'You just wear a mask': An Interpretative Phenomenological Analysis study to explore the impacts of bereavement by suicide among peer support group members.

Abstract

Suicide is widely acknowledged as a pervasive global public health issue. Support for those bereaved by suicide (postvention) is a neglected area of research. Suicide loss survivors (SLS) struggle with guilt, stigma, and a drive to comprehend. This study aimed to assess the ramifications of bereavement by suicide within a cohort of peer-support group members. Data were collected using in-depth face-to-face and online semi-structured interviews. Audio-recordings of the interviews were transcribed and analysed via Interpretative Phenomenological Analysis. Eight people, recruited from a UK Peer Support Group, participated. Five Group Experiential Themes emerged: decohesion of life; 'You just wear a mask'; perpetual psychological conflicts; persistent underlying frustration with 'the system'; the beacon of peer support. Findings provide insights into the mindset of a cross-section of those bereaved by suicide and the all-encompassing, pervasive, life-shattering consequences of becoming a SLS. These include the duality of their inner torment and public persona, perpetual possession of conflicting thoughts and perspectives, and alienation. A unique level of comprehension as to the power of peer-support groups is also outlined. Implications for practice include the signposting of postvention services requiring enhancement and the vital role played by peer-support groups in assisting those impacted.

> **Implications for practice:**
>
> - Peer support is a cornerstone of suicide bereavement coping strategies and offers a unique environment where survivors feel truly understood and accepted.
> - Emergency workers, healthcare professionals and coroners need to be (better) trained in the impact of bereavement by suicide, resulting in greater empathy for survivors.
> - All services available to survivors, including peer support, need to be signposted early, consistently and with appropriate follow-up.
> - Survivors of bereavement by suicide should have a voice in policy setting and procedures should encompass their lived experience.

Keywords: Suicide Loss Survivor, Bereavement, Peer Support, Postvention

Introduction

The annual death rate by suicide is more than 700,000 globally (World Health Organisation, 2019) with many suicides unreported due to misclassification (mostly as 'natural causes', 'accidents', 'unknown' or even 'homicides') and cultural taboos (World Health Organisation, 2014). Suicide-loss survivors (SLSs) are those who have experienced the suicide of a close family member, or a friend, and face persistent, distressing trauma (Levi-Belz & Birnbaum, 2022). In his review of 40 years of US grief therapy private practice, primarily with suicide survivors, Jordan (2020) suggests that losses to suicide are differentiated by 'perceived intentionality' and 'perceived responsibility', reflecting the voluntary nature of the deaths and the SLSs' drive to designate accountability and deal with their own guilt.

Prior exposure to suicide has been noted as an indicator for suicide but, in their meta-analysis of 34 independent studies, Hill et al. (2020) suggest that, while the increase in risk is supported, it is not consistent and should be assessed based on specific experiences. SLSs are prone to anxiety, depression and pathological 'complicated grief' (CG). CG has been found to induce the avoidance of situations evocative of the loss, which can inhibit the grieving process (Nam, 2016). SLS levels of CG range from 62.8% (Bellini et al., 2018) to 78% (Dyregrov & Dyregrov, 2005). More recently, the term 'Prolonged Grief Disorder' (PGD) has been adopted by the American Psychological Association as a new mental disorder in the context of those bereaved traumatically (Lenferink et al., 2022). The rate of PGD, or PGD combined with post-traumatic stress disorder (PTSD), has been observed at 84% within those bereaved by suicide (Grafiadeli et al., 2022). SLSs also struggle with self-blame (Testoni et al., 2019), stigma (Sheehan et al., 2018; Ali & Rehna, 2023), hopelessness, severe psychological stress, with CG contributing to their increased suicide risk (Bellini et al., 2018). Guilt and a sense of being a burden, as a SLS, have been found to be important contributors to prolonged grief symptoms (Levi-Belz & Ben-Yaish, 2022).

The continuing relationship of SLSs to the deceased has been found to be important in influencing their grieving and coping behaviours, which impacts family dynamics (Levi-Belz, 2016; Zavrou et al., 2022). Bereavement by suicide has been found to considerably influence relationships within families, through multifaceted means of communicating emotions that can

lead to mutual support but can also be divisive or foster avoidance. The overall stance, adopted by the family group, can also influence individual SLSs' coping strategies (Creuzé et al., 2022).

As a coping strategy, sharing with others has been shown to be a beneficial to SLSs (Levi-Belz & Lev-Ari, 2019). Although research into the outcomes of attending suicide bereavement peer-support groups, requires improved study methods (Abbate et al., 2022), the positive potential of such organisations has been noted (Higgins et al., 2022) and there is evidence that they provide sources of optimism and acceptance within a confidential and trusting environment (Griffin et al., 2022). While attendance at peer-support groups may stir up complex and difficult emotions, they can, nonetheless, play a part of helping SLSs adjust (Hybholt et al., 2022). Support groups can also play an important role in countering isolation, experienced by SLSs, in relation to stigmatisation (Goulah-Pabst, 2023). Despite the extensive need, most of the support for those bereaved by suicide (postvention) comes from the voluntary sector (Pitman, 2018), even though there is a consensus that suicidality is a substantial public health issue (Zortea et al, 2020).

This study aimed to assess the ramifications of bereavement by suicide and capture the lived experiences of those affected, within a cohort of peer-support group members.

Method

<u>Design</u>

This study used a qualitative approach, based on semi-structured interviews (SSIs) to gather information for Interpretative Phenomenological Analysis (IPA) per Smith et al. (2021). Given the poignant and complex subject matter to be studied, SSIs were appropriate to garner rich and experiential information. The iterative aspect to this approach, within and across participants, facilitates the development of theories as to underlying and/or common attributes plus the identification of novel, rare or unique perspectives (Smith et al., 2021). As an approach, IPA acknowledges the researcher's role and how prior conceptions influence the interpretation. The procedure is dynamic and recognises that the researcher actively contributes to the outcome, as IPA involves a dual interpretation process. That is, the interpretation of their own lived experiences by the participants and, subsequently, the interpretation of how they relate their life episodes, and associated feelings, by the researcher.

It should be noted that the first author (primary researcher) has personally been bereaved by suicide, losing his youngest son in 2017. This was known to participants and will therefore have had an influence on the execution of the interviews, as well as the subsequent analysis. While it could be argued that participants will have made assumptions as to the researcher's understanding of the impact of losing a loved one to suicide, and potentially shared less detail, it is the researcher's belief that this was more than balanced by participants perceiving a kindred spirit, being more relaxed, and therefore more open regarding their experiences and emotions, and the overall impact their losses have had on their lives.

<u>Participants</u>

Eight participants were recruited by the lead researcher via purposive opportunity sampling from a UK Peer Support Group (PSG) membership; five of whom also volunteered with PSG as either peer support group meeting facilitators or attending the phone helpline. The age of the bereaved ranged from 23 to 65 (mean = 40.88) years old. The participants included seven females and one male; whereas those lost comprised of two females and seven males (one participant lost two brothers). The male participant lost his sister with the other losses being a son, daughter, brother, two brothers, father, partner, and father. The age of the person lost ranged from 21 to 60 (mean = 32.67) years old. The elapsed years, since the loss, ranged from two to 25 years (mean = 10.06). Table 1 summarizes participant demographics and includes pseudonyms for each. In the analysis, some quotes include references to the individuals lost to suicide, or other family members, by name; these are also pseudonyms.

Table 1.

Demographic information.

Pseudonym	Age	Sex	Relationship of the person lost	Age of the person lost	Sex of the person lost	Years since loss
Lucy	50	F	Son	21	M	2
Kevin	23	M	Sister	28	F	3
Mary	65	F	Daughter	38	F	2.5
Ann	52	F	Brother (1)	21	M	25
			Brother (2)	15	M	21
Stephanie	33	F	Brother	25	M	6
Lottie	23	F	Father	44	M	12
Barbara	55	F	Partner	60	M	4
Emma	26	F	Father	42	M	15

Materials & Procedure

The SSI schedule was crafted based on experience and knowledge of topics in the literature and arising in PSG meetings. Participants were provided with an information sheet which covered the background of the study (including the project leader and ethical committee approval), and they gave written informed consent, prior to the interviews; they were also provided with a debrief sheet, including resources for support, at the conclusion of the interviews. Four of the eight interviews were conducted in person, with the remainder being online via Zoom. All interviews were conducted by the primary researcher. The SSI schedule was followed as a guide only, with the actual flow of the discussion being directed by the aspects the interviewees wished to focus on and/or explore. After the capture of demographic data, participants were initially asked about impact of their loss(es) in terms of trauma. Thereafter, unless information had already been volunteered, participants were asked open-ended questions about impacts relating to family, friends and relationships, work and the workplace, the healthcare system, the legal system and the context of suicide in society. Probing was utilised, to elicit further specifics, with care taken not to solicit pre-defined concepts. It was estimated that interviews would take approximately 45 minutes. In practice, each interview lasted until the participant indicated they had no more to offer. The actual durations ranged from c. 32 to c. 75 (mean = c. 56) minutes. The eight audio recordings of the interviews were transcribed verbatim, including the interview questions and any interjections. Any pertinent changes in demeanour and/or emotional responses were also noted within the transcripts.

Once this process was completed, the audio recordings of the interviews were deleted. Following the approach outlined by Smith et al. (2021) firstly, via multiple readings, initial, exploratory notes were recorded against the text to capture considerations, connections, including clear consistencies, and divergences, in the feedback from interviewees. Secondly, these initial notes were reviewed and used to formulate a set of experiential statements reflecting psychologically relevant recurrent terms and concepts in an interview transcript. Thirdly, experiential statements were reviewed to derive Personal Experiential Themes (PETs) for each participant. Next, in establishing relationships between PETs, themes were aggregated into a smaller number of Group Experiential Themes (GETs). The analysis was carried out iteratively, with each transcript being assessed on its own merits prior to the next one being reviewed. Lastly, PETs and GETs were modified and extended through multiple passes within and between the transcripts.

Ethics

British Psychological Society ethical considerations were adhered to, including obtaining ethical approval from the University of West London School of Human and Social Sciences Ethics Panel. All study support documents (Information Sheet, Informed Consent, Semi-Structured Interview Schedule, and Debrief Sheet) were provided to the PSG leadership for review, prior to finalisation and applying for institutional ethical approval. Participants were provided with their individual transcripts for review so that they could request any changes to facilitate anonymity. Only one participant exercised the opportunity to request changes, which were very few and minor. Making them did not detract from the context, of the passages affected, nor did they obscure the analysis and findings.

Analysis

Through Interpretative Phenomenological Analysis (IPA) five Group Experiential Themes (GETs) emerged: decohesion of life; 'You just wear a mask'; perpetual psychological conflicts; persistent underlying frustration with 'the system'; the beacon of peer support. The GETs, and sub-themes, are summarised in Table 2.

Table 2.

Summary of Group Experiential Themes (GETs) and Sub-Themes

GET 1: Decohesion of life	GET 2: 'You just wear a mask'	GET 3: Perpetual psychological conflicts	GET 4: Persistent frustration with 'the system'	GET 5: The beacon of peer support
Life unravelling	Forever changed	Desire to know the unknowable	Loss of trust in the healthcare system	'It's not just me'
Family fractures	Loss of joy	Logic vs. emotion	Trauma exacerbation	Understanding and acceptance
Priority shifts	Isolation	Frustration vs. understanding	Lack of support / signposting	Giving back
Disempowerment	Pretence	Breaking the silence vs. perpetuating the taboo	Insufficient investment	Gaps

Decohesion of life

Participants universally related how the loss of their loved one(s) and, in some cases, events leading up to the loss(es), caused their lives to be drastically impacted, resulting in a degradation in their ability to retain control and a loss of cohesion regarding what each of them had perceived as normality beforehand. All participants indicated a very strong attachment to those lost, whether the relationship had remained tight or become stretched by negative behaviours, such as substance abuse, or estrangement. Regardless of what came before, survivors felt the losses as hammer blows with the impact manifested in numerous forms that undermined what they previously regarded as a 'normal life' (*life unravelling*).

> *'... you're never going to live a normal life and…everything in your life has to stop as well.'* [Kevin].

> *'For six months I didn't go out my house…I had no desire…to go anywhere.'* [Lucy].

For those that lost parents, and to a lesser extent those that lost siblings, a sense of abandonment was common:

> *'I think your child brain…kind of was, like, "Oh I wasn't good enough to make him stay."'* [Lottie].

> *'…he feels angry towards her now…she was always supposed to be there…his big sister.'* [Mary].

This sub-theme also encompasses the sense of loss for what can now never be:

> *'And things that I find tough will be, for example, my son, Davey, never knowing my brother. The fact that Charlie wasn't at our wedding, etc. I find those things tough!'* [Stephanie].

Participants related far-reaching and permanent shifts in the pattern of their relationships with others, encompassing how they perceive and are perceived. The bereaved tend to view the value of things differently and what previously seemed mutually important, subsequently only holds appeal to the non-bereaved (*priority shifts*). This encapsulates the very strong sense, shared across most participants, that what beforehand appeared consequential, became trivial, even annoying:

> *'Priorities change…what you thought was important, you realise is no longer important.'; 'And, I have very close friends, but now I just feel a bit distant from them and even though I do want to be with them, and meet up every now and then, it's so different. It's so different because things that they talk about just don't interest…me anymore.'* [Lucy].

> *'…your perspective really changes on life. Just in general, everything is, like, unimportant., you know, everything's…it's like "what's the point?"'* [Kevin].

Discordance within the family unit is reflected in the sub-theme *family fractures* in relation to frequent reports of family/friend cohorts, or individuals, becoming siloed in the way they both handled and communicated their grief. This also encompassed the apportioning of blame and anger:

'...people take that out on each other. Certainly, my family, they did anyway, you know. Even to some extent my sister's friends, a lot of them fell out...'. [Kevin].

'So, I am estranged from his sons, who I thought of as my sons. They were my stepsons and I loved them very dearly. That, actually, was a massive bereavement. I was bereaved of them, as a result of their father's death.' [Barbara].

While understanding and encouragement from others can be apparent in the immediate aftermath of a suicide bereavement, this has been found to often wain thereafter:

'...I've got a lot of cousins and, at first, everybody was, like, "Oh, you're like a sister to us", "We're there for you" etc. And that's just not really been the case...so I often...feel ...you give the show...but it's not...meaningful.' [Stephanie].

Survivors related mixed experiences both with respect to specific family members, or friends, and over time:

'...it's fractured...some relationships, strengthened some.' [Lottie].

Prioritising others seemed common, especially amongst those that had lost siblings:

'I went into an automatic mode of looking after my parents essentially.' [Stephanie].

The final sub-theme, of this GET, is the overarching sense of *disempowerment* expressed in a variety of forms. A sense of fragility was often related to the overwhelming trauma of losing a loved one to suicide:

'And I think for me that impact, that emotional impact, but I've also, you know, after all I, I can't control things and so I think that challenged me as a person in terms of my self-esteem and my confidence.' [Ann.]

"...emotionally...it makes you feel very vulnerable." [Barbara].

'You just wear a mask'

This GET reflects participants' sense of needing to create, and maintain, a façade that they are coping much better than is really the case, even though feeling irrevocably and forever changed by their bereavement. While the specifics of how people feel post-bereavement, and the coping mechanisms they adopt, vary considerably there appears to be a shared understanding that the event transformed their lives completely and eternally (*forever changed*):

'...I'm not the person I was, it's just changed me forever. I look at myself in the mirror, I don't even recognise who I am.' [Mary].

'...you're never going to live a normal life and...everything in your life has to stop as well.' [Kevin].

Participants reported their ability to enjoy aspects of life, that they previously embraced, as severely diminished and often impossible (*loss of joy*). This inability, in the context of activities that included other family members, or broader groups, also exacerbated participants' sense of

guilt. These aspects can be further compounded by associations with activities that relate to the loved one they lost to suicide:

> *'Recently I've got a new car which, in the past, that would have been a huge achievement…I haven't driven it…it's in my drive. I had no interest in it…I think part of that was because Ben and I've been saving for a car as well, so it was a part of…our story!'* [Lucy].

> *'So, we're not the…happy, carefree family we were.'* [Mary].

Feeling disconnected from those around them (*isolation*) was often related by participants. While there was a general belief that suicide is being talked about more openly, participants also reported a continued sense of a lack of societal appreciation of both the suffering of survivors and the broader impact of suicide.

> *'…whilst there's an awful lot of lip service given to, suicide not being a taboo, and let's talk about it…think it's exactly that…lip service.'* [Stephanie].

Additionally, driven by the combined emotional impact of their trauma, avoidance, stigma (real or perceived), and their sense of a lack of commonality with others, participants frequently described how they had chosen to withdraw. Hence, there was often an admission that SLSs may contribute to their own isolation:

> *"…I've been a hard person to help because…I don't want to be bothered with anybody."* [Mary].

In the context of the sense of a massive, and permanent, reality shift, an inability to derive enjoyment, and being made to feel isolated, if not actively avoiding contact to mitigate dealing with others' lack of comprehension, participants noted that they often adopt an outwardly far more positive stance, and relay to others that they are coping and adapting, when, in reality, they inwardly feel very different and continue to struggle will all aspects of their bereavement and daily activities (*pretence*):

> *'I just feel like you're very…isolated and a lot of the time you just wear a mask, and you mask how you're feeling, and you just get on with it, because other people don't understand. And I do get that, because I just think, me before this happened…I wouldn't really, truly understand the gravity of it. And how it sinks into every aspect of your life, like…just getting up in the morning as an achievement.'* [Lucy].

> *I've had to…just get better at pretending. And, on outside I suppose, people think 'Oh yeah, she's a lot better'…when…its' all, to me, it's all pretend…it's exhausting. Just coping with... being in everybody else's world. And people sort of use the word 'better', you know, and I don't really feel things get 'better'. You just get better at it.* [Mary].

Perpetual psychological conflicts

Awareness of prior, or current, mental health struggles in the deceased did not necessarily seem to translate into expectedness, with common reactions of surprise and disbelief. While pre-suicide behavioural issues were noted with, in some instances, medical intervention and/or

mental health difficulties, they were not evident in many cases. Even where a history of mental health problems was known, in relation to the deceased, the act of suicide still came as a complete shock, seemingly totally out of keeping with the person survivors knew and loved. In either scenario, the conflict between a great desire to understand why their loved one took their life, and an acknowledgment that some elements can never been known, is a recurrent challenge for SLSs (*desire to know the unknowable*).

'...you're so heartbroken that I don't...never understanding why is a big, big thing for me.' [Mary].

'I don't know why and...and that's the...that's the hardest aspect, of at all because you...you haven't got any of those answers and...there were days where I would just sit and go over it and over it and over it and try and think of every little possibility like I was trying to work out some cryptic puzzle of some sort and I just realised I'm not going to get anywhere with this.' [Lucy].

In cases where there was no apparent indication of suicidality, participants berated themselves for missing signs. Conversely, where mental health issues had been known, and even though participants believed they had done everything they could in the circumstances, they berated themselves for not doing more (*logic vs. emotion*):

"...and of course, all the guilt as well, that comes with suicide. It's really hard to push past the idea that there's something you could have done." [Lottie].

'I'd fall into that cycle of thinking through what had happened and trying to work out why and how I could have changed it...' [Lucy].

Regarding characteristics of the personality of those lost, participants' overwhelming sense was that they had strong positives in their lives and were viewed favourably by others. This also contributed to conflicting perceptions and a gulf in comprehending the positive existence their loved ones appeared to have and the reality of their action to end their lives:

'...that...just doesn't really make sense...how can you have the best day of your life and then the next day...throw it all away...' [Kevin].

In some cases, only in retrospect did pre-bereavement behaviour strike survivors as a potential forewarning, with the associated guilt of not recognising it at the time:

'Looking back, I think possibly for, a period...we started to see things that maybe were red flags, in hindsight.' [Stephanie].

Another internal conflict stems from participants typically harbouring a perpetual sense of frustration at the apparent lack of understanding of others. While SLSs are frustrated by people, including sometimes those close to them, not saying/doing 'the right thing', or saying/doing what they perceive as the wrong thing, there is broad acknowledgement that those not bereaved by suicide can never appreciate the true nature of its impact (*frustration vs. understanding*):

'I'm conflicted. Sometimes I want...not sympathy I want, I think it's more acknowledgement! That I've been through a difficult time. But you know it's not sympathy, I don't want them to change the way they talk, because of what I've been through, because I just don't want them to do that.' [Emma].

'You have a different lens on when something like this has happened here. And maybe, if there's some way, of getting an understanding of…that different lens. Out there to other people it would help, but I don't know what the answer is to that, it's complex.' [Mary].

Even though they acknowledged that suicide is more often spoken about these days, participants considered the societal taboo regarding suicide to broadly remain intact, with the associated stigma, and a connected misconception that it only occurs within families that are somehow atypical, rather than the fact that it can happen to anyone. There is also a concern that some social media avenues are misused, especially in the context of celebrity deaths. Extending that to the wider media, survivors welcomed balanced coverage, including some recent TV documentaries, but are sceptical as to motives and consider it to be in vogue with no real depth or sustained empathy. Participants relayed a strong wish to breakdown cultural barriers, regarding suicide and related bereavement, but struggled with what they perceived as exploitative approaches that perpetuate inaccuracies and misconceptions (*breaking the silence vs. perpetuating the taboo*):

'I found that program…I was a bit upset in the sense that they seemed to focus more on his grief, as a child, as opposed to that his grief by suicide.' [Emma].

One participant perceived greater sensitivity in how the mainstream media portray suicide, with a significant shift towards greater empathy and understanding:

'…you look at the media from the 2000s, and the sort of TV shows that we had then, it just wouldn't fly today …the culture has shifted… we are a lot more sensitive, were lot more compassionate.' [Kevin].

However, in some instances, participants related a distinctly unsympathetic attitude, and this seemed to be more prevalent in local media:

'…I called the editor and to say, "Look we haven't managed to tell friends and family yet…we haven't managed to reach everyone yet and it's on your front page", and the editor just said to me something to the effect of "I don't decide what makes the news. The news makes itself."' [Stephanie].

Persistent frustration with 'the system'

Interactions with medical professionals, with respect to the person that ultimately took their own life, were generally thought to have been ineffectual, but that is bound to be influenced by the ultimate outcome (*loss of trust in the healthcare system):*

'…in my mind, he may have been at risk at that…transition point from one drug to another.' [Barbara].

'She was trying to get a diagnosis but was on the waiting list…' [Kevin].

A lack of transparency and consistency across various healthcare professionals, driven to an extent by data privacy but also procedural deviations and/or communication failures, was flagged in terms of diminished overall care and limiting family member's ability to intercede due to their resulting lack of knowledge:

> *'...I do want the NHS...to look at their practices and how they can improve...because if anything I just want change. Because Ben was discharged from care because he hadn't enrolled at a GP. And I didn't know that he'd be discharged in the February, and Ben passed away in the June, and during that time he tried to enrol at a GP and wasn't able to.' '...I just felt Ben was forgotten in life and in death.'* [Lucy].

In a number of cases, it was noted that aspects of organisations, and/or individuals within them, and dealing with officialdom added a level of negative emotional impact (*trauma exacerbation*). Some noted being blocked by the legal framework, due to their status in law, in terms of being recognised as next-of-kin, with respect of the person lost, regardless of their role. Others found the legal bureaucracy challenging, and lacking empathy, when dealing with those bereaved and distressed.

> *'...they* [Coroner's office] *should have accepted what was said...in* [Country] *instead of having to go through it all again for no need...we couldn't find any legal basis for what they were doing. Anyway, so that added another layer of trauma...'* [Mary – regarding repatriation].

As a consequence of bereavement by suicide, participants often dealt with a number of services such as the NHS (both in the immediate aftermath but also in seeking care), the police and coroners but were not directed to PSG, or similar, reflecting an apparent lack of awareness of support organisations and how they could assist (*lack of support / signposting*):

> *'But the doctors themselves seem to be at a loss. They weren't able to signpost or...suggest anything.'* [Ann].

> *'So, I've been left to my own devices and there was no help offered whatsoever.'* [Lucy].

While some participants reported their workplaces being very supportive and flexible, others felt completely let down by their employers both in terms of the level of empathy displayed and a willingness to comprehend both the devastating nature and longevity of their bereavement:

> *'...as soon as you step back into a workplace, people expect you to be better, because you're back. If anything, people just tried to ignore it.'* [Lucy].

> *'So, I never went back* [to work] *and so that's kind of being an added bereavement because I really feel I've lost my career as well.'* [Mary].

With respect to the government's focus on suicide, the bereaved considered that too much of the care for survivors, and those at risk, is left to charitable organisations, and that the government should have a persistent, fully funded program in place to address the multitude of needs currently going unattended, if not unnoticed (*insufficient investment*):

> *'...the government could be doing an awful lot more; I think so much falls to the third sector -'* [Stephanie].

Several participants raised concerns regarding the potential impact of the COVID-19 pandemic:

> *'...loneliness, isolation, obviously, financial difficulties...might lead to someone feeling suicidal. I think the government there have a lot to answer for, in hopefully saving these people!''* [Emma].

There was a broad view that the way in which society engages with the concept of suicide needs to significantly change. Some participants noted this should involve a focus on the specific

language used and reaching young people, to raise awareness on the challenges of the modern world and inform them of where help is available:

> *'But we do need to be really open…and frank about our language…and talking about suicide and not being afraid to say the word, but letting children understand what that means…it's as adults and as educators we need to…make sure people are aware of that. … another key component is, is creating awareness around the importance of support after suicide, because ultimately…it's prevention.'* [Ann].

The beacon of peer support

Throughout the process of conducting the interviews, and the analysis, it was abundantly clear that all those that took part in the study have an overwhelmingly, highly favourable opinion of PSG and the work it performs. One of the major benefits participants related was a sense of relief that they were not the only ones facing the challenges resulting from their loss and that there are others that truly understand their feelings and needs (*'It's not just me'*):

> *'…I felt for the first time…everyone in the room understood my grief essentially.'* [Stephanie].

Individuals noted that attending meetings had kept them going, changed their lives for the better or even saved their lives:

> *'…the main thing that's helped me through this, is meeting people through PSG who've lived through this experience.'* [Lucy].

> *'…I've said this to the lady that runs the group…I've told her that I think she saved my life.'* [Emma].

Many participants reported that their experience, and the shared empathy with other PSG members, had resulted in them becoming more tolerant and less critical of others (*understanding and acceptance*):

> *'…my experience, of bereavement, has made me…a more accepting, and less judgmental, and more empathetic person.'* [Barbara].

At the same time, the common bond, shared with others bereaved by suicide, caused a realisation of participants' prior lack of any real conception as to the significant and far-reaching impact of being a SLS:

> *"…I'm experiencing these things myself now, whereas before I had no understanding this how that felt and...and almost that was more triggering in a way, because the more I felt it, the more I then understood it. And I felt terrible that I wasn't able to understand that before. And I just thought if I've had that bit of insight before, I may have dealt with things very differently because I would have had that understanding."* [Lucy].

There was also a frequent indication of the desire to help others bereaved by suicide via volunteering or other means (*giving back*). This also helped survivors by providing a sense of purpose relating to their loss(es):

> *'And I am keen to be, genuinely helpful in whatever way I can be to anybody who needs some help following a bereavement by suicide.'* [Barbara].

> *'I think it's made me look at people in a different way and want to help them.'* [Emma].

This GET also reflects participants' thoughts on how PSG operates, and could perhaps hone its services (*gaps*):

'...I think sometimes it would be helpful to have a meeting, or a group, just for parents, just for siblings, just for spouses...' [Mary].

There was also a note of frustration, notably by some participants that also volunteer with PSG themselves, that raising of its profile, and thereby reaching the bereaved sooner, could and should be more apparent:

'...I feel that PSG has a lot of potential...obviously does great work... but I don't feel that the organisation is organised enough... to really get the work that they do out there!' [Stephanie].

Discussion

This study provides novel insights into the personal and social impacts of suicide bereavement and reveals how its myriad components are mutually exacerbating and amplified throughout the continued existence of SLSs. Participants in this study felt a typical sense of having a life prior to their loss and beginning a new, distinct, one post-bereavement (Andriessen, 2014). This study shows that as well as changing individual SLSs irrevocably, subsequent dynamics, with family, friends, the workplace and institutions, are forever influenced by the complex and pervasive influences of suicide loss. The broad and life-changing implications of suicide bereavement have been noted elsewhere (Suija et al., 2022). As well as permanently shifting the way in which SLSs deal with family and friends, along with a radically shifted sense of what is important in many aspects of their lives going forward, some noted a significant transition in their ability to function in their work environments. Some chose to keep a narrow focus, avoiding perceived extraneous influences on their core role, while others found it impossible to continue and consequently mourned the loss of their career, adding to a sense of exposure and loss of worth. Studies have suggested a direct impact of suicide bereavement on employment status, including problems with focus, self-reliance and drive plus an increased likelihood of occupation loss of 80% in those bereaved by suicide compared to natural death bereavement (Pitman et al., 2018) and a greater likelihood of being unemployed five years post-bereavement (Bélanger et al., 2022).

As part of a sense of being changed forever by their bereavement, SLSs reported both struggling to extract any enjoyment out of life, especially in the context of activities previously shared with those they lost, and, in some instances, increased guilt at not being enthusiastic about interests other surviving family members wished to pursue. There was a broad sense of not being understood, if not ignored, and a sense of the broader population wanting to keep SLSs veiled for fear of having to acknowledge both the reality of SLSs' bereavement and also that they, themselves, are not immune to the potential consequences of suicide loss. SLSs very often feel isolated by this but can contribute to their own isolation by distancing themselves from groups, individuals, and challenging situations. While having a public persona, somewhat at variance to a private one, is far from uncommon, SLSs often feel that they must maintain a constant pretence, frequently denying their true feelings, and wearing a mask of strength and fortitude, whilst inwardly crumbling. This approach can negate an avenue for sharing and result in solitude and seclusion (Levi-Belz & Lev-Ari, 2019).

In what might be deemed examples of cognitive dissonance, SLSs often perceive ongoing, directly conflicting perspectives relating to their bereavement. The conflict between a great desire to understand why their loved one took their life, and an acknowledgment that some elements can never be known, is a recurrent challenge for survivors (Jordan, 2020). Such conflicts exacerbate the trauma and contribute to a lack of acceptance and can undermine the potential for post-traumatic growth. In some ways, such conflicts could be reflective of the oscillations described in the Dual Process Model (confrontation vs. avoidance) of bereavement coping (Stroebe & Schut, 2010) but differ is an apparent, longstanding coexistence, rather than alternation.

Resentment towards the healthcare system was noted, in some cases, due to SLSs frustration with siloed care and a lack of willingness, or ability, of services to maintain a single overview of care for those that were lost. This was exacerbated by organisational restrictions,

both prior to and after the losses, on sharing of healthcare information with family members. Other studies have found that SLSs can feel prohibited from pragmatic participation in their loved one's care (Hultsjö et al., 2022). Access to healthcare bereavement support services was noted as being highly variable both in terms of availability and quality. Healthcare system gaps have been identified as a key barrier to SLSs to help-seeking (Geležėlytė et al., 2020). A loss of confidence in primary healthcare, prior to suicide loss, has been found to contribute to SLSs lack of confidence in it meeting their needs going forward (Suija et al., 2022).

Most SLSs reported receiving little, or no, guidance, from any source, on how to cope and obtain bereavement support. Due to the lack of signposting, SLSs need seek out help, at a time when their ability to do so is significantly impeded. A survey of postvention experts backed that the provision of practicable knowledge, and navigation assistance regarding aspects of post-bereavement life, are both essential in the initial aftermath (McGill et al., 2023). It should be noted that their immediate, post-bereavement mental state may be a barrier to SLSs being able to process, and retain, factual content relating to support services. However, this highlights the need for such services to be offered frequently, and on numerous fronts, to maximise the likelihood those in desperate need being able to gain access.

Many survivors in this study acknowledged that they, themselves, had never seriously considered that suicide would impact their lives until it happened. There is a sense that the vocabulary within society regarding suicide is fundamentally wrong and that societal perspectives need to be radically realigned. A UK-wide survey, of those bereaved or affected by suicide, emphasised the need for a coordinated, multi-disciplinary proactive approach to postvention, with a focus on practicalities (McDonnell et al., 2022). A recent Australian study indicated that, although mutually desired among all parties, efforts at incorporating lived experience into policy co-creation are not having the desired outcome (Pearce et al., 2022). In the context of public health programs, research has suggested that support focussed on helping SLSs deal with their grief, rather than other corollaries, and that is targeted at those that most need it, rather than a blanket approach, should be a priority (Levi-Belz et al., 2023). Several participants raised concerns as to the downstream ramifications of the COVID-19 pandemic, which has been recognised as a potential risk in the literature (Gratz et al., 2020; Gunnell et al., 2020), however, any associated increase in suicide rates has yet to be confirmed, although vigilance, regarding this aspect, is urged (Appleby et al., 2021; Sinyor et al., 2022). Regarding healthcare and legal systems appearing to operate in isolation, a greater public health approach, including school-based programs and proactive reach outs to the bereaved, has been suggested as a more effective overall approach to both prevention and postvention (Andriessen et al., 2019).

SLSs in this study strongly represented the opinion that bereavement by suicide is distinct from other types, reflecting some other studies (Nam, 2016; Sheehan et al., 2018). Participants reported a strong sense of community, and the unique ability of their fellow bereaved to comprehend their suffering in a way those not affected can never fully understand, which matches the findings of studies on self-disclosure (Levi-Belz, 2016; Levi-Belz & Lev-Ari, 2019). While there are significant negative ramifications of bereavement by suicide, some participants – unsurprisingly the ones bereaved the longest – did relate what has been termed post-traumatic growth (Levi-Belz, 2017; Jordan, 2020) such as increased resilience, being non-judgemental, optimism and benevolence. Consistently it was remarked that PSG has been invaluable to those bereaved, in line with Cerel et al., (2009) who reported 94% found such peer support meetings mediumly to extremely valuable. However, research has indicated that only a small proportion

of those bereaved by suicide attend peer support groups (Andriessen & Krysinska, 2012). Although PSG has been greatly beneficial to all participants, most noted they stumbled across PSG and feel that much more should be done to raise its profile and engage emergency services, and healthcare professionals, to actively signpost it to those in need. A lack of awareness, and consequent uptake, of peer-support activities has also been observed in Ireland (O'Connell et al., 2022). There is a common drive to help others bereaved by suicide with most participants in this study either already active within PSG or indicating a firm wish to give back to those that have helped them. A strong sense of community was evident which reflects both the vulnerability of those bereaved by suicide and the belief that only those similarly bereaved can ever really understand what they have endured and continue to face.

Strengths and Limitations

Qualitative studies of SLSs are infrequent, and a rare cross-sectional perspective was gained. A shared lived experience facilitated openness and a willingness to disclose, with many participants noting the experience as cathartic. Participants that volunteer with the PSG may have different perspectives to others, within and without, and the convenience sampling, from the peer support organisation members, is a limitation. While the risk was consciously acknowledged, during the study execution, the researcher's role as a PSG volunteer may have inadvertently introduced positive bias towards the organisation. This was mitigated by meeting at a time and location removed from any regular PSG activities and by encouraging participants to provide their honest opinions. Reflexivity considerations include a possible sub-conscious leaning towards those with similar experiences and perspectives to the lead researcher's own experience in this area (see Design section for details).

Future Studies

Establishing the extent to which the findings of this study are more broadly applicable requires research involving participants with more diverse backgrounds. Differential suicidality has been found in ethnic minority groups in England and Wales (Özen-Dursun et al., 2023) and facets of suicide bereavement specific to those of certain sexual orientations have been identified (Jones & Crossland, 2023). Notably, men are more reticent in seeking assistance for mental health issues (Ellis, 2018) and relate barriers even when appreciating the value of support groups (Cramer et al., 2014). Additionally, men do not typically participate in suicide bereavement research (Andriessen et al., 2019) which is both in line with the participants of this study and the available pool of PSG members from which to recruit.

Conclusion

During the preparation of this paper, other IPA studies of suicide bereavement have been published that, while relating different themes, are not unaligned with those reported herein (Kaur & Stedmon, 2022; Lee, 2022). The study findings also provide insights into the mindset of a cross-section of those bereaved by suicide. The trauma of suicide bereavement is well-documented, but this study discerns the all-encompassing, pervasive, life-shattering consequences of becoming a SLS. It also provides a view into the inner lives of SLSs and how they continually struggle to cope with their devastation, while maintaining a veneer of being able to adapt and recover, to meet the expectations, real or perceived, of others. A prevalent component identified, of the aftermath of suicide bereavement, not noted elsewhere to the authors' knowledge, is the perpetual possession of conflicting thoughts and perspectives that constantly battle for supremacy in the minds of SLSs. This study highlights how SLSs feel largely uncared for, and to an extent ostracised, by the systems (healthcare, legal, employment, governmental) that would be expected to provide comfort and support. Finally, as an insight into a specific peer-support group PSG, it provides a unique level of comprehension as to the power of such organisations and their ability to save individuals, provide a community with deep and meaningful empathy, and facilitate SLSs managing through immense difficulties and their radically changed existence.

Acknowledgements

References

Abbate L, Chopra J, Poole H, & Saini P (2022) Evaluating postvention services and the acceptability of models of postvention: A systematic review. *OMEGA-Journal of Death and Dying, 0*(0), 1–41, 00302228221112723. https://doi.org/10.1177/00302228221112723

Ali U, & Rehna T (2023) Grief Reactions and Suicide Bereavement in the Context of Stigma among Parents: An Interpretative Phenomenological Analysis. *Annales Médico-Psychologiques, 181*(7), 598–603. https://doi.org/10.1016/j.amp.2022.04.016

Andriessen K (2014) Suicide bereavement and postvention in major suicidology journals: lessons learned for the future of postvention. *Crisis, 35*, 338–348. https://doi.org/10.1027/0227-5910/a000269

Andriessen K & Krysinska K (2012) Essential questions on suicide bereavement and postvention. *International Journal of Environmental Research and Public Health, 9*(1), 24-32. https://doi.org/10.3390/ijerph9010024

Appleby L, Richards N, Ibrahim S, Turnbull P, Rodway C, & Kapur N (2021) Suicide in England in the COVID-19 pandemic: early figures from real time surveillance. *Available at SSRN:* https://ssrn.com/abstract=3781695 or http://dx.doi.org/10.2139/ssrn.3781695

Bélanger S.M, Stene-Larsen K, Magnus P, Reneflot A, Christiansen SG, & Hauge LJ (2022) Employment status and bereavement after parental suicide: A population representative cohort study. *BMJ Open, 12*(9), e064379. https://doi.org/10.1136/bmjopen-2022-064379

Bellini S, Erbuto D, Andriessen K, Milelli M, Innamorati M, Lester D . . . Pompili M (2018) Depression, hopelessness, and complicated grief in survivors of suicide. *Frontiers in Psychology, 9*, 198, 1-6. https://doi.org/10.3389/fpsyg.2018.00198

Cerel J, Padgett JH, Conwell Y & Reed Jr GA (2009) A call for research: The need to better understand the impact of support groups for suicide survivors. *Suicide and Life-Threatening Behavior, 39*(3), 269-281. https://doi.org/10.1521/suli.2009.39.3.269

Cramer H, Horwood J, Payne S, Araya R, Lester H, & Salisbury C (2014) Do depressed and anxious men do groups? What works and what are the barriers to help seeking? *Primary health care research & development*, *15*(3), 287-301. https://doi.org/10.1017/S1463423613000297

Creuzé C, Lestienne L, Vieux M, Chalancon B, Poulet E & Leaune E (2022) Lived experiences of suicide bereavement within families: A qualitative study. *International Journal of Environmental Research and Public Health, 19*(20), 13070. https://doi.org/10.3390/ijerph192013070

Dyregrov K & Dyregrov A (2005) Siblings after suicide - 'The forgotten bereaved'. *Suicide and Life-Threatening Behavior, 35*(6), 714-724. https://doi.org/10.1521/suli.2005.35.6.714

Ellis K (2018) Identifying and addressing barriers to men seeking help for depression. British *Journal of Mental Health Nursing, 7*(3), 130-136. https://doi.org/10.12968/bjmh.2018.7.3.130

Entilli L, Ross V, De Leo D, Cipolletta S & Kõlves K (2021) Experiences of parental suicide-bereavement: A longitudinal qualitative analysis over two years. *International Journal of Environmental Research and Public Health, 18*(2), 564. https://doi.org/10.3390/ijerph18020564

Erlangsen A, Runeson B, Bolton JM, Wilcox HC, Forman JL, Krogh, J…Conwell Y (2017) Association between spousal suicide and mental, physical, and social health outcomes: a longitudinal and nationwide register-based study. *JAMA psychiatry, 74*(5), 456-464. https://doi.org/10.1001/jamapsychiatry.2017.0226

Geležėlytė O, Gailienė D, Latakienė J, Mažulytė-Rašytinė E, Skruibis P, Dadašev S & Grigienė D (2020) Factors of seeking professional psychological help by the bereaved by suicide. *Frontiers in psychology, 11*, 592. https://doi.org/10.3389/fpsyg.2020.00592

Goulah-Pabst DM (2023) Suicide loss survivors: Navigating social stigma and threats to social bonds. *OMEGA-Journal of death and dying, 87*(3), 769-792. https://doi.org/10.1177/00302228211026513

Grafiadeli R, Glaesmer H & Wagner B (2022) Loss-related characteristics and symptoms of depression, prolonged grief, and posttraumatic stress following suicide bereavement. *International journal of environmental research and public health, 19*(16), 10277. https://doi.org/10.3390/ijerph191610277

Gratz KL, Tull MT, Richmond JR, Edmonds KA, Scamaldo KM & Rose JP (2020) Thwarted belongingness and perceived burdensomeness explain the associations of COVID-19 social and economic consequences to suicide risk. *Suicide and Life-Threatening Behavior, 50*(6), 1140-1148. https://doi.org/10.1111/sltb.12654

Griffin E, O'Connell S, Ruane-McAteer E, Corcoran P & Arensman EP (2022) Psychosocial outcomes of individuals attending a suicide bereavement peer support group: A follow-up study. *International Journal of Environmental Research and Public Health, 19*(7), 4076. https://doi.org/10.3390/ijerph19074076

Gunnell D, Appleby L, Arensman E, Hawton K, John A, Kapur N . . . the COVID-19 Suicide Prevention Research Collaboration (2020) Suicide risk and prevention during the COVID-19 pandemic. *The Lancet Psychiatry, 7*(6), 468-471. https://doi.org/10.1016/S2215-0366(20)30171-1

Higgins A, Hybholt L, Meuser OA, Eustace Cook J, Downes C & Morrissey J (2022) Scoping review of peer led support for people bereaved by suicide. *International Journal of Environmental Research and Public Health, 19*(6), 3485. https://doi.org/10.3390/ijerph19063485

Hill NT, Robinson J, Pirkis J, Andriessen K, Krysinska K, Payne A . . . Lampit A (2020) Association of suicidal behavior with exposure to suicide and suicide attempt: A systematic review and multilevel meta-analysis. *PLoS Medicine, 17*(3), e1003074. https://doi.org/10.1371/journal.pmed.1003074

Hultsjö S, Ovox SM, Olofsson C, Bazzi M & Wärdig R (2022) Forced to move on: An interview study with survivors who have lost a relative to suicide. *Perspectives in Psychiatric Care, 58*(4), 2215-2223. https://doi.org/10.1111/ppc.13049

Hybholt L, Higgins A, Buus N, Berring LL, Connolly T, Erlangsen A & Morrissey J (2022) The spaces of peer-led support groups for suicide bereaved in Denmark and the Republic of Ireland: a focus group study. *International journal of environmental research and public health, 19*(16), 9898. https://doi.org/10.3389/fpsyg.2020.01131

Jones H & Crossland C (2023) *LGBTQ+ Bereavement by Suicide Research Study*. Support After Suicide Partnership.

Jordan JR (2020) Lessons learned: Forty years of clinical work with suicide loss survivors. *Frontiers in psychology, 11*, 766. https://doi.org/10.3389/fpsyg.2020.00766

Kaur R & Stedmon J (2022) A phenomenological enquiry into the impact of bereavement by suicide over the life course. *Mortality, 27*(1), 53-74. https://doi.org/10.1080/13576275.2020.1823351

Lee E (2022) Experiences of bereaved families by suicide in South Korea: A phenomenological study. *International Journal of Environmental Research and Public Health, 19*(5), 2969. https://doi.org/10.3390/ijerph19052969

Lenferink LI, Eisma MC, Smid GE, de Keijser J & Boelen PA (2022) Valid measurement of DSM-5 persistent complex bereavement disorder and DSM-5-TR and ICD-11 prolonged grief disorder: The Traumatic Grief Inventory-Self Report Plus (TGI-SR+). *Comprehensive psychiatry, 112,* 152281. https://doi.org/10.1016/j.comppsych.2021.152281

Levi-Belz Y (2016) To share or not to share? The contribution of self-disclosure to stress-related growth among suicide survivors. *Death Studies, 40*(7), 405-413. https://doi.org/10.1080/07481187.2016.1160164

Levi-Belz Y (2017) Relationship with the deceased as facilitator of posttraumatic growth among suicide-loss survivors. *Death Studies, 41*(6), 376-384. http://dx.doi.org/10.1080/07481187.2017.1285372

Levi-Belz Y & Ben-Yaish T (2022) Prolonged grief symptoms among suicide-loss survivors: The contribution of intrapersonal and interpersonal characteristics. *International Journal of Environmental Research and Public Health, 19*(17), 10545. https://doi.org/10.3390/ijerph191710545

Levi-Belz Y & Birnbaum S (2022) Depression and suicide ideation among suicide-loss survivors: a six-year longitudinal study. *International journal of environmental research and public health, 19*(24), 16561. https://doi.org/10.3390/ijerph192416561

Levi-Belz Y, Krysinska K & Andriessen K (2023) What do we know about suicide bereavement, and what we can do to help suicide-loss survivors? *International journal of environmental research and public health, 20*(8), 5577. https://doi.org/10.3390/ijerph20085577

Levi-Belz Y & Lev-Ari L (2019) 'Let's Talk About It': The Moderating Role of Self-Disclosure on Complicated Grief over Time among Suicide Survivors. *International Journal of Environmental Research and Public Health, 16*(19), 3740. https://doi.org/10.3390/ijerph16193740

McDonnell S, Flynn S, Shaw J, Smith S, McGale B & Hunt IM (2022) Suicide bereavement in the UK: Descriptive findings from a national survey. *Suicide and Life-Threatening Behavior, 52*(5), 887-897. https://doi.org/10.1111/sltb.12874

McGill K, Bhullar N, Batterham PJ, Carrandi A, Wayland S & Maple M (2023) Key issues, challenges, and preferred supports for those bereaved by suicide: Insights from postvention experts. *Death studies, 47*(5), 1-6. https://doi.org/10.1080/07481187.2022.2112318

Nam I (2016) Suicide bereavement and complicated grief: Experiential avoidance as a mediating mechanism. *Journal of Loss and Trauma, 21*(4), 325-334. https://doi.org/10.1080/15325024.2015.1067099

O'Connell S. Tuomey F, O'Brien C. Daly C, Ruane-McAteer E, Khan A . . . Griffin E (2022) AfterWords: A survey of people bereaved by suicide in Ireland. *National Suicide Research Foundation (NRSF), Healing Untold Grief Groups (HUGG).*

Özen-Dursun B, Kaptan SK, Giles S, Husain N & Panagioti M (2023) Understanding self-harm and suicidal behaviours in South Asian communities in the UK: systematic review and meta-synthesis. *BJPsych open, 9*(3), e82. https://doi.org/10.1192/bjo.2023.63

Pearce T, Maple M, Wayland S, McKay K, Shakeshaft A & Woodward A (2022) Evidence of co-creation practices in suicide prevention in government policy: a directed and summative content analysis. *BMC public health, 22*(1), 1-12. https://doi.org/10.1186/s12889-022-14313-3

Pitman A (2018) Addressing suicide risk in partners and relatives bereaved by suicide. *The British Journal of Psychiatry, 212*(4), 197-198. https://doi.org/10.1192/bjp.2017.46

Pitman A, Khrisna Putri A, De Souza T, Stevenson F, King M, Osborn D & Morant N (2018) The impact of suicide bereavement on educational and occupational functioning: A qualitative study of 460 bereaved adults. *International journal of environmental research and public health, 15*(4), 643. https://doi.org/10.3390/ijerph15040643

Pitman A, McDonald K, Logeswaran Y, Lewis G, Cerel J & Erlangsen A (2022) Proportion of suicides in Denmark attributable to bereavement by the suicide of a first-degree relative or partner: Nested case–control study. *Acta Psychiatrica Scandinavica, 146*(6), 529-539. https://doi.org/10.1111/acps.13493

Sheehan L, Corrigan PW, Al-Khouja MA, Lewy SA, Major DR, Mead J . . . Weber S (2018) Behind closed doors: The stigma of suicide loss survivors. *OMEGA-Journal of Death and Dying, 77*(4), 330-349. https://doi.org/10.1177/0030222816674215

Sinyor M, Knipe D, Borges G, Ueda M, Pirkis J, Phillips MR . . . the International COVID-19 Suicide Prevention Research Collaboration (2022) Suicide risk and prevention during the

COVID-19 pandemic: one year on. *Archives of suicide research, 26*(4), 1944-1949. https://doi.org/10.1080/13811118.2021.1955784

Smith JA, Flowers P & Larkin M (2021) Interpretative Phenomenological Analysis Theory, Method and Research. London: Sage.

Stroebe M & Schut H (2010) The dual process model of coping with bereavement: A decade on. *Omega, 61*(4), 273–289. https://doi.org/doi:10.2190/OM.61.4.b

Suija K, Rooväli L, Aksen M, Pisarev H, Uusküla A & Kiivet R (2022) Coping with suicide loss: A qualitative study in primary health care. *Primary Health Care Research & Development, 23,* e41. https://doi.org/10.1017/S1463423622000263

Testoni I, Francescon E, De Leo D, Santini A & Zamperini A (2019) Forgiveness and blame among suicide survivors: a qualitative analysis on reports of 4-year self-help-group meetings. *Community Mental Health Journal, 55*(2), 360-368. https://doi.org/10.1007/s10597-018-0291-3

World Health Organization (2014) Preventing suicide: A global imperative. World Health Organization: Geneva, Switzerland.

World Health Organization (2019) Suicide worldwide in 2019: Global Health Estimates. World Health Organization: Geneva, Switzerland.

Zortea TC, Cleare S, Melson AJ, Wetherall K & O'Connor RC (2020) Understanding and managing suicide risk. *British medical bulletin*. https://doi.org/10.1093/bmb/ldaa013