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Breaking the news of the violent death of a close person to children under 18 years of age: A qualitative interview study

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ABSTRACT


Children who lose a close person to suicide or homicide will most likely receive this news from a carer. The caregiver's personal beliefs and approaches to addressing the topic will influence the child. A total of 10 interviews were conducted with carers of children aged 0–17 years, and the data were analyzed using reflexive thematic analysis. Four themes were developed, exploring: (1) how carers attempted to manage the task of delivering the news of death to the child and discussing it using careful wording; (2) how some carers' desire to protect the child from the truth hindered honesty and open conversations; (3) how and why some carers deliberately challenged societal taboos; and (4) how external influences prompted conversations about the topic. The discussion projects potential consequences for the children and their families. It also derives necessary societal changes, support measures, and further research suggestions.

Introduction

The violent death of a loved one is a dramatic and highly stressful life event that complexly influences numerous areas of the bereaved lives (Rynearson, 2006). The moment of being told the news of the violent death of a close person and the circumstances surrounding it affects the survivor's bereavement process significantly (De Leo et al., 2015, 2020; Ombres et al., 2017). The challenges associated with the highly responsible task of delivering death notifications and the burden on the delivering person have been the subject of most studies. This ranges from the experiences of medical specialists such as doctors and nursing staff (De Leo et al., 2015, 2022; Naik, 2013; Ombres et al., 2017) to police officers (De Leo et al., 2015, 2022; Heuft et al., 2008) and those involved in crisis intervention (Lasogga, 2011). Various guidelines, protocols, and training programs for these situations are on offer for professionals (De Leo et al., 2020). While most of these manuals aim to improve the notifiers' communication skills with adults, there is hardly any advice on breaking the news to children and adolescents. In any case, it is usually a bereaved

parent or carer¹ who has to fulfill the task of delivering the news to the child while having to cope with the potentially traumatizing experience of having lost a loved one. It is unlikely that they will receive any guidance or help finding suitable words.

A very small body of research examines the experience of parents and carers having to break the news about the (imminent) death of a loved one to their children. This is mostly in connection with fatal illnesses and palliative care, creating a different timeline and predictability (Kopchak Sheehan et al., 2014; MacPherson, 2005). It appears that no comparable research exists for sudden and violent deaths such as suicide or homicide. Notably, even though the DSM5 specifies learning about something traumatic occurring to a loved one (e.g., learning a parent has been murdered) as a possible etiological variable in the diagnostic criteria for trauma- and stressor-related disorders in children and adolescents (American Psychiatric Association, 2013; Thakur et al., 2016). Furthermore, research has shown suicide and homicide to have severe and distinct effects on children and adolescents. For example, children of parents who have died through

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suicide have an increased risk of mental illnesses such as depression, psychosis, and personality disorders (Wilcox et al., 2010). Additionally, the risk of these children and adolescents dying through suicide later in life is drastically increased (Guldin et al., 2015; Jakobsen & Christiansen, 2011) by as much as 82% compared to children who have lost a parent in an accident (Guldin et al., 2015). Children who were younger than six when they lost a parent to suicide are particularly at risk (Guldin et al., 2015).

In addition to post-traumatic stress disorder (PTSD) as a short- and long-term consequence (Alisic et al., 2015; Feldman Hertz et al., 2005) and traumatic grief (Alisic et al., 2015), children and adolescents who have lost a parent to homicide are also exposed to numerous other risks to their mental health and well-being. According to a systematic review (Alisic et al., 2015), children with such experiences have an increased risk of developing attachment disorders, adjustment disorders, behavioral disorders, emotional disorders, and conduct problems. An increased risk of severe mental disorders and self-harm was also found in a study by Lysell et al. (2016). Adolescent survivors of homicide are significantly more likely to report depression (Rheingold et al., 2012), and children who have lost a parent to homicide also have a higher risk of suicide later in life (Jakobsen & Christiansen, 2011; Lysell et al., 2016).

For children, their primary carers naturally play a significant role in overcoming trauma (Finkeldei et al., 2022; Kultalahti & Rosner, 2008; Scheering & Zeanah, 2001), not least by influencing and determining post-traumatic factors, including communicating about the event. The role of communication and carers' responses in trauma processing in children has been the topic of two recent systematic reviews (Afzal et al., 2023; Sloover et al., 2023). Both found communication between the carer and the child to affect the child's post-traumatic stress symptoms. Communication between parents and children appeared to have a mostly positive effect on the well-being of children (Sloover et al., 2023). Nonetheless, this depended on the communication between the carer and the child. Discussing the potentially traumatic event in a way that validated the child's feelings and encouraged it to talk about them was overall found to benefit the child's well-being (Sloover et al., 2023), as did responsiveness of the carers, perceived helpfulness, and a shared narrative. In the case of low sensitivity and responsiveness of carers, children's adjustment was worse (Sloover et al., 2023). Furthermore, negative parental appraisal related to the potentially traumatic experience was associated with higher levels of post-traumatic stress symptoms in children (Afzal et al., 2023; Hiller et al., 2018).

While communication about the potentially traumatic experience might lead to more or less beneficial outcomes for the child, both systematic reviews showed an association between lack or avoidance of communication and an increase in children's post-traumatic stress symptoms (Afzal et al., 2023; Sloover et al., 2023). It is believed that limiting the children's opportunities to talk about the potentially traumatic event might inhibit processes linked to recovery from PTSD (Afzal et al., 2023; Ehlers & Clark, 2000). Younger children are primarily dependent on talking about the event with adults due to developmental factors in language development and narrative production (Salmon & Bryant, 2002). They need adults to facilitate memory and appraisal to correct possible misconceptions and aid coping through regulating emotions (Salmon & Bryant, 2002). Another relevant developmental factor that needs to be considered is developing a mature understanding of death in children. Even though more minor children might not grasp every component of the concept of death (Kane, 1979; Speece & Brent, 1992), it is essential to use clear and concrete language when talking to them (Wolfelt, 2013). This aids their understanding of death and some underlying concepts, such as death's irreversibility, facilitating their processing and mourning (Wolfelt, 2013). Introducing children to terminology like suicide can provide them with the necessary words to express their experiences. Consciously using the word suicide, even if children might be too young to understand the connotations, can also be a means of desensitizing children to the social stigma surrounding suicide (Mitchell et al., 2006).

Neither of the reviews on the role of communication and carers' responses in trauma processing in children included studies specific to suicide or homicide as a potentially traumatic event. Nevertheless, essential implications can be drawn from them. Particular situation families affected by suicide and homicide find themselves with taboos surrounding the topic and a feeling of having to keep the cause of death secret (Chapple et al., 2015; Hanschmidt et al., 2016; Oexle et al., 2020; Peters et al., 2016; Pitman et al., 2018), may even exacerbate the risks of non-communication. Another critical factor might be that the carer will likely be directly affected by the violent death themselves. High levels of distress in the carer could manifest in avoiding the topic (Hiller et al., 2016), also hindering communication. Parental PTSD has been shown to result in lower sensitivity toward the child (Meiser-Stedman et al., 2007) and harsher communication (Murphy et al., 2016; Sloover et al., 2023), both of which negatively influence the child's processing (Sloover et al., 2023).

Considering the unique situation carers and children find themselves in after the suicide or homicide of a close person and the implications this might have for their communication, it is apparent that we need to understand better how they navigate this challenging task to offer suitable and specific support. Therefore, this study aims to learn more about carers' experiences of delivering the news of and talking about the violent death by suicide or homicide of a close person with children. It approaches the subject exploratory by conducting semi-structured interviews with affected carers. An inductive analysis approach is applied to capture as many relevant points as possible without being limited by preexisting ideas or concepts. The results show possible consequences for the children and their processing.

Methods

Design

There were various reasons to adopt a qualitative methodology for this study, some of which are found in somewhat general advantages of a qualitative research paradigm (Tolich & Davidson, 2019). The study seeks to generate rich data about a particular and narrow topic. There is no strict hypothesis, but rather research questions, aims, and objectives, and an inductive approach was favored. While patterns are sought, there is no goal to generalize findings, and differences and divergences can be accommodated and explored, which helps work with possibly "contradictory" data, as might be expected when researching such a highly individual and personal topic. As it was expected that there might only be a relatively small number of participants, a qualitative approach also appeared more suitable and promised a greater chance of significant results. The inevitable personal involvement of the researcher in qualitative research was especially desired, as it offered a protective factor for participants during data collection.

When considering the particulars of researching topics involving vulnerable populations, there are also clear and more specific advantages for a qualitative research methodology: Qualitative research offers the unique opportunity to learn from those who have experienced the phenomenon under investigation, especially as "qualitative research commits to seeing the world from the research participants' own perspectives" (Liamputtong, 2007, p. 8). Participants are given a chance to tell their (life) stories, which in turn offer "a clear window into the lived experiences of the participants" (Liamputtong, 2007, p. 9). It is often challenging to be let into "the relatively closed

and highly protected boundaries of families' experiences" (Daly, 1992, p. 4) the opportunity to form a relationship with the participant, which qualitative research affords (Liamputtong, 2007), hopefully leading to establishing trust and rapport (Braun & Clarke, 2013), is precious to this particular research.

As interviews are believed to be ideally suited to experience-type research questions (Braun & Clarke, 2013; Willig, 2013; Witzel & Reiter, 2012), this data collection method was chosen for this study.

Study population and recruitment

Interview participants were recruited mainly via an online survey, part of the research project "Kurswechsel" (Changing Course). This survey was conducted between July 18 and October 4, 2022, and addressed close carers of children who had experienced the suicide or homicide of a close person when under 18 years of age. The invitation and the link to the online survey, including the interview information, were published on the AETAS Children's Foundation website and distributed through various multipliers. These multipliers include AGUS e.V., ANUAS e.V., Die Arche, Nicolaidis Young Wings, other self-help groups, crisis intervention teams, and funeral homes, among others. More recruitment occurred through word of mouth. Individuals wishing to participate contacted the primary investigator via email or telephone and provided a contact option of their choosing. They were then approached by the primary researcher with more information on the research and to possibly schedule an appointment for an interview.

No remuneration or other compensation was offered for participation in the study. All participants were informed of the offer to contact the AETAS Children's Foundation for support, should this be required.

Informed consent

Written informed consent was obtained in advance from all participants. Participants could withdraw their consent and cancel their participation at any time. At the beginning of the interview, they were reminded to take breaks or end it at their discretion.

Protection of confidentiality and privacy of participants

Maximum effort was made to protect the participants' confidentiality and privacy. No real names were used to label or document any data. Participants were asked

to choose a pseudonym, which was then used to label the short questionnaire, the audio file of the interview, the accompanying notes, and the transcript. No personal data or data that could identify individuals was recorded at any point.

Data collection

The semi-structured interviews took place between August 17, 2022, and December 8, 2022; all data were collected in German. The primary investigator conducted the interviews.

Interview guide

The interview guide covers five topics after starting with an opening question inviting the interviewees' free account. The opening question was worded as follows: "In this research project, we are looking at the delivery of the news of the violent death of a close person to children under the age of 18 years old from the perspective of close caregivers. This is a situation you know from your own experience... Would you tell me a little bit about it?" Any spontaneously arising follow-up questions to clarify aspects of the carers' account would be asked after the first account of the interviewee.

Ad-hoc questions were prepared for the following topics: Information about the family; The death of a close person; Talking to the children about the death; Help and support; and Additional challenges and burdens.

The only other fixed question of the interview guide was the following close-up question: "Is there anything I didn't ask about that you think is important for us to know?"

Data analysis

Interview recordings were transcribed by a professional transcription service according to the extended rules according to Dresing and Pehl (Dresing & Pehl, 2020).

In planning to focus on patterns of meaning across the dataset, an inductive approach of reflexive thematic analysis (RTA) was chosen as the method of data analysis (Braun & Clarke, 2013, 2022).

RTA is a widely used method of analyzing qualitative data, valued for its flexibility and usefulness in answering a wide range of research questions and analyzing various qualitative data types (Braun & Clarke, 2013; Trainor & Bundon, 2021). The data are

organized by identifying, analyzing, and reporting themes (patterns) in a data set while maintaining its rich detail (Braun & Clarke, 2006). The inductive approach chosen for this study lets coding and theme development be directed by the content of the data itself rather than by existing concepts or ideas (Braun & Clarke, n.d.).

In their seminal paper "Using Thematic Analysis in Psychology," Braun and Clarke (2006) outline a structured guideline for conducting TA consisting of six steps or phases, which are (1) familiarization, (2) generating initial codes, (3) generating themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report.

All steps of RTA were followed rigorously. Semantic and latent codes were developed to capture explicitly expressed and more implicit meanings (Braun & Clarke, 2022). This iterative analytic process also involved generating further codes that captured aspects informed by attachment theory while remaining true to the inductive nature of the analysis. The sometimes differently named codes from numerous rounds of coding of all transcripts were then amalgamated and collapsed. Codes were then clustered and organized into candidate themes, which were checked against the research question and the data. The codes which stood out as relevant to the research question were then used to further theme development. The initial familiarization, coding, and analysis were conducted in German. Further coding, analysis, and the writing of the analysis report were done in English. The primary investigator who conducted the data analysis was experienced in analyzing qualitative data.

Reflexivity

The first author, the primary investigator, is a health scientist; the second and third authors are psychologists at the AETAS Children's Foundation. The AETAS Children's Foundation has a stance firmly rooted in attachment and family systems theories. It is essential to acknowledge the viewpoint of the researchers, as it will have influenced both the development of the study, including the interview guide, and the interpretation of the results. The decision to conduct interviews with carers rather than with the affected children themselves also reflects this. Therefore, it is presupposed that carers are usually best suited to co-regulate their children. Consequently, they are fundamental in their children's processing of highly stressful events. They are understood to be facilitators of their children's processing, making the carers' needs

and demands in the situation under study elementary for the well-being of the whole system.

The primary investigator with experience working with marginalized populations is also a certified psycho-trauma counselor. She approached the research project from the perspective of a health scientist but will have been influenced by her knowledge of psycho-traumatology. This was desirable in this case, as it offered a protective factor for the participants during the interviews. No participant knew the primary investigator in any other capacity than that of a researcher.

Ethical approval

The ethics committee of the Technical University of Munich on June 22, 2022, granted ethical approval for this interview study (approval number 2022-252-S-NP).

Results

A total of 10 interviews were included in the analysis for this paper. The participants' demographics are summarized in Table 1.

The interviewees were carers for a total of 23 children. At the time the violent death of a close person occurred, their ages ranged from 8 months to 17 years ($M=8.2$, $Mdn=11$).

In nine of the 10 cases, the violent death had been through suicide, and in one case, through homicide. At the time of data collection, the deaths had occurred between one and 18 years ago. In most cases, the deaths were of the interviewee's spouse, in one case of their parent, in one case of their sibling, and in two cases of their child. Four participants had been in the care of the AETAS children's foundation following the death.

Table 1. Sociodemographic characteristics of participants.

Variable	Frequency ($n=10$)
Age (years)	Range 34–59 $M=47.6$ $Mdn=49.5$
Gender	Women 8 Men 2
Highest educational level	A-Levels (Abitur) 1 Vocational training 1 University of Applied Sciences degree 2 University degree 6
Residence	Large city (100,000 inhabitants or more) 4 Medium-sized town (20,000–100,000) 1 Small town (5,000–20,000) 1 Village/rural region 4

Participants described their experiences surrounding the suicide or homicide of a close person to different degrees of detail, depicting complex and heterogeneous situations. Many elaborated on the circumstances that led to the death and the time leading up to it, giving accounts varying from carers having feared that it might come to the death (in case of known mental illness or intimate partner violence) to the death being unexpected and a shocking surprise to everyone. Some interviewees stated they had a clear and undistorted recollection of the news of the death and the time afterward. Conversely, others described gaps in memories and uncertainty about the timeline of occurrences. The latter phenomenon is common after traumatic experiences (van der Kolk et al., 1997), and participants who experienced this were reassured that this did in no way diminish the usefulness or validity of their accounts.

There is a tremendous amount of information and insight into numerous and diverse topics to be gained from the participants' accounts. Nonetheless, the results and discussion sections in the scope of this paper will focus on the details relevant to the research question. Implications for carers, children, and their systems will be stated, and consequences will be projected.

Four themes relating to the research question were developed from the data. These are *There is no script*; *They can't handle the truth!*, *Just talk!* and *Taking your cue from others* which will be presented in turn.

There is no script

There is no, no script for such a situation. (Helene).

Helene's words, which lend themselves as a name for this theme, strikingly describe a situation with no predetermined or intuitive wording within the usual behaviors and competencies of carers. Most participants in this study expressed feeling unsure about what to say. Notably, the situation was beyond the scope of everyday parenting behavior. If there were individuals viewed as professionals present, the carers looked to them for guidance. In many accounts, carers expressed an awareness of not knowing what to say and an associated fear of "doing something wrong" and wreaking irrevocable damage by saying or doing the wrong thing. Robin expresses this by saying:

But thank God they [psychosocial emergency care team] were on site relatively quickly. And, um, I asked him how, uh/how I could best tell [youngest son]. And then he immediately told me a sentence (...) And then I actually used exactly this wording. So [youngest son]

sat on my lap in the kitchen. And, um, so/that's exactly what I told him. (...) I was very, very grateful, simply because I got the right wording/the right wording for me, so that I didn't do as much wrong as I probably would have, if I hadn't known. (Robin)

Some carers even said that being supplied with wording and explanation models was what was needed most in the situation. Or, as Kim put it, "What I needed most was to somehow have a few sentences that I could use to make the incomprehensible a bit more understandable."

Asked what was most helpful when Andreas found his wife after her suicide, he answered, "The colleagues from the crisis intervention team, right? Because that, um, then really takes hold. And I think, if you do something really wrong in those moments (.) um, yeah?" As far as the consequences of "wrong" words or actions are concerned, he remains vague and leaves it unanswered. Having only told his children that something terrible had happened to their mother and to wait upstairs, it was the crisis intervention team, who arrived shortly afterward, who delivered the news of the death to the children. In this account, too, Andreas expresses the conviction that those first moments really count and permanently influence processing and children's lives. This sentiment could be found in several of the accounts.

A slightly different view is taken by Kim, who discusses the desire to optimize the way they speak to their children, saying, "I (.) had the feeling that this is something that I would like to discuss as well as possible with my children and I have the feeling that I am lacking something to be able to do that." Although they stress in their account that as a competent mother and a professional in psychology, they were better prepared than many other carers might have been. Nonetheless, Kim experiences insecurities about the "best" way of discussing the suicide with their children. This again conveys the belief that what and how it is communicated influences the children's processing. While other carers focused on the detrimental effect that the "wrong" communication might have, in this case, there appears to be the idea that the "right" communication can aid in setting the children on the best path. Nevertheless, the "right" communication is not apparent to the carer—neither intuitively nor through their parenting and professional knowledge.

They can't handle the truth

While no carer in this study kept the death from the children, the cause of death was omitted by several, even if only at first. An apparent impulse of carers

in this situation was to "protect the child" and not tell them about the violent nature of the death or death itself. Stephan puts it "But at that age it was quite clear to us that we couldn't confront them with something like that."

Some of the carers in this study were apprehensive to use the word suicide when talking to their children. Stephan said, "They still don't know that it was a suicide. I mean, they are now three and five. Um, (.) they wouldn't understand it [the word suicide] either." The sentiments this father expressed were mirrored in some of the other accounts, although all other participants disclosed the mode of death to their children promptly.

The idea of the children's age being the reason for not telling them the death was through suicide was not always the reasoning behind the omission of facts or the choice of wording. Even when delivering the news to older children, there seemed to be an impulse to "relay it as gently as possible" (Stephan) or to "paraphrase it, to describe it" (Andreas).

Um (...) jee, so we didn't explain (.) directly to them um (*groans*)/(6) well, it's a bit difficult. Um (...) we didn't go into too much detail. (.) Um, but just um, simply said that she died, so to speak, fell asleep as peacefully as possible, something like that. (Stephan)

Stephan's words show the carer's inhibition and difficulty using clear and precise language. Not only does he use euphemistic language to describe dying to his children, but he even goes as far as telling a liar to protect them from the cruelty of the truth. Later in the interview, Stephan discussed how hardly anyone knew about the cause of death, highlighting a general reluctance to talk about suicide. While he expressed that he found this inability to speak openly about suicide a burden and a cause for stress, the taboo surrounding the subject seemed to leave him no choice in the matter.

Just talk!

Several participants described there to be a family history of suicide, which is taboo in the family, leading to estrangement and a lack of processing. All of those having experienced how multiple tabooed suicides in the close family show an immense burden and were determined not to carry on this behavior with their children. Even when faced with the persistent taboo within the family and social circle, they cultivated an open and honest exchange with their children:

So it was always kind of, suicide was always present, but it wasn't talked about. And that's why it was all

so clear to us straight away and and that's why it was immediately clear to me and now I've had enough of this secrecy and I'm going to be open about it. (Helene)

The openness about the cause of death appeared to be universal in carers describing similar taboos within their family. They openly discussed suicide or homicide within the family and with a broader group of friends, acquaintances, and colleagues. Thus, some felt they were setting a good example for the children and were role models, offering orientation.

Wishing to talk to the children openly but not having the words to do so posed challenges for the carers. Several interviewees did not have anyone advising them on wording, leaving them with a feeling of having to make do with what they were able to come up with themselves:

I think (...) there's no right and wrong. I don't think you do everything right. Certainly not everything was right, but it was basically all I could say in the situation. So it was often not so much deliberate as it was more out of a feeling. (Helene)

Helene's account seems to imply that not having "better" wording left her with no choice but to say what spontaneously came to her. She also acknowledged that mistakes were likely made due to the lack of a script for this situation, as there seemed to be an equal chance of getting it wrong rather than right. Her sentiment that there is no wrong and no right again highlights the carers' experience that there is a lack of predefined and correct script in these situations. However, rather than not speaking about the violent death at all, for fear of saying something wrong, these carers chose to take that risk rather than carry on the tabooing of the topic, which they believed to be more damaging potentially.

Taking your cue from others

Some interviewees talked about how their hand was forced to talk about the cause of death when they would rather have avoided doing so. For example, Kim said they only did so "Because my son simply asked. Um, at that point I thought that if he didn't ask, um (...) I wouldn't tell him at first because I didn't know how to tell him."

Including providing another example of a carer not wanting to discuss the circumstances surrounding the death due to lack of words, this quote illustrates that to some carers, actively lying appeared not to have been an option. While Kim would have happily omitted the details, lying to a direct question of their son

seemed to have been out of the question. Therefore, their son's question forced Kim to disclose the cause of death.

Anja recounts that she was told by the person from the crisis intervention team who was present after her husband's suicide that she should tell her son straight away. This was not concurrent with her impulse not to tell her son about it then and there. She quoted the person as saying, "Tell your children now that dad is dead because everything else will be difficult" (Anja). An ominous threat or danger arising from not telling the child immediately that their father was dead was implied in the professional's words. Although Anja later mentioned that it was understandable and probably for the best that she informed her son straight away, she still maintained that the professional's "threat" made her do it. She even went as far as using the exact wording this person specified. In these highly stressful situations, carers seemed to doubt the professional knowledge of helpers either not or were so lost for words of their own that any wording appeared plausible and a relief. Several accounts relayed how some of the behavioral instructions and wording given by professionals, which were accepted without challenge, might, in hindsight, have seemed counterintuitive or not concurrent with the usual culture of communication within the family. One carer spoke about how the professionals told her to keep the cause of death from the children. This she did—although this was not concordant with her very open approach to communication about her husband's suicide—until there were external circumstances that forced her to reveal the truth to the children. Nevertheless, carers' experience with someone offering them impulses for action and guidance was portrayed as helpful and positive.

A different reason for carers being told to tell their children about the cause of death straight away was also mentioned in some interviews. In these accounts, the carers again felt that they were "forced" by someone else to relay the circumstances of the death to their child, but not because of some ominous consequences the omission might have:

[Helper] dictated to me [*laughs*] what I must say to the children. And I always realised that I needed a day or it took quite an effort, to have to tell the children. And she said there's no way around it. Who else should say it but me? (Nele)

Here, Nele made it clear that the reasoning behind her having to tell her children about her husband's death and the cause of death lay in an inherent duty and obligation of carers. It was suggested that carers

should or even have to be the ones to tell the children. Although, in this account, it appeared to be the helper who mentioned the carer's obligation to deliver the news, the notion of this obligation was not always conveyed by others. The sentiment of having a duty to the children, even if it was hard and other protective impulses toward the children needed to be overcome to do so, was common in many interviews and seemed to spring from the carers' convictions.

As far as talking about the suicide or homicide in the time following the delivery of the news, many carers described taking the lead from the children. They recounted how they reacted to the children's cues and questions rather than proactively initiating conversations. Anja said this clearly: "I only ever talked to the children about it when I felt that something was bothering them or when they told me something." In some families, this meant many conversations and answering different children's different demands. As Andreas described it, "However, with the children, there were lots and lots of conversations. And really depending um, yes, depending on the day, on the state of [everyone on] the day, you just cried or (.)." The carer's wish to fulfill the needs of the children was clear from this account.

In some of the other families the challenges lay elsewhere. Checking in with the children and being aware of their wishes concerning communication about the death sometimes highlighted the children's reluctance or even refusal to talk. From this also arose the need to adapt to various needs flexibly:

Well, you should always stay in contact with the children and check, because everyone is different, and I can see that with my two [children]. (.) And always check: what do I say, when, how. And also to bear it when the children signal: Not now. (Vivien)

From Vivien's words, it was clear how she attempted to negotiate her offers of talk, the topics of conversation, and her phrasing per the children's demands. Carers described different facets of this selfless behavior to put the children's needs before their own. For example, there seemed to be no room for Vivien's wishes and need to talk in the above-case scenario. It is also apparent that the children's refusal to speak sometimes burdened her. Other carers also recounted how they suffered when the child did not want to talk about the death. For example, when Tomke said, "He didn't want to. That was terrible for me because he just didn't want to talk. He didn't want to, right?" For one interviewee describing this situation, the suffering mainly sprang from a feeling of loneliness at not having their family to discuss the death. Mostly,

carers were worried about the children who refused to discuss the death. This refusal to talk lasted a long time in some accounts describing it. Two participants whose losses occurred more than 10 years ago relayed that their children refused to discuss the deaths for 10 years.

Discussion

From the accounts of the carers' experiences, this study found implications for the delivering of the news of and talking about the violent death of a close person through homicide or suicide to children under four themes: (1) *There is no Script*, exploring how carers attempted to handle the task of delivering the news of death to the children and discussing it. Further, how carers felt they had no intuitively right words for this. They simultaneously assumed that the wrong words would be potentially harmful and have far-reaching consequences for the children. (2) *They can't handle the truth*, describing how carers fear that children will be harmed by being told about death, thereby opting for half-truths, white lies, and euphemistic language. (3) *Just talk!*, which covers the accounts of carers feeling that children need to know the truth and aiming for a transparent way of talking about the (cause of) death within as well as outside the closest family. (4) *Taking your cue from others*, looking at how the dialog about death is shaped by external forces and prompts.

Each of these themes highlights different facets of the many interconnected challenges the carers face and their ways and means of navigating them. Although the circumstances surrounding the deaths are quite heterogeneous in the individual accounts, there are many topics relevant to all carers.

While there appears to be an overarching feeling of not being equipped for the task of communicating about a close person's death through suicide or homicide with children by the repertoire of everyday intuitive parenting skills, the carers in this study derive different courses of action from this. Some carers feel that their lack of script would likely result in choosing the "wrong" words or actions. Regarding the consequences of wrong words or actions, carers remain vague and leave them as an ominous threat to the child's well-being. As the type of communication between carer and child plays a vital role in whether it is conducive to the child's processing (Sloover et al., 2023), the carers' caution is well founded. The wish to communicate in the best possible way and to not burden the child further is commendable, especially

since negative trauma-related parental appraisal, such as the preoccupation with the perceived vulnerability or ongoing impairment of the child, or self-blame for the potentially traumatic event, is associated with PTSS in children (Afzal et al., 2023; Hiller et al., 2018; Williamson et al., 2019). Especially the implications of self-blame in this context are highly relevant, as bereavement through suicide is associated with increased feelings of guilt and self-blame compared to other causes of death (Bell et al., 2012; Hanschmidt et al., 2016; Pitman et al., 2016; Tal et al., 2017; Wagner et al., 2021).

The lack of script carers' experience leads some to seek advice from professionals (if available) either in the acute situation or later. Most carers feel that expert input concerning how to talk to the child about the death is very helpful and makes them feel more secure when facing this unusual and stressful task. While carers are grateful for advice and even concrete wording suggestions, especially when they ask for it, at least one carer in this study felt somewhat pressured into action. Even though Anja feels that the expert's input to tell her child about the death straight away was correct and that it was the right thing to do, she also recalls feeling an ominous threat insinuated in the expert's words. This highlights the responsibility professionals hold in these situations. From other fields of research concerned with parents' decision-making for their children, it is known that parents can perceive decision-making as burdensome and distressing, especially when there are high levels of uncertainty and the potential outcomes are considered particularly serious (Jackson et al., 2008). Especially when carers feel shocked and overwhelmed, as would likely be the case in the situations under study, they perceive these emotions to interfere with their decision-making ability. When carers perceive a risk to their child as implied, they are likely to make quick decisions based on what they believe the professionals' advice or opinion to be (Snowdon et al., 2006). While this might not usually be something carers regret, there is also evidence for carers experiencing experts implying threats to their child's well-being as a motivation for decision-making as stressful and potentially traumatic (Reed et al., 2017).

Other carers in this study feel the need to protect their child from the cruel truth as more important than disclosing the cause of death to them. Wanting to protect the child, as understandable an impulse as it is, comes with risks. From being attuned to their parents' emotional state and not least from snippets of overheard conversations, children sometimes develop their own narrative about the death (Gancarz

Davies & Salloum, 2014). As Gancarz Davies and Salloum (2014, p. 235) state: "These stories, created without direct adult involvement to correct for distortions and to clarify misinformation, can leave children struggling in isolation and in a confused state between reality and fantasy." While at play at all ages, these mechanisms are most pronounced in younger children, when the risk of children intertwining their story with magical thinking and making a connection to the allocation of fault is high (Busch & Kimble, 2001). In these cases, filling the gaps in the narrative with misinformation increases the risk of self-blame for the loss (Howarth, 2011; Lampton & Cremeans, 2002). The lack of orientation, for example, about the reasons for the death or the possibility of other carers or close persons dying, in itself, can become a cause for difficulty in trauma processing in children. Interestingly, similar mechanisms seem to work not only in more minor children, but also in adolescents. Feelings of guilt and responsibility for the death of a parent are much more pronounced in adolescents, when the cause of death remains unclear to them or if they are given distorted or insufficient information about the death (Harris, 1991). The carer's attempt to protect the child or adolescent from the cruel reality could, therefore, end up backfiring and leave them in a very upsetting and burdening situation. Furthermore, a prerequisite for children to adjust to the death of a carer is to have a realistic and coherent understanding of what has happened (Mitchell et al., 2006). This also highlights the importance of using clear and understandable wording when talking to children about death. Some carers in this study attempted to soften the blow using euphemistic or metaphoric language. Unfortunately, this is known to lead to misunderstandings. To say that someone "is gone" implies they might come back, and to use the word "sleep" suggests they might wake up again.

For these reasons and to convey the permanency of death, communication with children about death must be as clear and honest as possible in order to orient them (Mitchell et al., 2006). While this holds for deaths by any cause, Mitchell et al. (2006) stress the added importance when death occurs through suicide. Unfortunately, this is made even more difficult due to the sparse language when suicide is concerned (Fairbairn, 1995; Zyl, 2020). The limited and often judgemental language that is used in the context of suicide adds to the general stigmatization and taboos surrounding this cause of death (Sommer-Rotenberg, 1998; Zyl, 2020). The societal stigmatization of both homicide and suicide is known to push the bereaved into isolation through not being able to discuss the

topic. This can be assumed to be of the utmost importance at the time, and through individuals distancing themselves (Hanschmidt et al., 2016; Oexle et al., 2020; Peters et al., 2016; Pitman et al., 2018; Ross et al., 2021). This taboo and stigmatization can be assumed to lead to carers losing potential support and help from their social environment, both for themselves and the children. The burden of adhering to this taboo and not revealing the cause of death to others, thereby cutting himself off from support and the opportunity to talk about the death, is clearly expressed in Stephan's account. As social withdrawal and lack of social support are associated with adverse processing and the development of PTSD in children (Kultalahti & Rosner, 2008; Trickey et al., 2012), the very nature of the cause of death and its social implications are likely to negatively impact trauma processing in families not going against societal mainstream.

Some carers in this study consciously broke with the taboo and worked against the stigmatization of the cause of death by talking openly about it. Several accounts convey how carers experienced the detrimental effects of taboo and stigma themselves when other close individuals, for example, family members, died through suicide. One hazard of keeping the cause of death from parts of the family is that, over time, secrets can increase chronic anxiety in families and limit family relationships (Knauth, 2003). Notably, this is something several interviewees describe. Not wanting to perpetuate these dynamics seems to have enabled the carers to go down a different route for their children's benefit. The open approach to the topic is advantageous, as growing up in a family and a wider social circle, where everyone knows the same story and uses the same wording and explanation models, offers a sense of stability and orientation for the child. This is particularly important, as a cohesive joint narrative within the family benefits children's well-being after potentially traumatic events (Sloover et al., 2023). Furthermore, families' dysfunctional communication patterns hinder recovery (Sloover et al., 2023).

While the conscious use of the word "suicide," even if children might be too young to understand the connotations, can be a means of desensitizing children to the social stigma surrounding suicide (Mitchell et al., 2006), some carers in this study were reluctant to do so. This appears to be due to the belief that children under a certain age are unable to understand concepts such as suicide or homicide. Similar conviction runs deep among carers, lay people, and professionals in the field of psychosocial emergency care. While the development of an understanding or even

detailed knowledge of suicide is indeed dependent on age, Normand and Mishara (1992) found this to happen quite often earlier than anticipated. Furthermore, the development of concepts of death speeds up through children's own experiences (Kane, 1979). Although a child might not fully grasp a specific concept of a life-changing event (yet), this does not mean they are not affected by it (Wolfelt, 2013). Therefore, the consequence of a lack of understanding should not automatically be to keep the truth from the child. Age-appropriate explanations are possible for any age (Wolfelt, 2013), and compassionately discussing the death can help children process the event (Sloover et al., 2023). Developmentally timed and sensitive disclosure of potentially traumatic events has also been shown to result in positive outcomes in children, while silencing was shown to be harmful (Dalgaard & Montgomery, 2015).

Several carers discuss how they wait for the child to start the conversation. This communication pattern between carers and children appears not to be uncommon after potentially traumatic events (McGuire et al., 2019). While this may reflect a sensitive and child-oriented approach, the reasons behind this behavior can be diverse. Not wanting to upset the child by initiating the conversation is often the reason behind the carer's choice to wait for the child to approach them (McGuire et al., 2019; Sloover et al., 2023; Williamson et al., 2017; 2019). Several carers expressed this sentiment in this study. The unwelcome, insensitive, and repeated discussion of traumatic events by the carer might retraumatize the child (Scheering & Zeanah, 2001), and co-rumination by the carer and child is related to increased symptoms of PTSD in children (Felix et al., 2020; Sloover et al., 2023), this might well appear favorable at first glance. It is essential to remember that children might not initiate conversations to protect the carer (Field et al., 2014; Sloover et al., 2023). Children are known to sometimes hide the intensity of their feelings about the violent death of a close person from their parents as to not add to their burden (Dyregrov, 2008; Feldman Hertz et al., 2005) or because they want to support them (K. Dyregrov & Dyregrov, 2005). Especially if the carer themselves is traumatized, they might not recognize this behavior in their child, as they are likely less attuned to their child's emotions and needs, especially when showing symptoms of avoidance and withdrawal (Scheering & Zeanah, 2001). The carers' approach of waiting for the child to open up the discussion has to be seen in this complex context. As Sloover et al. (2023) found, the favorable processing of the potentially traumatic event

is very much dependent on parental sensitivity. Giving inviting, possibly nonverbal cues can be a way for carers to navigate this challenging situation (Wolfelt, 2013), especially since communication about potentially traumatic events is more likely to occur when children perceive the carer to be open and receptive to this (Sloover et al., 2023).

It is remarkable and commendable that most carers in this study put the perceived communication wishes of the child before their own. Even if this meant they could not discuss the death with those closest to them, such as their family, they followed the child's lead, as was, for example, the case for Vivien and Tomke. The needs arising from carers themselves feeling they cannot discuss the death, especially in the event of the other parent having died, should be the subject of further investigation.

The sentiment of having a duty to be the one to tell the children about the death and its cause, some carers expressed, poses a fascinating field for further research. Although this duty was sometimes conveyed by third parties, for example, in Nele's case, most carers appear to have an inherent feeling of obligation. Even if it is hard to break the news and other protective impulses toward the child need to be overcome to do so, it often appears to be the carers' convictions and, notably, wish to be the person to tell the child. As the trusted attachment figure is best suited to co-regulate the child after a highly stressful event and to facilitate processing (Finkeldei et al., 2022), this impulse offers favorable opportunities. The implications of why the carers feel the duty, and if this might also be linked to protective feelings or ideas about good parenting, could be the subject of future research.

Strengths and limitations

To the best of our knowledge, this is the first study to investigate the experiences of carers in delivering the news of violent death to children under the age of 18 years old. Due to the specific nature of deaths through suicide and homicide and their implications, this study contributes valuable insights into the needs and demands of a hitherto invisible population under significant threat of future mental illness and trans-generational perpetuation of suicide. The heterogeneity of the sample and their accounts paint a multifaceted and rich picture of the phenomenon under study, covering several areas of importance to the development of aid and support structures and services.

Nevertheless, several limitations to this study exist. The most obvious limitation is that selection bias can be assumed. As all but one participant was recruited

via the online survey, a first-selection bias applies to the study rather than the interviews. It is known that individuals with high educational qualifications are disproportionately represented in online surveys (Blasius & Brandt, 2009). The sample of participants mirrored this tendency: more than half (69.4%) of the participants had completed a university degree. In contrast, neither people without a degree nor with a lower secondary school leaving certificate were represented in this sample. The interview study sample also showed this overrepresentation of high educational qualifications.

Furthermore, most participants came from a convenience sample. As six of the ten participants were recruited through direct contact by the AETAS Children's Foundation, they either received support and help from the AETAS Children's Foundation (four cases) or were at least offered it (two cases), even if they did not take AETAS up on the offer. The wish to give something back or stress how helpful the AETAS Children's Foundation was could influence these participants' accounts. Only four participants were recruited through multipliers and had not been in contact with the AETAS Children's Foundation.

Another limitation related to the sample structure is that all participants are white cis persons and portray only one facet of a diverse society.

Most participants received advice or counseling since the death, and it could be argued that they represent a population practiced in emotional literacy. This can be assumed not to represent the entire population of carers facing the topic under investigation.

Finally, it has to be acknowledged that processes during the potentially traumatic period and afterward can have an unknown effect on recall accuracy, possibly resulting in recall bias.

Conclusion

Carers who have to break the news about a close person's death through suicide or homicide to children find themselves in highly stressful and burdening situations. Being lost for words and negotiating exactly when and what to say, making decisions on their own about something that many carers view as potentially harmful and life-altering for the children, leaves some carers literally speechless and others relying on instructions from professionals or other third parties, often without questioning them. Being supplied with wordings or models to explain something as unfathomable as the suicide or homicide of a loved one, and behavioral recommendations are viewed as

extremely helpful and orienting by the carers. This leaves professionals in this field with an immense responsibility that needs to be used carefully and wisely. This is because they enormously influence a highly vulnerable and susceptible population. Carers must be given guidance, orientation, and information to empower and enable them. Offering aid and support in these particular and extraordinary situations requires a community of thoroughly educated and trained professionals. They need to possess an understanding of underlying topics relevant to trauma processing, the unique needs of families after homicide or suicide, and a systemic understanding and perspective.

Carers' testimonies provide essential clues for the future development of adequate support services for adults and children. Services must be timely and low-threshold to meet a population's needs in a highly stressful and burdened situation. Of particular importance for the population is that services are free of taboos and do not stigmatize certain behaviors or causes of death. This is especially relevant, as the "lack of script" seems to be exacerbated by the fact that suicide and homicide remain socially stigmatized and taboo topics. While this remains the case, society falls short of its responsibility toward its children. An editorial in *The Lancet* called parental death through suicide a "last taboo" even in public health (The Lancet Public Health, 2022), which was responded to by a letter from Alisic et al. (2022) referring to parental death through homicide as a "double taboo." As long as these taboos endure, children bereaved by these causes of death will remain primarily unseen and without support. Particularly in light of the importance of social support in trauma processing, we should not leave these children, carers, and families alone. Society needs to overcome the stigma and taboos surrounding violent deaths through suicide and homicide and needs to stop ignoring those most vulnerable parties affected by them. To start these much-needed conversations, children, carers, professionals, and society alike need to be equipped with stigma and blame-free, compassionate language to talk about (parental) suicide and homicide. This could be the subject of public health campaigns, as these topics have been neglected in this field (Alisic et al., 2022; The Lancet Public Health, 2022). Investments are urgently called for in the (public) health as well as professional and peer support systems for children, adolescents, and their carers after suicide and homicide.

To the best of our knowledge, this study is the first to provide an account of carers' experiences with

delivering the news of a violent death through homicide or suicide to children. Further, it offers many windows of insight into situations previously invisible to research. Further research to extend knowledge in this field, especially with a more diverse study population, is desirable as it is primarily exploratory. It may be pertinent for future research to explore further and understand how interventions can be more attuned, accommodating, and responsive to carers' needs. This includes exploring how these interventions can be delivered reliably and with low thresholds and what structural prerequisites are necessary for comprehensive implementation.

Note

1. This paper refers to carers as persons who take primary responsibility for a child and care for it in everyday life. Due to the diversity of family constellations, these can be several different people, such as mothers, fathers, but also other attachment figures and foster parents. This does not include people who care for children exclusively in a professional context, such as childminders or teachers.

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References

Afzal, N., Ye, S., Page, A. C., Trickey, D., Lyttle, M. D., Hiller, R. M., & Halligan, S. L. (2023). A systematic

- literature review of the relationship between parenting responses and child post-traumatic stress symptoms. *European Journal of Psychotraumatology*, 14(1), 2156053. <https://doi.org/10.1080/20008066.2022.2156053>
- Alisic, E., Krishna, R. N., Groot, A., & Frederick, J. W. (2015). Children's mental health and well-being after parental intimate partner homicide: A systematic review. *Clinical Child and Family Psychology Review*, 18(4), 328–345. <https://doi.org/10.1007/s10567-015-0193-7>
- Alisic, E., Vaughan, C., Morrice, H., Joy, K., & Chavez, K. M. (2022). A double taboo? Children bereaved by domestic homicide. *The Lancet Public Health*, 7(10), e810. [https://doi.org/10.1016/s2468-2667\(22\)00228-6](https://doi.org/10.1016/s2468-2667(22)00228-6)
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*. (5th ed.). APA. <https://doi.org/10.1176/appi.books.9780890425596>
- Bell, J., Stanley, N., Mallon, S., & Manthorpe, J. (2012). Life will never be the same again: Examining grief in survivors bereaved by young suicide. *Illness, Crisis & Loss*, 20(1), 49–68. <https://doi.org/10.2190/IL.20.1.e>
- Blasius, J., & Brandt, M. (2009). *Repräsentativität in Online-Befragungen*. Springer.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE.
- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide* (1st ed.). SAGE.
- Braun, V., & Clarke, V. (n.d.). *Understanding TA*. University of Auckland. Retrieved October 31, 2022, from <https://www.thematicanalysis.net/understanding-ta>.
- Busch, T., & Kimble, C. S. (2001). Grieving children: Are we meeting the challenge? *Pediatric Nursing*, 27(4), 414–414.
- Chapple, A., Ziebland, S., & Hawton, K. (2015). Taboo and the different death? Perceptions of those bereaved by suicide or other traumatic death. *Sociology of Health & Illness*, 37(4), 610–625. <https://doi.org/10.1111/1467-9566.12224>
- Dalgaard, N. T., & Montgomery, E. (2015). Disclosure and silencing: A systematic review of the literature on patterns of trauma communication in refugee families. *Transcultural Psychiatry*, 52(5), 579–593. <https://doi.org/10.1177/1363461514568442>
- Daly, K. (1992). The fit between qualitative research and characteristics of families. In J. F. Gilgun, K. Daly, & G. Handel (Eds.), *Qualitative methods in family research* (pp. 3–11). Sage Publications.
- De Leo, D., Anile, C., & Ziliotto, A. (2015). Violent deaths and traumatic bereavement: The importance of appropriate death notification. *Humanities*, 4(4), 702–713. <https://doi.org/10.3390/h4040702>
- De Leo, D., Congregalli, B., Guarino, A., Zamarrelli, J., Valle, A., Paoloni, S., & Cipolletta, S. (2022). Communicating unexpected and violent death: The experiences of police officers and health care professionals. *International Journal of Environmental Research and Public Health*, 19(17), 11030. <https://doi.org/10.3390/ijerph191711030>
- De Leo, D., Zamarrelli, J., Viecelli Giannotti, A., Donna, S., Bertini, S., Santini, A., & Anile, C. (2020). Notification of unexpected, violent and traumatic death: A systematic review. *Frontiers in Psychology*, 11(, 2229. <https://doi.org/10.3389/fpsyg.2020.02229>
- Dresing, T., & Pehl, T. (2020). Transkription. In G. Mey & K. Mruck (Eds.), *Handbuch Qualitative Forschung in der Psychologie* (pp. 835–854). Springer Fachmedien. https://doi.org/10.1007/978-3-658-26887-9_56
- Dyregrov, A. (2008). *Grief in children: A handbook for adults second edition*. Jessica Kingsley Publishers.
- Dyregrov, K., & Dyregrov, A. (2005). Siblings after suicide – “The forgotten bereaved. *Suicide & Life-Threatening Behavior*, 35(6), 714–724. <https://doi.org/10.1521/suli.2005.35.6.714>
- Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38(4), 319–345. [https://doi.org/10.1016/S0005-7967\(99\)00123-0](https://doi.org/10.1016/S0005-7967(99)00123-0)
- Fairbairn, G. J. (1995). Our impoverished language of suicide and self harm. In G. J. Fairbairn (Ed.), *Contemplating suicide – The language and ethics of self harm* (pp. 36–45). Routledge.
- Feldman Hertz, M., Prothrow-Stith, D., & Chery, C. (2005). Homicide survivors: Research and practice implications. *American Journal of Preventive Medicine*, 29(5 Suppl 2), 288–295. <https://doi.org/10.1016/j.amepre.2005.08.027>
- Felix, E. D., Afifi, T. D., Horan, S. M., Meskunas, H., & Garber, A. (2020). Why family communication matters: The role of co-rumination and topic avoidance in understanding post-disaster mental health. *Journal of Abnormal Child Psychology*, 48(11), 1511–1524. <https://doi.org/10.1007/s10802-020-00688-7>
- Field, N. P., Tzadikario, E., Pel, D., & Ret, T. (2014). Attachment and mother-child communication in adjustment to the death of a father among cambodian adolescents. *Journal of Loss and Trauma*, 19(4), 314–330. <https://doi.org/10.1080/15325024.2013.780411>
- Finkeldei, S., Kern, T., & Rinne-Wolf, S. (2022). Psychosoziale Notfallversorgung von Kindern nach hoch belastenden Lebensereignissen. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz*, 65(10), 1023–1030. <https://doi.org/10.1007/s00103-022-03586-z>
- Gancarz Davies, S., & Salloum, A. (2014). What about the very young child. In E. K. Ryneson (Ed.), *Violent death: Resilience and intervention beyond the crisis* (pp. 233–254). Routledge.
- Guldin, M.-B., Li, J., Pedersen, H. S., Obel, C., Agerbo, E., Gissler, M., Cnattingius, S., Olsen, J., & Vestergaard, M. (2015). Incidence of suicide among persons who had a parent who died during their childhood. *JAMA Psychiatry*, 72(12), 1227–1234. <https://doi.org/10.1001/jamapsychiatry.2015.2094>
- Hanschmidt, F., Lehnig, F., Riedel-Heller, S. G., & Kersting, A. (2016). The stigma of suicide survivorship and related consequences – A systematic review. *PLoS One*, 11(9), e0162688. <https://doi.org/10.1371/journal.pone.0162688>
- Harris, E. S. (1991). Adolescent bereavement following the death of a parent: An exploratory study. *Child Psychiatry and Human Development*, 21(4), 267–281. <https://doi.org/10.1007/bf00705931>
- Heuft, G., Weiss, U., Schütte, N., Reinecke, S., Bär, O., Runde, B., & Bastians, F. (2008). Psychische Belastung durch traumatisierende Ereignisse im Beruf-Prävention

- im Polizeidienst (Bundesanstalt für Arbeitsschutz und Arbeitsmedizin).
- Hiller, R. M., Halligan, S. L., Ariyanayagam, R., Dalgleish, T., Smith, P., Yule, W., Glucksman, E., Watson, P., & Meiser-Stedman, R. (2016). Predictors of posttraumatic stress symptom trajectories in parents of children exposed to motor vehicle collisions. *Journal of Pediatric Psychology, 41*(1), 108–116. <https://doi.org/10.1093/jpepsy/jsv068>
- Hiller, R. M., Meiser-Stedman, R., Lobo, S., Creswell, C., Fearon, P., Ehlers, A., Murray, L., & Halligan, S. L. (2018). A longitudinal investigation of the role of parental responses in predicting children's post-traumatic distress. *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 59*(7), 781–789. <https://doi.org/10.1111/jcpp.12846>
- Howarth, R. (2011). Promoting the adjustment of parentally bereaved children. *Journal of Mental Health Counseling, 33*(1), 21–32. <https://doi.org/10.17744/mehc.33.1.a2m06x0835352741>
- Jackson, C., Cheater, F. M., & Reid, I. (2008). A systematic review of decision support needs of parents making child health decisions. *Health Expectations, 11*(3), 232–251. <https://doi.org/10.1111/j.1369-7625.2008.00496.x>
- Jakobsen, I. S., & Christiansen, E. (2011). Young people's risk of suicide attempts in relation to parental death: a population-based register study. *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 52*(2), 176–183. <https://doi.org/10.1111/j.1469-7610.2010.02298.x>
- Kane, B. (1979). Children's concepts of death. *The Journal of Genetic Psychology, 134*(1), 141–153. <https://doi.org/10.1080/00221325.1979.10533406>
- Knauth, D. G. (2003). Family secrets: An illustrative clinical case study guided by Bowen family systems theory. *Journal of Family Nursing, 9*(3), 331–344. <https://doi.org/10.1177/1074840703255451>
- Kopchak Sheehan, D., Burke Draucker, C., Christ, G. H., Murray Mayo, M., Heim, K., & Parish, S. (2014). Telling adolescents a parent is dying. *Journal of Palliative Medicine, 17*(5), 512–520. <https://doi.org/10.1089/jpm.2013.0344>
- Kultalahti, T. T., & Rosner, R. (2008). Risikofaktoren der Posttraumatischen Belastungsstörung nach Trauma-Typ-I bei Kindern und Jugendlichen. *Kindheit Und Entwicklung, 17*(4), 210–218. <https://doi.org/10.1026/0942-5403.17.4.210>
- Lampton, C., & Cremeans, K. (2002). Recent advances in the understanding of childhood grief and mourning. *Marriage and Family, 5*, 467–476.
- Lasogga, F. (2011). Überbringen einer Todesnachricht. In F. Lasogga & B. Gasch (Eds.), *Notfallpsychologie* (pp. 347–356). Springer. https://doi.org/10.1007/978-3-642-15308-2_19
- Liamputtong, P. (2007). *Researching the vulnerable: A guide to sensitive research methods*. SAGE.
- Lysell, H., Dahlin, M., Långström, N., Lichtenstein, P., & Runeson, B. (2016). Killing the mother of one's child. *The Journal of Clinical Psychiatry, 77*(3), 342–347. <https://doi.org/10.4088/jcp.14m09564>
- MacPherson, C. (2005). Telling children their ill parent is dying: A study of the factors influencing the well parent. *Mortality, 10*(2), 113–126. <https://doi.org/10.1080/13576270500102872>
- McGuire, R., Hiller, R. M., Cobham, V., Haag, K., & Halligan, S. L. (2019). A mixed-methods investigation of parent-child posttrauma discussion and the effects of encouraging engagement. *European Journal of Psychotraumatology, 10*(1), 1644127. <https://doi.org/10.1080/20008198.2019.1644127>
- Meiser-Stedman, R., Smith, P., Glucksman, E., Yule, W., & Dalgleish, T. (2007). Parent and child agreement for acute stress disorder, post-traumatic stress disorder and other psychopathology in a prospective study of children and adolescents exposed to single-event trauma. *Journal of Abnormal Child Psychology, 35*(2), 191–201. <https://doi.org/10.1007/s10802-006-9068-1>
- Mitchell, A. M., Wesner, S., Brownson, L., Gale, D. D., Garand, L., & Havill, A. (2006). Effective Communication With Bereaved Child Survivors of Suicide. *Journal of Child and Adolescent Psychiatric Nursing, 19*(3), 130–136. <https://doi.org/10.1111/j.1744-6171.2006.00060.x>
- Murphy, L. K., Rodriguez, E. M., Schwartz, L., Bemis, H., Desjardins, L., Gerhardt, C. A., Vannatta, K., Saylor, M., & Compas, B. E. (2016). Longitudinal associations among maternal communication and adolescent posttraumatic stress symptoms after cancer diagnosis. *Psycho-oncology, 25*(7), 779–786. <https://doi.org/10.1002/pon.3918>
- Naik, S. (2013). Death in the hospital: Breaking the bad news to the bereaved family. *Indian Journal of Critical Care Medicine, 17*(3), 178–181. <https://doi.org/10.4103/0972-5229.117067>
- Normand, C. L., & Mishara, B. L. (1992). The development of the concept of suicide in children. *OMEGA – Journal of Death and Dying, 25*(3), 183–203. <https://doi.org/10.2190/7TG9-NVG3-1RBJ-UDAH>
- Oexle, N., Feigelman, W., & Sheehan, L. (2020). Perceived suicide stigma, secrecy about suicide loss and mental health outcomes. *Death Studies, 44*(4), 248–255. <https://doi.org/10.1080/07481187.2018.1539052>
- Ombres, R., Montemorano, L., & Becker, D. (2017). Death notification: Someone needs to call the family. *Journal of Palliative Medicine, 20*(6), 672–675. <https://doi.org/10.1089/jpm.2016.0481>
- Peters, K., Cunningham, C., Murphy, G., & Jackson, D. (2016). 'People look down on you when you tell them how he died': Qualitative insights into stigma as experienced by suicide survivors. *International Journal of Mental Health Nursing, 25*(3), 251–257. <https://doi.org/10.1111/inm.12210>
- Pitman, A. L., Osborn, D. P. J., Rantell, K., & King, M. B. (2016). The stigma perceived by people bereaved by suicide and other sudden deaths: A cross-sectional UK study of 3432 bereaved adults. *Journal of Psychosomatic Research, 87*, 22–29. <https://doi.org/10.1016/j.jpsychores.2016.05.009>
- Pitman, A. L., Stevenson, F., Osborn, D. P. J., & King, M. B. (2018). The stigma associated with bereavement by suicide and other sudden deaths: A qualitative interview study. *Social Science & Medicine, 198*, 121–129. <https://doi.org/10.1016/j.socscimed.2017.12.035>
- Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth, 17*(1), 21. <https://doi.org/10.1186/s12884-016-1197-0>
- Rheingold, A. A., Zinzow, H., Hawkins, A., Saunders, B. E., & Kilpatrick, D. G. (2012). Prevalence and mental health outcomes of homicide survivors in a representative US sample of adolescents: data from the 2005 National Survey of Adolescents. *Journal of Child Psychology and*

- Psychiatry, and Allied Disciplines*, 53(6), 687–694. <https://doi.org/10.1111/j.1469-7610.2011.02491.x>
- Ross, V., Kólves, K., & De Leo, D. (2021). Exploring the support needs of people bereaved by suicide: A qualitative study. *Omega*, 82(4), 632–645. <https://doi.org/10.1177/0030222819825775>
- Rynearson, E. K. (2006). *Violent death: Resilience and intervention beyond the crisis*. Routledge.
- Salmon, K., & Bryant, R. A. (2002). Posttraumatic stress disorder in children: The influence of developmental factors. *Clinical Psychology Review*, 22(2), 163–188. [https://doi.org/10.1016/s0272-7358\(01\)00086-1](https://doi.org/10.1016/s0272-7358(01)00086-1)
- Scheering, M. S., & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress*, 14(4), 799–815. <https://doi.org/10.1023/a:1013002507972>
- Sloover, M., Stoltz, S. E. M. J., & Van Ee, E. (2023). Parent–child communication about potentially traumatic events: A systematic review. *Trauma, Violence & Abuse*, 2023, 15248380231207906. <https://doi.org/10.1177/15248380231207906>
- Snowdon, C., Elbourne, D., & Garcia, J. (2006). “It was a snap decision”: Parental and professional perspectives on the speed of decisions about participation in perinatal randomised controlled trials. *Social Science & Medicine*, 62(9), 2279–2290. <https://doi.org/10.1016/j.socscimed.2005.10.008>
- Sommer-Rotenberg, D. (1998). Suicide and language. *Canadian Medical Association Journal = Journal de L'Association Medicale Canadienne*, 159(3), 239–240.
- Speece, M. W., & Brent, S. B. (1992). The acquisition of a mature understanding of three components of the concept of death. *Death Studies*, 16(3), 211–229. <https://doi.org/10.1080/07481189208252571>
- Tal, I., Mauro, C., Reynolds, C. F., Shear, M. K., Simon, N., Lebowitz, B., Skritskaya, N., Wang, Y., Qiu, X., Iglewicz, A., Glorioso, D., Avanzino, J., Wetherell, J. L., Karp, J. F., Robinaugh, D., & Zisook, S. (2017). Complicated grief after suicide bereavement and other causes of death. *Death Studies*, 41(5), 267–275. <https://doi.org/10.1080/07481187.2016.1265028>
- Thakur, A., Creedon, J., & Zeanah, C. H. (2016). Trauma and stressor-related disorders among children and adolescents. *Focus*, 14(1), 34–45. <https://doi.org/10.1176/appi.focus.20150026>
- The Lancet Public Health. (2022). A last taboo in public health. *The Lancet Public Health*, 7(8), e647. [https://doi.org/10.1016/s2468-2667\(22\)00175-x](https://doi.org/10.1016/s2468-2667(22)00175-x)
- Tolich, M., & Davidson, C. (2019). Science and social science. In M. Tolich & C. Davidson (Eds.), *Social science research in New Zealand: Many paths to understanding* (pp. 34–48). Auckland University Press.
- Trainor, L. R., & Bundon, A. (2021). Developing the craft: Reflexive accounts of doing reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 13(5), 705–726. <https://doi.org/10.1080/2159676X.2020.1840423>
- Trickey, D., Siddaway, A. P., Meiser-Stedman, R., Serpell, L., & Field, A. P. (2012). A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clinical Psychology Review*, 32(2), 122–138. <https://doi.org/10.1016/j.cpr.2011.12.001>
- van der Kolk, B. A., Burbridge, J. A., & Suzuki, J. (1997). The psychobiology of traumatic memory. *Annals of the New York Academy of Sciences*, 821(1), 99–113.
- Wagner, B., Hofmann, L., & Grafiadeli, R. (2021). The relationship between guilt, depression, prolonged grief, and posttraumatic stress symptoms after suicide bereavement. *Journal of Clinical Psychology*, 77(11), 2545–2558. <https://doi.org/10.1002/jclp.23192>
- Wilcox, H. C., Kuramoto, S. J., Lichtenstein, P., Långström, N., Brent, D. A., & Runeson, B. (2010). Psychiatric morbidity, violent crime, and suicide among children and adolescents exposed to parental death. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(5), 514–523. <https://doi.org/10.1016/j.jaac.2010.01.020>
- Williamson, V., Butler, I., Tomlinson, M., Skeen, S., Christie, H., Stewart, J., & Halligan, S. L. (2017). Caregiver responses to child posttraumatic distress: A qualitative study in a high-risk context in South Africa. *Journal of Traumatic Stress*, 30(5), 482–490. <https://doi.org/10.1002/jts.22215>
- Williamson, V., Creswell, C., Butler, I., Christie, H., & Halligan, S. L. (2019). Parental experiences of supporting children with clinically significant post-traumatic distress: A qualitative study of families accessing psychological services. *Journal of Child & Adolescent Trauma*, 12(1), 61–72. <https://doi.org/10.1007/s40653-017-0158-8>
- Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.
- Witzel, A., & Reiter, H. (2012). *The problem-centred Interview*. SAGE.
- Wolfelt, A. D. (2013). *Finding the Words: How to Talk with Children and Teens about Death, Suicide, Homicide, Funerals, Cremation, and other End-of-Life Matters*. Companion Press.
- Zyl, S. V. (2020). The language of suicide: Prevention and stigma. *Mental Health Matters*, 7(1), 1–2. <https://doi.org/10.10520/EJC-203bdee02f>