University of Strathclyde Glasgow

Mental Health Foundation

Bereavement by suicide in later life: Project Report

Why did we conduct this study?

Losing a significant person because of suicide will have a major impact on those left behind. The experiences of people in later life who have been bereaved by suicide is an under-researched area. Given that later life can also be a time of major transition, opportunities and challenges, this study explored:

1. What can we learn about the experiences of being bereaved by suicide from those in later life who have lived experiences?
2. How does the experience of being bereaved by suicide impact on the individual in later life?
3. How do these experiences influence specific support needs and help-seeking in later life?

What did we do in this research?

The study was conducted between November 2020 and June 2021. This coincided with the COVID-19 pandemic.

Suicide prevention strategies in the UK are developed by the devolved governments of its four nations. To understand how these strategies are talking about or meeting the needs of people in later life, we sampled and examined these in more depth. We looked at the national strategies for England, Scotland, Wales, and Northern Ireland. In England where these are managed regionally, we looked at a sample of 58 suicide prevention strategies developed throughout rural and urban locations.

We then conducted in-depth interviews with 24 adults, predominantly female, from different backgrounds aged between 60 and 92 years old (approx. 40% were 60-69yrs; 40% were 70-79yrs and 10%were 80yrs+) who have been bereaved by suicide to explore their experiences, circumstance and how they sought and got help. Their relationship to the person that died varied and included being a partner, parent, parent-in-law, grandparent, aunt/uncle and sibling. We also conducted interviews with 15 providers or practitioners who work in bereavement support, suicide prevention and professionals in health and social care.

This study was also co-produced with people with the lived experience of bereavement by suicide, namely with two peer researchers aged 60 years + who conducted most of the interviews with older people. This collaborative approach to the study design, examining and evaluating the findings aimed to make the research more accessible and to draw on authentic knowledge grounded in experience.

What did we find?

In the Suicide Prevention Strategies

There was some evidence of how suicide and later life is currently perceived in suicide strategies throughout the UK. How it is being addressed remains very limited despite the high risk facing older individuals, there is clearly still a gap.

The national strategies for England, Scotland, Wales, and Northern Ireland comprised of 187 pages, and the term 'older' was referred to just fourteen times in England's strategies, twice in the Welsh strategy, and three times in the Northern Irish strategy. The term was not used in the Scottish strategy. As an alternative, 'Ageing' was referred to just once in the English and Northern Irish strategy. The 58 strategies for England comprised a total of 1577 pages and were launched from

2016 onwards. Only 34 of these referred to people using the different terms associated with later life (e.g. 'old or 'older', 'elder', 'ageing) and on average about three times.

The main message in the strategies highlighted a need to support individuals when they have been bereaved by suicide and the organisations who are facilitators of bereavement support. Organisations such as Survivors of Bereavement by Suicide [SOBS], The Compassionate Friends, Samaritans, and Cruse Bereavement Care were reported as the key players in supporting people bereaved by suicide, but not exclusively. However there was no specific strategic reporting of services tailored for those bereaved by suicide in later life.

From people bereaved by suicide

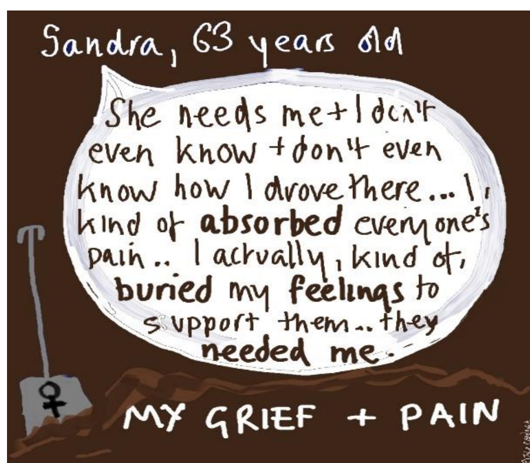
Being bereaved by suicide was consistently described as **a life-changing experience**, 'like a bomb going off' leaving behind devastation not comparable to other bereavements or stressful life experiences. Many spoke about having failed in helping or saving the person and feeling judged and stigmatised. Parents and partners particularly blamed themselves for not having seen the warning signs and where they did, they were **not always listened to and their concerns taken seriously**.

In the immediate aftermath, there were many accounts of being **left without information**, advice and support, particularly from some professionals involved. Some situations were **dealt with in a thoughtless, insensitive manner** causing extreme hurt and anger, which people experienced as harmful when trying to make sense of their experiences. Some professionals actively avoided contact or acted defensively. In some situations, people in later life reported that they received incorrect information, and were left to work out what should happen next for themselves. There were several examples of people having to give bad news on their own and **without support** to other people in their networks.

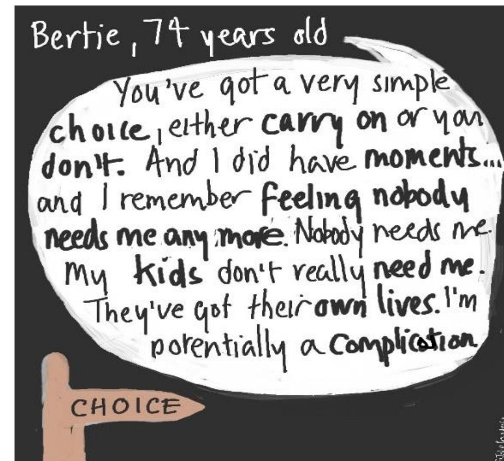
In relation to their own family and other friendship networks, people described **positive and negative impacts the suicide had on these relationships**. There were instances where people they knew very well, literally crossing the street, in some cases to avoid contact, not mentioning the death, being afraid to ask them how they were and how they could help. Some people described **fractured relationships within the family** particularly if there was a history of family trauma or social problems. This made communication and support for each other more challenging. For those in blended families where there were different dynamics in the relationship with the person who died by suicide, people got caught up in arguments and were excluded from decisions such as funeral arrangements. They were also denied contact with younger members of the family such as grandchildren, nieces/nephews after the event, which again caused a lot of distress and the person felt ignored and insignificant.

Small acts of kindness from friends, family, and neighbours were helpful and comforting. This included receiving hugs, meals on the doorstep, flowers, and notes on anniversaries, sometimes from unexpected sources.

Some people due to their age and standing in the family had unprecedented demands and expectations made to take up an intensive caring role for example in supporting both older parents, adult children who were parents and as guardians. They gave examples of people's health deteriorating rapidly which they associated with the trauma of the loss. **This lack of attention to their own emotional, physical and practical needs** often led to a feeling of invisibility and loss of self-worth, which could interact with their perception of themselves as an older person. There were examples where it seemed a lack of self-care and support led to post-traumatic stress and a 'breakdown' and there were no structured routes for people to get the support they needed for their mental health. It was hit and miss whether they were able to access a skilled person who was able to recognise the situation and provide support such as the family doctor.



Participants reflected on **how the suicide has or may impact their later life.** This included: feeling there would not be anyone to 'look out for you', experiencing loneliness, as well as future losses such as having no more time with a loved one to create memories or having (more) grandchildren. Some of these experiences in living with grief in later life led to reflections on mortality, suicidal thoughts, and how they would cope with their own health and care needs. Some did not actively seek help for their health problems and accepted poor health as a consequence of ageing and grief.



There were **transformation experiences** where people engaged with peer networks, were active in suicide and bereavement support, found meaningful therapeutic services and were highly motivated in these areas using their own experiences in a very positive way.

Professional and provider perspectives

Professionals felt some **older people are less able to 'open up'** about how they are coping in their grief with family and friends and conversations about death by suicide were still considered taboo. It was suggested that this might result from growing up in a society where death by suicide was considered a criminal act.

Professionals felt the pain and upset experienced by people in later life bereaved by suicide may be 'overlooked' by their family and friends or professional services if they did not have the most significant relationship to the person that died, such as a grandparent, aunt or uncle. Often, participants stated how being older meant that they struggled to talk to their loved ones about their bereavement from suicide as '**they had to keep it together to support the rest of the family'**.

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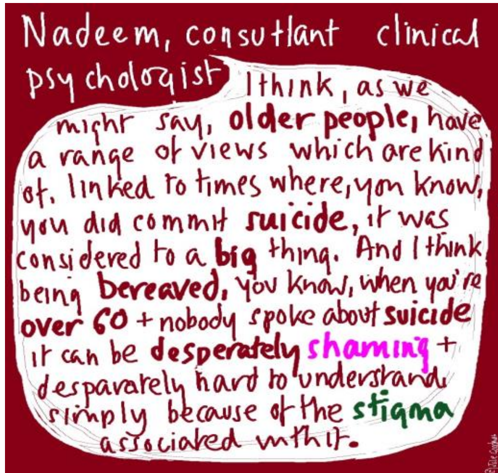


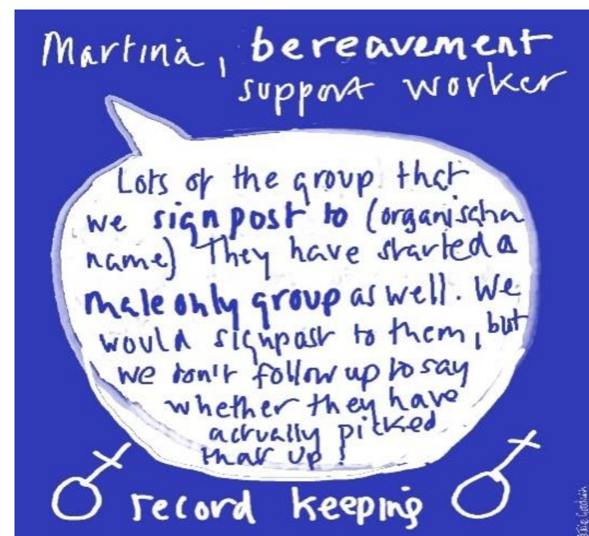
– it was considered to **be** a big thing.
It was believed some people in later life had **fewer social networks** available to provide emotional and practical support after a bereavement by suicide. This included families living too far away and feeling 'a burden' or not entitled to ask them for help.

Providers reported that people do access bereavement support services, online forums, or walking groups to meet others who have been bereaved by suicide. Some believed it was helpful when an older person met others who had been bereaved by suicide for a period of years, as this **offered them 'hope'** that it is possible to 'keep on living' while navigating the sadness of experiencing a death by suicide.

Professionals believed **feelings of shame** about the circumstances of how someone important died may act as an obstacle for accessing peer-support groups and services if they were older. Others perceived barriers included a **lack of access to web technologies** to join online forums. They may also feel that they would stand out or perceive it as 'weak' or not coping to want to talk about their grief. **A lack of available bereavement support services within rural areas** is also a deterrent for those not as mobile or confident due to the impacts of ageing.

Participants highlighted the **importance of providing psychosocial support** to people bereaved by suicide in later life. While some suggested the means and mode of support, it seemed many felt other health or social care services were better placed to provide these elements of care. However, professionals were often unaware of what these services provided and did not have any further information to signpost how people might have accessed the service or whether it was helpful to those in later life. Some service providers **did not follow up** or have the ability to follow up once an individual had been passed on

Professionals perceived it was useful to provide people with reassurance that while it may be difficult to understand the reasons why someone important to them died from suicide, they were not to blame for the death happening. It was also believed that there is a need to promote clear and open language in communities to **enable older people to talk about their bereavement experiences** and providing opportunities to tell their 'story' could help with navigating their grief.

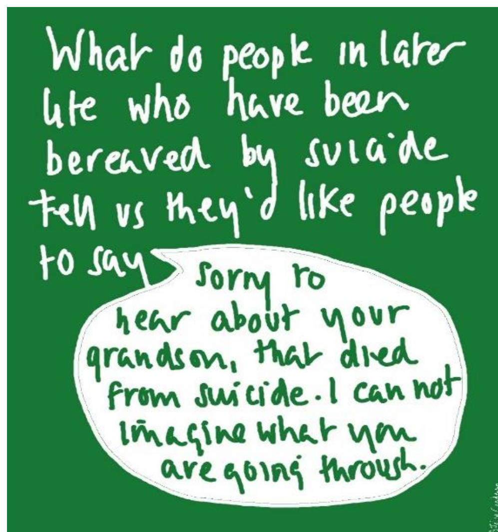


What do these findings mean?

The findings offer a novel contribution to our understanding of the experiences of this population impacted by bereavement in later life who may be less recognised or visible.

The experience of bereavement by suicide profoundly shapes the remaining future for people in later life. This is regardless of what period in their life this happened.

The findings illustrate complexity in the stigmatisation that older people might face in these circumstances and generational differences.These are compounded by internalised ageism, societal factors that contribute to ageism, which can prevent them from seeking and accessing support. People in later life gave accounts of transformative experience (and of opportunities such as understanding, awareness, peer support, and charitable work) that was so valuable to others and helped with the ongoing living experience and radical acceptance.



What can we learn?

This was an exploratory and descriptive study which did not necessarily represent everyone's experiences but nevertheless has provided concrete pointers and, in our view, a stimulus to improving and providing better support for people in later life who have been bereaved by suicide. Understanding these different experiences is a first step towards developing nuances in the best responses for later life.

Top ten recommendations

1. These findings confirm existing evidence on the experience of bereavement by suicide such as the persistence of stigma, shame and moral injury associated with suicide. Age is no exception.
2. There is a significant role for timely active psychosocial interventions to reduce complications in later life
3. Therapeutic support must be tailored to the access needs of people in later life.
4. The inclusion of older people bereaved by suicide in national suicide prevention strategies should focus efforts to reduce harm that impact on subsequent ageing experiences.
5. Bereavement by suicide must be considered alongside the effects of other loss experience(s) and in the context of the interpersonal and structural impacts of ageism in society.
6. Identifying individuals with lived experience requires improved surveillance with routine assessment across services that interact with people in later life.
7. Professionals in ageing services should be better trained and supported to be confident to include in their practice, the impact of suicide exposure and interventions.
8. Professionals need the right language, confidence and skill to discuss issues about suicide with people in later life and to articulate concerns where they observe issues, particularly the person's own suicide risk.
9. A lifecourse perspective is important when talking about suicide, personal meaning, trauma, social exclusion and marginalisation in later life.
10. Further studies should include: comparison of experiences of those bereaved by suicide in later life with other traumatic bereavements and losses. longitudinal approaches using mixed methods; involvement of people with lived experience; unifying research with policy themes on ageing that help inform and enrich our understanding of pathways in suicide and ageing care.

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