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Kynde, Anette Juel; Erlangsen, Annette; Berring, Lene Lauge; Larsen, Erik Roj; Buus, Niels

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Re-constructing parental identity after parents face their offspring's suicidal behaviour: An interview study

A. Juel [a,b,c,*], A. Erlangsen [b,d,f,e], L.L. Berring [a,c], E.R. Larsen [c,g], N. Buus [c,h]

[a] Psychiatric Research Unit, Psychiatry Region Zealand, Fælledvej 6, 4, 4200 Slagelse, Denmark
[b] Danish Research Institute for Suicide Prevention, Mental Health Centre Copenhagen, Gentofte Hospitalsvej 15, 4, 2900, Hellerup, Denmark Copenhagen, Denmark
[c] Department of Regional Health Research, University of Southern Denmark, J.B. Winsløws Vej 19, 3, 5000 Odense, Denmark
[d] Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, 624 N. Broadway, S850, Baltimore, MD 21205, USA
[e] Center of Mental Health Research, Building 63, The Australian National University, Canberra ACT 2601, Australia
[f] Copenhagen Research Center for Mental Health, Mental Health Centre Copenhagen, Gentofte Hospitalsvej 15, 4, 2900 Hellerup, Denmark
[g] Mental Health Department Odense, University Clinic, Mental Health Service, J. B. Winsløws Vej 18, 5000 Odense, Denmark
[h] School of Nursing and Midwifery, Faculty of Medicine, Nursing and Health, Monash University, Clayton, Victoria, Australia

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ABSTRACT

Introduction: Parents are affected when their offspring engages in non-fatal suicidal behaviour. Although research exists on parents' mental and emotional state when they realise this behaviour, relatively little attention has been devoted to exploring how their parental identity is affected.
Purpose: To explore how parents re-constructed and negotiated their parental identity after realising that their offspring was suicidal.
Method: A qualitative exploratory design was adopted. We conducted semi-structured interviews with 21 Danish parents who self-identified as having offspring at risk of suicidal death. Interviews were transcribed, analysed thematically and interpreted by drawing on the interactionist concepts of negotiated identity and moral career.
Findings: Parents' perspectives on their parental identity were conceptualised as a moral career encompassing three distinct stages. Each stage was negotiated through social interaction with other people and the wider society. Entry into the first stage, *disrupted parental identity*, occurred when parents realised that they could lose their offspring to suicide. At this stage, parents trusted their own abilities to resolve the situation and keep their offspring safe and alive. This trust was gradually undermined by social encounters, which caused career movement. In the second stage, *impasse*, parents lost faith in their ability to help their offspring and to change the situation. Whereas some parents gradually resigned entirely to *impasse*, others regained their trust in their own abilities through social interaction in the third stage, *restored parental agency*.
Conclusion: Offspring's suicidal behaviour disrupted parents' self-identity. Social interaction was fundamental if parents were to re-construct their disrupted parental identity. This study contributes with knowledge about the stages characterising the reconstructive process of parents' self-identity and sense of agency.

1. Introduction

Worldwide, suicide accounted for 8.5% of all deaths among young people aged 15–29 years in 2012. Yet, non-fatal suicidal behaviour, which can be defined as thinking about suicide, planning for suicide and attempting suicide, is highly frequent among young persons (World Health Organization, 2014). The young persons' families and friends are often deeply affected by this behaviour, especially as young people are more likely to seek help from informal caregivers than from formal health care providers (Rowe et al., 2014). Current suicide prevention policy and practice tend to consider suicidal behaviour as an individual rather than a societal problem, which, in effect, implies that individuals and their families feel responsible for the act (Fitzpatrick, 2018). This positions parents as significant caregivers to offspring with suicidal behaviour; a task that parents regard as very demanding and burdensome (Barksdale et al., 2009). Their strains are further exacerbated by

* Corresponding author.Psychiatric Research Unit, Psychiatry Region Zealand, Fælledvej 6, 4, 4200, Slagelse, Denmark.
E-mail addresses: akyn@regionsjaelland.dk (A. Juel), annette.erlangsen@regionh.dk (A. Erlangsen), lelb@regionsjaelland.dk (L.L. Berring), erikrojlarsen@gmail.com (E.R. Larsen), niels.buus@monash.edu (N. Buus).

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the limited support that parents in this situation receive from their social network and the healthcare sector (Morgan et al., 2013; Hvidkjaer et al., 2020). As a consequence, parents experience psychological distress and low well-being (Morgan et al., 2013) and may experience suicidal thoughts themselves (Hvidkjaer et al., 2020).

Qualitative studies have shown that parents react emotionally with shock, anger and confusion to their offspring's suicidal behaviour (Ferrey et al., 2016; Hughes et al., 2017). They constantly fear for their offspring's life and safety (Rose et al., 2011; Buus et al., 2014a). Although some parents initially react with denial, this is typically followed by sadness, grief and disappointment (Daly, 2005; Oldershaw et al., 2008). Furthermore, parents may experience guilt and self-blame because they feel responsible for their offspring's behaviour (McDonald et al., 2007; Hughes et al., 2017). Their feelings of helplessness and hopelessness may be intensified by professional caregivers' irreverent attitude towards their situation (Lindgren et al., 2010; Rose et al., 2011). Therefore, the offspring's suicidal behaviour can set off a wave of different emotions in the parents.

Research has shown that offspring's suicidal behaviour strongly impacts on parents' perceptions regarding their parental role and identity; an issue that has so far been only sparsely investigated (Daly, 2005; Buus et al., 2014a; Wayland et al., 2021). Parents have described feeling a need to adjust their way of parenting but being uncertain about how to approach this readjustment (Nygaard et al., 2019). Some lose confidence in their parental skills and may begin to monitor and control their offspring (Rose et al., 2011; Ferrey et al., 2016). Parents have described practical tasks, for instance seeking professional support for the offspring, requiring substantial attention (Wayland et al., 2021). The offspring's suicidal behaviour is often considered an identity-defining event. In interviews, mothers have described how the event caused a perceived identity loss and that their former life and sense of normalcy seemed irretrievably lost (Daly, 2005). Parents have also described how the event carried a social stigma and that they felt a need to convince others that they were morally adequate and responsible parents (Buus et al., 2014a). Still, little is known about how parents potentially rebuild their parental identity.

Findings from 12 qualitative studies of the experiences of relatives (including a parent) of individuals with suicidal behaviour have been synthesised in a recent meta-ethnography (Juel et al., 2021). Drawing upon the concept of moral career, parents' perspectives on their situation and self-identity were adjusted in a staged process based on social interaction with other people and the wider society. At first, parents negotiated socials norms and hereby identified themselves as living an abnormal family life and as failing to be proper parents. Some parents got 'stuck in abnormality' because they did not interact with their surroundings in ways that enabled them to perceive or manage their situation differently, whereas others later regained a sense of normalcy. Therefore, social encounters with other parents facing similar difficulties may facilitate a shift of perspective. Still, an impaired parental self-image might potentially compromise parents' capability to fulfil their carer role, and knowledge about how parents rebuild their parental identity is therefore important to assist them in this process.

1.1. Theoretical framework

Interactionist theory suggests that identity is generated through ongoing social interaction between a person and wider society (Blumer, 1986). Parental identity can be conceptualised as a moral career (Hughes, 1937; Atkinson and Housley, 2003), which is the positioned and changing perspective on parenthood that a parent develops and negotiates over time. In contemporary Western cultures, ideals of good parenthood (Lind et al., 2016) are largely influenced by the notion of parental determinism, meaning that parents are more or less entirely responsible for the child's development (Furedi, 2001; Lee et al., 2014). Moreover, parents' role and contribution are considered fundamental to the child's success and well-being. Accordingly, a child's lack of well-being or dysfunctional behaviour may be considered the result of poor parenting practices (Lee et al., 2014). Parental identity and practices are informed by their children's behaviour, and a child's success or failure represents a moral statement about their capability as parents (Furedi, 2001). Although such ideals form a foundation for parental self-evaluation, they are fluid and may be re-negotiated continuously (Lind et al., 2016). Based on this interactionist framework, the present study aimed to explore how parents re-constructed and negotiated their parental identity after realising that their offspring was suicidal.

2. Material and methods

2.1. Study design

We applied a qualitative explorative design and collected data through video-recorded semi-structured interviews. The generated knowledge was epistemologically understood as constructed jointly by the participants and the interviewer, but situated in the particular social context of each participant (Holstein and Gubrium, 1995).

2.2. Participants

Participants were parents to offspring with suicidal behaviour. The study applied a purposive criterion sampling strategy (Patton, 2002). Participants were selected using the following inclusion criteria: a) being a parent who self-identified as having a son or daughter at risk of suicidal death or injury (under the age of 25 years at the time of the interview), b) feeling both physically and psychologically capable of participating in an interview and c) being fluent in Danish. Given that people interpret the severity of their offspring's non-fatal suicidal behaviour very differently (Hawton et al., 2012), we opted to use the parents' own understanding of this behaviour to guide the selection thereby ensuring that parents (at some point had) perceived their offspring as being at risk of suicide. The exclusion criteria were: a) parents who were having suicidal thoughts themselves or b) parents who were cognitively impaired and thus unable to take part in an interview.

2.3. Recruitment and inclusion

Participants were recruited from various settings, including suicide prevention clinics and centres for child and adolescent psychiatry. A short information leaflet was used for recruitment along with non-governmental organisations via websites and social media accounts. Lastly, we also used a snowball procedure in which parents were encouraged to invite other parents. Specifically, interested parents were asked to contact the first author who then provided information on the study and obtained informed consent. Parents were emailed a study information sheet and a copy of the study consent form and given a minimum of one week to consider their participation. Because of to the sampling procedure employed, the number of parents receiving information about the study remains unknown. However, 12 participants who received information on the study by phone declined to participate. Their reasons for opting not to participate were, among others, emotional distress, exhaustion and a wish to protect the anonymity of their child.

2.4. The interview guide

To ensure relevant and adequate questions, five parents to offspring with suicidal behaviour assisted in developing the interview guide supplemented by a comprehensive review of scientific literature (Juel et al., 2021). The outline and wording of the interview guide was discussed with parents to correct any misunderstandings and ambiguous wording. The interview guide was intended for semi-structured, narrative interviews and consisted of a list of main questions and possible follow-up questions (see Table 1). The first question encouraged

Table 1
Abbreviated interview guide.

Interview guide: main questions	Please tell me about:
	- the time, when you first became aware that your offspring wanted to end his/her own life. - your experiences of finding support. - how you took care of yourself. - your experiences of being a parent in this situation. - how the co-parent of your offspring reacted. - how your entire family reacted. - how other people beyond your family reacted. - your strongest feelings. - how this situation has changed your view of yourself.

participants to provide a narrative account of the particular point in time when they had realised that they could lose their offspring to suicide. The guide sought to explore how parental self-identity was negotiated through social interaction, for instance, with their offspring, families, friends and professionals. Changes in this regard were addressed through questions, such as "How was your experience of being a parent at the time when you first realised your offspring was suicidal"? and "How is your experience of being a parent now"? Throughout the interview, the interviewer encouraged participants to expand their narrative by repeating significant words to prompt participants to continue developing their line of thought.

2.5. Interviews

The first author (AJ, a PhD student trained in qualitative research and mental health nursing) conducted the 21 parent interviews (4 fathers and 17 mothers, including a parent couple) from September 2019 to November 2020. The participants were recruited via non-governmental organisations (n = 6), suicide prevention clinics (n = 3), centres for child and adolescent psychiatry (n = 7) and by snowball sampling (n = 5). The interviewer knew none of the participants before the interviews. Given that the interview addressed emotional and sensitive issues, participants were asked to select a convenient time and location, hence ensuring a 'democratisation' of the process by letting parents help arrange the interview (Herzog, 2012). The majority of the parents requested being interviewed at their home (n = 14), workplace (n = 2) or at a nearby psychiatric facility (n = 5). As a token of appreciation, parents received a gift card. Participants varied with respect to age, sex, age of offspring, length of time since they first realised that they could lose their offspring to suicide and current living situation (see Table 2). Interviews lasted an average of 128 min (range 86–174 min) and were transcribed verbatim by a research assistant. Subsequently, the accuracy of the transcriptions was checked against the recordings by the first author.

2.6. Ethics

Approval by the Danish Data Protection Agency was obtained ahead of the study [VD-2018-470, I-Suite 6730]. All participants who consented to participating had been given written and verbal information about the study. An anonymous version of the interview transcripts was used for the analysis. A safety plan obliged the interviewer to conduct a debriefing with each participant by telephone and to encourage distressed participants to see a counsellor. Four participants accepted this offer.

2.7. Data analysis

Data were analysed and interpreted thematically through systematic comparisons of data and memo writing (Coffey and Atkinson, 1996; Charmaz, 2014). Each interview transcript was carefully read in order for the analyst to become familiar with its content. Subsequently, an open coding of each interview transcript was conducted. This consisted

Table 2
Sample characteristics.

Participant: number, relation, age at interview	Offspring: relation, age at interview, presence of diagnosis	Time since first suicidal behaviour, i. e. initiation of *disrupted parental identity*	Living situation (alone/co-parent/new spouse)
1, mother, 40-45	Daughter, 10–15, no diagnosis	2 years	Alone
2, mother, 45-50	Daughter, 15–20, no diagnosis	1 year	Alone
3, mother, 55-60	Son, 15–20, diagnosis	4 years	Co-parent
4, mother, 45-50	Daughter, 20–25, diagnosis	2 years	Co-parent
5, mother, 55-60	Daughter, 15–20, no diagnosis	4 years	Alone
6, mother, 50-55	Daughter, 15–20, no diagnosis	5 years	Alone
7, father, 45-50	Daughter, 15–20, no diagnosis	1 year	New spouse
8, mother, 55-60	Daughter, 20–25, no diagnosis	1 year	New spouse
9, mother, 50-55	Daughter, 15–20, diagnosis	4 years	Alone
10, mother, 45-50	Daughter, 15–20, no diagnosis	1 year	Co-parent
11, mother, 50-55	Daughter, 15–20, no diagnosis	3 years	New spouse
12, father, 45-50	Daughter, 20–25, diagnosis	3 years	Co-parent
13, father, 55-60	Son, 20–25, no diagnosis	5 years	Co-parent
14, mother, 45-50	Daughter, 15–20, no diagnosis	8 years	Alone
15, mother, 40-45	Daughter, 15–20, no diagnosis	3 years	Alone
16, mother, 45-50	Daughter, 15–20, no diagnosis	1 year	Co-parent
17, mother, 40-45	Daughter, 15–20, no diagnosis	1 year	Alone
18, mother, 45-50	Son, 15–20, diagnosis	3 years	Alone
19, mother, 55-60	Daughter, 20–25, diagnosis	5 years	Alone
20, father, 50-55	Daughter, 15–20, no diagnosis	1 year	Co-parent
21, mother, 45-50	Daughter, 15–20, diagnosis	3 years	New spouse

of rephrasing pieces of information to condensed segments that still preserved a high level of detail. For each transcript, the condensed data segments were copied into a text file and grouped by their common properties. The texts were then re-read and grouped into 67 initial categories. Categories were compared across participants to identify links between categories. Furthermore, as part of the systematic comparison, all participants were tabulated in an excel spreadsheet where columns were added representing possible perspectives and their corresponding social interaction over time (Miles and Huberman, 1994). Through the comparisons, a sequential pattern was identified across participants, and memos presenting highly contextualised data segments were developed. The final interpretation of themes drew heavily on the interactionist concepts of negotiated identity and moral career. The first author conducted the analysis aided by the last author.

3. Findings

Parents' perspectives on their parental identity were conceptualised as a moral career encompassing three distinct stages. Each stage was negotiated through social interaction with other people, among others, offspring, families, friends, professionals and the wider society. This also included organisational structures within the healthcare system. An important component in the continuous negotiation was whether the

parents perceived themselves as conforming to social norms of proper parenthood. The first career stage, *disrupted parental identity*, was defined as the period starting when parents realised that they could lose their offspring to suicide. Although parents perceived that they no longer conformed to socially acceptable ideas of parenthood, they generally trusted their abilities to resolve the situation and keep their offspring safe and alive. This trust was, however, gradually undermined through social encounters, leading to the second stage, coined *impasse*. At this stage, parents lost faith in their ability to help their offspring and to change the situation. Whereas half of the parents gradually resigned entirely to *impasse*, social encounters helped the other half to regain trust as reflected by the third stage, *restored parental agency*. As such, the stages constituted a continuum with career entry at stage one. Transition to stage three was contingent on going through stage two. The career process was dynamic and transition to stage three was feasible for those parents who engaged in social interactions that restored their sense of agency. Each of the three stages are described below with illustrative quotations.

3.1. Disrupted parental identity

All parents had experienced that their offspring's suicidal behaviour disrupted parental identity. For the majority of parents, the disruption came suddenly when they were confronted with their offspring's disclosure of suicidal thoughts or a suicide attempt. For a few parents, the disruption manifested gradually as they realised the severity of their offspring's numerous and intensifying self-harming acts.

In transitioning to this stage, parents believed that they complied with normative ideals of good parenthood. Thus, they regarded themselves as good parents with a successful family life. They therefore tried to negotiate and, in effect, delay this disruption. They cognitively evaluated that their offspring's difficulties were related to growing up. A few parents even considered the acts of self-injury a useful coping strategy when experiencing difficulties. Frequently, these explanations were adopted from professionals or family members. By resorting to such explanations, parents tried to minimise the severity of the events and uphold the perception of being good parents who were leading a normal family life. At some point, they aborted this approach and reconciled to *a disrupted parental identity*. They recognised that they were parents to an offspring who wanted to end his or her life and felt sad about the loss of their parental identity. They cognitively evaluated the suicidal events as serious and believed that their offspring could die by suicide and therefore worried about losing their offspring. A few parents never resorted to minimising the severity of the events and made no efforts to convince themselves or other people that they continued to live an ordinary family life.

As seen in the following data extract, parents initially sought to uphold a socially acceptable parental identity. This mother described how she had refused to acknowledge her son as suicidal four years earlier, even though he kept writing her letters disclosing suicidal thoughts to escape unpleasant psychotic symptoms:

"I was very much in denial in the beginning and thought that things might not be that bad; because then, for some time, it got better again; and, as a parent, I wanted my child to recover … and also because my parents rejected, quite adamantly, that anything was wrong [with my son]. So, I was very much in doubt about my own judgement. This probably also meant that, at first, I thought that it was probably not very serious; that I was probably only imagining things; that it was just a teenager thing" (Participant 3).

The mother wanted her son to succeed in life and considered his difficulties to be teenager issues. Hereby, she tried to downplay the severity of his suicidal thoughts and sought to conform to the idea of being a proper parent. Furthermore, because her own parents failed to acknowledge the severity of her son's difficulties, she held on to this explanation, thereby ignoring his suicidality.

While passing through the stage of *disrupted parental identity*, most parents blamed themselves for their offspring's difficulties and suicidal behaviour and felt that they had failed as parents. The sense of guilt and self-blame often arose from interactions with their offspring who blamed them for past life events or for being too hesitant in acknowledging the severity of their challenges. Other parents did not experience feelings of guilt.

Despite transitioning to the stage of *disrupted parental identity*, parents still believed in their personal agency to resolve the situation and in their own capacity to help their offspring. Thus, it seemed feasible to them that they would be able to reposition themselves as normal parents and return to previous ideas of good parenting and normal family life.

3.2. Impasse

At some point, all parents reasoned that the situation was beyond their control. Thus, by adjusting their self-image, they reached a stage of *impasse,* when they realised that they were unable to resolve their offspring's difficulties. This prompted strong feelings of powerlessness and helplessness because parents regarded themselves as single-handedly responsible for keeping their offspring safe.

The state of *impasse* was typically brought about through social interactions with their offspring, for instance, parents repeatedly experienced that their offspring refused to involve them or accept their help. Another contributing factor was the relationship to professionals; parents experienced that professionals ignored their insights into their offspring's situation and refrained from involving them. Parents felt pacified by a healthcare system that assigned diagnostic categories and delayed treatment due to administrative procedures, thereby preventing them from actively taking part in their offspring' recovery. A third factor was the relationship with the co-parent where diverging opinions could be challenging, for instance, if the parents did not agree on what would help their offspring.

In the following data extract, a mother describes how social interaction with both her daughter and professionals brought about the *impasse* state. The daughter refused to involve her, and professionals continually failed to understand the severity of her daughter's suicidal thoughts and thus abstained from offering therapy to the daughter. Leading up to this excerpt, the interviewer asked the mother what she remembered as particularly difficult:

"Not being able to do anything about it; that is to say, just feeling desperate and in despair; being so afraid; so afraid that it defies description; and then just have to be in it. I thought about cutting myself or doing something that could set me free, soothe my pain, take me out of that feeling" (Participant 5).

This profound distrust in her own agency prompted this mother to feel desperate and utterly confused. She constantly feared that she would lose her daughter to suicide and thought about ways to ease her feelings of an all-pervasive fear and powerlessness.

In this stage, parents' perception of having failed as parents was intensified. They regarded themselves as weak, wrongful and worthless because as parents they were expected to ensure that their offspring were well and enjoyed life. Therefore, parents disallowed themselves to feel happy and often felt sorry for themselves. A few parents were reluctant to disclose their offspring's suicidal behaviour to others because thereby they also disclosed their self-perceived failure as parents. A mother exemplified this reluctance to share details about her daughter's behaviour when building new relationships: "How much do I really want to disclose about my private life to begin with, because I don't want to be labelled as one who has an ah diseased daughter" (Participants 14). Although this mother felt that her daughter's behaviour potentially carried a social stigma to her parental identity, only very few parents voiced similar concerns.

All parents perceived the stage of *impasse* as unbearable and described an overwhelming feeling of desperation. Many listed different psychological and physical symptoms, which they believed were bodily responses to their distress. A small number of parents thought about ending their own life or wished that their offspring had never existed.

Parents tried desperate ways of changing the situation, such as complaining to hospital administrators or tracking down professionals outside treatment facilities. Still, parents consciously tried to convince their offspring that they were, in fact, able to help them, and concealed their uncertainty and weakness. Parents feared that - if they disclosed their desperation - their offspring might lose their last remaining will to live. A few parents also kept these feelings from their families and professionals, which made them feel intensely isolated.

Half of the parents acknowledged reaching the stage of *impasse* and their inability to help their offspring. This came about because parents lacked social interactions that might have confirmed their actions as useful. Some parents felt that they needed to distrust their own parenting skills because their offspring had been moved to a care facility. This resignation engendered an overwhelming feeling of hopelessness as they realised that they could no longer prevent their offspring from taking their own life. Thus, losing their offspring seemed to be inevitable, and some parents tried to reconcile themselves with the idea of a family life without their offspring.

A mother described how she gradually resigned to perceiving her situation as definitive in the course of a two-year period. Her daughter suffered from posttraumatic stress and was moved to a care facility following several suicide attempts:

"I have felt as if I did not ever really get through to the other side of it because every time a new measure was introduced, everything started afresh; i.e. we always found ourselves caught up in situations of chaos; and now I think that I have started to see it as if total chaos really is that other side; that which we have to relate to and live with" (Participant 4).

This mother had previously perceived the recurring suicide attempts as a temporary period of chaos. Continually experiencing that her actions were useless, she gradually resigned to *impasse* and thus came to perceive chaos as a definitive and permanent life condition.

Although social interaction failed to restore parents' trust in their personal agency, they experienced that relationships with others, for instance, relatives, friends, colleagues, spouses and even professionals, helped them endure. It made them feel less isolated when others took the time to listen to their troubles. Interaction with other parents who had faced similar difficulties with their offspring was particularly helpful, as they felt no need to explain and thus legitimise their feelings in these situations. Few parents reported that social interaction helped reduce their feelings of guilt and self-blame. However, their perception of being unable to help their offspring remained the same.

Social interaction with professionals gave parents incentives to stop trying to help their offspring. Professionals would remind the parents that their offspring might not wish to involve them in their treatment and that they were legal adults and, thus, responsible for their own suicidal acts. In this way, professionals helped parents to accept their family life situation and the *impasse*, which could be a relief. Social interaction was experienced as burdensome if people remained in a 'fix it' mode, while the parents tried to reconcile themselves with their inability to change things. For this reason, some parents chose to withdraw from relationships with grandmothers.

3.3. Restored parental agency

While some parents entirely resigned to the *impasse* stage, others gradually regained confidence in their parental qualities and transitioned to the third stage of *restored parental agency*. This self-confidence was typically regained through social interactions with their offspring who reassured parents that their actions were useful and contributed to resolving their difficulties. There was frankness about the suicidal behaviour, which strengthened parents' capability to intervene. Interactions with spouses, family and friends were also described as helpful. Even when spouses took a different viewpoint on the situation, these relationships were characterised by a sense of solidarity and mutual support. Discussing with their spouses, but also with family and friends what had occurred and assessing the pros and cons of different actions helped parents to see the situation from a different perspective and to approach the situation in new ways. Parents commonly prioritised relationships with family and friends that morally sanctioned their actions. Parents also emphasised that interaction with professionals had helped them. Parents described these professionals as 'extraordinary'; and because they had a less conventional take on the organisational system, professionals found time to guide them on how to cope with an offspring at suicidal risk. Through these social interactions, parents regained personal agency to help their offspring.

In some instances, parents had to modify their ideas on good parenting to restore a sense of agency. In the following data extracts, two parents disclosed how social interaction changed these ideals and their parental practices. One father described how at the time of his daughter's first suicide attempt he believed that he could help his daughter only by solving all her problems. Here, three years later, he reflected on how conversations with a psychologist had modified this parental approach: "I'm not going to be her doctor, I'm her father and, therefore, I've decided to support her as much as I can in what she asks for. I am reluctant to express my opinion in most situations" (Participant 12). Thus, by adjusting his parental practices and adopting a less intervening role in his daughter's life, this father regained parental agency. In the below text, a mother, eight years later, tells about her daughter who had a suicide attempt at age eleven. At the time of the interview, the daughter was living in a care facility and her mother reflected on how she had gradually adjusted her perception of how to be a valuable parent:

"My daughter has to learn to cope with her difficulties without me because she needs to create a life that is meaningful and motivates her to keep on living; and I just have to acknowledge that is not something I can do for her; so now I must have the right simply to be a mom; I will only give her my love and care; but I am not the one to solve her problems" (Participant 14).

Similar to the quoted father, this mother had perceived herself as valuable to her daughter only if she solved all of her problems. Over the years and through social interaction with her family, she had adjusted her expectations and realised that she would help her daughter more by focusing on being an affectionate mother.

This *restored parental agency* rebuilt parents' self-image. They believed that they were, in fact, valuable, and this gave them hope. It made parents feel stronger and reduced their sense of guilt and self-blame. A father disclosed how social interaction with his friends had repaired his self-image as a father. At the time, when he was confronted with his daughter's suicidal thoughts, he blamed himself for her suicidality and distrusted his parental ability. In his account, he revealed how he gradually had altered this initial understanding: "When I thought more carefully about it [daughter's suicidal thoughts], I realised that it has not that much to do with me as a person, I was not the one who triggered it, it was more about those situations uh and the personality that my daughter has that triggered it" (Participant 20). Through social interaction with his friends, this father was relieved of his burden of guilt and restored his identity as a good father.

The majority of the parents felt proud to have overcome this disruptive life event and believed that they had gained valuable insights. Parents appreciated the intimacy that the suicidality had brought into their relationship with their offspring. This gratitude was shared by parents who had remained in *impasse*.

4. Discussion

Three distinct stages were identified in this study of how parents constructed and negotiated parental identity after realising that their offspring was suicidal. Each stage reflected a perspective on parental identity founded by social interaction with other people and the wider society, and included a focus on whether parents felt able to help their offspring. The analysis indicated that all parents passed through the first two stages, but only half of all parents progressed to the third career

stage. Transitions seemed to depend on social interactions that helped parents restore their parental identity and sense of agency. No distinct boundaries existed between the stages, and the amount of time spent in each varied from one parent to another.

The moral career of the parental identity is in accordance with previous findings from studies of straight parents to gay children (Johnson and Best, 2012). Here, parents became deviant, not by their own action but by association with their child (Johnson and Best, 2012). The parental career comprised phases in which parents increasingly accepted their changed parental self; from "coming out" and disclosing their child's deviant sexual identity, to reworking their networks and re-aligning their activities to publicly support gay rights. The primary mechanism for progressing through these phases was peer interaction. In meetings, parents gathered repertoires of meaning that allowed them to produce a new parental self (Johnson and Best, 2012). Peer interaction or support is defined as assistance and encouragement provided by an individual who is considered an equal (Dennis, 2003) and facilitates learning through social comparison and shared experience of emotional and psychological pain (Shilling et al., 2013). In our study, only few parents had participated in peer support groups prior to their interview, which precluded that they had any insights into the effects of this type of interaction. However, peer interaction between parents to offspring with suicidal behaviour has previously been evaluated as helpful (Buus et al., 2014b; Hughes et al., 2017).

A meta-ethnography offered insight into how relatives (including parents) redefined their self-identity and situation after realising that a next of kin was suicidal (Juel et al., 2021). By focusing exclusively on parents, the present study generated detailed insights into how parents negotiated self-identity. However, conflicting perceptions were expressed regarding healthcare professionals' contribution to parents' sense of self. While professionals were earlier perceived to be highly influential on how parents evaluated their own perceived caregiver competency (Juel et al., 2021), professionals in the present study were regarded as less influential in the reconstructive process of parents' self-identity. We suggest that the reason for this discrepancy may be that the meta-ethnography encompasses studies that explicitly focused on exploring relationships with professionals.

Comparable transitional stages of identity have been described for caregivers to relatives with depression (Hansen and Buus, 2013; Priestley and McPherson, 2016). Here, caregivers initially assumed an 'absorbed' identity where they lost their sense of self because of a strong commitment to their relative, but then they gradually developed an 'integrated' identity where they regained a sense of self through self-preservation strategies and a less close connection to their relative (Hansen and Buus, 2013). The same identity transformation has been depicted as a cyclical psychosocial process comprising four overlapping phases (Priestley and McPherson, 2016). Identity transformation seems to be a universal experience for individuals who are exposed to stressful caregiving situations. In a similar manner, our study found that parents were committed to resolving the situation and keeping their offspring alive, and they assumed an 'absorbed' identity (Hansen and Buus, 2013). Caregivers developed an 'integrated' identity where they separated themselves from their depressed next of kin. For parents, such separation seemed to require that they assumed less personal responsibility for their offspring, and only some parents were able to relieve themselves from this perceived obligation.

The concept of 'biographical disruption' (Bury, 1982) has been used as a framework for understanding experiences of parenting a child with cancer (Young et al., 2002) and with autism (Rasmussen et al., 2020). When a 'biographical disruption' of parents' lives occurs, parents are forced to reassess their previous assumptions regarding parenthood through a process of re-thinking and re-examining their role as parents. For instance, a diagnosis of life-threatening cancer in a child led to a biographical shift in mothers' self-identity and intensified their need to provide comfort for and ensure the child's physical and emotional well-being and cooperation with treatment (Young et al., 2002). The diagnosis of autism in a child similarly disrupted parents' self-understanding but simultaneously brought feelings of cohesion because the diagnosis enabled parents to re-evaluate their perception of being inadequate parents and to develop a coherent sense of self (Rasmussen et al., 2020). As seems to be the case for cancer and autism, suicidal behaviour in a child apparently causes biographical disruption to parents' lives. For cancer and autism, the diagnosis was the primary mechanism causing the disruption, but no parents negotiated its accuracy as it brought them relief (Young et al., 2002; Rasmussen et al., 2020). In the present study, we showed that when parents realised that their offspring was suicidal, this also caused disruption, but this realisation was not relieving, why parents tried to ignore suicidal events. A sense of personal agency to exert influence on a child's care seems universal to rebuild a disrupted parental identity.

The traditional mother stereotype is that they bear the greatest responsibility for childcare and upbringing (Valiquette-Tessier et al., 2019), whereas fathers assume a more peripheral parenting role. However, these stereotypical roles are increasingly being redefined as fathers are becoming more involved in childcare practices (Lind et al., 2016). Indeed, this conventional parenting pattern was not identified in our data. Only one father (participant 12) took on a more peripheral role to rebuild his parental agency, whereas the other fathers regarded themselves as their offspring's primary caregiver. Thus, it is not possible to differentiate the present interpretation according to gender. Moreover, the offspring only counted three sons, which conforms to existing prevalence data showing that suicidal behaviour occurs more often in females than in males (Hawton et al., 2015). However, whether suicidal behaviour affects a son or a daughter, we suggest that the stages of disrupted parental identity, impasse and restored parental agency are the same.

4.1. Methodological considerations

The validity of our findings must be considered within their methodological and social context (Maxwell, 2012). One potential threat to validity is the sampled participants. The sampling procedure was based on self-selection, which may potentially imply selection bias towards more resourceful parents as parents who were feeling very emotionally distressed or exhausted might have declined participation. Furthermore, only three fathers agreed to be interviewed. Fathers may be more hesitant to participate, feeling a lesser need to talk about things than mothers do (Buus et al., 2014a). This suggests that resourceful mothers' perspectives might be over-represented in the findings. Even so, participants varied with respect to social contexts, for example, living situation and years since onset of disrupted parental identity. It would have been preferable to include parents of diverse ethnical and socio-cultural backgrounds who potentially navigate by different parental norms. Given that only some parents transitioned into the third career stage, the findings regarding this stage may be considered less comprehensive, but this issue could be addressed in follow-up interviews with parents situated within this stage.

The researchers' positioning and preconceptions might have influenced the interpretation of the findings (Maxwell, 2012). However, we strove to be reflective and account for this during data collection and analysis (Berger, 2015). By inviting parents to offspring with suicidal behaviour to provide feedback, we attempted to minimise the impact of our preconceptions on the contents of the interview guide. Although our theoretical framework was based on concepts of socially negotiated identity and moral career, which were used in an earlier study (Juel et al., 2021), we discussed other theoretical frameworks for the data analyses and thus tried to arrive at alternative explanations, for example, Rosa's (2020) theoretical thoughts on uncontrollability. Also, we rigorously looked for evidence that seemingly disconfirmed the interpretation and reported this evidence as part of our findings; for example, that some parents never negotiated their disrupted parental identity and never experienced guilt. By re-reading the original

transcripts several times, we improved the validity of the interpretation.

4.2. Clinical implications

An impaired parental identity was found to compromise parents' ability to care for their offspring. Insight into how to restore parental confidence is relevant for clinical practice. Healthcare professionals may help parents to become better caregivers by encouraging them to engage in social interaction with their spouse, relatives, friends and, if possible, their offspring. Alternatively, other sources of support, such as a website, might mitigate peer support to enhance a sense of parental agency. Indeed, digital health tools comprise a promising future way to augment and enhance healthcare, but should be developed through active stakeholder involvement in all phases of their design to ensure their relevance and success (Bhugra et al., 2017).

5. Conclusion

Offspring's suicidal behaviour was found to affect parents' sense of identity. Narrative interviews produced insights into the reconstructive process of parents' self-identity. All parents were found to undergo a stage of disrupted parental identity; some were able to rebuild this identity through social interaction with other people, whereas others were not. Healthcare professionals can support parents in this process by encouraging them to engage with their social networks.

Credit author statement

Anette Juel: Conceptualization, Methodology, Resources, Formal Analysis, Investigation, Writing – Original draft preparation, Writing –Review & Editing, Project Administration, Funding acquisition, Annette Erlangsen: Conceptualization, Resources, Writing –Review & Editing, Funding acquisition, Lene Lauge Berring: Methodology, Resources, Writing –Review & Editing, Erik Roj Larsen: Resources, Writing –Review & Editing, Niels Buus: Conceptualization, Methodology, Formal analysis, Writing –Review & Editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The data that has been used is confidential.

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