 56% compared to 23% for non-Māori.) states, "the majority of Māori suicides occur in young people aged 35 under years. Rates of suicide are higher among Māori males and females aged under 25 than in their non-Māori peers" (p. 122).

Lawson-Te Aho (1998) gives a cultural description of suicide as being a resolute self-inflicted injury causing death. Māori suicide, whakamomori, is interpreted to be, "a deep seated underlying sadness' and an in built tribal suffering" (Lawson-Te Aho's, 1998, p. 16). Durie's (1999) comments, suicide is a culturally unfamiliar phenomenon for Māori which indicates that the action has a prodigious bearing on present-day Māori. Moreover whakapapa bestows connections between Whānau, Hapū and Iwi. "The added dimension beyond the loss of a precious life is the loss of that Whānau member's unique contribution and continuation of whakapapa. Whānau, Hapū and Iwi are dependent upon each member for their continued existence" (ibid, p. 75). Lawson-Te Aho (1998) and Coupe's (2005) put suicide into a social, historical, political context. They suggest that high rates are indicative of the cultural subjugation and social fragmentation following rapid colonisation. Lawson-Te Aho (1998) suggested that in traditional society, the deed of suicide was limited within traditional culture was carried out mostly by bereaved women. There is suggestion that suicide was a method of reparation or recompense for

shame produced by a harmful act. Traditional society referred to the time before Māori were colonised by Britain. Contemporary Māori refers to Māori people post-colonisation, and Lawson-Te Aho says, suicide mostly involves young Māori men, isolated from their cultural values and principles as Māori.

A considerable proportion of young people in Aotearoa/New Zealand and other Western nations now die by suicide than at any other time in history. The "World Health Organisation (WHO) estimates that each year approximately one million people die from suicide, which represents a global mortality rate of 16 people per 100,000 or one death every 40 seconds. It was predicted by 2020 the rates of suicide death will increase twofold, to one every 20 seconds" (Statistics NZ, 2009, p. 3). Also, suicide amounted to, "526 (388 males and 138 females) deaths in 2006; 487 (371 males and 116 females) deaths in 2007; 497 (366 males and 131 females) deaths in 2008" (ibid, p. 3).

Suicide is committed by predominantly males. In Aotearoa/New Zealand, the "highest suicide mortality rates in 2008 being Māori Males (15-24 years) as opposed to non-Māori Males" (Ministry of Health, 2010, p. 2).

Suicide is a social issue for Māori youth aged 15 to 24 (Coupe, 2005). "The majority of Māori suicides occur in young people aged 35<years" (Beautrais, 2005, p. 122). Māori males have an advanced frequency of suicide with a frequency of "23.9 deaths per 100 000 in 2010 compared to 15.4 per 100 000 for non-Māori males Māori youth suicide rates in 2010 were more than 2.5 times higher than those for non-Māori youth" (Ministry of Health, 2010, p. 18). When ranked

alongside of other OECD countries, the New Zealand suicide rate for males aged 15 to 24 years in 2010 was the fourth highest, higher than in any other country except Iceland and Finland" (ibid. p. 37.) In 2010 Suicide death was recorded as the "second common cause of death for youth at a rate of 17.7 per 100,000 compared to 18.2 per 100,000" (ibid. p. 10) for traffic crashes. However a Chief Coroner claims, "New Zealanders taking their own lives is 50 per cent higher than the road toll" (Todd, 2010, p. 1). Judge Neil Maclean claimed that, "New Zealand rate of suicide received little attention in comparison with the road toll, even though significantly more people died" (ibid, p. 1). There is an abundance of articles, papers, and chapters that provide information and statistics on suicide (Ness and Pfeffer, 1990; McIntosh, 2009; Dyregov, 2002). The financial price tag of suicidal behaviour within the Aotearoa/New Zealand public is high (O'Dea and Tucker, 2005).

2.2 Bereaved

Death and bereavement are not unknown to Whānau. Epidemics have taken a great toll on the lives of our forbearers. Māori were not strangers to death. In fact, history highlights that typhoid, smallpox, influenza, confiscation of land, musket and Māori wars wiped out large portions of the Māori population (Durie, 2002). Death in the early period of infancy was common, and it was uncommon for Whānau not to lose a family member at an early age.

The loss of and absence of a member of the Whānau is a forfeiture of future possibilities. The loss of heritage epitomizes an abysmal and avoidable calamity for the whole Whānau (Mikaere, 2002). This loss of life through suicide, positions

the continued existence of whakakapapa in jeopardy. The additional aspect beyond that of grieving the loss of a valued life is the lack of participation and involvement by the Whānau member and that continuance of their whakapapa has ended (Ihimaera and MacDonald, 2009).

An issue that emerges in literature is the way to identify people who are grieving the loss of a 'loved one' through suicide. Some researchers have inclined to name this group 'survivors', whereas others have contended that this can possibly be unclear because the expression 'survivors' is likewise applied to denote those who are survivors of attempted suicide. The shared convention in Aotearoa/New Zealand literature to describe this group is the label 'bereaved by suicide' (Beautrais, (2005), Ehrhardt and Ehrhardt, 2004).

The experiences and needs of families bereaved by suicide are underrepresented in the literature. Families have been described as the forgotten people (Ehrhardt and Ehrhardt, 2004). Furthermore, whilst there is growing acknowledgment of the necessity to improve awareness of the reactions of those grieving a death by suicide, literature on Whānau bereaved by suicide is virtually non-existent. Whānau have been invisible in the research. An abundance of studies focussed more on Western experiences of suicide and the subject of 'suicide' has been tapu in Māori society. Recently in Aotearoa/New Zealand and overseas, an acknowledgment of the need to enhance awareness of the responses of survivors of suicide and provide them with resource provision has been recognized. Therefore, the New Zealand Youth Suicide Prevention Strategy has recognised as

an important part of their policy the delivery of efficacious "support to those who are bereaved or affected by a suicide" (Associate Minister of Health, 2006, p. 27).

For a certain period, studies have specified that one of the most devastating incidents to transpire for families is the death of a child. The death of a child seems inappropriate, unnatural and unacceptable because they are expected to live long. The suicide of a child is causes further pain to families because of the unanswered questions and feelings of the future dreams for the family being unfulfilled. (Nixon and Pearn, 1997; Biggs, 2002)

Various researches have been led in England and the United States of America that compare responses of suicide survivors; that is parents, siblings and friends grieving death by suicide and other unexpected deaths such as accidents and homicide (Kovarsky 1989; Range & Niss 1990). Similarly, findings were obtained by Jordan (2001) and Reed (1998) who provided evidence that grief connected to suicide contrasts with grief related to different methods of death due to the complex intricacies that accompany losing a person in this manner. In a more recent report published by The Christchurch School of Medicine and Health Services, it has been highlighted that suicide bereavement might vary from grieving different kind of deaths in that there is a fervent requisite to acquire and attain meaning, sense, and significance in the death (Beatrais, 2005). Moreover, studies collectively indicate that there are intense periods of blame, liability, and accountability, and stronger emotional states of disowning and relinquishment; greater incidents of stigmatization and exclusion and definite influences to family structures in particular how families communicate and interact (Cleiren, 1999;

Beautrais, 2005; Ness & Pfeffer, 1990;). Thus, an exploration of the responses and coping mechanisms by bereaved Whānau members would be a valuable contribution to current understanding.

2.3 Coping

Durie, (2000) &Lawson Te Aho, (1998) maintain that how death is perceived and understood alongside of about what occurs to people when they die and how we make sense of suicide, are culturally demarcated. A Westerner, Hedtke (2000) maintains a modernist approach to death and says people must get over their grief and move on in life. In spite of that response, Māori are taught that a bereaved person should behave and grieve so they can let go of hurt and a way for Whānau to cope with the lost.

When a person dies, a relationship with them does not pass away because death is not final. It can be seen as an invitation to a new relationship with the dead loved one. According to Barnes (2006), in her studies on African American's responses to suicide, the bereavement process turns out to be further problematic for African Americans, purely for the fact that in their cultural community there are no support mechanisms or provision in which to grieve. The reality that suicide yet continues to be 'an act of shame' in African American populations creates challenges in completing grief processes for many suicide survivors. Families of the person who has committed suicide encounter an emotional manifestation and a holistic healing process is required. Barnes indicates the occurrence of suicide continues to be concealed in African American communities because of the stigma of shame attached to the act. Therefore, the way families cope are unwritten.

According to Berry, (1997) the stress and coping approach, as the expression might insinuate, was started in the arena of psychosomatic inquiry on trauma and anxiety. Western evidence maintains this sojourning encounter can be a demanding phenomenon that incites adaptive reactions. John Berry, a chief authority on stress and coping methods, developed Lazarus-Folkman's 'Stress and Coping Theory' located in arena of psychology and offers a detailed 'Stress and Coping Framework' on multicultural adaptation (Meng Liu, 2008).

The notion of coping, from Western literature, discusses an individual's behavioural and cognitive exertions to control, manage or modify demands beyond their resources (Kumpst, 1994). These efforts can both be engaged at dealing with or amending the stresses (problem-focussed efforts) or governing the emotions produced by those demands (emotion-focused efforts) (Lazarus & Folkman, 1984; Lindsey & Yates, 2004). Death by suicide in a Whānau (family) is understandably a highly stressful situation that generates intense emotions. For the Whānau bereaved by the suicide, the coping process is two-fold, not only do the bereaved Whānau have to cope with the grief but also issues around suicide. These include issues of shame, guilt, stigma and isolation. Closely related to the term coping is the concept of adjusting. Adjustment refers to the outcome and fit of the coping efforts with the demands placed on an individual. Adjustment is therefore a person's accommodation of personal and environmental demands (Lazarus & Folkman, 1984).

2.4 Grief

Philosophies of grief and loss established in the 1960s by Westerners have remained significant in influencing bereavement. Kubler-Ross (1991) tells of a five-stage model of grief and bereavement that comprise denial, anger, bargaining, depression, and acceptance. Intense grief reactions consist of depression, anxiety and post-traumatic stress disorder which can affect the extent of the bereavement course, making it lengthier with a slower recovery period (Lindsey and Yates, 2004).

Grief is an agonizing undertaking and striving to make sense and create meaning of a death by suicide, is recognized as an incredibly demanding procedure for those bereaved by suicide (Wertheimer, 1991). Samy (1995) denotes the grief trajectory as being complex and contingent on several variables. For instance, if the pre-death association with the deceased was in discord (or not) and whether the suicide was expected (Bailley, 1999) the pain could have been lessened if those bereaved by suicide felt a degree of support (Callahan, 2000). It is believed to be a challenging process for the bereaved to talk about their feelings and emotions after the death and discuss socio-cultural norms (Dunne, 2000; Minois, 1999). Findings from quantitative research propose that numerous aspects may impact on the suicide-bereavement experience. The combined effects of former medical, relational, biological, and social influences on suicide all accentuate the story in an individual's suicide bereavement (Beautrais, Joyce, & Mulder, 1997; Cullen & Connolly, 1997; Makinen, 2002; Platt & Hawton, 2000; Williams & Pollock, 2002). Very few qualitative studies have reported on the lived experience of the bereaved, possibly reflecting the fact that it is difficult to access this population (Dyregrov et al., 2003). Given that suicide survivors are at great danger

for completed suicide, the necessity to afford appropriate and effective support networks has been acknowledged (Clarke & Goldney, 2000; Turecki, 2001). This concern is appropriately echoed in the frequently cited statement 'postvention is prevention for future generations' (Shneidman, 1969).

The people bereaved by suicide from Western statistics, account for about six people suffering from grief after each suicide (Shneidman, 1972; Clark & Goldney, 2000). Annually this approximates to at least six million persons worldwide who grieve a suicide death (Wong et al., 2007). Nevertheless, this number underrates the quantity of those actually affected by suicide particularly if considering siblings, parents, grandparents (Cantor, 1999).

The devastation suicide leaves behind for the grieving survivors, is not a new phenomenon (Cain, 1972). However, Suicidology; the study of suicide, has emphasised the need to understand and treat suicidal individuals. Much of the consideration of the mental health profession has focussed on people who commit suicide and seldom addressed what occurs for those people who have endured the suicide of a family member.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This Chapter reviews literature that relates to Māori experiences of bereavement and suicide. While there is considerable literature, nationally and internationally, concerning suicide, literature on Māori is not immense. Research recounting Māori and their experience of suicide in Aotearoa, from both an individual or family perspective, are deficient. The consequences of a death by suicide on those family members left behind, continues to be under conceptualized and inadequately comprehended. Kalischuk, Hayes & Grieving (2003); Beautrais (2005), Wong, Chan, Wincy & Beh (2007), Maple, Edwards, Plummer and Minichiello (2010) noted a growing appreciation of the necessity to better appreciate the reactions of those bereaved by suicide.

Suicide has being defined as "purposefully self-inflicted injury resulting in death" (Coupe, 2005, p. 45). Maple et al. (2009) explain suicide as the conscious deliberate action of ending one's own existence. Risks of suicidal behaviour are increased among people with mood disorders, anxiety disorders, substance abuse addictions, and antisocial behaviours. Other risk elements that have influenced the increased incidence of suicide include the exposure to trauma, life stresses, childhood adversity, family instability, unemployment, socioeconomic, and cultural factors (Beautrais, 2005).

An examination of the literature was carried out by means of the Massey University library catalogue and databases. The Index NZ; contained quality abstracts from journals and research that are not available anywhere else. The Social Science Indexes which include EPSCO and Proquest. These contain sociological and psychological journal articles. Newztext Plus has articles that reflect societal views on suicide. The National Bibliographic Database, Psychological Abstracts, PubMed, Social Sciences Index, Social Work Abstracts, and Sociological Abstracts are other data bases that were searched. Additional searches of the SPINZ (Suicides Prevention Information New Zealand) databases and Ministry of Health, Mental Health Commission's websites and Ministry of Social Development Information Centre database will be undertaken.

Material on Māori, Whānau, Indigenous, and minority groups that were grieving a suicide death was read. Other written information was carefully chosen on the basis of year of publication being under ten years old was preferred. Google searches were useful in tracing some specific literature. The themes are presented as subheadings followed by commentary. The themes are: 2.1 Suicide; 2.2 Bereaved; 2.3 Coping; 2.4 Grief; and 2.5 Frameworks. A conclusion ends the Chapter.

2.1 Suicide

Suicide is a major preventable public health issue (Cerel Padgett, Conwell, & Reed, 2009; Jordan and McIntosh, 2011; Said, 2008). For more than 30 years, international study and national policy proposals have endeavoured to curtail this phenomenon, by collecting beneficial information regarding those 'at risk' of suicide. However suicide remains to be the third-primary reason of fatality for

Māori (Collings and Beautrais, 2005). Moreover, suicide is reported as a main reason for of death in New Zealand, particularly avoidable deaths for the ages of 15-44 year olds (Ministry of Health, 1998). Significantly, in 2002, suicide caused more deaths than traffic fatalities (Ministry of Health, 2004). This current upsurge in suicide fatalities among Māori makes it essential to comprehend this phenomenon. Coupes (2005) epidemiology studies ascertained that rates for Māori increased 56% compared to 23% for non-Māori.) states, "the majority of Māori suicides occur in young people aged 35 under years. Rates of suicide are higher among Māori males and females aged under 25 than in their non-Māori peers" (p. 122).

Lawson-Te Aho (1998) gives a cultural description of suicide as being a resolute self-inflicted injury causing death. Māori suicide, whakamomori, is interpreted to be, "a deep seated underlying sadness' and an in built tribal suffering" (Lawson-Te Aho's, 1998, p. 16). Durie's (1999) comments, suicide is a culturally unfamiliar phenomenon for Māori which indicates that the action has a prodigious bearing on present-day Māori. Moreover whakapapa bestows connections between Whānau, Hapū and Iwi. "The added dimension beyond the loss of a precious life is the loss of that Whānau member's unique contribution and continuation of whakapapa. Whānau, Hapū and Iwi are dependent upon each member for their continued existence" (ibid, p. 75). Lawson-Te Aho (1998) and Coupe's (2005) put suicide into a social, historical, political context. They suggest that high rates are indicative of the cultural subjugation and social fragmentation following rapid colonisation. Lawson-Te Aho (1998) suggested that in traditional society, the deed of suicide was limited within traditional culture was carried out mostly by bereaved women. There is suggestion that suicide was a method of reparation or recompense for

shame produced by a harmful act. Traditional society referred to the time before Māori were colonised by Britain. Contemporary Māori refers to Māori people post-colonisation, and Lawson-Te Aho says, suicide mostly involves young Māori men, isolated from their cultural values and principles as Māori.

A considerable proportion of young people in Aotearoa/New Zealand and other Western nations now die by suicide than at any other time in history. The "World Health Organisation (WHO) estimates that each year approximately one million people die from suicide, which represents a global mortality rate of 16 people per 100,000 or one death every 40 seconds. It was predicted by 2020 the rates of suicide death will increase twofold, to one every 20 seconds" (Statistics NZ, 2009, p. 3). Also, suicide amounted to, "526 (388 males and 138 females) deaths in 2006; 487 (371 males and 116 females) deaths in 2007; 497 (366 males and 131 females) deaths in 2008" (ibid, p. 3).

Suicide is committed by predominantly males. In Aotearoa/New Zealand, the "highest suicide mortality rates in 2008 being Māori Males (15-24 years) as opposed to non-Māori Males" (Ministry of Health, 2010, p. 2).

Suicide is a social issue for Māori youth aged 15 to 24 (Coupe, 2005). "The majority of Māori suicides occur in young people aged 35<years" (Beautrais, 2005, p. 122). Māori males have an advanced frequency of suicide with a frequency of "23.9 deaths per 100 000 in 2010 compared to 15.4 per 100 000 for non-Māori males Māori youth suicide rates in 2010 were more than 2.5 times higher than those for non-Māori youth" (Ministry of Health, 2010, p. 18). When ranked

alongside of other OECD countries, the New Zealand suicide rate for males aged 15 to 24 years in 2010 was the fourth highest, higher than in any other country except Iceland and Finland" (ibid. p. 37.) In 2010 Suicide death was recorded as the "second common cause of death for youth at a rate of 17.7 per 100,000 compared to 18.2 per 100,000" (ibid. p. 10) for traffic crashes. However a Chief Coroner claims, "New Zealanders taking their own lives is 50 per cent higher than the road toll" (Todd, 2010, p. 1). Judge Neil Maclean claimed that, "New Zealand rate of suicide received little attention in comparison with the road toll, even though significantly more people died" (ibid, p. 1). There is an abundance of articles, papers, and chapters that provide information and statistics on suicide (Ness and Pfeffer, 1990; McIntosh, 2009; Dyregov, 2002). The financial price tag of suicidal behaviour within the Aotearoa/New Zealand public is high (O'Dea and Tucker, 2005).

2.2 Bereaved

Death and bereavement are not unknown to Whānau. Epidemics have taken a great toll on the lives of our forbearers. Māori were not strangers to death. In fact, history highlights that typhoid, smallpox, influenza, confiscation of land, musket and Māori wars wiped out large portions of the Māori population (Durie, 2002). Death in the early period of infancy was common, and it was uncommon for Whānau not to lose a family member at an early age.

The loss of and absence of a member of the Whānau is a forfeiture of future possibilities. The loss of heritage epitomizes an abysmal and avoidable calamity for the whole Whānau (Mikaere, 2002). This loss of life through suicide, positions

the continued existence of whakakapapa in jeopardy. The additional aspect beyond that of grieving the loss of a valued life is the lack of participation and involvement by the Whānau member and that continuance of their whakapapa has ended (Ihimaera and MacDonald, 2009).

An issue that emerges in literature is the way to identify people who are grieving the loss of a 'loved one' through suicide. Some researchers have inclined to name this group 'survivors', whereas others have contended that this can possibly be unclear because the expression 'survivors' is likewise applied to denote those who are survivors of attempted suicide. The shared convention in Aotearoa/New Zealand literature to describe this group is the label 'bereaved by suicide' (Beautrais, (2005), Ehrhardt and Ehrhardt, 2004).

The experiences and needs of families bereaved by suicide are underrepresented in the literature. Families have been described as the forgotten people (Ehrhardt and Ehrhardt, 2004). Furthermore, whilst there is growing acknowledgment of the necessity to improve awareness of the reactions of those grieving a death by suicide, literature on Whānau bereaved by suicide is virtually non-existent. Whānau have been invisible in the research. An abundance of studies focussed more on Western experiences of suicide and the subject of 'suicide' has been tapu in Māori society. Recently in Aotearoa/New Zealand and overseas, an acknowledgment of the need to enhance awareness of the responses of survivors of suicide and provide them with resource provision has been recognized. Therefore, the New Zealand Youth Suicide Prevention Strategy has recognised as

an important part of their policy the delivery of efficacious "support to those who are bereaved or affected by a suicide" (Associate Minister of Health, 2006, p. 27).

For a certain period, studies have specified that one of the most devastating incidents to transpire for families is the death of a child. The death of a child seems inappropriate, unnatural and unacceptable because they are expected to live long. The suicide of a child is causes further pain to families because of the unanswered questions and feelings of the future dreams for the family being unfulfilled. (Nixon and Pearn, 1997; Biggs, 2002)

Various researches have been led in England and the United States of America that compare responses of suicide survivors; that is parents, siblings and friends grieving death by suicide and other unexpected deaths such as accidents and homicide (Kovarsky 1989; Range & Niss 1990). Similarly, findings were obtained by Jordan (2001) and Reed (1998) who provided evidence that grief connected to suicide contrasts with grief related to different methods of death due to the complex intricacies that accompany losing a person in this manner. In a more recent report published by The Christchurch School of Medicine and Health Services, it has been highlighted that suicide bereavement might vary from grieving different kind of deaths in that there is a fervent requisite to acquire and attain meaning, sense, and significance in the death (Beatrais, 2005). Moreover, studies collectively indicate that there are intense periods of blame, liability, and accountability, and stronger emotional states of disowning and relinquishment; greater incidents of stigmatization and exclusion and definite influences to family structures in particular how families communicate and interact (Cleiren, 1999;

Beautrais, 2005; Ness & Pfeffer, 1990;). Thus, an exploration of the responses and coping mechanisms by bereaved Whānau members would be a valuable contribution to current understanding.

2.3 Coping

Durie, (2000) &Lawson Te Aho, (1998) maintain that how death is perceived and understood alongside of about what occurs to people when they die and how we make sense of suicide, are culturally demarcated. A Westerner, Hedtke (2000) maintains a modernist approach to death and says people must get over their grief and move on in life. In spite of that response, Māori are taught that a bereaved person should behave and grieve so they can let go of hurt and a way for Whānau to cope with the lost.

When a person dies, a relationship with them does not pass away because death is not final. It can be seen as an invitation to a new relationship with the dead loved one. According to Barnes (2006), in her studies on African American's responses to suicide, the bereavement process turns out to be further problematic for African Americans, purely for the fact that in their cultural community there are no support mechanisms or provision in which to grieve. The reality that suicide yet continues to be 'an act of shame' in African American populations creates challenges in completing grief processes for many suicide survivors. Families of the person who has committed suicide encounter an emotional manifestation and a holistic healing process is required. Barnes indicates the occurrence of suicide continues to be concealed in African American communities because of the stigma of shame attached to the act. Therefore, the way families cope are unwritten.

According to Berry, (1997) the stress and coping approach, as the expression might insinuate, was started in the arena of psychosomatic inquiry on trauma and anxiety. Western evidence maintains this sojourning encounter can be a demanding phenomenon that incites adaptive reactions. John Berry, a chief authority on stress and coping methods, developed Lazarus-Folkman's 'Stress and Coping Theory' located in arena of psychology and offers a detailed 'Stress and Coping Framework' on multicultural adaptation (Meng Liu, 2008).

The notion of coping, from Western literature, discusses an individual's behavioural and cognitive exertions to control, manage or modify demands beyond their resources (Kumpst, 1994). These efforts can both be engaged at dealing with or amending the stresses (problem-focussed efforts) or governing the emotions produced by those demands (emotion-focused efforts) (Lazarus & Folkman, 1984; Lindsey & Yates, 2004). Death by suicide in a Whānau (family) is understandably a highly stressful situation that generates intense emotions. For the Whānau bereaved by the suicide, the coping process is two-fold, not only do the bereaved Whānau have to cope with the grief but also issues around suicide. These include issues of shame, guilt, stigma and isolation. Closely related to the term coping is the concept of adjusting. Adjustment refers to the outcome and fit of the coping efforts with the demands placed on an individual. Adjustment is therefore a person's accommodation of personal and environmental demands (Lazarus & Folkman, 1984).

2.4 Grief

Philosophies of grief and loss established in the 1960s by Westerners have remained significant in influencing bereavement. Kubler-Ross (1991) tells of a five-stage model of grief and bereavement that comprise denial, anger, bargaining, depression, and acceptance. Intense grief reactions consist of depression, anxiety and post-traumatic stress disorder which can affect the extent of the bereavement course, making it lengthier with a slower recovery period (Lindsey and Yates, 2004).

Grief is an agonizing undertaking and striving to make sense and create meaning of a death by suicide, is recognized as an incredibly demanding procedure for those bereaved by suicide (Wertheimer, 1991). Samy (1995) denotes the grief trajectory as being complex and contingent on several variables. For instance, if the pre-death association with the deceased was in discord (or not) and whether the suicide was expected (Bailley, 1999) the pain could have been lessened if those bereaved by suicide felt a degree of support (Callahan, 2000). It is believed to be a challenging process for the bereaved to talk about their feelings and emotions after the death and discuss socio-cultural norms (Dunne, 2000; Minois, 1999). Findings from quantitative research propose that numerous aspects may impact on the suicide-bereavement experience. The combined effects of former medical, relational, biological, and social influences on suicide all accentuate the story in an individual's suicide bereavement (Beautrais, Joyce, & Mulder, 1997; Cullen & Connolly, 1997; Makinen, 2002; Platt & Hawton, 2000; Williams & Pollock, 2002). Very few qualitative studies have reported on the lived experience of the bereaved, possibly reflecting the fact that it is difficult to access this population (Dyregrov et al., 2003). Given that suicide survivors are at great danger

for completed suicide, the necessity to afford appropriate and effective support networks has been acknowledged (Clarke & Goldney, 2000; Turecki, 2001). This concern is appropriately echoed in the frequently cited statement 'postvention is prevention for future generations' (Shneidman, 1969).

The people bereaved by suicide from Western statistics, account for about six people suffering from grief after each suicide (Shneidman, 1972; Clark & Goldney, 2000). Annually this approximates to at least six million persons worldwide who grieve a suicide death (Wong et al., 2007). Nevertheless, this number underrates the quantity of those actually affected by suicide particularly if considering siblings, parents, grandparents (Cantor, 1999).

The devastation suicide leaves behind for the grieving survivors, is not a new phenomenon (Cain, 1972). However, Suicidology; the study of suicide, has emphasised the need to understand and treat suicidal individuals. Much of the consideration of the mental health profession has focussed on people who commit suicide and seldom addressed what occurs for those people who have endured the suicide of a family member.

on survivors of suicide. Even though little information on the number of suicide survivors exist, the statistics are significant. For example, in the United States, there is a minimum of 4.6 million individual persons who have lost someone to

suicide death (McIntosh, 2009). These survivors include mothers, fathers, siblings', aunties, uncles, spouses, extended family members, teachers, therapists, and neighbours. The effect of suicide bereavement extends from insignificant to overwhelming, depending on a variety of factors and can be ultimately life changing.

Personal narratives on grief, death and loss use a powerful metaphoric language. It contributes to the academic understanding of the experience and is particularly appropriate as a means of exploring the evolving nature of grief (Gilbert, 2002). The abrupt and unanticipated loss of a young person is an overwhelming experience and grief caused by other types of sudden traumatic death that are unexpected, and often violent in nature, can have similar effects of those survivors of a person lost to suicide (Cleiren, 1999). In the first two years post-death, recovery perhaps is longer.

2.5 Frameworks

Similarities in suicide tendencies, according Raphael & Swan, (1999) maybe depicted amongst the indigenous peoples of New Zealand, Australia Canada and the United States of America. A reaction to the imposed assimilation and subjugation of Māori and Indigenous peoples was the formation of harmful behaviours as managing tools. This phenomenon typically known as Post-Colonial Traumatic Stress Disorder illustrates indicators such as poor self-image, violence towards spouse, children and siblings. Whānau members are inept at identifying with their Iwi (tribe), and their identity is built on where they reside (urban) instead of genealogy and ancestry, (Tariana, 2000). Similarly, Te Aho's (1998) use of the

concept of acculturative stress describes symptoms of "lowered mental health status that includes, confusion, anxiety, depression, feelings of marginality and alienation, heightened psychosomatic symptoms level and identity confusion" (p.17). Acculturation, she suggests, remains to be a practice that has negative effectson present-day Māori.

Māori see health as holistic. This represents for them a four-sided concept representing four basic beliefs of life: Te Taha Hinengaro (psychological health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health) and Te Taha Whānau (family health). Te Whare Tapa Wha is a Framework that was conceptualised by Durie (2002), which may be usefully applied to health concerns that may affect Māori from their physical wellbeing to Whānau wellness. The Whānau is the central base for Māori societal structure. Consequently there is the contention that research into suicide needs to be "placed in the context of strengthening the Whānau as the core unit of Māori development" (Lawson-Te Aho, 1998, p. 6). An overall benefit is the contribution toward enriching the wellbeing of all Māori and working in the direction of Whānau, Hapū and Iwi health care.

In Aotearoa New Zealand and overseas, there have been numerous studies undertaken on the general topic of suicide both in Aotearoa/New Zealand and internationally. Findings from such suggest that suicide is an individual and exclusive catastrophe for the families, whānau, extended whānau, friends and communities (Beautrais, 2005; Coupe, 2005; Blakey, Rippon & Wang, 2006; Wong, Chan, Beh, 2007).

One of the commitments of The New Zealand Suicide Prevention Strategy 2006-2016, is to "reduce the harmful effect and impact associated with suicide and suicidal behaviour on families". Accordingly one of the seven goals of the NZSPS is to "support families/Whānau, friends and others affected by a suicide or suicide attempt" (Associate Minister of Health, 2006, p. 1). As a component of the execution of the National Youth Suicide Prevention Strategy and the implementation of a national all ages suicide prevention strategy, the Ministry of Youth Development (MYD) has initiated this commentary to review existing evidence based information regarding: bereavement by suicide; the impact of bereavement by suicide on family members, Whānau and significant others; and the inferences of this information. Youth suicide has been recognized and acknowledged as a resounding international, national, public and mental health crisis of epidemic proportion, despite development in the amount of suicide prevention programs, (Leenaars & Diekstra 1997). The immediate and future health and social repercussions concomitant with adolescence suicide are vast, involving every family survivor, the family as a group, the community and in due course the public.

Research in recent years has increasingly been exploring suicide prevention approaches, examining whys and wherefores of suicide alongside of the variables which can have an effect on risk including cultural, social, historical and spiritual elements. However, a comprehensive literature base on the impacts of Māori Whānau bereaved by suicide is yet to be developed. Of the studies undertaken to date, an extensive range of literature has had a robust emphasis on youth. Some

studies have focussed on interrelated information on bereavements from sudden infant death syndrome (SIDS), cultural mourning traditions and practices, traditional cultural notions of family, investigation on the nature of racial distinctiveness in New Zealand, health models from Māori and the Pacific, health and well-being, and subjective data. Researchers have used a variety of measuring instruments and study designs to study and describe suicide, leading to considerable variation and contradictory findings amongst studies. Compounding these conflicting results is the broad spectrum of cultures covered by the studies (Barnes, 2006). Some investigations have focussed on the quantitative measurements of suicide, while others have included an emphasis on searching the reasons behind suicide and proposing methods to suicide prevention. Although this makes it difficult to generalise findings and draw comparisons between studies, it has nevertheless created a body of work that outline the difficult challenges and traumatic experiences faced by families bereaved by suicide.

2.6 Conclusion

Suicidal death is a preventable loss. Rangatahi (young adults), who make the decision to die by their own hand, is tragic. Young adult suicide has its greatest impact on Whānau. The death of a young adult due to suicide may represent many things to Whānau survivors. The Whānau can feel a loss of: their child, possibilities and aspirations; a shared future prospect together; and part of oneself. For Whānau left behind, the grief and speculation of why the suicide occurred, and the anguish and sorrow of bereavement can endure with them for the remainder of their lives. It can affect the very form of Whānau, their physical, spiritual, social and emotional strength and erode the fundamental foundation of Māori society.

Literature describing suicide, and the aftermath of suicide, provided some insights for Whānau. The continued occurrence of suicide in Whānau has grabbed the attention and concern of the mental health profession. Studies focussed on those who commit suicide and seldom addressing the impact to Whānau who have survived the suicide of someone close to them, is changing. Writings assert that families, whose family member dies through suicide, experience more culpability and guilt, more frequently pursue an explanation for the death, and seem to encounter not as much communal support compared to those survivors who lose a family member to other causes. Moreover, those bereaved by suicide, encounter feelings of premeditated denunciation and intentional rejection, which distinguish them from other mourners who are grieving the death of a family member.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter provides philosophies, ideologies and methods that pertain to the research carried out in this thesis. Some of these philosophies and methods are endorsed by Western theorists and others are guided by a Māori paradigm. The congruence of both approaches has been apparent, as was the perceptible divergence. This chapter begins with an account of the general aim of the research. In as much as the positioning of my research is about Māori peoples, I commence with discoursing Māori experiences and awareness of research inquiry into their lives. Next, I examine views of Māori methodologies and elucidate how Māori Centred methodology was a valuable influence for my research. Following, I proffer an overview of a case study approach and how this is an appropriate methodology for my research. As the four case studies sourced in this research are located in a Māori context, it is critical to acknowledge the various approaches that are relevant to a Māori methodology. These considerations will endorse how these areas became imperative tools for my research methodology. Finally, in this chapter are located the research procedure and methods section.

3.1 Māori and Research

In the process of understanding philosophical underpinnings of Māori centred research, the essential factor is to comprehend its origins. It has been documented that Māori people for the most part, have been recognised as some of the most

highly investigated and studied participants, globally (Smith, 1999; Kovach, 2005). Historically research in Aotearoa/New Zealand/New Zealand has been driven by western, Eurocentric, ontological and epistemological assumptions (Davidson and Tolich, 2003). Within such paradigms, Māori experiences and understandings have not adequately been accommodated. Western research methodologies have been viewed as colluding with other dominant colonial discourses in the denial and invalidation of Māori knowledge, language and culture (Smith, 1996; Walker, 1997; Bishop, 1996; Cram, 2001). As such Māori knowledge has been typified as 'other' within the science, technology, and research sector. In response to the unhelpful, unacceptable ways that western approaches have portrayed Māori. Also, as a result of both a Māori dissatisfaction with dominant western forms and control of research around issues affecting Māori, and having a desire to recover and reinstate Māori ways of knowing (McKinley, 1995), various approaches to research have developed. According to Cunningham (1998) the emergence of Kaupapa Māori research theory was a deliberate contestation to reposition Māori research away from the restraints of a western positivist paradigm, assigning it to an epistemology centred on Māori ideology and practices.

It has become imperative that "Māori research is carried out from a Māori cultural framework" (Bishop, 1998, p.119). An ontological construct termed 'Kaupapa Māori' theory, contests a western paradigm that sanctions the researcher as the key recipient of the research wherein the researcher sets the agenda as well as controls the research process and decision making processes. Primarily, it challenges the failure "to locate Māori at the centre of the exercise or to even seriously incorporate Māori needs" (Durie, 1996, p.2).

An understanding of the various Māori research approaches necessitates the recognition of the underlying "philosophical and theoretical orientations" (Kiro, 2000, p.16) which constitute these approaches.

3.2 Kaupapa Māori Research

A Kaupapa Māori approach to research recognises as well as promotes aspects of Māori knowledge and understanding (Smith, 1996; Cram, 2001). Essentially it indicates research for the purposefulness of Māori development, centred on Māori ideology and values (Durie, 2002). Kaupapa Māori research involves traditional belief and ethics and encompasses approaches that strive toward Tino Rangatiratanga (Henry & Pene, 2001). Established on a Māori world view; Kaupapa Māori theory (Pihama, 1993; Tuhiwai-Smith, 1999) not only incorporates essential beliefs, ideologies, theories and practices but also is a "reassertion of Māori epistemological construction of the world….and asserts the validity and legitimacy of te reo and tikanga Māori….and challenges dominant ideologies which serve to marginalise te reo and tikanga Māori" (Kiro, 2000, p. 12). It recognises principles inherently linked to Te Ao Māori. Thus for this reason it is fundamentally all around identifying as Māori. Simply, as Kiro (2000, p.16) suggests "it reflects those values and behaviours that reinforce this identity and that distinguish our uniqueness as a people".

Kaupapa Māori research is culturally engendered and sited with the incorporation of a Māori world perspective utilising Māori beliefs, understandings, approaches,

methods, traditions, conventions, te reo, principles and philosophies. As such, the fundamental principles of a Kaupapa Māori methodology derive from the premise, by Māori, for Māori control of the research process (Moewaka Barnes, 2000); consequently placing Māori and Māori experiences and interests as the focus for the study (Bishop, 2004). Bevan-Brown, (1998); Bishop, (1997b); Cunningham, (1998); Mead, (1996) believe Kaupapa Māori Research needs to be culturally adequate and evaluated by culturally suitable approaches thus ensuring research process and outcomes are mutually inspiring and valuable to the research participants.

Inside of a Kaupapa Māori research approach according to Powick (2002), ethics are defined from a Māori viewpoint by way of tikanga, thus mirroring Māori principles. Bevan-Brown (1998) exclaims that it is a Maori researcher's obligation to carefully plan the gathering of materials and as such involves reciprocated regard, and reliance and frequently befalls "a te wā"; the right time. In the use of interviewing processes, emphasis is placed on the:

- Participants selecting the time and place of interview;

- Participants having Whānau support whenever possible;

- Use of language in describing participant's rights in the research process;

- Bringing some kai when interviews are in participants homes;

- Provision for participants who may have travelled to an interview;

- Ensuring participants know how to contact the researcher after interview if they wish to add, take away or even withdraw from participating;

- Knowing support people and services should participants require support.

Cram (2001) and Smith (1999) have established notions that align with the ethical matters of kaupapa Māori research. Such concepts ensure that issues of accountability and benefit are addressed. Notions that are described by Kennedy and Cram (2010) Smith (2004) are reflected in the following guidelines by Te Awekotuku (1991, p.16).

- aroha ki te tangata – addresses the need for respectful, genuine relations;

- kanohi kitea – that addresses the need for personal contact;

- titiro, whakarongo korero – addressing the need for manaaki tangata;

- kia tupato – that addresses environments,

- karakia – confidentiality and humbleness;

- kaua e takahia te mana o te tangata – that addresses the notions of mana;

- kaua e mahaki – that addresses the issues of superiority surrounding knowledge. It also reminds the researcher to be humble throughout the research process.

These are distinctly Māori ethics that enunciate the fundamentals of research incorporating Māori as subjects as opposed to Māori as objects of investigation.

A core ethic of Kaupapa Maori research is the relationship ethic based on kinship links (Smith, G., 1997). The appeal 'Nō hea koe?' associates people at many levels, such as where we come from or who our connections are – at the same time distinguishing the connections and variances. Bishop (1996, p. 152) views this as "…identifying, through culturally appropriate means, your bodily linkage,

your engagement, your connectedness, and therefore unspoken but implicit connectedness to other people". A relationship ethos similarly involves ideas of the researcher as well as the participant exploring concurrently, being taught from each other in the milieu of researcher obligation and participant control.

The principles and practices illustrated within whakawhānaungatanga, guide the research process (Bishop, 1998). Whānaungatanga as a research process influences the establishment of relationships and the mutual sharing of power and control. Vital to the research relationship is the awareness and acknowledgment of the researcher's positioning in the field. The researcher situates himself/herself within the research as a participant, permitting an experiential point of view of 'observing, doing and learning'. It is also acknowledged that this experiential positioning ensures one of a teina – learner position rather than a tuakana – leader, knower. Because the researcher is also the participant they become holistically connected and not merely concerned with procedures and results. It is research that is "negotiated with the community who remain informed and involved throughout the study" (Mead, 2003, p. 128).

3.3 Māori Centred Research

As a consequence of the negative experiences and processes experienced within the health research arena, the Māori Centred framework was developed and presented by Durie (1996) at the Hui Wkhakapakari in Hongoeka, 1996 (Pomare, Keefe-Ormsby, Ormbsy, Pearce, Reid, Robson, & Waten-Hayden, 1995)). The methodological strategy adopted in this research, is the Māori Centred approach.

As this proposed research concentrates exclusively on Māori adults, the research procedures and practices will be cognizant with "Māori culture, Māori knowledge and contemporary Māori realities" (Durie, 1996, p.2) Yet it is to be acknowledged that Māori are not homogeneous, as such our lived experiences as Māori are divergent. Such variances are mirrored in our involvement in Te Ao Māori, our capacity as well as proficiency in the usage of Te reo, and knowledge of tikanga. In essence it recognises diverse Māori realities.

A major construct of a Māori Centred methodology is that it positions Māori experiences and knowledge at the core of the research and "does not ignore the importance of other approaches" (Durie, 1998, p.91). Māori centred research applies Māori methods and analyses and can be included alongside of western methodologies and analyses (Cunningham, 1998; Powick, 2002). It is inclusive of Māori views and philosophies as such, draws the paradigm Māori from the margins of Western viewpoint and opinion and re-establishes it at the centre of the knowledge paradigms (Smith, 1992). Wilson (2004) identified the creation of Māori knowledge as an end product to a Māori centred approach. A Māori Centred approach, Wilson (2004) elucidates an array of notions which consist of concepts comparable to Kaupapa Māori research. These include Māori remaining in control of the research process; the utilisation of a holistic approach which takes into account the dynamic relations of Māori and participants being the primary beneficiaries of research. While identifying as Māori is imperative, the researcher still needs to will have the essential abilities and knowledge to attain the beneficial results for Māori (Kiro, 2000). Regardless of the ethnicity of the researcher, valuable research necessitates the researcher exhibiting research as well as

cultural and research components, wherein "the objectives of the research will take precedence over the origin of the researcher, and provided the initiative remains with Māori; a Māori Centred approach need not be compromised" (Durie (1996) claims that ibid. p.239)

Essentially it is imperative to ascertain the methodological basis of the approaches utilised in research. According to Huff, (2009, p. 182), procedures to research are theoretically intended to "bring us closer to what it is we are trying to understand". Moreover he suggests approaches to research invariably comprise "the principles behind the set of methods used" (p. 182) within an inquiry. Therefore, it is imperative that as a researcher, I have a perception and knowledge of the various research approaches that are beneficial to my arena of inquiry and which are acknowledged as academically rigorous as well as being comprehensively sound when put into practice.

Within the area of social science research, there is a twofold commonly recognised classification of research methodologies; which include the quantitative as well as the qualitative research methodologies. In determining the choice of research method, Howe and Eisenhart (1990) emphasise that the expediency as well as the suitability of the approach to objective(s) of the inquiry and the research questions which initiated the research, should be a paramount deciding factor. Based on this consideration and upon appraising literature on research methods some of which include Denzin & Lincloln, 2005b; Huff, 2009; Punch, 2009;); qualitative inquiry has been implemented as the methodology for this particular research. Justification for

this choice was deliberated in terms of its alignment with the research objectives and in accordance with the research questions which influenced this research.

Cunningham (1998) & Powick (2002) suggest that for Māori centred research one of the obvious challenging features is the twofold obligation to not only Māori but also universities. Various advocates of the qualitative research approach; (.e.g. Berg, 2009; Denzin & Lincoln, 1998, 2005, 20005b; Stake, 2005), were influential in my preference of employing qualitative methods. Whilst not solely dependent upon their influence, the choice of research methodology was endorsed by the circumstance that there was a dearth of information and investigation carried out on the current research topic.

3.4. Researcher positioning

Kaupapa Māori theory appraises the philosophies and procedures of Māori research methods that inform the process of outlining and organizing the most appropriate and beneficial approach this study. This study endeavour arose as a pre-requisite to my professional development and employment as an academic tutor at the Waikato Institute of Technology, which meant that the aims and objectives of the study, derived from myself rather than Whānau, Hapū, or Iwi. The choice of the research approach came about after deliberating which approach best suited who I was as an individual. As a Māori female, raised predominantly in a small rural township with ninety percent Māori population, but moving to live overseas and returning home infrequently, I did not feel confident within Te Ao Māori. With limited understanding of tikanga and lack of ability to speak the Māori language, I did not fit comfortably in one research approach;

Māori or Western. I felt inexperienced to undertake and uphold the practice guidelines existing within a Kaupapa Māori approach. However I could connect and relate with aspects of Māori Centred research. This was mainly because of my personal biography and life experience as a woman of both Māori and English ethnicity. I believed I was unable to completely approach research from a traditionalist Kaupapa Māori research point of view. Moreover, the initial intention instigating this research was my own professional development, not Whānau, Hapū or Iwi. For this reason, I took the guidance from my supervisor and chose a methodology that best suited my style as a researcher and my cultural positioning as a Māori woman. The Māori centred approach matched my strengths and attributes but more importantly, it made available, safe, suitable set of guidelines, informed by Māori for research with Māori.

3.5 Qualitative Research

The intent established in this research was to furnish an investigative awareness into 'bereaved Whānau' experiences of suicide. Because literature in this field of study is sparse, this study is a deliberate attempt to understand first-hand experiences of Whānau bereaved by suicide. A consideration of the lived experience of parents bereaved by the suicide death of their young adult child is a necessity to complement the current quantitative efforts of suicidology.

Denzin and Lincoln (2005a) propose, "Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meaning's people bring to them" (p. 3). According to Cresswell (2005), qualitative research techniques, are an appropriate fit for studies on subjects that

are reasonably new in a subject area. Accordingly, such methods facilitate a comprehensive, detailed investigation to a subject. Qualitative methodologies incorporate a selection of research approaches that include, case study, discourse analysis, ethnography, phenomenology, autobiography, grounded theory (Grbich, 2007), amongst others. Such qualitative approaches enable the collection of rich descriptive data

Most significantly, qualitative researchers attempt to gain knowledge and insight of the world we live in, beginning firstly, from the research participant's world view. Thus, to appreciate any human experience, phenomenological questions that inquiers into kinds of events people experience, are asked (van Manen, 1990). The objective is a comprehensive account of a phenomenon by those people who live through and are subjected to various experiences. Qualitative research is recommended when the objective of the study explores a human experience that is detailed, information rich and will occur over time (Neuman, 1994; Ritchie & Lewis, 2003) such as the topic of this study.

3.5.1   Research Design

In this section I explain the research procedure, method and engagement with participants within a case study framework. Also this section is an explanation and rationale for collating and analysing the data elicited from the interviews. Themes from the data and the findings sections are located under each case study. These can be found in chapters four.

3.5.2   Case Study Methodology

The qualitative strategy implemented to direct the research design is the case study approach. In undertaking social science research, the case study is a strong selection. Case-study research has been renowned in the advancement of disciplines such as sociology anthropology, psychology, management and social work.

This study used a case study approach in conjunction with qualitative research methods; mostly relying on individual accounts and narratives to explore the "lived experience" (Van Manen, 1990, p. 70), as taped during the interviews. As a qualitative approach the case study research, is appropriate in certain situations when the emphasis is on "contemporary phenomena" (Yin, 2003), inside of an actual life context (P. 1). So developing a case-study research design, the researcher thus aims to attain a comprehensive knowledge base and understanding of the phenomena and their meaning. Case studies therefore provides an outline to systematically investigate in more details the key pieces of information, responses and coping strategies of Whānau bereaved by suicide.

Corresponding with a Māori worldview, the case study approach derives from a holistic perspective. Conspicuously, there are various features of the case study methodology that parallel with aspects of Māori methodology. For instance, a case study approach is concerned with a context (internal and external) and location (history and contemporary) (Berg, 2007). This approach is also both important and relevant for research with Māori communities (Smith, 1999; Battiste, 2000). Hancock & Algozzine (2006) suggest that both approaches also value the place of

a variety of meaningful sources of information. Explicitly the inclusions of narratives are vital aspects for both approaches. In knowing this, it facilitated a purposeful resolve in selecting the appropriate methodology for this research.

In developing a case-study design the researcher aims to achieve a careful comprehension of the phenomena and their meaning. Moreover, Guba and Lincoln concur that the final results of case studies is a 'thick description', an analysis of the significance of information in relation to "cultural norms and mores, community values, deep-seated attitudes and notions" (cited in Merriam, 1998, p.11). Considering aspects of culture, values, perspectives, social issues and notions implies the inclusion of any number of variables in a case and therefore contributes to its complexity (Gillies, 2006,). Stake (2003) endorses the inclusion of a wide range of variables and issues because the aim of case-study research is to increase a deep awareness that focuses on the particular or uniqueness of the case. He further acclaims

> "that the actual interest of case study is specification, not generalisation: we take a particular case and come to know it well, not primarily as to how it is different from others but what it is, what it does. There is emphasis on uniqueness and that implies knowledge of others that the case is different from, but the first emphasis is on understanding the case itself" (Stake, 1995, p. 8).

Furthermore, literature highlights the case study as a mode of naturalistic generalisations, where the reader of the case study "comes to know some things told, as if he or she had experienced it. Enduring meanings come from the encounter, and are modified and reinforced by repeated encounter" (Stake, 1995,

p. 145). Thus positioned within a Māori centred and kaupapa Māori knowledge claim, case-study inquiry sufficiently expedites the fusion of Māori cultural exemplifications that include, language, traditions values and beliefs, experiences, and oral testimonies, during the process, and offers a methodologically disciplined domain for Māori research (Gillies, Tinirau & Mako, 2006).

According to Punch (2009), the overall theory of the case study approach is the study of a single or a number of cases with attention to detail, to promote a complete comprehension of the cases in their normal milieu(s), identifying the significance of context as well as the complexities contained in the cases. Likewise a case study involves systematic research of an event/s, to understand how it operates or functions or about a specific subject with the aim of explaining an issue or phenomenon (Berg, 2007). As a research approach, case study methodology was particularly suitable to investigating conditions "where little is known about what is there or what is going on; when it is necessary to get under the skin of a group, or to view a case from inside out" (Barton, 2008, p. 48).

Moreover, "Case study is an exploration of a 'bounded system' or a case (or multiple cases), over time, through detailed, in-depth data collection involving multiple sources of information and rich in context" (Creswell and Maietta, 2002, p. 162). Likewise Hancock & Algozzine, (2006), confirms case studies are fully descriptive, because material is accessed utilising a variety of sources. Therefore in this present study the interviewing of various Whānau bereaved by suicide, served as a source of information across time; as well as literature, and researcher notes, exclusively for the intent of gathering deep, meaningful data.

An epistemological case study methodology denotes information as set within the distinctive features (e.g. time, place, individuals, and event) of the cases examined (McMillan & Schumacher, 2010). In reference to a case study methodology Stake (2005) recognizes three different categories of case study familiar to Social Science research. Firstly, 'Intrinsic case studies' are motivated by an inherent research interest to improve the general understanding of a specific case. However, the next type is commonly referred to as the 'instrumental case study' wherein the case is not the central focus of the researcher however provides insight into other phenomena and permits detailed examination into a subject. The final case study is the 'collective case study' or 'multiple case studies' (Yin, 2000). This category examines a number of cases to increase knowledge and awareness of phenomenon.

In this study, the chosen case study is the multiple case study approach. Punch (2009) exclaims multiple case studies affords comprehension into the issue or theme by comprehending the issue or theme in-depth

3.5.3 Ethical Considerations

"Ko tau hikoi i runga i oku whariki, your steps on my whariki,

Ko tau noho i toku whare, your respect for my home,

E huakina ai tōku tatau, tōku matapihi, open my doors and windows" (Barnes, 2000, p 4)

An understanding of this whakatauaki establishes that for doors and windows to be opened it is essential that researchers walk quietly (ibid. 2000). Therefore

narratives and stories should not be probed without valuing participants who decide to contribute and without consideration of the obligations of researchers. Consequently this mode creates conditions whereby there is no deception or duping of participants; where entering into sacred spaces is a collaborated partnership. Various research practices, techniques and consulting processes have to be precise, whereby at the close of the research all those linked to the research venture are enlightened, enhanced, and pleased to have been associated with it.

Researching the topic 'suicide bereavement,' necessitated thoughtful provision to address ethical issues. For research focussed on loss and grief, Māori tikanga provides assistance in regards to arenas of eminent sensitivity. Thus any research endeavour that may impact on an individual's tapu or mana, should be considered sensitive, despite the person being dead or alive. This particular research topic was delicate, and like the karanga, summoned emotive feelings as it unlocked the memories of mamae and hurt for the whanau who have died. Because of its delicate disposition and since there was a venturing into the sphere of the dead, karakia in the form of covering and safeguard was necessary for those involved in this project (Cram, 2004). The following whakatauki advises precaution and careful deliberation when embarking on research in areas of high sensitivity. Four months after the death incident, is recommended as a suitable time for survivors to discuss their traumatic experiences (Cooper, 1999).

Specific deliberation was given to the intricate make-up of the data required of the participants. Well-defined, distinct protocols were carefully chosen to ensure

participants were totally advised and guided of their entitlements and of my responsibilities, for the extent of the research. When a person dies tragically, and unexpectedly, through suicide, dynamics form to produce circumstances of the upmost sensitivity. What became obvious was the specific attention essential in constructing a project which would be responsive to and protective of the requirements of participants. In this study I had direct interactive exchanges with the participants, as well as the oversight of all interviews. As a considerably qualified and experienced Social Worker and Counsellor, I was capable of engaging in the interview discussions with bereaved parents, during which I was receptive and conscious of my own self-care (Maple & Edwards, 2009).

A code of Ethical Conduct for Research, Teaching and Evaluation involving Human participants propounded by The Massey University Human Ethics Committee (MUHEC) designates various requisites for researchers of Massey University to abide by while carrying out research studies concerning participants who identify as Māori. The different requisites necessitate researchers relate the principles of Te Tiriti o Waitangi specifically, protection, participation, and partnership to their research pursuit, thus ensuring researcher appreciation of both individual rights and group rights as well as the recognition of Māori research approaches. Cultural variance or difference affords provision for Māori participants to speak in Māori, the acceptance of Māori cultural concepts as legitimized knowledge, as well as the application of tikanga when undertaking research with Māori participants. As such, these principles and ethical assertions advocate logical justifications in terms of why this research will follow a certain path and validate the usage of Māori research methods as the ideal and central approach of

this research. By 2011, a submission for consent of a planned study was finished and subsequently approved by the Massey University Human Ethics Committee.

3.4.4   Sample Selection

I chose a sampling method that was appropriate to the qualitative, multiple case study method. A blending of both purposive (Patton, 2002) and snowball (Patton, 1990); otherwise known as whakawhānaungatanga (Bishop, 1996) sampling techniques, were applied in the selection method for ascertaining vital informants for 'information rich' and 'illuminative' data. The goal and aim was to increase understanding and meaning from the information as opposed to empirical generalisation of the population (Patton, 2002). As the most appropriate techniques for this study, purposive and snowball sampling allowed for samples to be nominated centred on the research purposes. The purposive sampling method, used in qualitative research, is a particular method, wherein subjects are selected because of definite characteristics (Patton, 1990). The participants that were selected had the following characteristics: availability; were good examples for this study as they were parents of young adults' children that had taken their life through suicide, and who were also known to the key contact people. I was able to identify and invite key support personnel, who were community health workers, to assist with recruitment and endorsement for conducting the research. On my behalf these key people, identified and approached various likely participants, who they knew were survivors of suicide. These key community people became my negotiators in gaining the initial consent and my access to all Whānau.

3.4.5   Participants: Case Recruitment and Selection

The study was advertised on flyers and given to selected key contact people, working within Māori organisations and who were also facilitators of suicide support groups. In this instance, key informants were able to identify Whānau who had a family member die by suicide, who then approached Whānau (family) with information about the study. Potential participants were advised and given an account of the requirements requisite of them, should they elect to participate. An information pack was made available to them, with written specifics of the research proposal, at which time parents were accorded the opportunity to take part in the research. The key contact people acquired the name, telephone and details of persons inclined to participate or who were interested in further information. Telephone calls and emails were made between the researcher and key contact people in regards to interested participants; interview times and places, established by the participants.

The key contact people spoke face to face with potential participants and used the flyer to explain the research. Having support from these key personnel in gauging interest and preparing participants was invaluable. Four parents from Māori families decided to be involved in in-depth discussions and converse about how they responded to and coped with experience of their young adult child's suicide. The parents comprised of three mothers, and a father. At the choosing of the participants, an interview was undertaken with a parent as well as sibling of one of the deceased. In another interview a Grandfather interviewed alongside of an uncle of the deceased as they considered her, their whangai (adopted) daughter because they had raised her from birth. The ages of participants varied between

late forties to early fifties. One participant was subjected to the suicide death of her child within a five month period of being interviewed – recently sufficient to recall the immediate effects of the suicide death. The majority of participants experience with suicide occurred between 7-9 years. Every one of these participants believed that they even still were able recollect the bereavement process, even though the suicide had transpired quite a few years prior to the interviews.

3.4.6. Consents

Both written and verbal consent were required of parents, preceding the commencment of the interviews. The interviews were audiotaped, and lasted approximately 2-3 hours. Interviews were carried out at the very least five months post-suicide.

3.4.7. Interview Process

Interviewing is a necessary technique for acquiring case study data since for the most part, according to Yin (2003) the case study encompasses human activities, as such is informed and explained using the voice of the participant. Every interview with participants were face-to-face. Research with Māori incorporates he kanohi kitea, which is articulated by Cram, (2001) in the whakatauaki, "He reo e rangona, engari, he kanohi – a voice may be heard but a face needs to be seen" (p.43). The interviews were facilitated by the researcher in a locality established through the participants. At the time of the research, all participants resided in various small rural townships located in various locations in the central North Island, prior to interviewing them. A consent form (see Appendix III) was required to be completed.

Being manuhiri (guest) in the homes of the Whānau and being privy to some of the participants' most delicate but intense thoughts and feelings has been a privilege and a source of honour for me as a researcher. Researcher facilitation enabled participants to freely express and manifest feelings and thoughts in ways which permitted participants to regulate all movement and progression during the interviews. The subsequent rich information is verification in regards to the suitability of not only the particular approach but also the interviewer's skill and ability to connect and build trust with the Whānau.

Having found a counsellor available to the participants throughout the extent of the interviews, indicated suitable assistance was instantly accessible in the chance concerns arose whilst interviews were taking place and immediately following the interviews. The vulnerable, sensitive disposition of this study made this incredibly pertinent to the procedure and came as an outcome of strategic safety control and pre-planning to guarantee that field crisis could be minimised or dealt with competently. In most cases relying on instinct as well as trained expertise as a Social Worker/Counsellor and making subtle perceptive judgement calls, which was vital because every so often respondents became emotional whilst recollecting and relating their experiences.

Two colleagues acting as consultants provided a safety mechanism, contributing interventionist backing, encouragement and supervision. The strength acquired through having the knowledge that there was direct access to a valuable back up

system was a crucial aspect affording reassurance all through the interview process.

In response to the research objective, I sought to inquire into the participants' narratives, whilst permitting them to share their stories in ways that they would be at ease with. In fulfilling this, various selection of design approaches were utilised, involving encouraging the participants to decide what the structure of their interview would look like; to be interviewed on their own or with other family members as well as permitting them the selection and option of the venue and location for the interviews. These interviews precluded introducing ourselves and discussing various aspects of our families and letting the participants know my whakapapa connections. All interviews involved eating kai, (food); a central feature of forming connections one with another, but also with this setting is moreover fundamentally accepted to be a correct critical feature of Māori tikanga, in establishing noa among participants. Such an occurrence affords an opening for whakawhānaungatanga (Bishop, 1997); a fundamental process for creating rapport and building relationships.

The interviews were commenced with a particular open-ended sentence that began with: "in the best way you feel is appropriate for you, perhaps starting with sharing a bit about before your child's death and your experiences ever since the death of your child". This statement was thoughtfully formulated to permit the participants 'entrance' into the research focal point, which was the story of their experiences with suicide. Denscombe's (2007) approaches to useful interviewing became my strategies during the course of each interview. These encompassed

basic counselling skills like active empathetic listening, being non-judgemental; being considerate to intense feelings and being comfortable with silence and pauses in the discussion; and lastly using techniques like checking back, prompting, probing, clarifying and summarising, to elicit information.

Following, I only used prompts from their narrative to inquire into an area of their story more intensely or to elucidate areas I was unsure of. Commencing at the inception of this study, I intuitively recognized how imperative it would be to honour and pay tribute to these parents' stories in all ways, and I required a process which would provide this. In this way, faith, perception of shared meaning, alongside of hope were attributes of this research dialogue, in ways not always characteristic for the most part of researchers (Lofland & Lofland, 1995). These interviews summons people to be spectators of their own story (Epston, 1995).

Following the interviews I was able to leave the homes of the families with the awareness and understanding, that I had sufficiently conveyed my gratitude and appreciation for the participants. I voiced the privilege of having been afforded the opportunity to be a witness to the stories of these Whānau. I developed what Miller & Crabtree (1994) call an integrative process whereby I engaged in reading applicable literature, pondering, reflecting, reading participants accounts of their experiences, re-reading and making sense of field notes.

3.4.8 Qualitative analysis

Thematic analysis centres on distinguishable common subjects and patterns of behaviour identified with the intention of developing theory. Stake (1995) suggests qualitative data analysis involves the processes of scrutinizing, classifying, and organizing along with continually analysing evidence in response to attaining the objectives of the research. Ascertaining themes requires linking to the aims and questions of the inquiry which are being examined. These themes, they advocate "evolve from the saturation of the collected information" therefore researchers ought to strive to foster themes "that represent separate and distinct categories of findings" (Hancock and Algozzine, 2006, p.61).

After the tapes were transcribed, the interviews were scrutinized and clustered by organizing the incidence of diverse themes followed by the creation of a template of classifications and allocating all evidential data inside of each category (Yin, 2003). Then an analysis was formulated traversing the cases, which entailed recognising the incidence of themes or patterns of behaviour in the dialogue. Next common themes were recorded by rate of recurrence and relativeness to the research topic and purpose.

3.6 Conclusion

Māori research methodology underpinned by Kaupapa Māori theory, were fundamental elements informing this study. This approach seemed fitting considering the aim and focus of this research. Māori centred research placed Māori at the core of all research involvements and practices, with participants playing a major role in the research procedure. Furthermore it provided the opportunity for the researcher to incorporate a western scientific methodology in

conjunction with a Māori paradigm, with the outcome; the achievement of a better understanding of the phenomena. The research design was guided by the incorporation of the case study approach.

The subsequent chapters report the findings of this research design, starting with parents voices presented in individual case studies, and continuing with a thematic analysis of the research information.

CHAPTER FOUR: CASE STUDY

4.0 Introduction

This chapter introduces the participants, their experiences and their dialogue about responding and coping with the suicide of their young adult child. By means of open-ended interviewing the participants were assisted in generating and forming their own insights and speak to their own experiences. These narratives have been arranged, collated and organised into case studies. The central themes and concepts depicted in the case studies include emotional responses such as shock, anger, denial, sadness; coping in response to young adult suicide; whanau functioning, support and psychological and social isolation.

In this section the parent's various emotional responses will be highlighted first, followed by dialogue on how parents coped with the suicide of their whānau member. The interview dialogue is bullet pointed.

4.1 Case Study One – Participant 1 (P1)

This interview took place with the participant's son present and some of his dialogue has been included as per the request of the participant. The participants were a sixty year old Grandfather and his thirty-nine year old son, both of which raised the 17 hear old female suicide victim (hanging) up until her death. The participant's, interviewed 7 years post suicide, described the deceased as "a bright young girl" however he expressed concern regarding her behaviour.

4.1.1 Emotional Responses to young adult suicide

These participants comprehensively conveyed undergoing shock, panic and disbelief on finding the body of their daughter in the wardrobe, wherewith they recalled the family being overcome and stunned with disbelief and panic:

- "My son was the one who actually found her in the closet, you know, like and you know I was in the room and you could hear the screams, it was in the house and he screamed you know, I've never heard a grown person you know and it sounded funny. There was screaming and yelling" (P1, 10/1/2012).

The participant's son recounts his reactions to finding the body:

- "I spun out you know started yelling out to him and he came running in with his machine still half on you know because he had to jump out of the bed because he heard the way I screamed, he knew there was something wrong and he come running in and when he saw her I could have lost him that night too because he was on the verge of having a heart attack or like shock you know. 'Dad don't you dear' help me try to get her off" (P1, 10/1/2012).

He further elaborates on other family members reactions on discovering the body:

- "My other nephew was living with us at the time and he come running in and saw what was going on and screamed his head off and I just told him to shut up and get a knife you know because it was a shock. Aunty, she freaked out and started crying and crying. I really didn't know what I was doing" (P1, 10/1/2012).

This quote exemplifies reactions to this hanging suicide. Specifically it highlights intense emotions. This participant described feelings of shock, numbness and turmoil, during which he and his family strained to fathom the realty of the death. Other responses stated comprised of the affective general emotional responses linked to severe grief which was demonstrated by crying and longing for the dead loved one. The family's initial reaction was one of disbelief and shock, even though the victim had manifested the intent to suicide as was illustrated in the following quote:

- "We had signs. We did question her about it because she was doing self-mutilation. She was cutting herself. She would say 'oh I'm not like that Granddad I wouldn't do anything like that" (P1, 10/1/2012).

Some of the key emotional responses that derive from the narratives were that of irritation and anger:

- "There was a lot of anger….It was a shocker you know because we all brought that little witch up. I was furious you know" (P1, 10/1/2012).

In this instance the anger was directed at the deceased for ending her life:

- "I wouldn't visit her for a whole year because I was all angry, you know how dear she do that you know what did we do for you, to do this and my father, my mother you know how dear you I was furious" (P1, 10/1/2012).

Moreover the anger was also at having missed the opportunity to prevent the suicide. The frustration of which is illustrated in the following narrative:

- "That's what really made us angry, you know, we missed it, you know, we were right there and we didn't hear a thing" (P1, 10/1/2012).

Moreover, he reported feeling angry and disappointed at being deceived. He reports confronting the victim about her self-mutilation:

- "I caught her and I said are you cutting yourself, she goes nah. I grabbed her looked at her arms and I saw all these things and I questioned her and I said look if you don't like it here you know you're more than welcome to go home or if anything happens you'll kill us. She goes 'oh I won't do anything stupid, I'm into Marilyn Manson. I said well I hope that's what it is because damn if anything happens you'll kill your grandfather, 'oh nah, nah, nah I'd never do that she goes" (P1, 10/1/2012).

He further elaborates being angry at the victim for giving up and discarding the support which had been suggested. In essence this deception was essentially seen as a rejection of the family's effort to reach out and support her:

- "I was more or less hurt to why she did it you know I just would've loved to have known. Something I could not understand. I thought I was being more open for her. Why didn't she confide in me?" (P1, 10/1/2012).

This quote draws attention to the lingering anger after seven years post suicide toward the victim, however he discloses:

- "Deep in her heart she mustn't of been a very happy girl" (P1, 10/1/2012).

Post-suicide the participants' son's anger spilled over into close family relations, as revealed in the following narrative:

- "I hated everybody; I hated my father, my mother and hated my brothers" (P1, 10/1/2012).

4.1.2   Coping in response to suicide

Part of the coping with this traumatic event was the unrelenting need to find an answer to 'why' she suicide. Reoccurring throughout this participant's dialogue was the questioning as to "why" the suicide had occurred. This is reiterated in the next quote:

- "We still don't know why that's the only thing, 'why' that's the question, it's just why" (P1, 10/1/2012).

The unanswered question had major effects in this participant's struggle to answer 'why'. An example of his need to have had an answer is illustrated by his simple statement:

- "I would have loved to have known" (P1, 10/1/2012).

The next quote highlights the participant's self-blame and questioning process:

- "Were we too soft or were we too hard you know. That's what I couldn't understand" (P1, 10/1/2012).

He clarifies this dilemma by affirming:

- "It's just not understanding that's all" (P1, 10/1/2012).

Despite speculating on the possible explanations for the suicide; seven years post-suicide, this participant commented:

- "I still haven't forgiven her; I still don't know why she did it" (P1, 10/1/2012).

The participant's son however had to come to accept that he would never receive answers as to why his family member had taken his life and had arrived at the conclusion that:

- "At the end of the day it was up to herself and she chose that way out instead of coming to talk about it" (P1, 10/1/2012).

The son reported finding the body at the place of the suicide and suffered recurring waking imageries of the family member at the time of death:

- "Oh torture really because you can never get rid of it just the image aye her in the closet" (P1, 10/1/2012).

The son reported coping in various ways to the suicide event and victim:

- "Every time I thought about her I just wanted to cry and cry and cry and so I ended up turning to others things you know just to cope, yeah well everything you know cause in the end I thought well oh fuck it if you want me to join you I'm gona join you soon. It was a big slap, couldn't even go and see her at her funeral because I just didn't want to face her. I wouldn't go in, I just wanted to block it out…..I would just drink, drink and do my own thing" (P1, 10/1/2012).

Prior to the suicide, family functioning consisted of family gatherings. However as demonstrated by the narratives, accusations of fault finding caused family conflict and resulted in a family split:

- "It split everybody up it did split a lot of us up. Now they hardly ever come down…..lots of ups and downs…we had some big arguments, an ugly situation to be in for the whole family" (P1, 10/1/2012).

Wherein he was accused and blamed as being the reason to why the victim killed herself. Such accusations and blame he suggests broke the family in half. A shift in how the family functioned due to the effect of the suicide on the family unit was reiterated by this participant. Individual members of the family were affected to such a degree; they isolated themselves in their grieving process as opposed to coming together to support one another.

The participant's' sons account of striving to cope and deal with the death was to seek out support outside of the family

- "I even tried looking for help you know to come through that grief thing….but nobody was here to help me you know" (P1, 10/1/2012).

4.1.3 Summary

This participant highlights feelings of shock, panic, disbelief as well as numbness and confusion in response to the suicide death. Hurt, hate and disappointed were also a part of responding to the death. As a means of coping, what was pertinent to this participant was seeking answers as to why the death occurred. There was also self-blame and fault finding amongst the family. The need to socially isolated was another aspect of coping as well as seeking support outside the family.

4.2 Case Study Two – Participant 2 (P 2)

The dialogue of this case study incorporates an interview that took place with the participant's daughter present, and some of her dialogue has been included as per the request of the participant. The participants were a fifty-five year old mother and a thirty year old sister. The participant's, interviewed 7 years post suicide.

4.2.1   Emotional Responses

Clearly articulated in the narrative was the account of the participant's expression of shock in hearing of her son's suicide. The participant's daughter discussed how her brother had expressed suicide ideation, however despite this expression; the research participant's daughter's account of being advised of the death of her family member incorporated the following:

- "I just went 'what did he do it'? I said did he do it? She goes come on come home. I was like f…. him f… that. I stayed on the computer and all the cousins were like come on now. Nah why Waste that shit. It was ugly. F… that I aint gona even cry for him, I aint gona shed no tears" (P2, 21/3/2012).

She then recalls how it was for her:

- "It was ugly, specially the hanging bit. Oh it was hard, it was too hard, overwhelming really" (P2, 21/3/2012).

Also the participant (mother) describes the death of her child as:

- "A devastation at first, no tears shedded in a couple of days" (P2, 21/3/2012)

Expanding on this, the portrayal of the participant's father's feelings is contained in the next statement:

- "He was heartbroken. It devastated my dad. He would always say "waste my mokopuna " (P2, 21/3/2012).

In describing her emotional response to her child's suicide, the participant referred to the notion of being depressed' as well as totally confused. As part of the emotional response to the 'death' was the disbelief or denial of its occurrence. The participant's daughter reaction to the incident included anger and not wanting to see or hear about what had happened and so isolated herself, physically and

psychologically from the body and the mourners until she eventually went to the marae and saw her family member in his coffin:

- "Yeah soon after I seen him in the coffin, that was everything gone" (P2, 21/3/2012).

Initially the immediate reaction to the news of the suicide was the expression of irritation and anger

- "You a…......you c…. and piker" (P2, 21/3/2012).

Interestingly, this anger at the victim was closely followed by an empathetic statement of:

- Oh well its finally ended, he's finally with nana and healed. No more stress now he's got to go through. At least it's over for you now" (P2, 21/3/2012).

The participant mentioned the 'hurt' expressed by a family member,

- "My oldest nephew just walked into the Marae, he just walked in to Whare Moe and just booted my son, swore at him, he said f' you, and booted the coffin. (P2, 21/3/2012).

4.2.2   Coping in response to young adult suicide

Evident as part of the grieving process for this family, was the process of attribution of guilt. In the following quote, the participant describes how she was struggling with holding herself responsible as well as her husband, for the suicide death:

- "I was blaming myself as well as blaming my husband and lashing out at him" (P2, 21/3/2012).

In expanding on this notion; 'charging of responsibility', she further elaborates:

- "You end up blaming your bloody family and blaming whoever, the closest ones to you" (P2, 21/3/2012).

A sense of helplessness of not knowing what to do for their child was evidenced by the participant's expression of:

- "I went into a bit of was it me? What could I have done? And the blaming side of the things as a mother" (P2, 21/3/2012).

The persistent questioning and doubting of self, was characteristic of the participant's frame of mind:

- "What could I have done, what did I miss or how did I miss it and why couldn't he talk to me. I could have done more, why didn't I see it, how could I have missed it. I should have been more attentive" (P2, 21/3/2012).

Overall, feelings of guilt were obvious through the research participant's interrogation of what she may well have overlooked in regards to identifying the victim's resolve to end his life. Such a realisation is expressed as:

- "We just didn't know how to help, that's really what it was" (P2, 21/3/2012).

This poignant statement highlights a dilemma this family had to cope with, which was, they did not know how to respond to their family member who was struggling with mental health issues and other life issues which they say ultimately lead to his decision to end his life. This participant acknowledges finding a range of ways to cope with the suicide death.

As means of coping, this participant stated that she turned to her local pastor for support:

- "We had a pastor down here, Pastor Pauli, I was talking to Pastor…….we use to have fellowship with the pastor. I was even praying I always believe in the lord" (P2, 21/3/2012).

She also would visit her local general practitioner:

- "My doctor would say 'oh it's a lot of stress, there's a lot of stress on me" (P2, 21/3/2012).

- As a consequence of her visits to the doctor, his diagnosis of her was that she was suffering with depression. Another means of support was accessed, with the purpose of finding healing:

- "I went for some healing through psychics my own ones that I know" (P2, 21/3/2012).

This choice of support proved pivotal for her wellbeing as she highlights:

- "I know that when I left there I wasn't as guilty as I felt you know heaps of that had gone, had lifted". They took a whole lot of weight off me" (P2, 21/3/2012).

As well as undergoing her own grief, the participant had other family member's grief to consider as well. She reasons:

- "I had to be strong for my family as they were hurting…..but we all come together as a family we had too" (P2, 21/3/2012).

The coming together as a family sustained their ability to cope with the impacts, as a group and support one another:

- "I kept in touch just about every week telling everyone I loved them, so they would sort of heal together" (P2, 21/3/2012).

An obvious act of striving to attain family resilience was glimpsed in the following remark:

- "Just the strength of all the family, I thank them really for that, I thank them cause it brought my family so much closer…we had to pull together and get through this together" (P2, 21/3/2012).

As such, this survival mechanism allowed family members the chance to deal with with the aftermath of the suicide. Yet one of the barriers that impinged on the families ability to cope, as identified by the participant, was the 'stigma' around suicide and people's attitudes toward suicide and therefore their views about how the 'tupapaku' should be treated. Whilst on the marae, the participant overheard a conversation that entailed:

- "Back in the day you know they never use to have suicide people go on the Marae and I knew of that korero when I was a kid" (P2, 21/3/2012).

This perspective served to heighten stress levels of the family already in mourning. The taboo around 'suicide' as evidently expressed at the Marae generated various emotions:

- "I just got a shock. I was really getting angry and hurt and looking; thinking come on somebody better bloody say something" (P2, 21/3/2012).

Moreover this perspective became the catalyst for the family to feel 'judged', 'shamed', 'shunned' and effectively experiencing a perception of:

- "Being cast out or more less" (P2, 21/3/2012).

These emotional manifestations are particularly severe in light of the fact that 'being cast out' was particularly painful for the participant who points out:

- "Yeah specially from their own aye" (P2, 21/3/2012).

Support came in the way of a Kaumatua, who stood and proclaimed:

- "That will never happen here" (P2, 21/3/2012).

This action by the Kaumatua, essentially provided a mandate and settled the unspoken uncertainty that people had around suicide and tikanga. With obvious relief the participant acknowledged and:

- "I thanked the pastor for bringing it up cause at least it was said in front of a lot of people" (P2, 21/3/2012).

4.2.3 Summary

Participant two's emotional responses to her son's suicide death, ranged from shock, disbelief, sadness, anger, hurt and a feeling of devastation. Her coping responses included making contact with her pastor, doctor and kaumatua. Having a family that supported one another was pivotal to this participant's ability to cope with the death of her son. 'Blame of self and family' for the death were also methods of coping.

4.3 Case Study Three – Participant 3 (P 3)

The dialogue of this case study incorporates an interview that took place with the mother of a 20 year old male suicide victim. The participant interviewed 9 years post suicide.

4.3.1 Emotional responses

For the participant, the suicide death of her son was a traumatic event. For the participant's family, the impact also was far-reaching, as was highlighted by the participant's dialogue:

- "I was really traumatised when he hung himself"……this death was just overwhelming. It impacted on them emotionally, psychologically, umm lots of tears……they were devastated, just overwhelmed, and devastated…..there was a deep deep pouritanga" (P3,17/4/2012)

This participant compared her grieving process to that of a 'rollercoaster' and described her sadness as:

- "I'd be angry to him, I'd be happy and sad and very angry and I found that I went through an emotional rollercoaster" (P3, 17/4/2012).

Her irritation and anger was acknowledged when she says:

- "I got angry and went through a very angry stage because I had a photo of him on my mantel piece and I would come home and look at him and start swearing at him 'you know you crazy kid, you know, you know what the hell? What did you think you were doing, look what you've done, look what you've left behind. " (P3,17/4/2012)

Anger was also a part of the interrogative process, as this participant continually explored reasons as to why the suicide may have happened:

- "That's the biggest impacting question, why did my son do it?" (P3,17/4/2012)

Her struggle for an answer and her frustration at not gaining an answer is manifest in the following narrative:

- "The question just drove me insane almost, um because yah no when you're trying to analyse and become so severely analytical around, why it happened and you just want answers" (P3,17/4/2012)

She further exclaims that this questioning process of searching for answers lasted for two years:

- "These questions going round, round, round, round and round. I think at least two years at, least two years the question of why this keeps spinning around in the head over and over and over again try to find answers trying to pull things apart try to critically um process and analysis" (P3,17/4/2012)

As part of the questioning process, this participant considered the reasons for her son's suicide and what she may perhaps have overlooked in relation to recognising his emotional turmoil prior to the suicide:

- "He hadn't had drugs in his system, it was just alcohol. Then I thought about the other situation, was it because he moved out? Was it because he got angry at us you know and he didn't want to leave home because he now had to spread his wings and be responsible, was that what contributed you know?" (P3, 17/4/2012)

This participant had no warnings of her son's intent to suicide:

- "He wrote a note but he wrote a little note and the note was wrote to my ex-husband and it was something to the effect I love you I love you "G" and you mean more to me than my own dad you were a dad to me than my own dad something to that effect…..there is no signs…..suicides don't have signs" (P3, 17/4/2012)

For the participant, the anger was about the devastation of a wasted life, a life young, full of talent. There was a sense of frustration and helplessness of not knowing what to do for their child. The following quote encapsulates the devastation:

- "you're a bloody waste you know you're a waste, you had everything going for you, young and stern yeah that was the level of the emotions you get taken too" (P3,17/4/2012).

This participant described or implied feelings of 'guilt' associated with the suicide. Overall, feelings of guilt were apparent through research participant's interrogation of her role in inadvertently contributing to the suicide death. She admonishes that there was a lot of:

- "Self-blame, yeah lots of self-blame, really felt like I had umm been, I contributed to the cause of suicide. I went into a bit of 'was it me' what could I have done and the blaming side of things as a mother" (P3, 17/4/2012).

This advanced to:

- "Trying to brake myself down in terms of doing a self-assessment, self-analysis yah no critical analysis of myself to see what it was that I did. Was it me? Yeah doing a lot of that" (P3, 17/4/2012).

This development progressed to further self-analysis of:

- "What could I have done, what did I miss or how did I miss it and why couldn't he talk to me about it. I should have been more attentive" (P3, 17/4/2012)

4.3.2 Coping in response to young adult suicide

The family strove to cope with the after effects of the suicide. This participant commented how it would affect her life:

- "It would affect you know my day to day living in terms of going to work, um looking after family life, um relationship" (P3,17/4/2012).

Struggling to cope with the aftermath was difficult for this participant as she had not only her emotions to cope with also her whanau responses to the suicide. The participant illustrates her husband's response to their son's suicide and states:

- "He continued being depressed really depressed. He continued on being depressed and non-motivated, changing jobs, he went through one job to another couldn't hold a job down. He couldn't get out of bed for two and a half days" (P3, 17/4/2012).

Continuing she suggests that for her:

- "husband at times there were some moments of suicide risk you know throughout the first two years after the death you know because they didn't feel like they wanted to live either, because it wasn't worth it without Pauly there was nothing to live" (P3,17/4/2012).

- "I had to keep things running had to keep the coal burning and fires burning, and the coals running, cos someone had to do it......so I had the Whānau kids playing up, husband wanting to commit suicide, and trying to run two jobs.

As a means of coping she states:

- I just was mana wahine. I just called on whatever resources I can pull on to support the Whānau" (P3, 17/4/2012). I did a lot of karkaia timatanga and come home karakia whakamutunga

Support was a key factor in coping with the emotional trauma of the suicide death of the family member. Support for the participant was pivotal and emanated from various sources that comprised; her workplace, her class members, and her neighbours:

- "The workplace where I was working I was working here at Raukura they came and awhid me and gave me time off work. The participants that I was delivering classes to was giving me aroha but no there was a lot of manaakitanga, I never received anything negative, it was all supportive. The neighbour sent food over flowers, and they were non Māori neighbour. I didn't expect it because I hardly knew them" (P3, 17/4/2012).

An additional mode of support was provided by victim support:

- "I had the victim support come on board and they are lovely victim support you know you don't know really processes of those engagements are a lot and they were very very supportive and they brought me some information about suicide" (P3,17/4/2012).

The other manner of support derived from meeting with other survivors of suicide:

- "I'm ending up along pathway of meeting different people. At the hui where I was going to, meeting people there, who were also victims of suicide of Whānau." (P3, 17/4/2012).

4.3.3.2 Psychological and Social isolation

Other means of coping with the suicide for the family was that of social isolation:

- "No motivation……. yah know just stayed in their rooms……just isolated. "This suicide impacted at another level where he became isolated and smoked drugs like you wouldn't believe it, marijuana and drugs, shut down the world really" (P1, 17/4/2012).

- "The stages of grief were tapu not wanting people to come into our lives and not wanting to go in other people's lives, huddling together , being isolated as a Whānau in those first few weeks, keeping ourselves tapu

as such and the noa probably come out as we started coming to the realisation and the truth of we can't change what happen we can only better our lives and make sure it doesn't happen again and do our best to inform each other as Whānau and be tika and pono" (P1, 17/4/2012).

4.3.3.3 Summary

For this participant the emotional responses to the suicide death involved feelings of devastation, of anger, feeling overwhelmed, happy then sad, as well as depression. Means of coping with the suicide death included, support from the workplace, class members, neighbours, victim support, and a suicide support group. For this participant coping also involved social and psychological isolation and family support.

4.4 Case Study Four - Participant 4 (P 4)

The dialogue of this case study is derived from an interview that took place with the mother of a 20 year old Maori male that had been deceased for four months.

4.4.1 Emotional responses

This participant described feeling shocked at being notified of the suicide death of her son. Another emotional response she identified was feeling a sense of anger, particularly as she witnessed the impact of the death on her children:

- "I just went into shock. Coz I was on the floor, my youngest one came by me and I saw him crying, then I went to anger because it was how could you do this to us, why didn't you tell us?   For some reason, yeah I got a bit angry, because I looked at his brothers and could sense how it affected them. He left them behind. Everybody just was in shock, just

shock…..they went really quiet….just quiet. Everything was like a blur after that" (P4, 26/4/2012).

Similarly, this participant described her husband's reaction as also being in a state of 'shock' but she also exclaims he exhibited:

- "A lot of hurt. He was devastated. He did look pissed off, yep. When we got to the undertakers in Hamilton, yeah he had that look of, just anger. It's just the thought of having to go up there and get your boy and bring him home in a box, in a coffin. Yeah, he was angry, but not like rrrrr angry, there was anger there. It was just all the other different emotions as well. He was really sad, just very sad. Really quiet (P4, 26/4/2012).

Alongside of the feelings of anger was the search for the individual accountable for their son's suicide and so accusation of guilt was primarily directed toward the 'tohunga' (spiritual healer) whom they had been visiting prior to their son's suicide. According to the participant, the 'tohunga' (spiritual healer) revealed to them post-suicide, that he could have healed their son. For these participants there was no doubt had the 'tohunga'(spiritual healer) healed their son, his death would have been avoided:

- "All the faith that he had in our tohunga is just gone, from that moment. My husband says never, ever again is he going back there to see him, ever again" (P4, 26/4/2012).

This participant described feelings of 'guilt' associated with self-blame and trying to figured out why the suicide occurred. These feelings were made manifest through the participant's interrogation of her role in inadvertently contributing to the suicide and what she might have missed in terms of what:

- "I should have, would of, could of done, but I didn't" (P4, 26/4/2012).

The parents approached their son and asked him if he had suicidal tendencies but was assured he did not. This left them with feelings of helplessness in that their endeavour to reach out and support and their son, had been in vain. Another factor exasperating the feelings of guilt and self-blame, was that on the night of the suicide, the son's friends had made several attempts to ring his parents to warn them of their sons strange behaviour. The participant had switched her phone off. In hindsight, the participant saw this as being her missed opportunity to prevent his suicide.

4.4.2 Coping in Response to young adult suicide

For the participant, coping with grief meant getting over the loss as well as finding ways to live through it. There were a variety of ways identified in the participant's dialogue that describe how she and her husband coped with their grief and loss.

Coping techniques included psychological coping:

- "I had to find somewhere to put all my grief, grieving, my feelings, thoughts and emotions just so that I could pick my whanau up so that we can try and carry on. I will address my son's issues or whatever it was at another time" (P4, 26/4/2012).
- "Like for myself I find ways for myself to cope. I used to like going for walks and stuff like that. I actually still quite enjoy that, that helps, like an outlet for me" (P4, 26/4/2012).

Another technique evident in the findings was the ability and resilience to continue on with the daily activities

- "For me, I'm one of those ones like one of those ones like harden up. Get up. Stand up and just carry on. I've been brought up like that. Get over it. When you're sick or something like that. You could be half dead and still have to carry on and live life, as we do. We still got to go to work. Reality eh. Reality kicked in and it was just like... ideally I would have loved to have just fallen over and just grieved and grieved and grieved" (P4, 26/4/2012).

This participant described the physiognomies exhibited by close family members in their response to loss and grief:

- "Oh, just getting up in the morning was hard for my sons. One of them was having dreams that they'd see their brother crying and he was sad. And my other boy, he was saying he was visualising how his brother had did it. My husband didn't cope very well neither of us did but I could see him falling. He did nothing….. Just sitting. ……..Didn't really want to see anybody" (P4, 26/4/2012).

Other coping techniques included accessing social support from friends, family and work colleagues:

- "Yeah I've been to the support group meetings once or twice. Even just talking to friends or whanau, all that sort of thing helps. Talking definitely helps. I was getting support from my whanau. People would come over, to give their aroha and share the pain with us" (P4, 26/4/2012).

Such social support networks became a shared platform for the participant and her family to express their emotions and gain support in their grieving process. One of the main sources of support came at a pivotal time immediately following the suicide. The learning institution where the suicide victim was a student arranged

for the body to be brought back to the grieving family and made large financial donation. There was widespread support evidenced in the amount of time and effort people gave to the bereaved family. This provided much relief for the family. The participant revealed closer relationships within the family after the suicide. The family as reported by the participant displayed better relationships within the family in the sense that they got along better and became more helpful and supportive toward other family members. However as pointed out by the participant:

- "Just getting up in the morning was hard for my sons. My husband just didn't want to go anywhere, apart from home to the urupa, the shop. No-one wanted to go to the shop. But at the end of the day we still had to get milk and bread. We still had to get those things. I would have loved to just fallen oven, cried, cried, cried, done nothing. But then I looked at my husband and my children and I could see them falling over. I had to stay standing and sort my whanau first" (P4, 26/4/2012).

4.4 Summary

For this participant the emotional responses to the suicide death involved feelings of shock, of anger and hurt, devastation and sadness. Their means of coping with the suicide death included, finding the person responsible for the death, self-blame family support and social support.

4.5   Conclusions

In this chapter, the four participant's dialogue has been presented as case studies. Responding to, and coping with suicide, have been the themes linking each case study. The stories told by the participants offered a unique awareness and understanding into Survivors' grieving in response to suicide bereavement not only

that suffered throughout the initial months following the death, but also how it has continued to affect them in their lives, concurrently.

These parents have portrayed an array of emotions that have affected them in various ways and on various levels, in response to the suicide death of their children. The common reactions as disclosed by participants were shock, disbelief, numbness, physical sickness, fear and panic. Some participants discussed being overwhelmed by the intensity of their feelings and wondered if they were losing control.

A feature shared by all parents was that, grieving a child death was particularly difficult. But what made the grieving even more challenging, as highlighted by the participants was fact that the death was sudden, and of a violent disposition, which added to the already intense grieving.

All research participants described or implied feelings of 'guilt' associated with the suicide. Such feelings of guilt were accompanied by the reoccurring question of 'why' the suicide. Thus a coping technique evident in the findings was the cognitive searching and questioning. Reoccurring during the course of the interviews was the theme, "why" the suicide had transpired. Integral to coping with the impacts of suicide, were the elusive efforts to discover a rejoinder to the critical "why" question" which expended a lot of participants' energies. These attempts stirred parents to cognitize over the period preceding the suicide episode and to consider the signs that may reveal some motivation or reason for the suicide. Accusations of fault and resulting family conflicts were not uncommon for two of the participants.

In coping with a suicide death, another technique which all participants identified attaining was support either by family, friends, pastor, work colleagues or support groups. What was made evident by three participants was that 'family' was the principal support system and that social support groups for families bereaved by suicide were non-existent at the time of death of their child.

The overall research question in this research sought to firstly consider the Whānau stories of surviving the suicide of the adult child and to explore the responses of Whānau to suicide of the adult child as well as explore coping strategies that enable parents/family survive the impact of a suicide of relative. The literature review has presented studies directly associated with the research question. The case studies have presented dialogue of four parents bereaved by suicide. The chapter following renders an analysis of the key themes that emerge from out of the data.

CHAPTER FIVE: FINDINGS & DISCUSSIONS

5.0 Introduction

"If telling my story can comfort another survivor, then I will continue to tell it. If I can get information into the hands of someone who can save a life, then I am doing something incredible. I may never know for sure that my work has saved a life. I can live with that; I don't want to live with the 'what if' questions of never having tried." (Reussow, cited in American Foundation of Suicide Prevention, n.d.).

In the writing up of a case study report, Gillham (2000) and Yin (2003) advise that there is not a commonly established structure, even though there are particular elements generally located within case studies. Such reports are descriptive with the inclusion of major participants' narratives, revealing important data and approaches utilised to understand the report and endorse the case study's qualitative data. When undertaking case study research, the crucial feature of reporting findings is the repeated, continual examination and evaluation of acquired information to recognize and categorise answers to questions being considered. Stake (1995) reveals that in case study research, a chief element in the analysis of the data is the development and modification of interpretations from the findings of which deductions are elicited.

This chapter examines the information gathered in this research, a critical review of the case study data and its relevant application to the literature examined. The purpose of this study was to examine survivor's stories of how they responded to

and coped with the suicide death of their child. Like the previous chapter, all dialogue is specified with speech marks. The chapter is presented in three sections. Section one: Grieving in response to young adult suicide; Section two: Coping in response to young adult suicide; Section three: Conclusions.

5.1 Theme: Grieving in Response to Suicide

Grieving in response to suicide describes the participant's perspectives of grieving the loss of their young adult child to suicide and discusses their emotional responses. Participants interviewed exhibited and conveyed numerous responses in grieving the loss of their family member to suicide; therefore the initial theme was categorized: "Grieving in Response to young adult suicide". This section will discuss the first theme; grieving in response to suicide. Specifically the different aspects uncovered in grieving in response to suicide, which Jordan & McIntosh (2011) say there are common features of suicide bereavement) will be discussed, these will include:

- Shock, panic and disbelief,

- Irritation and anger,

- Betrayal, rejection and abandonment,

- Guilt and self-reproach

A small number of experiences in life are as disturbing as the suicide of a family member (Fine, 2004). As a result of the suicide and death, extreme disturbance into the lives of surviving parents as well as family, occurs. This study informs readers of the perplexing disposition of the grieving process resulting from young adult suicide; this understanding is reinforced by Jordan (2001) who postulates that "traumatic grief is one likely sequelae of a suicide" (p. 97). The narratives

gathered provided a unique insight into participants grieving in response to suicide bereavement, not only that experienced throughout the early months following the suicde, but also how it has continued to affect them in their lives, concurrently.

The common reactions as disclosed by participants were shock, disbelief, numbness, devastation, anger, sadness, fear and panic; effects that exhibit a salient likeness to posttraumatic stress reactions. Similar responses are described in a study investigating family members bereaved by suicide in Switzerland, wherein the participants reported suffering shock on ascertaining the body of the dead family member (Van Dongen, 1991). Some participants were overwhelmed by the intensity of their feelings and struggled to deal with them.

5.1.1   Shock, Panic and Disbelief

Of interest is the notion that survivors of suicide are commonly thought to be an at risk group for experiencing disruptions in their physical and psychological performing (Van Dongen, 1993). In this study, grief was manifested by a whole range of intense feelings. Particularly, the suddenness and the violent nature of the suicide death provoked an assortment of responses by the participants. Research participants comprehensively conveyed undergoing shock, panic and disbelief on finding the body or else being advised of the death of their family member. In describing the experience of initially being informed of the suicide, one participant simply stated, *"It was ugly"* (P 2, 10/01/2012). Most of the participants talked about the disbelief they exhibited, that they just couldn't believe it was true. They experienced shock and protected themselves by way of repudiation, incredulity, and detachment. One participant described how *"she asked me to go*

dress him and stuff, I went 'no'. I just stayed back home and everything (P 2, 10/01/2012*). Further, this participant commented "*I was sure as like nothing happened but as soon as I seen him, I just dropped with tears and really believed it, that it really did happen, it was like a whole lot of wave of things".* It would appear, this family member did not want to cry or see the body as this would endorse that their child was really gone. Disbelief accompanied with shock, Van Dongen (1990) believes, assists the bereaved family in shielding themselves from the severe realities of the suicide.

There were some distinct connections between how the parents described their responses to the suicide and what previous research has found. The responses; "*Just felt overwhelmed and devastated*" (P1, 10/1/2012) were echoed in the parent's experiences. All of the participants reported experiencing emotional responses related with severe grief, which included crying and longing for their child. The early months were a phase of extreme pain, distress and turmoil. The reactions of suicide survivors of this study were in overall comparable with the findings of earlier studies (Cleiren, 1993; Knieper, 1999).

5.1.2   Irritation and Anger

An additional significant theme that derived from the narratives was the participant's references of being subjected to emotive reactions comprising of irritation and anger. It would seem anger as reported by all the participants, was directed in many instances at the deceased. Fine (2006) establishes that suicide is unalike other deaths in that when parents mourn the death of a child through homicide they can emit wrath at the perpetrator, but the uniqueness of suicide

death is that the perpetrator is also the victim. To appreciate this is to realise that in an instant the life that whānau had built together during the 16-21 years with their child had ended suddenly and unexpectedly, without time for goodbyes. Further participants spoke to the issue that the children they thought they knew better than anyone else, was now dead by their own hand, and as parents they had been unable to stop it. One participant expressed anger and disappointment at being deceived which ended up in a family member walking up to the coffin, who then swore at the deceased and booted the coffin. In essence this deception, according to the participants deprived them of the chance to provide parental guidance and support.

5.1.3   Betrayal and Rejection

Other key themes emerging from this research were the heightened feelings of rejection and betrayal suffered by parents. All the participants' narratives attest to the experiences of parents who felt rejected and betrayed as a result of a suicide dea. Lindqvist, Johansson & Karlsson (2008), suggest that the act of children deliberately and intentionally committing suicide can be identified as the utmost rejection of family members. This notion of betrayal and rejection is shared by Jordan, (2001) & Watson & Lee, (1993) who claim suicide is a massive rejection of the parents who conceived and nurtured that life. These aspects were also recalled by the participants. For example, most participants expressed the betrayal of their child at deliberately leaving the family. One participant explained his position of not having forgiven his daughter for ending her life. His sense of betrayal and rejection at her actions was evident as he indicated visiting his daughter's grave site and speaking out loud "I asked you and you said no" (P1,

10/01/2012*). This statement acknowledges previous research wherein they conclude; what is evident from the interviews was the participants' grapple with a personal sense of blame for not having prevented the death (Cerel, Conwell & Reed, 2009). Knapp (1987) substantiates this notion of 'sense of blame' encapsulated by the participants, in her claim that, parents blame themselves for not being more cautious and attentive.

As a consequence of participants grappling with 'a sense of blame,' a salient aspect of the emotional state of participants was the feeling of helplessness. From the narrative findings, the young adult victims had concealed their suicidal ideation from not only their parents but also from their extended family. Of the participants who knew of their child's suicidal tendencies they remarked that they had confronted their child but had been met with denial, but yet they had tried to support them. An excellent example of 'helplessness was illustrated by one participant who simply asked *"what could I have done?"* (P2, 21/3/2012). The next statement by a participant *"what did I miss or how did I miss it and why couldn't he talk to me about it"* (ibid.) establishes a quandary that participants found themselves in and which previous studies confirm about the deliberateness of the actions of young adult (Begley & Quayle,2007).

5.1.4   Guilt, Reproach & Self-Blame

Similar to Begley & Qualyle's research (2007) the participants in this research, struggled with a sense of self blame for not having stopped the suicide death and as consequence were left with feelings of guilt. A usual reaction is that parents feel responsible for not being more attentive. Ideas like*, "I could have done more"* (P2,

21/3/2012)*, "Why didn't I see it?"* (P3, 17/4/2012)*, "How could I have missed?" (P2, 21/3/2012)*, *"I should have been more attentive"* (ibid.), were expressed by participants. A sense of helplessness for not knowing what to do for their child was apparent.

The proposal that parents suffer from bereavement overload, resulting from a sense of guilt and failure as parents (Rando, 1995) resonated with the participants experiences. On the night of the suicide, one participant relates how her son's friends had made several attempts to ring her phone to warn her of their son's strange behaviour. She had had her phone switched off. In hindsight, the participant saw this as being her missed opportunity to prevent his suicide. Another participant fared similarly; she hadn't heard the phone ring, when her brother called her for the last time – a coincidence that left her with sleepless nights after his death. These and similar events torment many surviving dependents of victims of suicide. All the bereaved participants conveyed feeling a sense of self-reproach and guilt and recognised it as an integral part of loss. However, participants were also explicit in explaining a sense *of "what did I miss and 'what could I have done"?* (P2, 21/3/2012). For them, their limited knowledge about suicide made them incapable of supporting their child or even preventing the death.

From this study two issues emerge. All the participants knew there was a problem with their child. What was poignantly evident in the narratives was that families did not know how to help their child even though they tried to reach out and support their child as best they could. The other issue was that the young person either

denied the ideation or hid the ideation. As such the participants expressed a sense of powerlessness and helplessness of not able to not only help their child as well as not knowing how to help their child. This signifies another dilemma for the 'silence of suicide'.

"There is no signs…..suicides don't have signs" (P 3, 17/04/2012).

And even when their younger son notified them of their older son's suggestion of *"going to kill himself"* (P 3, 17/04/2012), they still could not believe that he would do it because it was "out of character. Self-blame was highlighted by a participant who described*, "yeah lots of self-blame, really felt like I had contributed to the cause of suicide…..trying to brake myself down in terms of doing a self-assessment….yah critical analysis of myself to see what it was that I did. Was it me?"* Further, this participant commented *"that slight inner guilt of maybe we didn't give enough help or didn't give enough time to him"* (P 3. 17/04/2012).

5.2 Theme 2: Coping in Response to Suicide

There was an array of ways identified in the findings that participants undertook in their trajectory of grief and loss. Coping techniques included, gaining support and psychological and social isolating. Another technique evident in the findings was the cognitive searching and questioning and finding the reason why the suicide occurred, alongside of whanau functioning. Most of the participants talked about the physiognomies exhibited by them or close family members: *"He continued being depressed really depressed, and non-motivated, changing jobs, he went through one job to another couldn't hold a job down. This suicide impacted at another level where he became isolated and smoked drugs like you wouldn't believe it, marijuana and drugs; shut down the world really"* (P 3, 17/04/2012).

A reoccurring theme emerging out of the qualitative data was the stigmatization of suicide survivors arising from the loss of a child. From an initial appraisal of the narratives the main points highlighted were the attitudes toward the dead child's body and the appropriateness of it lying in state at the marae. One participant felt the brunt of the stigma and expressed her hurt about the rejection because "*some of them have ideas that they should not be in the same graveyard as everyone else*" (P4, 26/4/2012). All the participants were stigmatised by significant others present at the funeral of their dead child, who expressed against having the body at the marae since it was 'death by suicide'; *"gees I was really getting angry and hurt and frustrated, I just got a shock",* (P 2, 21/03/2012). The foremost idea is that those bereaved by suicide anticipated significant others to behave in a supportive and helpful manner in the wake of what was for them the most disturbing catastrophe they had experienced. Surviving participants reported being in great psychological pain, and experienced pressure and unsupportiveness, when they anticipated consolation and relief; it was not surprising that negative responses were an added burden in the participant survivor's grieving (Neimeyer & Jordan, 2002). One grieving participant pointed out that empathic failures were least expected *"especially from your own aye, you know being cast out more or less"* (ibid.)

This analysis suggests survivors were aware of the potentially stigmatizing nature of suicide. They described feeling estranged from people outside the family, because they perceived the persons who had not experienced the loss of a family member through suicide could not appreciate their pain. This is consistent with research, which has indicated that parents are preoccupied with their grief, and

their feelings of alienation from normality are exacerbated by the discomfort of those around them who do not know what to say (Riches & Dawson, 2000, Clabburn 2007). The experience of social isolation adds a sense of shame to the guilt and responsibility. The stresses on the participants was enormous *"it was hard to talk about to anybody. Not everybody spoke about it. You could have more swear words than just saying the word suicide"*, *"some of the whanau find it a bit hard to approach it, like as soon as my brother's name will come up in a conversation it just goes quiet and no one knows where to start"* (P 1,10/01/2012).

5.2.1 Social and Psychological Isolation

Returning to public life for the first time after the death is an alarming experience for many bereaved parents (Schiff, 1977). Arnold (2011) highlights since the parents' world has dramatically changed, there is a sense of dismay to realize that, for other people, life continues as normal. In one specific narrative in this study, a participant refers to a particular experience she had when returning back to work after her son's suicide wherein she realized everyone around her was carrying on with normal life and she wondered *"why are you smiling?, why are you happy…?."* (P 3, 17/04/2012). She remarks she *"didn't want to be confronted with people that were happy because it wasn't fair"* (ibid.). With three participants there was a sense that some friends, neighbours and the wider community felt uncomfortable around the bereaved family.

Several reports reveal the reason underpinning this phenomenon, as being the 'unease' or 'discomfort' around which people feel in dealing with suicide death (Harwood, Hawton, Hope & Jacob, 2002; McIntosh, 1996; Van Dongen, 1993). Similarly, participants reported difficulty in communicating to others about the

suicide death. Literature suggests difficulty in communication is closely linked to emotional states of guilt and shame; which are distinctive characteristics of suicide grief compared to bereavements by other traumatic deaths (Harwood, et.al). From this perspective Begley & Quayle's (2007) contention was accurate when they theorized that survivors eluded social interfaces as they because of the need to regulate their emotions, which in turn strengthened their certainty that people had altered their behaviour toward them.

These findings lend support to more recent studies which conclude that as survivors come upon more stigma and grief complications, their need for support group involvement will increase.

5.2.2 Support

Precious study has found that the process of tangihana is the conduit for family support in times of grief. The findings in this research propose that the experiences of suicide survivors at the tangihana process, where they expected significant others to actively support them, the opposite occurred where participants reported feeling rejected, humiliated, frustrated and hurt. Although it can appear paradoxical for bereaved stricken survivors to experience these feelings during a 'tangihana', it is not surprising given that suicide is commonly seen as a "bad death" in Maori culture, where the deceased traditionally were buried outside the gates or near the gates for people to walk over them.

Our findings propose that after a loss parents can normally anticipate to discover their greatest essential grief support from children, spouses, family, close friends and significant others. However, when these groups do not give the kinds of support required, as this study suggests occurred, then survivors will be forced to

access for help and support elsewhere. A family or close social network becomes a shared platform for the "in-groups" to express their emotions and gain support. Begley & Quayle (2007) conclusively state that suicide death is a "powerful social force on participants in that it regulates attachments to suicide bereavement groups" (p. 32). The providers of social support were either informal sources, which are family and friends. The family or local social systems become a common arena for the bereaved to convey their reactions, grief and maybe extend support. Arnold (2011) in her study on parents grieving the loss of a child found that parents underwent personal growth when engaging in social activities and support groups

Immediately following the suicide most participants had felt supported by their communities in that there was widespread support in the amount of time and effort people attending the tangihana gave to the bereaved family. However once the tangihana was over the families found that in some instances they were left on their own to grieve. Congruent with the findings of this study, the way people experience their grief depends on the kind of support available from family and community (Riches & Dawson, 2000). Dyregrov & Dyregrov's (2008)) study showed that brief early support was minimal whereby data evidenced only about one in four participants in fact shared in support groups.

At the time of the suicides, some of the participants revealed not having a choice to grieve via support groups because there weren't any to attend. According to a study undertaken with African Americans, a large number of participants revealed a difficult grieving process when losing a loved one to suicide, due to the circumstances families found themselves in. Primarily, they had no forum whereby

they could grieve. Barnes, (2006) reiterates, experiencing nowhere to find support and assistance, impedes the healing process. He further argues if suicide has no clear meaning in the different groups within various communities, then how do those members operate communally to acquire or create services or resources for the prevention of suicide and support groups for suicide-survivors.

It has been recognised that social support understood to be unsupportive deters coping (Hogan & De Santis, 1994). When one of the participants had trouble with her son's addictive behaviours, she was able to make contact with various community people, which facilitated her son receiving mental health support from the District Health Board. There were organizations equipped to deal with her requests when her struggled with drug addiction, however there were no immediate accessible support to address her child's suicide. This predicament-the parental experience with a child having addiction issues alongside of the event of surviving the suicide of the child-are not correspondingly incorporated into the mental health system with the community. Noticeably in various communities are agencies that act in response to drug abuse, violence, gangs, truancy, domestic violence, but nothing openly related to and focused on suicide prevention or support for survivors.

The value of 'support' has been documented in previous research. The participants who were parents bereaved by child death, highlighted utilising various sources of support for comfort after the loss of a child. Moreover they also reflected the leanings from their own experiences of the importance of reaching out to families, friends, and church communities.

At the time of undertaking research interviews the prevalence of Maori suicide was attracting media attention and had resulted in various rural communities developing suicide support groups. Two respondents, who at the time of being interviewed had, had a loved one, die within an 18 month period, the other a four month period had been members of support groups, within their communities. These support groups, run by Māori had been recently organised at the time of the interviews. However research participants exposed families having to cope without suicide support groups.

Instead one participant stated turning to her local pastor for fellowship "*I was even praying I always believe in the lord*" (P 2, 21/03/2012). She also turned to her local general practitioner, *"my doctor would say 'oh it's a lot of stress, there's a lot of stress on me"* (ibid). She was diagnosed with depression by her doctor. *"I went for some healing through psychics my own ones that I know"* (ibid.).The eventual outcome was that participants reported being unable to cope with their inner turmoil and subsequently broke rank and engaged in self-harm behaviours or sought professional support.

5.2.3 Whānau functioning

There were apparent links relating to how participants explained their family relationships and what findings from earlier research assert. The suggestion that survivors' may experience a positive outcome in relationship to the death of a loved one (Frantz, Farrell and Trolley, 2001) resonated with the bereaved participants. Moreover, Cvinar, (2005); McIntosh, (1997) concur a suicide death can bring family members closer together. Their research found that subsequent to

the passing away of a family member, survivors were expected to report stronger family ties, functioning more independently, and being more in tune with their life priorities i.e spending more time with family and friends. Similarly, in this study, participants provided insights into their relationships with their children and other family members, describing their interactions as being positive and mutually supportive: *"I visit relatives and friends. I get along with family I show empathy and support to my family"* (P 2, 21/03/2012). It would appear from the examples provided by participants, better relationships within the family are apparent, in the sense that they got along well and became more empathic and supportive toward other family members. *"Just the strength of all the family, I thank them really for that, I thank them cause it brought my family so much closer…we had to pull together and get through this together"* (P 4, 26/04/2012). Another participant reiterated being able to come together as a family, *"they were hurting but we all come together as a family we had too"* (P 2, 21/03/2012).

However, Worden (1982) claims that the dynamism behind suicide death can create family dysfunction and can pull the complete family into disarray. Dunn and Morrish-Vinders (1987–1988) found in their studies that twice as many survivors reported more distant relationships within the family than reported an increase in closeness of relationships after the suicide. The rationale suggests that the shared involvement of undergoing sorrow and grief can render individuals within families incapable of offering necessary comfort and encouragement to each other, eventually creating long term disruption within the family (Vachon & Stylianos, 1988). For instance, changes in how families performed and operated were apparent post suicide as participants referred to the extreme void brought about by

the suicide death in the family unit. It would appear from the examples provided by the participants that as a result of suicide death, families experienced conflict amongst themselves. .

An escalation in marital strain was recounted by a participant who described themselves as being "*aggressive as well as offensive….. there was a lot of ups and downs and fights. We had big arguments, an ugly situation to be in for the whole family*" (P 1, 10/01/2012). This quote highlights the discord and the combined involvement of pain and distress that could prohibit family members from providing the much needed care and consideration for each other, subsequently leading to family dysfunction (Vachon & Stylianos, 1988). For two participants, narratives highlighted the propensity for family members to blame one another for influencing or causing the suicide. However two of the bereaved parents defined their family relationships as encouraging and affirming, wherein family members were not caught in expounding blame on one another for being part of the cause of the suicide.

For another participant, the suicide event split the family in half, as a consequence, seven years later; some family members do not have anything to do with each other whilst the other half are supportive of each other. Similar responses are described in a study investigating family functioning. Not only did the participants, have difficulty coping with grieving for the loss, but they showed their grief in different ways .The participants described even though they were all mourning for the same loss, they often felt isolated in their grief . It would seem *"My kids I couldn't get them to sit down and talk about it, especially for the boys they didn't*

want to hear about it. That was hard because I could see them going through some tough straining emotions" (P 2, 21/03/2012). What was evident in this study was that there was one individual in each family that had the role and task of keeping the family functioning; essentially they were the anchors of the family. *"I had to be strong for my family"* Further this participant spoke to the issue of *"I had to be strong for my family…. "I kept in touch just about every week telling everyone I loved them, so they would sort of heal together"* (P2, 21/03/2012).

5.2.4 Finding the reason: "Why"

Arising during the course of the interviews was the theme, "why" the suicide had transpired. Integral to surviving or coping with the impacts of suicide, were the elusive attempts and efforts to discover an answer to the pivotal "why" question". This process in essence consumed a lot of the participants' energies. The point that their child had brought a deliberate, abrupt end to his/her life was incongruent with their earlier beliefs about the deceased individual and their view of life. The interviews were filled with dialogue of; *"How can this be?"* (P 4, 26/04/2012*), "That's the biggest impacting questions, why did my son do it?"* (P 2, 21/03/2012).This "tormenting questioning" according to Van Dongen (1990) stimulates family members to go through again and again the period preceding the suicide episode, considering signs that may reveal some motivation or reason for the suicide.

This has major effects as parents struggle to answer 'why'. An excellent example of this struggle was illustrated by a participant who simply *asked "Why could they have not come to me, why does a simple teenage problem like relationship struggles have to end in death?" (*P 3,17/04/2012). Participants in over half the

families surmised about a variety of factors that may have influenced their child's decision to end their lives, including mental health, depression, relationship difficulties.. Despite speculating on these possible explanations, survivors' continued to repeatedly cognitize about the "why question". For all survivors', finding the answer to this perplexing question became a drawn out pursuit. Ten years post-suicide, a father recalled visiting his daughter's gravesite each year with the same comments he makes to his daughter *"I still haven't forgiven you….I asked you and you said no…….Why? I loved you"* (P 1,10/1/2012). This narrative highlights the reality for all the survivors in having to come to "grips", of not getting answers as to why their family member died by suicide.

Participants accounted on visiting the gravesite of their family member, or talking to a photo, and express their anger and pain at not knowing at not having any answers: *"What did you think you were doing? You're a bloody waste, you know you're a bloody waste and you had everything going for you, young and stern"* (P 3, 17/04/2012). This cognitive discord inspired survivors drove them to hypothesize about the reasons for the suicide or pursue material that would aid in explaining and clarifying the suicide. *"Was it because he moved out, was it because he got angry at us and he didn't want to leave home because he had to now spread his wings and be responsible he was twenty-one he had to grow up and get on with life, was it that that contributed yah now this is all these questions going round and round and round, umm"* (ibid.). For some of the participants there was no doubt; "*if he didn't have a mental health problem, he would still be alive"* (P 2, 21/03/2012), *or "if the friends had told us that she was talking about ending her life, she'd still be alive"* (P 1 10/01/2012).

It would also appear from the narratives provided, that participants were exposed to the pressure from others to explain the suicide. In the following quote, one participant alluded to "*People asking 'why did he do it*" (P 3, 17/04/2012). This participant further shared that she was left in a quandary of "*How was I gonna answer. I don't know but I wanted to have an answer I really did want to have not the answer but an understanding to give across*" (ibid.). Similar to this study's findings, Range & Calhoun (1990) echo the notion that survivor's' encounter the struggle of continuously having to give details and explanations for their dead child's decision to suicide. Another intention for the cognitive searching and questioning was the search for the person responsible – accusation of guilt. Accusations of fault and the resulting family conflicts are not uncommon after a suicide.

Families are fraught with the need to make sense of and find meaning to the sudden death and as an approach to coping, search for a reason or for the person responsible for the suicide. Allegations of fault were not unusual in this study. According to previous research, such a predicament specifically entails the pursuit of the reason and the question - if and by what means the suicide could have been prevented. For the participants it was apparent this mostly meant locating the person/s accountable or answerable for the death of their child. All surviving parents unanimously made endless attempts to give this unbelievable incident some meaning in their determination to comprehend why and what took place. An outcome evident was the never-ending ruminating over a death that in their opinion was needless. *"I guess you start blaming the lack of understanding and*

then having to go to the system he was going to Henry Bennett for almost a year and there was still not much information" (P 2, 21/03/2012).

5.3 Conclusion

There is nonetheless a great deal to examine in regards to the particular experiences of responding to the loss of a young adult child that has died by suicide. The incidents of stigmatization, guilt, shame, and blame are significant elements that are a consequence of an unquiet grieving process for those bereaved by suicide. The absence of reasons for the suicide death is also a prominent concern in the bereavement process. Moreover needing to find the reason as to why the suicide occurred is an essential factor in coping with the suicide.

The purpose of this research focussed on the bereavement experiences of adults whose child had died by suicide; specifically to explore the responses of those bereaved by suicide and to explore how parents coped after the death. These stories of grief make available understanding and awareness into the type of concerns that volunteer and governmental groups may take into account when offering support to person bereaved by suicide.

In this study it was found that reactions of Māori suicide survivors were in over-all consistent with the former results undertaken in other countries (Cleiren, 1993; Knieper, 1999; Silverman, 1995). For instance the psychological suffering (i.e., shock and disbelief, anger, guilt), and stigmatization, experienced by bereaved parents, parallel what has been reported in other empirical research (Clark &

Goldney, 2000; Jordan, 2001). This research also found that death by suicide brought some families members closer together as well as created the opposite effect of fragmenting families, as was the case of studies in other countries.

CHAPTER SIX: CONCLUSION

6.0 Introduction

This chapter will firstly overview the aim of this research along with an overview of the main ideas from the earlier chapters. A synopsis in regards to the findings as well the inferences for counselling or social work practice will follow. This chapter will conclude with recommendations.

My work as a Social Worker and Counsellor with vulnerable populations led me to this research as well as the need to fulfil university academic requirements . Māori whānau bereaved by suicide have been rarely been investigated. Understanding what happens to whānau when their young adult child dies through a suicide death was a major aim of this study. The research question ultimately inquired an examination of stories of surviving the suicide of the adult child. It expected to give an inclusive viewpoint of whānau surviving the suicide death of their loved one.

The aims of the research focus on understanding parent's experiences of grieving the loss of their child and understanding the coping strategies that help parents survive suicide death. For that reason, it was essential to commence by recognising the dearth of the national and international available on Maori experiences of bereavement and suicide. Chapter two also began by offering a Western perspective of suicide, contrasted with a Maori definition as well as identifying risk indicators that have increased the incidence of suicide. Statistical data highlighted the incidents of suicidal behaviour for Maori and non-Maori, with emphasis on suicide being a major reason for avoidable deaths in New Zealand.

The cultural context of suicide was presented with particular reference to the impacts of suicide for Māori Whānau with regards to the impacts on whakapapa. The death of a child was discussed, recognising it as one of the most traumatising occurrences for parents. This introduced a discussion on suicide survivor's responses to unexpected child death. The notion of coping was explored with reference to Lazarus-Folkman's 'Stress and Coping Framework'. Following the concept of grief was examined with an overview of grief models. Finally chapter two concludes with a discussion around various frameworks in relation to the focus of this research; Māori Whānau bereaved by suicide.

This chapter prepared the landscape for this study, setting the grounds for the successive chapters.

Chapter three discussed the methodology utilised in developing this research inquiry. In as much as the focus of the study was on Māori it imperative to use a process that was methodologically applicable, appropriate and the best fit for Māori. Moreover, methodological philosophies of Kaupapa Māori research were identified and discussed whereby providing a rationale for the usage of a Maori centred approach. The common denominator for both Maori centred research and Kaupapa Māori research is that both engage a Māori methodology and analysis. The divergence becomes apparent with the engagement of Western methods and analysis.

A Case study approach provided a plan to analytically examine in specific the main points of data; responses and coping strategies of Whānau bereaved by suicide. Paralleling with a Māori worldview, the case study approach comes from a holistic

perspective and was suitable to investigating conditions "where little is known about what is there or what is going on; when it is necessary to get under the skin of a group, or to view a case from inside out" (Barton, 2008, p. 48). What was required in this research was knowledge and understanding of families bereaved by suicide therefore increasing knowledge around how families responded and coped with a suicide death. In the course of using a case study approach the researcher obtained in-depth, rich data, allowing the voices of families bereaved by suicide to be received and understood. This chapter was closed with a discussion on the ethical considerations, case recruitment and the interview process.

The fourth chapter introduced the participants (families) and their experiences which were analysed, collated and organised into case studies. Firstly the individual case studies was analysed and themes from each case study were cross matched with the other case studies. The central themes and concepts depicted in the case studies fell under two main headings; responses to young adult suicide and coping in response to young adult suicide. The reoccurrence of emotional responses such as shock, anger, denial, sadness were identified as were the coping in response to young adult suicide; whanau functioning, support and psychological and social isolation. Within each case study, quotes from the participant's narrative were utilised to corroborate the themes.

The fifth chapter examined the data collected in the research, offering a critical examination of the case study information and its pertinent application to the

literature. The section headings in this chapter included grieving in response to young adult suicide and coping in response to young adult suicide.

6.1 Implications for practice

Insights revealed by this small group of participants highlights the far-reaching impacts that young adult suicide generates in its trajectory is one of the ultimate encounters faced by survivors. Of key significance is survivors need to address their aggrieved turmoil – not only in relation to their grief and loss but also in acknowledgement and respect of the personal disruption they are compelled to suffer as a consequence of the suicide.

The experiences and needs of families bereaved by suicide have been scarcely expounded in the literature as such the grieving families have been defined according to Ehrhardt and Ehrhardt, (2004) as the forgotten people.

Some of what has developed out of this research are potential theories. Firstly grief can be problematic in the absence of structured communal or organisational support programs. Secondly, when there is a deficiency of meaning and understanding to suicide, preventative and interventional strategies are scare or non-existent within communities.

1. Support and Interventions

Jordan (2001) advises that not all those bereaved by suicide develop difficult grief reactions and require additional support for their bereavement. However, this study suggests that immediate responsive services at the early phase of suicide bereavement is not only crucial but needs to be made accessible to the family.

The impact of the lack of social support evident in communities compounded the families' ability to grieve. Shahtahmasebi and Mclean (2011), state that due to dearth of suitable post-suicide support families have undergone a problematic grief trajectory and have been unable to "grieve the way they want or would like" (ibid. pg.4). What this study reveals is the requirement for more social support within Maori communities, which was prevalent within all participants' narratives.

Significant consideration and responsiveness to the issues, individuals and families afflicted post-suicide will enlarge our understanding of suicide bereavement and more importantly spearhead more effective interventions to support survivors' struggles in confronting and healing from their loss. Not only is our understanding about Maori suicide survivors developing, but interventions, empirically based for these individuals and whānau are essentially non-existent. Access to suicide support groups was often badly timed, limited and insufficient or at worst null and void. Moreover, information about suicide lacking so essentially families was and is ill-informed.

Recommendations

In Aotearoa/New Zealand, new emerging volunteer support groups need to be created in order to make available, support and assistance to adults bereaved by suicide. The basis for these set-ups is that 'adults bereaved by suicide' have need of positive outreach provision and contact to other survivors so that they are equipped to cope with the deliberate self-inflicted death of a relative.

Clearly, families bereaved by suicide require organised systems of care support made available to them

The pivotal question that requires urgent answers is: are community agencies and other general support services and professionals prepared to respond to the complex emotional needs of families bereaved by suicide.

The original intention and purpose of the New Zealand Youth Suicide Prevention Strategy (NZYSPS) stipulates "the provision of effective support to those who are bereaved or affected by suicide" (Associate Minister of Health, 2006, p. 27). The NZYSPS has to be observed to be increasingly pre-emptive about initiating better results for adults bereaved by suicide through the establishment and delivery of primary support services.

One suggestion that NZYSPS can consider is the formation of a working party to develop care support policies and resource allocation. The presence of suicide survivors on the working party would be beneficial in creating policies around resource allocation and care support packages. The rationale for this is that policies and support packages need to be appropriate and responsive to the specific needs of families. This working party also need to devise strategies for the implementation of informational support for families.

Another recommendation is the establishment of new volunteer support groups The foundation for these set-ups is that adults who are bereaved by suicide have access to responsive affirmative outreach provision of community services and connection to other survivors. The outcome of which would be whānau who are

better equipped to manage and cope with the intentional self-inflicted death of their child.

From the involvement and knowledge of this study, it is also recommended that a responsive model of intervention to assist potential survivors of suicide as Shneidman (1981) recommends, to "live longer, more productively, and less stressfully than they are likely to do otherwise" (p. 349) is implemented.

What is also imperative is that interventions should be devised and provided by those who are informed about death, loss, grief and bereavement from a Maori worldview.

Given this current situation of minimal services for survivors, it affords an opportunity for researchers to plan and propose methodically comprehensive investigations on the effectiveness and usefulness of interventions for survivors. This requires urgent attention. Open dialogue with suicide survivors needs to occur to ensure that communities are aware of the needs of suicide survivors and begin to respond to those needs.

2. Professional competencies

What will be evident for professionals, who will work with whānau grieving a suicide death, is the intensity of whānau emotional responses. Professionals need to be aware and acknowledge that these responses are expected, natural and appropriate given the distinct, unique nature of grieving a death by suicide.

Recommendations

Whānau require easy, available access to trained professionals that may include counsellors, psychologists, social workers, whānau support workers. It is imperative that these professionals are trained in the specific cultural, spiritual and emotional imperatives of Maori whānau bereaved by suicide. Therefore training packages informed by suicide survivors need to be devised and implemented and undertaken by those professionals who work with bereaved families of suicide.

3. A new look at 'suicide'

Within the New Zealand public arena suicide remains the 'the best kept secret' which has helped preserve suicide's taboo status. The way in which people grieve becomes more difficult for Māori simply because, the stigma around suicide death complicates the grieving process. Participants felt isolated in their grief and chose not to be exposed to the scrutiny of others. Barnes (2006) suggests "if people view suicide as a family failure, then this can be the determining factor of whether or not to come out (p. 347)."

Recommendations

As a recommendation Barnes (ibid. p. 347) recommends that the:

"Definition of suicide needs to be redefined, not as a family failure but as a way of death that is most likely to occur under certain conditions, and not as evidence of personal weakness, giving up, selfishness, getting revenge, or any of the other simplistic labels that are often associated with it."

For this to occur open forums of discussion need to be facilitated beginning with the policy makers in the Ministry of Health, non-governmental social service agencies, professionals including social workers, mental health workers, counsellors, psychologists, community workers and families within communities.

Additional studies are required to elucidate communal and societal reactions to suicide death and suicide survivors. Specifically this exploration should endeavour to investigate how Maori communities view and comprehend suicide.

As the concluding point, the findings of this research enhance the literature of grief and loss by providing a starting point for further examination of Maori whānau responses and coping mechanisms, to trauma and violent death. However this research is restricted with a relatively small sample size, and would benefit by undertaking a more extensive, in-depth research into Maori whānau responses and coping mechanisms to young adult suicide.

REFERENCES

American Association of Suicidology. (2006). *Survivor of suicide fact sheet.* Retrieved September 1, 2011 from http://www.suicidology.org/index.html

American Foundation for Suicide Prevention. (N.D.). *Personal survivor's stories.* Retrieved August 11, 2011 from http://www.afsp.org/index.cfm?page_id=FF1A0F15-D2AD-1355-4F00BDC24A3418DD

Arnold, S. (2011). Sing no sad songs: Grieving the death of a young adult child from cancer. Retrieved November 25, 2011 from http://www.google.co.nz?#hl=en&output=search&sclient=psy-ab&q=%

Associate Minister of Health. 2006. *New Zealand suicide prevention strategy 2006-2016.* Wellington: Ministry of Health.

Bailley, S., Kral, M., & Dunham, K. (1999). Survivors of suicide do grieve differently: Empirical support for a common sense proposition. *Suicide and Life-Threatening Behaviour, 29,* 256–270.B

Barnes, D. (2006). The aftermath of suicide among African Americans. *Journal of Black Psychology* 32(3), 335-348. Retrieved from http://jbp.sagepub.com

Barnes, H. (2000). Kaupapa Māori: Explaining the ordinary. Auckland, New Zealand: University of Auckland Alcohol & Public Health Research Unit.

Brton, P. (2008). Kind of ritual Pakeha tikanga – Māori experiences of hospitalisation: case study. Unpublished thesis. Massey University.

Battiste, M. (2000). Maintaining aboriginal identity, language, and culture in modern society. In M. Battiste (Ed.), *Reclaiming indigenous voice and vision* (pp. 192-208). Toronto, ON: UBC Press.

Beautrais, A., Joyce, P., & Mulder, R. (1997). Precipitating factors and life events

    in serious suicide attempts among youths aged 13 through 24 year. *Journal*

    of American Academy of Child and Adolescent Psychiatry, 36, 1543-1551.

Beautrais, A. (2003). Suicide in New Zealand: time trends and epidemiology. *New*

    Zealand Medical Journal, (4), 383-399.

Beautrais, A. (2005). *Suicide postvention support for families, whanau and*

    significant others after a suicide. Canterbury Suicide Project. Christchurch

    School of   Medicine and Health Services.

Begley, M., & Quayle, E. (2007). The lived experience of adults bereaved by

    suicide. *Crisis,* 28(1), 26–34.

Berg, L.B. (2007). *Qualitative research methods for the social sciences* (6th ed.).

    Boston, MA: Pearson Education.

Berg, L.B. (2009). *Qualitative research methods for the social sciences* (7th ed.).

    Boston: Allyn & Bacon.

Berry, J., Sam, D. (1997). Acculturation and adaptation. In J.W.Berry, M.H. Segall

    & C. Kagitcibasi (Eds.), *Handbook of cross-cultural psychology, Vol. 3, Social*

    behaviour and applications (pp. 291-326). Boston: Allyn and Bacon.

Bevan-Brown, J. (1998). *By Māori, for Māori, about Māori – Is that enough*? Paper

    delivered to Te Oru Rangahau Maori Research and Development conference:

    7-9 July 1998, Massey University.

Biggs, C. (2002). The sudden and unexpected death of a sibling and its impact on

    surviving children and adolescents: A family perspective. *Grief matters, 5*(2),

    31-34.

Bishop, R. (1996). *Whakawhānaungatanga: Collaborative research stories.*

    Palmerston North: Dunmore Press Ltd.

Bishop, R. (1998). Freeing ourselves from neo-colonial domination research: A Maori approach to creating knowledge. *International Journal of Qualitative Studies of Education, 11*(2),199-219.

Boswell, S. S. (2008). *Increasing narrative coherence in the bereaved: The effect of narrative review on grief reaction.* Retrieved from http://books.google.co.nz/books?hl=en&lr=&id=siCHDy-iavYC&oi=fnd&pg=PR4&dq=Increasing+narrative+coherence+in+the+bereaved&ots=BhI3HdXCq7&sig=eE5MTOYW7gISda_wz9VZ8VQ6hDc

Cain, A. C. (Ed.). (1972).*Survivors of suicide.* Springfield, Ill: Charles C. Thomas.

Callahan, J. (2000). Predictors and correlates of bereavement in suicide support group participants. *Suicide and Life Threatening Behaviour, 30*, 104–124.

Cantor, C. (1999), Letter to the editor: Reply to Joseph M. Rothberg. *Suicide and Life-Threatening Behaviour, 29*(3) 91-102.

Cerel J., Padgett, J, Conwell, Y., & Reed, G. (2009). A call for research: The need to better understand the impact of support groups for suicide survivors. *Suicide & Life Threatening Behaviour, 39*(3), 269-281.

Clabburn, P. (2007). Facing life after losing your son. Retrieved November 20, 2010 from http://news.bbc.co.uk/2/hi/health/7109834.stm.

Clark, S. & Goldney, R. (2000). The impact of suicide on relatives and friends. In K. Hawton & K. van Heeringen (Eds.), *The international handbook of suicide and attempted suicide* (pp. 467–484). Chichester: John Wiley & Sons.

Clarke, C.S., & Wrigley, M. (2004). Suicide -related bereavement and psychiatric morbidity in the elderly. *Irish Journal of Psychological Medicine, 21*, 22–24.

Cleiren, M. (1999). Phenomenology of bereavement process after suicide, traffic accident and terminal illness (in spouses). Retrieved September 23, 2009, from http://www.springlink.com/content/vhpcgvb9r17lgdtu/ .

Collings, S & Beautrais, A. (2005). *Suicide prevention in New Zealand: A contemporary perspective*. Wellington: Ministry of Health.

Cooper, J. (1999). Ethical issues and their practical application in a psychological autopsy study of science. Clinical Nurse, 8(4), 467-475.

Corr, C. Nabe, A & Corr, D. (2000). Death and dying: Life and living. Belmont: Wadsworth.

Coupe, N. (2005). *Whakamomori. Māori suicide prevention.* (Doctoral dissertation). Palmerston North, New Zealand: Massey University.

Cram, F. (1997). Developing partnerships in research: Pakeha researchers and Māori Research. *Sites: A Journal for South Pacific Cultural Studies,* 35, 44-63.

Cram, F. (2001). Rangahau Māori: Tona tika, tona pono: The validity and integrity of Māori research. In M. Tolich (Ed.). *Research ethics in Aotearoa New Zealand* (pp. 35-52)*.* Auckland: Pearson Education NZ Limited.

Cram, F. & Kennedy, V. (2004). Researching with whanau collectives. *MAI Review,* 3, 1-12. Retrieved on 13 August 2011 from http://review.mai.ac.nz.

Creswell, J. W. & Maietta, R, C. (2002). Qualitative research. In D.C. Miller & N.J

    Salkind (Eds.). Handbook of research design & social measurement (6th ed.,

    pp. 143-184). Thousand Oaks, CA Sage.

Creswell, J.W. (2003). *Research design: Qualitative, quantitative, and mixed*

    methods approaches (2nd ed.). Lincoln: Sage Publications.

Cunningham, C. (1998). *A framework for addressing Māori knowledge in research,*

    science and technology. Paper presented at the Te Ora Rangahau Maori

    Research and Development Conference, Massey University, Palmerston

    North.

Cutrona, C. E. (1981). *Social support in couples.* London: Sage publications.

Cullen, A., & Connolly, J. (1997). Aspects of suicide in rural Ireland 1978–1994.

    Archives of Suicide Research, 3, 43–52.

Cvinar, J. (2005). Do suicide survivors suffer social stigma: A review of the

    literature. *Perspectives in Psychiatric Care*, 41, 14-21.

Davidson, C., & Tolich, M. (Eds). (2003). *Social science research in New Zealand:*

    Many paths to understanding (2nd ed.). Auckland: Pearson Education New

    Zealand Limited.

Denscombe, M. (2007).*The good research guide* (3rd ed). England: Open

    University Press.

Denzin, N.K., & Lincoln, Y.S. (Eds.). (1998). *The landscape of qualitative research:*

    Theories and issues. Thousand Oaks, CA: Sage Publications.

Denzin, N. & Lincoln, Y. (Eds.). (0025). Handbook of qualitative research (3rd ed).

    ThousandOaks, CA: Sage.

Denzin, N.K.., Lincoln, Y. S., & Smith, L.T. (2008). *Handbook of critical and indigenous methodologies.* Los Angeles, CA: Sage.

Dunn, R. & Morrish-Vidners, D. (1987-1988). *The psychological and social experience of suicide survivors. Omega 18*(3), 175-215.

Dunne, E.J. (2000). *Survivors after suicide: The experience in the United States.* Paper presented at the Youth Suicide meeting (Proceedings of the Fifth Annual Conference). Ennis, Co.Clare.

Dunne, E., McIntosh, J. , Dunne-Maxim, K (Eds.) (1987). *Suicide and its aftermath.* New York: W.W. Norton, 1987.

Durie, M. (1996). *Characteristics of Māori health research.* Unpublished paper presented at the Hui Whakapirpiri, Hongoeka Marae, Plimmerton, New Zealand.

Durie, M. (1999). Mental health and Māori development. *Australian and New Zealand Journal of Psychiatry, 33*, 5-12.

Durie, M. (1998). *Te mana te kawanatangata the politics of Māori self-determination*, Auckland: Oxford University Press.

Dusablon, T. (2008). *First grade predictors of adolescent suicide – related ideation in a urban sample: A latent class approach.* Unpublished Doctoral thesis, University of John Hopkins, Baltimore, Maryland.

Dyregrov, K., D., & Dyregrov, A. (2003). Predictors of psychosocial distress after suicide, SIDS, and accidents. *Death Studies, 27*, 143–165.

Dyregrov, K. & Dyregrov, A. (2008). *Effective grief and bereavement support.* London: Jessica Kingsley Publishers.

Edwards, S., McCreanor, T., & McManus, V. (2005). Collaborative research with Māori on sensitive issues: The application of tikanga and kaupapa in

research on Māori sudden infant death syndrome. *Journal of Social Policy of New Zealand*, 25.78-90,

Ehrhardt, H. & Ehrhardt, P. (2004). Support for Māori, Pacific and Asian family, whānau and significant others who have been bereaved by suicide. Wellington: Ministry of Youth Development.

Epson, D. (1996). *Catching up with David Epston: A collection of narrative practice-based papers p*ublished between 1991 and 1996*. Dulwich Centre Publications.

Fay, B. (1996). 'Do you have to be one to know one?' *Contemporary philosophy of social science*: *A multicultural approach.* Oxford*: Blackwell publishers

Fine, C. (1996). *No time to say goodbye: Surviving the suicide of a loved one.* New York: Doubleday.

Fine, C., & Myers, M. (2006). *Touched by suicide: Hope and healing after loss.* New York: Gotham Books.

Franz, T. Farrell, M., & Trolley, B. (2001). Positive outcomes of losing a loved one. In R.A Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 191-209). Washington, DC: American Psychological Association.

Germain, C. (1993). Ethnography: The method. In P. Munhall & C. O. Boyd (Eds), *Nursing research: A qualitative perspective* (2nd ed., pp. 237-268). New York: National League for Nurses Press.

Gilbert, K. (2002). Taking a narrative approach to grief research: Finding meaning and stories*. Death Studies*, 26, 223-239.

Gillham, B. (2000). *Case study research methods.* Suffolk: MPG Books Ltd.

Gillies, A., Tinirau, R., & Mako, N., (2006*). Whakawhanaungatanga: An indigenous Networking tool.* Palmerston North, New Zealand: Te Au Rangahau Business Colloquium, College of Business, Massey University.

Grbich, C. (2007). Qualitative data analysis: An introduction (1st ed.). Los Angeles Sage Publications.

Handkcok, D. & Algozzine, B. (2006). Doing case study research: practical guide for beginning researchers. New York: Teachers College Press.

Harwood, D., Hawton, K., Hope, J., & Jacoby, R. (2002). The grief experiences and needs of bereaved relatives and friends of older people dying through suicide: A descriptive and case control study. *Journal of Affective Disorders, 72*, 185-194.

Hedtke, L. (2000). Dancing with death*. Gecko: A Journal of Deconstruction and Narrativel Ideas in Therapeutic Practice,* (2), 3 - 14.

Henry, E., & Pene, H. (2001). Kaupapa Māori: Locating indigenous ontology, epistemology and methodology in the academy. *Organisation, 8* (2), 234-242.

Hogan, N., & De Santis, L. (1994). Things that help and hinder adolescent sibling bereavement. *Western Journal of Nursing Research, 16* (2), 132-153.

Howe, K., & Eisenhart, M. (1990). Standards in qualitative (and quantitative) research: A prolegomenon. *Educational Researcher, 19*(4), 2-9.

Huff, A. (2009). Designing research for publication. Los Angeles: Sage

Publications.

Ihimaera, I. & MacDonald, P. (2009). *Te Whakauruora. Restoration of health:*

Māori suicide prevention resource. Wellington, New Zealand: Ministry of

Health.

 Irwin, K. (1994). Māori research methods and practices. *Sites, 28,* 25-43.

Jordan, J. (2001) Is Bereavement different? A reassessment of the literature.

Journal of   Mental Health Nursing, 17 (5), 351-362.

Jordan, J.R., & McIntosh, J.L. (2011). Is suicide bereavement different? A

framework for rethinking the question. In J. R. Jordan, & J.L. McIntosh (Eds,

pp. 19-42), *Grief after suicide.* New York, NY: Routledge.

Kalischuk, R., & Hayes, V. Grieving, mourning and healing following youth suicide;

a focus on health and wellbeing in families. *Journal of Death and Dying,*

48(1), 45-67.

Kiro, C. (2000). *Māori research and the social services.* Paper presented at Te

Puawaitanga o te tohu, Kaiawhina Ahumahi Hui 23-24 March: Waitangi.

Klass, D. (1999). The spiritual lives of bereaved parents. Philidelphia, MA: Taylor &

Francis.

Knapp, R. (1987) When a child dies: How parents react to and cope with one of

life's most devastating losses. *Psychology Today. 21*, 60-66.

Knieper, A. (1999). The suicide survivor's grief and recovery. *Suicide and Life Threatening Behaviour. 29(*4), 353-364.

Kovach, M. (2005). Emerging from the margins: Indigenous methodologies. In S. Strega &. Brown (Eds.), *Research as resistance: Critical, Indigenous and anti-oppressive approaches* (pp. 19-36). Toronto: Canadian Scholars Press.

Kovarsky, R. (1989). Loneliness and disturbed grief: A comparison of parents who lost a child to suicide or accidental death. *Archives of Psychiatric Nursing, 3,* 86–96.

Kubler-Ross, E. (1969). *On death and dying.* New York: Macmillan Publishing Company.

Kubler-Ross E., & Kessler, D. (2005). *On grief and grieving.* New York, NY: Elisabeth Kubler-Ross Family Limited Partnership and David Kessler, Inc..

Kumpst, M.J., (1994). Coping with pediatric: theoretical and research perspectives. In R.K. Bearison, & R.K. Mulhern (Eds.), *Pediatric psychooncology* (pp. 35-53). Oxford: Oxford University Press.

Lawson-Te Aho, K. (1998). *A review of the evidence: Kia piki te ora o te taitamariki*: Wellington: The New Zealand Youth Suicide Prevention Strategy.

Lawson-Te Aho, K., & Liu, J.H. (2010). Indigenous suicide and colonization: The legacy of violence and the necessity of self-determination. *International Journal of Conflict and Violence, 4*(1), 124-133. Retrieved on 13 August 2012 from www.ijcv.org/index.php/ijcv/article/view/65/191

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping.* New York: Springer.

Leenaars, A. & Diekstra, R. (1997). The will to die: An international perspective. In

    Bostis A et al (eds) Suicide: bio psychosocial approaches. Elservier,

    Amsterdam, p241-256

Lindqvist, P., Johansson, L., & Karlsson, U. (2008). In the aftermath of teenage

    suicide: A qualitative study of the psychosocial consequences for the

    surviving family members. Retrieved January 21, 2012

    http://www.biomeidcentral.com/1471-244x/8/26.

Lindsey, A. M. & Yates, B.C. (2004). Social support: conceptualization and

    measurement instruments. In M. Frank-Stromborg &R. K. Mulhern (Eds.),

    Instruments for clinical health-care research (pp.164-199). Boston. MA:

    Jones & Bartlett Publishers.

Lofland, J. & Lofland, L. (1995). Analyzing social settings. Belmont, CA:

    Wadsworth.

Macey, D. 2000, *The Penguin dictionary of critical theory.* London: Penguin

    Books.

Makinen, I.H. (2002). Suicide in the new millennium: Some sociological

    speculations. *Suicide and Life-Threatening Behaviour 23*, 91–92.

Maple, M. Edwards, H,. Plummer, D., & Minichiello, V. (2010. May), Human

    development: a life-span view. *Health & Social Care in the Community* 18,

    241-248.

McIntosh, J.L. (1987). Survivor family relationships: Literature review. In E.J.

    Dunne, J.L. McIntosh, & K. L. Dunne-Maxim (Eds*.), Suicide and its after-*

math: Understanding and counselling the survivors (pp. 73-84). New York, NY: W.W. Norton.

McIntosh, J.L. (1996). Doctoral dissertations on suicide from U.S and Canadian institutions of higher learning, 1990-1995. *Suicide and Life-Threatening Behaviour.* 26, 198-214.

McIntosh, J. L. (2003). Suicide survivors: The aftermath of suicide and suicidal behavior. In C.D. Bryant (Ed.), *Handbook of death and dying* (pp. 339-350). Thousand Oaks, CA: Sage Publications.

McIntosh, J. L. (2009, April 19). *U.S.A. suicide 2006: Official final data.* Washington, DC: American Association of Suicidology. Retrieved on 21 August 2011 from http://www.suicidology.org.

McKinley, E. (1995). Response: Maori and science education. *Access, 13* (2), 122-125.

McMillian, J. & Schumacher, S. (2001). Research in education. A conceptual introduction. (5th ed.). New York: Longman.

Mead, L. T. (1996). *Nga aho o te kakahu matauranga: The multiple layers of struggle by Maori in Education.* Auckland, New Zealand: University of Auckland.

Mead, H.M. (2003) *Tikanga Maori: Living by Maori values.* Wellington: Huia Publishers.

Meng Liu, A. (2008). *The effects of perceived immigration stress.* Mississippi: Proquest.

Merriam, S. (1998). Qualitative research and case study applications in education. San Francisco, CA: Jossey-Bass.

Mertens, D. M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods.* Thousand Oaks, CA: Sage.

Mikaere, A. (2003). *The balance destroyed: Consequences for Māori women of the colonisation of tikanga Māori.* Auckland: The International Research Institute for Maori and Indigenous Education and Ani Mikaere.

Miller, W. & Crabtree, B. (Eds.). Doing qualitative research (1st edition). Newbury Park, CA. Sage Publication.

Ministry of Health. (2006).*The New Zealand suicide prevention strategy 2006– 2016.* Wellington: Author.

Ministry of Health. (2008a). *New Zealand suicide prevention action plan 2008– 2012: The summary for action.* Wellington: Author.

Ministry of Health. (2008b). *New Zealand suicide prevention action plan 2008– 2012: The Evidence for Action.* Wellington: Author.

Ministry of Health (2010). *Māori suicide prevention: Paper for the Ministerial Committee on Suicide Prevention.* Wellington: Author.

Ministry of Health (2010). Suicide facts: Deaths and intentional self-harm hospitalisations. Retrieved on 24 August 2011 from http://www.health.govt.nz/publication/suicide-facts-deaths-and-intentional-self-harm-hospitalisations-2010.

Minois, G. (1999). History of suicide: Voluntary death in Western culture. (Trans. L. G. Cochrane). Baltimore: Johns Hopkins Univeristy Press.

Moewaka Barnes, H. (2000). *Kaupapa Māori: Explaining the ordinary*. Auckland:
    Whariki Research Group.

Moriarty, J. & Scott, A. (2008). *Ka mate ka ora.* Wellington, New Zealand.

Ness, D. E., & Pfeffer, C. R. (1990). Sequelae of bereavement resulting from
    sucide. *American Journal of Psychology*, 147(3), 279-285.

Neuman, W (1994) Social Research Methods: Qualitative and Quantitative
    Approaches, Boston: Allyn and Bacon

Nixon, J. & Pearn, J. (1997) Emotional sequelae of parents and siblings following
    the drowning or near drowning of a child. *Australian and New Zealand
    Journal of Psychiatry.* 11, 265-268.

O'Dea, D & Tucker, S. (2005). The cost of suicide to society. Wellington, New
    Zealand: Ministry of Health.

Patton, M. (1990). *Qualitative evaluation and research methods.* (2nd ed.).
    Thousand Oaks, CA: Sage.

Patton, M. (2002). Qualitative evaluation and research methods. (4th
    ed.).Thousand Oaks, CA: Sage.

 Pipi, K. (2003). *Māori and iwi provider success*: A research report of Interviews
    with successful iwi and Māori providers and government agencies.
    Wellington: Te Puni Kokiri.

Pihama, L. (1993). *Tungia te ururua, kia tupu whakaritorito te tupu o te harakeke: A critical analysis of parents as first teachers.* Unpublished Master's thesis, University of Auckland.

Platt, S., & Hawton, K. (2000). Suicidal behavior and the labor marker. In K. Hawton & K. van Heeringen (Eds.), *Suicide and attempted suicide* (pp. 309–384). New York: Wiley.

Pomare, E., Keefe-Ormsby, V., Ormsby, C., Pearce, N., Reid, P., Robson, B., & Watene-Hayden, N. (1995). *Hauora Māori standards of health III: A study of the years 1970 – 1991.* Wellington: Te Roopu Rangahau Hauora a Eru Pomare.

Powick, K (2002). *Māori research ethics: A literature review of the ethical issues and implications of kaupapa Māori research and research involving Maori researchers, supervisors and ethics committees.* Unpublished literature review, Waikato University, Hamilton.

Punch, K. (2009). *Introduction to research methods in education.* Thousand Oaks, CA : Sage.

Rando, T. (1995). Grief and mourning: Accommodating to loss. In H. Wass & R. Neimeyer (Eds.), *Dying: Facing the facts* (pp. 211-241). Washington, DC: Taylor & Francis.

Raphael, B. (1975) The presentation and management of bereavement. *Medical Journal of Australia.* 2, 909-911.

Range, L., & Niss, N. (1990). Long-term bereavement from suicide, homicide, accidents, and natural deaths. *Death Studies,14,* 423-433.

Reed, M. (1998). Predicting grief symptomatology among the suddenly bereaved. *Suicide and Life Threatening Behaviour, 28*, 285-301.

Rice, P. & Ezzy, D. (1999). Qualitative research methods. A health focus. Victoria: Oxford Press.

Riches, G., & Dawson, P. (2000). *An intimate loneliness: Supporting bereaved parents and siblings.* Buckingham, England: Open University Press.

Ritchie, J. & Lewis. J. (Eds.). (2003). *Qualitative research practice: A guide for social science students and researchers.* London: Sage.

Royal, C. (1992).*Te Haupapa.* Wellington: Bridget Williams Books.

Samy, M. (1995). Parental unresolved ambivalence and adolescent suicide: A psychoanalytic perspective. In B. Mishara (Ed.), *The impact of suicide* (pp. 40–51). New York: Springer-Verlag.

Schiff, H. (1977). *The bereaved parent.* New York: Crown.

Shahtahmasebi, S. & Mclean, C. (2011). Bereaved by suicide. *Primary Health Care:Open Access* 1:101. Doi:10.4172/phcoa.100010

Shahtahmasebi, S. (2008). Suicide research and adolescent suicide. Trends in New Zealand. The Scientific World JOURNAL (2008) 8, 287–302

Schneideman, E. S. (1969). *On the nature of suicide,* San Francisco: Jossey-Bass.

Seguin, M., Lesage, A., & Kiely, M. C. (1995). Parental bereavement after suicide and accident: A comparative study. *Suicide and Life-Threatening Behavior, 25*(4), 489-497.

Shneidman, E. (1972). Foreword. In A. C. Cain (Ed.) (1972), *Survivors of suicide.* Springfield, Ill: Charles C. Thomas.

Smith, G.H. (1992). *Tane-nui-a-rangi's legacy…propping up the sky: Kaupapa Māori as resistance and intervention.* Paper presented at the NZARE/AARE Joint Conference, DEakin University, Australia.

Smith, G.H. (1997).*The development of kaupapa Māori theory and praxis.* (Doctoral Thesis). Auckland: University of Auckland.

Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples.* Dunedin: University of Otago Press.

Shneidman, E. (1969). Prologue. In E.S. Shneidman (Ed.), *On the nature of suicide* (pp. 1–30). San Francisco, CA: Jossey-Bass.

Spradley, J. (1979). The Ethnographic interview. Belmont: Wadsworth.

Stake, R. (1995). *The art of case research.* Los Angeles, CA: Sage Publications.

Stake, R. (2003). Case studies. In N.K. Denzin, & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 134-164). Thousand Oaks, CA: Sage.

Tariana, T. (2000). Speech given to NZ Psychological Society Conference. Retrieved July 14, 2007, from http://www.converge.org.nz/pma/tspeech.htm

Te Awekotuku, Ngahuia. (1991). *He Tikanga Whakaaro : Research ethics in the Maori community.* Wellington: Manatu Maori.

Todd, R. 2010. *Suicides outnumber road deaths.* Retrieved August 12, 2010, from http://www.stuff.co.nz/the-press/news/4015232/Suicides-outnumber-road-deaths

Toynbee, A. (1968). Man's concern with death. Colombia: Hodder and Stoughton.

Turecki, G. (2001). Suicidal behavior: Is there a genetic predisposition? *Bipolar Disorders, 3*, 335–349.

Vachon, M. & Stylianos, S. (1988). The role of social support in bereavement. *Journal of Social Issues, 44*(3), 175-190.

Van Dongen, C. (1993). Social context of post suicide bereavement. *Death Studies17(*2). 125-141.

Van Dongen, C. (1990). Agonizing questioning: Experiences of survivors of suicide victims. *Nursing Research, 39*, 224-229.

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* Ontario, Canada: University of Western Ontario.

Walker, H. (1997). *"Beware the seeker of information and knowledge: research involving Maori".* An unpublished paper reflecting an indigenous Māori view on research in Aotearoa, private collection.

Watson, L. & Lee, D. (1993). Is there life after suicide? The systemic belief approach for "survivors" of suicide*. Archives of Psychiatric Nursing. 7*(1), 37-43.

Wertheimer, A. (1991). *A special scar: The experiences of people bereaved by suicide.* New York: Tavistock/Routledge.

Williams, J., & Pollock, L. (2002). The psychology of suicidal behaviour. In K. van Heeringen & K. Hawton (Eds.), *The international handbook of suicide and attempted suicide* (pp. 79–93). London: Wiley.

Wilson, D. (2004). *Nga Kairaranga Oranga: The weavers of health and wellbeing*. Unpublished A Grounded Theory Study, Massey University, Palmerston North.

Wong, P., Chan, I., Wincy, S., & Beh, P. (2007). What can we do to help and understand survivors of suicide in Hong Kong?: *The Journal of Crisis Intervention and Suicide Prevention, 28*(4),183-189.

Worden, J. (1982). *Grief counselling and grief therapy: a handbook for the mental health practitioner.* New York: Springer.

World Health Organization (2000-2011). *Preventing suicide: a resource series.* Retrieved March5, 2012 from

http://www.who.int/mental_health/resources/preventingsuicide

Yin, R. (2003). *Case study research design and methods* (3rd ed. Vol. 5). Los Angeles, CA: Sage.

.

APPENDIX I

INFORMATION SHEET

WHO AM I?

My name is Caroll Aupouri-Mclean. I am a student at Massey University. This research will contribute to me completing my Masters qualification in Social Work.

THE PURPOSE OF MY RESEARCH

The purpose of this research is to explore the lived experiences of parents who have lost a young adult child to suicide. By doing this research I hope to better understand how whānau respond and cope with the suicide. The information gathered and written up may help inform people about ways to support whānau that are bereaved and   improve current services that assist families experiencing the loss of a loved one.

WHAT HAPPENS IF YOU CHOOSE TO PARTICPATE

If you wish to become a participant in this research, I will get you to sign a *Consent Form* and arrange an interview time that is convenient for you. The interview may take between one to two hours and is conducted at the Waikato Institute of Technology. The interview is voice recorded and then transcribed by myself, the researcher. I will go through with you when the interview is complete and you will be asked to sign an *Authority for Release of Transcript* form. For your contribution to my research you will receive a koha, which will be kai. The total time commitment, should you decide to participate is two hours.

THE RISKS FOR YOU AND WHAT WILL BE DONE ABOUT THEM?

1. Issues addressed in the interviews are of a personal nature and could cause you some discomfort. Interviews are conducted in a sensitive manor however if topics do raise any personal issues for you there is a counsellor available

2. The information I gather from our interview goes towards the research findings and is then written up in a research report. To protect your privacy you will be given an alias name throughout the report.

WHAT WILL HAPPEN TO THE INFORMATION?

The information that I collected throughout my research is going to be stored in a locked cabinet in my office. The only people who will have access is the person who will transcribe the voice recording for each interview, and myself. Following the completion of the research you may have the tape from our interview returned or alternatively I will be destroyed. The transcripts will be handed over the Massey University School of Health and Social Services where they are stored safely and destroyed after five years.

YOUR RIGHTS

You do not have to take part in the project but if you do, you have the right to:

- ◻ decline to answer any particular question;
- ◻ withdraw from the study at any time before 1st February 2012;
- ◻ ask questions about the study at any time;
- ◻ provide information on the understanding that your name will not be used in
  my   research report;
- ◻ be given access to a copy of my research report when it is concluded;
- ◻ ask for the recorder to be turned off at any time during the interview.

CONTACTS DURING THE RESEARCH

If you have any concerns about anything to do with this research please feel free
to contact myself on the details below or t the Research Supervisors.

Researcher Contact Details:
Caroll Aupouri-Mclean Waikato Institute of Technology Private Bag 3036 Waikato Mail Centre Hamilton 3240 Telephone: 8348800 My email is: caroll.aupouri-mclean@wintec.ac.nz

Research Supervisor Details:	**Second Supervisor:**
Dr. Fiona Te Momo School of Health and Social Science Massey University-Auckland Campus Private Bag 102 904 North Shore Mail Centre Auckland 0632 Telephone on: 09 441 8166	Dr. Barbara Staniforth School of Health and Social Science Massey University-Auckland Campus Private Bag 102 904 North Shore Mail Centre Auckland 0632 Telephone on: 09 441 81

*This project has been reviewed and approved by the Massey University
Human Ethics Committee: Northern, Application. If you have any concerns
about the conduct of this research, please contact Dr Ralph Bathurst,
Chair, Massey University Human Ethics Committee: Northern, telephone
09 414 0800 x 9570, email humanethicsnorth@massey.ac.nz.*

FLYER

"No Time to Say Goodbye"
Personal Journeys of Whanau
Bereaved by Suicide

Kia ora Koutou,

My name is Caroll Aupouri-Mclean (Ngāti Porou, Tuwharetoa and Te Arawa). I am a student in a Massey Univeristy Master's Degree in Social Work. I am researching the journeys of parents who have lost a Rangatahi to suicide. I would like to invite parents to participate in this research. I understand the sensitive nature of this topic and if you are interested please contact me. My details are below:

Caroll Aupouri-Mclean
Waikato Institute of Technology, Private Bag 3036
Hamilton 3240
Telephone: 07 8348800
Email: caroll.aupouri-mclean@wintec.ac.nz

A small koha is provided to participants for the contribution to this research

APPENDIX III

CONSENT TO PARTICIPATE IN RESEARCH PROJECT

Project Title: "No Time to Say Goodbye": the Personal Journeys of Whānau

Bereaved by Suicide

Researcher: Caroll Aupouri-Mclean
Faculty Sponsor: Fiona Te Momo of Massey University
Introduction:
You are being asked to take part in an interview/ dialogue discussion facilitated by a student from Massey University as part of a research assignment under the supervision Fiona Te Momo also of Massey University

You are being asked to participate because you have had a particular experience that is applicable to the related discussion. Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose:
The purpose of this research is to explore the lived experiences of parents who have lost a young adult child to suicide. By doing this research I hope to better understand how whānau respond and cope with the suicide.

Procedures:
If you agree to participate in this research, you will be asked to:
- Participate in an interview of your choosing either individually or as a Whānau at a location of your discretion.
- The length of time the interview/Whānau discussion will depend on the individual/Whānau. The Researcher will be taking notes.
- Information will be electronically recorded
- Information will be transcribed after interviews are completed
- A copy of the transcript will be given back to Whānau to validate
- The tape/s used in the interview/s will be returned to Whānau

Confidentiality:
- All information gathered will be confidential and will be kept confidential. Pseudonyms will be used throughout the research process, unless directed otherwise by the research participant.

- In the research evaluation/analysis of the information the participant/s will be referred to by their pseudonym, to ensure confidentially and privacy of each participant, unless otherwise directed by the research participant.

Risks and Benefits:
Due to the sensitive nature of the topic, the information discussed may evoke emotions and thoughts which may cause distress and concern for the participants/Whānau. Participants are able to stop the interview or take time-out at any point in the interview. The opportunity to debrief during and at the conclusion of the interview is afforded the participants. A support person/counsellor will be made available if requested.

Voluntary Participation:
Participation in this research is voluntary. If you do not want to be in this project, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without prejudice. If participants currently have a relationship with the researcher their decision to participate or not will have no effect on their current relationship. All participants will be treated respectfully and honestly by the researcher.

Contacts and Questions:
If you have questions about the workshop, please feel free to contact me Caroll Aupouri-Mclean at email – caraupa4@gmail.com or caraupa4@students.co.nz
Cell phone – 0212399915
Landline – 07 850 5785.

Project Title: "No Time to Say Goodbye": Experiences of Whānau Bereaved By Suicide.

Statement of Consent:
Your signature below indicates that you have read and understood the information provided above, have had an opportunity to ask questions, and agree to participate in this research project. You will be given a copy of this form to keep for your records.

_____   _____
Participant's Signature   **Date**

_____   _____
Researcher's Signature   **Date**