

**University of West London**  
**M.Sc. Psychology Conversion**  
**Dissertation**

**An Interpretative Phenomenological Analysis qualitative study  
to assess the impacts of bereavement by suicide**

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**Abstract**

Suicide is widely acknowledged as a significant, and pervasive, global public health issue. This study aimed to assess how people felt impacted after the loss of a loved one to suicide, using a qualitative design. Data were collected using in-depth face-to-face and video semi-structured interviews. Audio-recordings of the interviews were transcribed and analysed via Interpretative Phenomenological Analysis. Eight people, recruited from Survivors of Bereavement by Suicide members, participated in the study. Five super-ordinate themes emerged from the data namely: Pre-bereavement Issues, Consequences, Perceptions, Organisational Challenges and Support Network. Findings show that survivors' lives are greatly affected and that they often feel that those they lost were let down by the healthcare system. Perceptions of losses vary by relationship and elapsed time. Further education and training are required for healthcare and legal professionals, plus the emergency services, to enhance understanding of the specific needs of those bereaved by suicide. There is a strong sense that society needs a much greater, and better, awareness of suicide, and its impacts, including the availability of bereavement assistance. Participants have been significantly assisted by participation in peer support groups but feel that the approach to postvention, and prevention, is highly fragmented and requires overhaul, with survivors having a much larger role.

## Introduction

### Background

Based on figures from the World Health Organisation, the death rate, by suicide, is approximately one million per annum, across the world (Turecki & Brent, 2016), with an estimated 25 of those bereaved, per incident, being deeply affected (Levi-Belz & Lev-Ari, 2019). In the US, it's been observed that the prevalence of loss by suicide is far greater than routinely considered, with half the populace exposed and a third bereaved (Feigelman, Cerel, McIntosh, Brent & Gutin, 2018). Rates vary across the globe both between and within countries, with as much as a ten-fold disparity across locations, reflecting socio-economic trends. In China, accessibility of deadly pesticides is thought to account for a three-fold higher incidence of suicide in rural areas and for the greater frequency amongst women (Turecki & Brent, 2016). In Europe, suicide frequencies are greater in the North and East (30/100,000 in Lithuania) and lower in the South and West (3/100,000 in Greece). Overall, the ratio of male to female suicides is 5:1, for the region, but it seems that cultural factors can have a strong influence as some migrant communities show rates more in common with their origins rather than their country of adoption (Spallek et al., 2015). A combination of substance abuse, poverty, and negative impact on their culture, may explain high rates of suicide amongst indigenous peoples. In the elderly, suicide is relatively common where there is a longstanding, underlying health issue. Rates amongst the younger population are increasing with both ideation and behaviour spiking in adolescence and young adulthood. Of those that die by suicide, approximately 45% consult their GP within one month of taking their lives but very few are diagnosed with a mental health issue. In general, while suicide death rates are greater in males, suicide ideation and attempts are more prevalent in females (Turecki & Brent, 2016). There are, however, apparent longstanding gender differences in rates, with Romania and Seychelles showing a particular prevalence of male suicide, the Eastern Mediterranean being close to parity and, in addition to China, Lesotho, Myanmar, Bangladesh, Morocco and Pakistan having a higher rate of female suicide, over a 17-year period assessed. Also, the selection of suicide method has been found to vary by gender and locality (Pridmore & Pridmore, 2020). Prior exposure to suicide, including by non-blood relatives and friends, is a particular risk indicator for suicide when compared to bereavement by other means (Zortea et al., 2020). It's possible that the increase in likelihood of suicide, by some survivors, is due to a perception that their loss has made suicide an acceptable option in determining their own fate. For the majority, though, losing someone to suicide is more likely to be a protective factor due to their mindfulness of the bearing on those left behind (Pitman et al., 2017). As might be expected, world events can have an impact on suicide rates and while conflicts around the globe currently receive more coverage, closer to home, the multi-generational

'Troubles' in Northern Ireland have been shown to cause an increase in the rate of suicide (O'Neill & O'Connor, 2020).

Studies have found that frequently used risk evaluation scales are not reliable, in isolation, to correctly suggest the likelihood of future self-harm and suicide with the outputs being no more accurate than chance (Steeg et al., 2018). There are developments of new scales, and one has been reported to show promise, still in conjunction with professional assessments but less reliant on self-reporting, in being more appropriately indicative of the risk (Calati et al., 2020).

### Survivors

A suicide survivor is typically considered to have lost a family member, or friend, with whom they had a significant relationship, and where their life is permanently shifted by the bereavement (Schneider, Grebner, Schnabel & Georgi, 2011). This is very different, in terms of the intensity and longevity of impact, from those who may be involved in suicide such as emergency services, healthcare workers, and witnesses, although some mental health professionals have been found to be distressed by dealing with suicide (Andriessen & Kryszynska, 2012) and a nested scale has been proposed that ranges from 'exposed' to 'affected' and, ultimately, 'bereaved'. Within the latter, it has been suggested that 'suicide-bereaved short-term' and 'suicide-bereaved long-term' are sub-categories where the prolonged scenario can lead to incapacitating sequelae (Cerel et al., 2014). Coping with grief is not a universal, nor linear, process and is impacted by numerous factors including the relationship to the person lost, gender of the bereaved and cultural norms. The Dual Process Model (Stroebe & Schut, 2010) suggests that the bereaved fluctuate between loss-oriented and restoration-oriented behaviours. The former deal with the direct impact of grief such as sadness, reminiscing and the circumstances that lead to the death, while the latter are to do with distractions, and new activities, but may involve a degree of avoidance or denial. This model was proposed over 20 years ago but a recent systematic review found it to be highly applicable across studies from 1999 to 2016 (Fiore, 2019). There is an apparent divergence between how suicide survivors perceive their bereavement as being different to other types, due to elements such as stigma, guilt, anger, abandonment, and longing to understand, versus the viewpoint common in the literature that all forms of bereavement are largely analogous (Andriessen & Kryszynska, 2012; Young et al., 2012). While some studies support those bereaved by suicide experiencing psychological distress above and beyond that associated with other types of loss (Nam, 2016; Sheehan et al., 2018) others suggest the difference is negligible (Carmassi et al., 2013). 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 survivors’ drive to designate accountability and deal with their own guilt.

Survivors of suicide are prone to anxiety, depression and pathological ‘Complicated Grief’ (CG). The concept of CG has been deliberated for a considerable time but has become recognised as a clinical condition (Nakajima, 2018). CG has been found to induce the avoidance of situations evocative of survivors’ loss, which can inhibit the grieving process (Nam, 2016). Those bereaved also struggle with self-blame (Testoni, Francescon, De Leo, Santini & Zamperini, 2019), stigma (Sheehan et al., 2018), Post-Traumatic Stress Disorder (PTSD), hopelessness, severe psychological stress, and can be at a greater risk of suicide arising from CG (Bellini et al., 2018). Sharing with others has been shown to be a major alleviant of such conditions (Levi-Belz & Lev-Ari, 2019). When assessed, in terms of overall demographics and suicide causality, trauma being inversely proportional to the age of the person lost was the only determining factor. The relationship the bereaved had with the deceased may define the way in which they grieve and influence the effectiveness of postvention (support for survivors) activities. This may reflect the cultural acceptability of suicide as a practice (Schneider et al., 2011).

### Relationships

Losing a parent to suicide has been associated with persistent abuse of alcohol and/or other substances, reduced capability, anxiety, and increased frequency of severe depressive episodes (Brent, Melham, Donohoe & Walker, 2009). Longer-term depression was observed where, during the initial nine months post-bereavement, survivors reported anxiety, anger, suicidality, other stressful events, PTSD, or lack of support and/or family unity. It can also be exacerbated by CG, self-esteem issues, lack of coping strategies, attribution of blame, and the loss being of a mother.

In the literature, there are relatively few studies looking at the ramifications of sibling loss to suicide. Post-traumatic psychological stress, from a Norwegian national study, has been found to be higher amongst surviving siblings living with their parents, attributed to the overall family shared burden, compared to their parents themselves and siblings living away from the family home (Dyregrov & Dyregrov, 2005). The latter may be somewhat protected by the separation, life circumstances and personal relationships. Parental hypervigilance was also a confounding issue, in many cases, and different perspectives, on both the individual and their loss to suicide, can be a barrier to communication regarding how each person is coping with their grief.

In Denmark, an analysis of a national registry showed that the loss of a partner to suicide, in comparison to other types of bereavement or the general population, lead to an increased likelihood of both physical and mental health issues. Survivors of losing a partner were also found to have reduced life expectancy and higher levels of divorce, children in care, sick leave, and unemployment (Erlangsen et al., 2017).

Parents bereaved by suicide often report trouble sleeping, invasive thoughts, alienation, loss of interest in pursuits, and problems concentrating. Also, PTSD has been found to be frequent amongst parents bereaved by the loss of a child to causes deemed 'violent' including accidents, homicides, and suicides, thereby often resulting in anxiety and depression plus resentment, diminished self-worth and difficulties coping (Murphy et al., 1999). Other research has found no correlation of parental gender (or that of the child lost) with depression and grief, with the authors noting that this may be due to their approach of soliciting participation from death records, rather than avenues such as support groups or clinicians, leading to a larger than typical number of males being involved (Harper, O'Connor & O'Carroll, 2015). Grief, and its associated health issues, has been demonstrated to be the most impactful life stressor, lasting several decades and, in essence, become a lifetime issue for parents, especially mothers (Harper, O'Connor, Dickson & O'Carroll, 2011). Poor coping mechanisms, such as excessive alcohol and/or substance use, and avoidance, reflective of depressive indicators, have been found in parents experiencing severe grief. These can become potentially life-threatening maladaptive practices and seem related to the bereavement process rather than the type of loss (Harper, O'Connor & O'Carroll, 2014). An Australian qualitative study found that surviving parents focussed on making sense of their loss, ways of dealing with it and striving for a greater understanding, which are in line with the Dual Process Model (Ross, Kölves, Kunde & De Leo, 2018).

People whose close friends take their lives are more likely to be concerned for other friends than their family members. While a suicide death, of a friend, can stimulate suicide ideation, especially where they believe they have similar susceptibilities, it is often protective in terms of raising awareness of the devastating impact (Pitman et al., 2017). Research into the implications of losing a close friend to suicide is a neglected area (Maple et al., 2017).

### Trauma

Where the person lost had made prior suicide bids, had long-term mental health issues, or demonstrated anti-social behaviour, survivors sometimes feel a sense of release at their passing (Schneider et al., 2011). However, following bereavement, typically ‘acute grief’ manifests as powerful and disturbing sensations. Psychological shock can be protective, in the short to mid-term, and prevent an individual being overwhelmed with gloom and desolation. This can allow them to deal with the administrative aspects of death such as registrars, funeral directors, travel, and finances. It is usually only a temporary reprieve, however, with distress and despondency setting in over the following period and, in some cases, not resonating fully until some months have passed. Whatever the timeframe for an individual, acute grief most often transitions into ‘integrated grief’, as they adapt to their loss and their new life, but for a few people, the dire pain and suffering of their bereavement perpetuates and is deemed CG (Young et al., 2012). The likelihood of CG is greater amongst those bereaved by suicide and typically involves issues with completing everyday tasks and work responsibilities, ability to socialise, depression, and a higher probability of suicidality. It has also been found to be potentially exacerbated by stigma associated with death by suicide (Hanschmidt, Lehnig, Riedel-Heller & Kersting, 2016). The question of whether they could have done something to prevent the suicide haunts many survivors (Levi-Belz, 2016). While there is general acknowledgement that survivors of sudden bereavements are more prone to suicide, a recent study found that, even when controlled for multiple variables, this is both more prevalent amongst suicide survivors and greater still in suicide survivors that lost a child (Hamdan, Berkman, Lavi, Levy & Brent, 2020). There are several potential avenues for support, including friends, family, colleagues, healthcare programs, therapists, and peer groups but the availability and effectiveness of these can vary considerably (Cerel, Padgett, Conwell & Reid, 2009; Pitman, 2018).

Results from a large-scale meta-analysis and systematic review, of media reports on suicide, showed that there is a material effect on the frequency of suicide in the general population where a celebrity is involved. The associated increase was noted as 13%, immediately after the report, but that was amplified to 30% where the method was included. Non-celebrity suicide reports did not seem to show a discernible effect. The authors suggest that improved adherence to reporting guidelines could moderate such influences (Niederkrotenthaler et al., 2020). Research has shown that social media plays a role in propagating clusters of suicidal behaviour in teenagers that identify with those they admire (contemporaries or the famous) that have taken their own lives (Hawton et al., 2020). Although somewhat less stigmatised than in the past, associated with historical religious and cultural practices, these days, in Western society, suicide is less overtly judged but implied criticism can still be subtly

expressed in terms of ostracism, seclusion and informal censure. Stigma can adversely affect survivors' mental health resulting in feelings of humiliation, reducing their quality of life, and increasing their own risk of suicide. There is a divergence of opinion on the de-stigmatisation of suicide itself, as some argue it is a deterrent to the act, whilst others contend it is an obstacle to the vulnerable seeking help (Scocco, Castriotta, Toffol & Preti, 2012). Regardless of socio-economic status, education, family circumstances, sex, and personal suicidality, research has shown that the intensity of psychological pressure experienced by survivors is directly related to their perception of stigma associated with their loss (Scocco, Preti, Totaro, Ferrari & Toffol, 2017). In their qualitative study, Peters, Cunningham, Murphy and Jackson (2016) concluded that the dynamics of stigma can lead to survivors feeling unable to share their feelings, thus cutting off an avenue for adjustment and disabling their ability to focus on positive memories. A large quantitative study indicated that those bereaved by suicide experienced stigma, remorse, and embarrassment, more intensely than where other causes of abrupt fatality, whether natural or unnatural, were involved (Pitman, Osborn, Rantell & King, 2016). Together, the phenomenological and magnitude information, from these studies respectively, highlights the pervasiveness of stigma, within the bereaved by suicide community, and the need to understand the factors involved in greater depth. There is also a significant cost to the economy associated with mental health in general and, specifically, suicide. In their 'economic case', Knapp, McDaid & Parsonage (2011) indicate that Applied Suicide Intervention Skills Training (ASIST) for GP's would be a highly cost-effective measure in terms of prevention and thereby meaningfully reduced losses and bereavement aftermath.

### Support

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. The bereaved tend to view the value of things differently and what previously seemed mutually important, subsequently only holds appeal to the non-bereaved. Lack of tolerance, on both sides, can lead to withdrawal and isolation (Dyregrov & Dyregrov, 2005). Despite appreciating a wide range of pragmatic and emotional support from peers, professionals, colleagues, as well as friends and family, suicide survivors can often be deflated by a sense that those around them either do not react to, or even show any awareness of, their struggles. With it being estimated that one out of four survivors get no explicit support, there is a significant obscured level of distress that remains unhandled and could be divulged with more persistent offers of assistance (Pitman et al., 2018).

Governments in various parts of the world, covering Australia, New Zealand, the US, and parts of Europe, including the UK, have introduced suicide prevention initiatives, embracing postvention. These programs encompass literature, online resources, awareness, fund raising, events and expositions plus days specified to promote the needs of those at risk and/or survivors. The value of such programs is largely unproven, and the societal taboo associated with suicide may still be a major barrier to these programs achieving their goals (Andriessen et al., 2019). Reflective of devolution, there are separate suicide prevention initiatives in England (Preventing suicide in England), Wales (Talk to me 2), Scotland (Every Life Matters), and Northern Ireland (Project Life 2). A missing component from all of them is a seat at the table for survivors in the setting of policies on prevention and postvention (Andriessen & Krysinska, 2012). Each of the four UK strategies has ministerial level oversight and in England the ‘Minister for Patient Safety, Suicide Prevention and Mental Health’ has responsibilities which include ‘suicide prevention and crisis prevention’. As a result of the COVID-19 pandemic, the undercurrent of increased mental healthcare issues is something which could have significant downstream ramifications (Gunnell et al., 2020). Of the four approaches, only the one for England acknowledges this increased risk and has been updated this year (Department of Health, 2021). Despite the growing need, most of the support for those bereaved by suicide comes from the voluntary sector (Pitman, 2018), even though there seems a broad consensus that suicide prevention and bereavement is a substantial public health issue (Andriessen, Krysinska, Kőlves & Reavley, 2019; Calati et al., 2020; Zortea, Cleare, Melson, Wetherall, & O’Connor, 2020).

Those bereaved by suicide are not only prone to their own mental health challenges, but they are also subject to struggles with family relationships, reduced abilities, finances, spirituality, and officialdom. Peer support groups have been found to be effective in providing for the diverse needs and difficulties of survivors, especially where psychological trauma is also being addressed with a medical professional (Andriessen & Krysinska, 2012). However, in Europe, it has been gauged that only about one fifth of the bereaved attend a support group and less than half receive psychotherapy. Admitting the need for assistance, fear of stigma, and seeking other sources, such as family/friends, self-medicating, and over-working, especially by males, are barriers to accepting support. Awareness that others have managed to adapt to, and survive, bereavement by suicide can be highly beneficial (Young et al., 2012). In the UK, Survivors of Bereavement By Suicide (SoBS; <https://uksobs.org/>) is a volunteer organisation that offers support and resources to adults. There is a national helpline, and online resources, but the main vehicle for offering support is via peer facilitated face-to-face meetings. By necessity, due to the pandemic, at the time this study was executed, all SoBS meetings had been run online, via Zoom, for approximately 15

months. In their systematic review of the efficacy of online support groups, Robinson and Pond (2019) found insufficient quantitative studies to draw conclusions from but did indicate that qualitative studies have demonstrated defined benefits for attendees and that survivors derive true value.

### Research Question

Andriessen (2014) analysed journal articles on suicide postvention and noted that, across 40 years, the number of articles on the topic is modest and mostly confined to the Western world via two publications that have a remit regarding survivor support activities. He suggests that research into supporting suicide survivors would benefit from their contribution and input, regarding terminology and classification, plus expansion to other localities, and reviews of resources such as social and online support. Later, the same author, with collaborators, reported results of a survey that concluded future postvention research should be cross-cultural, embrace theoretical models and integrate investigations with implementations (Andriessen, Dransart, Cerel & Maple, 2017). Associated gaps in the historical research of suicide survivor support assistance have been identified, comprising a focus on those impacted beyond immediate family, inclusion of minorities and the poor, inconsistent terminology and methodologies, plus in-depth assessments of the effectiveness of current postvention activities (Maple et al., 2017). Immediate access to a pool of participants afforded the opportunity for this study to focus on the latter, while accepting that the other factors are out of scope, due largely to the demographics of those that took part. Within a cohort of SoBS members, the aim of this study was to assess the prevalent factors of suicide related grief, their psychological impacts and both the commonalties and differences relating to loss of a partner, parent, sibling, or offspring. Variation based on the elapsed time since the bereavement was also assessed. Given the focus on participants' personal experiences, plus the researcher's exposure and perspective, Interpretative Phenomenological Analysis (IPA) was employed as the investigative approach.

## Method

### Design

This study was qualitative, using Semi-Structured Interviews (SSI's) to gather information for Interpretative Phenomenological Analysis (IPA). Given the poignant and complex subject matter to be studied, SSI's were likely to garner rich and experiential information that allowed meaningful coding and thereby indicative patterns to be derived. SSI's facilitated both a demonstration of empathy and a level of guidance across the interviews, whilst still allowing participants the flexibility to fully explore their stories and raise fresh topics. IPA was used to make overall sense of the experiences, shared by participants, and their connotations both in terms of the material bearings and the shift in thought patterns. 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 & Osborn, 2008). 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, in that IPA involves a two-step 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.

British Psychological Society (BPS) ethical considerations were addressed, including obtaining ethical approval from the University of West London (UWL) School of Human and Social Sciences Ethics Panel (Appendix I). The materials provided for informed consent and notification of the right to withdraw at any point. They were also provided to Survivors of Bereavement By Suicide (SoBS) leadership for review, and approval to recruit members was obtained prior to the study being initiated. That said, given the highly emotive nature of the investigative area, there were still potential risks that required mitigation. With the participants being drawn from those that regularly attend SoBS meetings, they have demonstrated their willingness to discuss the background to their bereavement and the associated trauma. The Debrief Sheet (Appendix F) points people towards sources of support (their GP, SoBS, MIND and The Samaritans) should they be required. The fact that the researcher has also been bereaved by suicide, and is known to them, put participants at ease and provided empathy to the interview process. The researcher had been a SoBS member for three and a half years, at the timeframe of the interviews and, as a trained SoBS volunteer for several months, had facilitated numerous group meetings (see Appendices G & H regarding SoBS volunteer confirmation). In the unlikely scenario, should potential participant self-harm have been suspected, the researcher is also a trained volunteer with CALM (Campaign Against Living Miserably) and could provide direction to the appropriate assistance. If an

extreme concern had arisen, the overall duty of care supersedes confidentiality and the police, NHS Mental Health provider (if known) or Social Services would have been contacted. This reflects SoBS operating procedures, plus BPS guidelines, and was made clear in the Participant Information Sheet / Consent Form (Appendix D). In respect of the researcher's wellbeing, there are four other volunteers, that facilitate the London Group, and the broader SoBS organisation to call upon if needed, plus frequent contact with the research supervisor.

### Participants

Via purposive opportunity sampling, eight participants were recruited, from within the SoBS membership, to take part in the study; five of whom volunteer with SoBS. The intent was to obtain a cross-sectional sample, reflecting the loss of a range of different family members (parent(s), sibling(s), partner(s) or offspring) and a span of elapsed times from the point at which the bereavement occurred.

The age of the bereaved ranged from 23 to 65 (mean = 40.88) years. The set of bereaved was formed of seven females and one male; whereas the sex of those lost was two females to seven males (one participant lost two brothers). The male participant lost his sister with the other losses being a son, daughter, brother, brother x 2, father, partner, and father. The age of the person lost ranged from 21 to 60 (mean = 32.67) years. The elapsed years, since the loss, ranged from two to 25 (mean = 10.06).

### Materials

All materials were created by the researcher, reviewed by the supervisor, and provided to SoBS leadership for review, prior to finalisation – see Appendix C for the SoBS agreement in principle and Appendix J for the SoBS indication to begin recruitment. The Information Sheet and Debrief Sheet were put together based on those deployed in previous assignments, adapted to the specific scenario of this study. The SSI Schedule was crafted based on the researcher's experience and knowledge of topics arising in SoBS peer support group meetings. Participants were provided with the Information Sheet which covered the background of the study (including the project leader and ethical committee approval), and they gave informed consent, prior to the interviews, plus they were provided with the Debrief Sheet, including the resources for support (see above), at the conclusion of the interviews.

The full SSI Schedule is included in Appendix E with the core questions, and two example probing questions, reproduced below:

1. What has been the impact of the **Trauma** on you as a person since your loss?
  - a. Potential follow-up questions:

- i. Has your physical and/or mental health been impacted?
2. Where not covered already, what has been the impact of your loss on your **Family, Friends and Relationships**?
3. Where not covered already, what has been the impact of your loss on your **Work and the Workplace**?
4. Where not covered already, what was your experience of the **Healthcare** system in relation to your loss?
5. Where not covered already, what was your experience of the **Legal (Police / Inquest)** system in relation to your loss?
6. What are your thoughts on how **Society**, in general, regards suicide?
  - a. Potential follow-up questions:
    - i. How do you feel that suicide is portrayed in the media?

### Procedure

The Information Sheet was emailed to participants in advance of the interviews. It offered the opportunity to ask questions and to preview the SSI schedule. Only one participant had questions and requested the schedule prior to the interview. A signed consent form was obtained from each participant before the interview with them. Half of the eight interviews were conducted in person, with the remainder being online via Zoom.

The SSI schedule (Appendix E) was followed by the researcher 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. The approach was to keep the questions as open as possible giving the participants full rein to cover what was important to them. Probing was utilised, to elicit further specifics, with care taken not to solicit pre-defined concepts. Participant input was gathered via audio recordings using a password/code protected Apple iPhone.

At the conclusion of each interview, participants were provided with the Debrief Sheet (Appendix F) which provided contextual information on suicide trauma and reiterated the ethical considerations. It also included contact information for the researcher and supervisor. At both the outset and conclusion, it was emphasised that the audio recordings would be deleted, post-transcription, all information provided would be anonymised, via pseudonyms, and kept confidential, plus that participants have the right to both review their transcript and withdraw at any time.

It was estimated, ahead of time, that interviews would take approximately 45 minutes. In practice, each Interview lasted until the participant indicated they had no more to offer. The actual elapsed times ranged from c. 32 to c. 75 (mean = c. 56) minutes.

The eight audio recordings of the interviews were transcribed into Microsoft (MS) Word, verbatim, including the researcher 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 from all sources, that is the Apple iPhone used for capture, the personal computer to which they were transferred for transcription and a backup on the researcher's UWL MS OneDrive. To facilitate traceability, line numbers were set across the overall set of transcriptions.

Following the approach outlined by Smith and Osborn (2008) and exemplified, for qualitative research in psychology, by Pietkiewicz and Smith (2014), firstly, via multiple passes, initial, illustrative notes were recorded against the text using MS Word Comments to capture considerations, connections, and summaries, including clear consistencies, and divergencies, in the feedback from interviewees. Within the transcripts, logically related portions of text with cohesive meaning, ranging from a single sentence to several paragraphs, were used as discrete units for analysis. Secondly, these initial notes were reviewed and used to formulate a set of codes reflecting psychologically relevant recurrent terms and concepts in an interview transcript. The codes were recorded on the document, also using MS Word Comments (and the initial notes removed); the final version of this document is included herein as Appendix B. Thirdly, with an established set of codes determined, these were reviewed to derive themes pervasive in the data. Next, in establishing relationships between themes, they were clustered into a smaller number of super-ordinate themes (see Table 1). Lastly, codes, themes and theme clusters were modified and extended through multiple passes within and between the transcripts. A total of 499 segments were coded overall.

Given the sensitive nature of subject matter, from an ethical standpoint, it is vital that information that could lead to the identification of non-high-profile individuals is redacted. The information obscured, in Appendix B, includes individuals' names (unless high-profile) and any other personal information that could divulge their identity.

## Analysis

This study set out to identify key themes raised when survivors of bereavement by suicide were asked to discuss the impact the loss of their loved one(s) has had on their lives, including trauma, health, and day-to-day functions. It also investigated their perceptions of external factors (society, government, support) and the variability of their opinions in the context of both their relationship to those they lost and the timeframe(s) of their loss(es). Via Interpretative Phenomenological Analysis (IPA), five theme clusters were elucidated: Pre-bereavement Issues, Consequences, Perceptions, Organisational Challenges and Support Network. The codes assigned to sections of texts reflect an orientation of concepts and feelings expressed by participants. An example of such an extract, relating to the trauma of bereavement by suicide, is: *“Yeah, my gosh! For six months I didn't go out my house. I just stayed at home. I had no desire...to go anywhere. I just, I think I was just trying to process it...”* (Appendix B, page 49, line numbers 141-143). Through iterative analysis of the transcripts, codes were aggregated into themes, and themes into super-ordinate themes (clusters) with numerous adjustments and realignments throughout the process. Finally, an overall mapping of theme clusters > themes > codes was achieved for further narrative analysis based on the derived structure (Appendix A). Table 1 presents the themes identified, for each super-ordinate theme, along with supporting data extracts from the interview transcripts in Appendix B.

Table 1.

*Themes regarding the impact of bereavement by suicide with supporting data extracts from the interviews.*

Theme Cluster	Theme	Data extracts (Appendix B starting page, line numbers)
Pre-bereavement Issues	Relationship(s)	“I felt very alienated from him because of his drinking.” (125, 2334-2335) “It doesn't really make any sense to me. We were, I thought we were close, although she lived a great distance.” (76, 907-908)
	Personality	“He was quite a big character, kind of someone that lit up the room and...very charismatic, very funny.” (117, 2112-2113) “This was out of character, looking back, because...it was a definite change, you know, that maybe should have signalled something.” (106, 1813-1815)
	Medical Intervention	“They put him on some medication. But he was very unwell. He actually couldn't sleep because his mind was just racing, so he couldn't even rest.” (46, 56-58) “...mirtazapine didn't really seem to be doing anything for him.” (125, 2343)
	Suicidality	“...I didn't have any idea that he was suicidal...” (126, 2355-2356) “My mum told me...she kind of always knew that he would die that way.” (139, 2736-2738)
	Consequences	“...what is probably one of the worst pains in the world.” (139, 2757)

*Themes regarding the impact of bereavement by suicide with supporting data extracts from the interviews.*

Theme Cluster	Theme	Data extracts (Appendix B starting page, line numbers)
	Shock and trauma	"...I always say that the biggest achievement in my life is surviving that loss." (143, 2863-2864)
	Medical consequences	"...part of the PTSD is...couldn't make decisions, I couldn't interact with people..." (79, 1012-1013) "...I did self-harm." (144, 2894)
	Sense of guilt and/or blame	"You don't know whether to feel angry, sad, sad for them! You miss them! Upset! Guilty!" (150, 3085-3086) "...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." (118, 2143-2144)
	Interactions with others	"...emotionally...it makes you feel very vulnerable." (135, 2639-2640) "...people give the throwaway comments like, 'I just want to kill myself', and I sit there festering inside, thinking seriously?" (142, 2846-2847)
	Focus	"I...threw myself into my work..." (140, 2771-2772) "...so I never went back to work and that's been a big identity issue for me..." (80, 1024)
Perceptions	The survivor's perspective	"...because, doing that to yourself...is just not what a sane person does." (128, 2419-2420) "...there's a sense of abandonment..." (140, 2786)
	Society's view on suicide	"I think that's the case for a lot of people, they don't know what to say..." (148, 3007) "I think people are becoming more and more aware that...it can happen to anyone at any time." (56, 353-354)
	Government's focus on suicide	"I feel that there needs to be...it needs to be in the public realm already, then there needs to be a body or a task force or whatever." (115, 2077-2078) "...it's about...really setting aside funding and money to train people...I think the government needs to support corporations and organisations and schools to do that..." (58, 411-414)
	Portrayal of suicide in the media	"...the one piece that I did see, had inaccuracies in it and was written in a rather lurid way." (135, 2631) "...I think, sadly, there's quite a lot of, sort of, 'bandwagon', in that, 'Oh God, they've, they've died by suicide', 'Oh, it's so sad, isn't it?'; I must write a post or, or whatever." (146, 2954-2956)
Organisational Challenges	Healthcare system	"...none of the practitioners has a, has a complete picture in order to offer the best help or...range of therapies or strategies." (132, 2543-2545) "I saw the mental health nurse once, she actually said to me, 'I don't think we've got anything we can offer you..." (82, 1094-1095)

*Themes regarding the impact of bereavement by suicide with supporting data extracts from the interviews.*

Theme Cluster	Theme	Data extracts (Appendix B starting page, line numbers)
Support Network	Legal system	<p>“...we wrote a letter to the coroner saying...I would like to have some answers. They gave me a date which was 5th of March [2021] and I'm still waiting for the answers.” (55, 316-318)</p> <p>“...because I'm not next of kin, I'm not legally anything.” (127, 2391-2392)</p>
	Family and friends	<p>“That, actually, was a massive bereavement. I was bereaved of them, as a result of their father's death.” (127, 2402-2403)</p> <p>“...my friends were fantastically supportive.” (129, 2442)</p>
	Organisations	<p>“Yeah, they were aware of it, so they were they were quite supportive to be fair...” (65, 583)</p> <p>“...I just wanted to...highlight the role of SoBS, in my journey. It has, like I said, it saved my life.” (149, 3048-3049)</p> <p>“...but it was, I think, that's the thing [SoBS] that kept me alive.” (51, 194)</p>
	Gaps	<p>“...there could be more...training for...health care professionals and the police. In that, you know, so they're able to direct people to charities like SoBS.” (147, 2990-2992)</p> <p>“...from my role as, in SoBS, sadly there needs to be more awareness of...just support! I mean, there's so many people that I've spoken to, that will mention that they don't know we exist!” (147, 2987-2989)</p>

Family relationships are typically complex with a major emotional trauma inevitably having a significant impact. The super-ordinate theme ‘Pre-bereavement Issues’ covers ‘Relationship’ aspects such as a history of family members, or friends, having mental health problems: *“And then, sadly, Y [brother] attempted suicide himself.”* (45, 25); and tensions and/or struggles that survivors were aware of: *“He had never had a diagnosis of alcoholism. But it is fair to say that his drinking was a problem to me.”* (125, 2323-2324), *“...before I knew it, I had to go and get X from university in the May...he'd completely crashed.”* (46, 33-34). There appears to be a clear divergence in terms of awareness of prior health and/or behavioural issues that were problematic to relationships before the suicide. Where pre-bereavement health challenges were clear, or emerged later, there was a common sense that the person that took their life did not receive the level of healthcare support warranted. It also includes the bonds survivors had with the ones they lost: *“...we were close and we kept in touch...”* (76, 914). 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. 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: *“...loads of friends, seemed to be really easy going, laid*

*back...*" (106, 1802), *"So that's...that's just doesn't really make sense, from that point-of-view, how can you have the best day of your life and then the next day...throw it all away..."* (67, 645-647), *"Headhunted...often for positions, and really extremely successful in her job."* (75, 884-885). 'Medical Intervention', with respect to the person that ultimately took their own life, was generally thought not to have been effectual but that is bound to be influenced by the ultimate outcome: *"...in my mind, he may have been at risk at that...transition point from one drug to another. Because all of the patient information leaflets say oh, this antidepressant medication may make you depressed, may make you suicidal..."* (128, 2416-2418). Finally, it encompasses 'Suicidality' in terms of the extent to which survivors were aware of it being even a consideration for their loved ones: *"...it was just a complete out of the blue thing..."* (76, 917-918).

*"And I didn't know, until after his death, that he had attempted to take an overdose three weeks before he actually died. So, he wasn't known to mental health services. He wasn't known even to his GP prior to that."* (88, 1269-1272),

Awareness of prior, or current, struggles did not necessarily seem to translate into expectedness, with common reactions of surprise and disbelief even where mental health and/or behavioural problems had been known for some time. In some cases, only in retrospect did pre-bereavement behaviour strike survivors as a potential 'red flag' with the associated guilt of not recognising it at the time.

There are extreme 'Consequences of Bereavement by Suicide' which is the next theme cluster incorporating the 'Shock and trauma': *"...I used to look at myself in the mirror...burst into tears..."* (64, 559), *"It's just like this big void and there's no end to it. And you, at the end of the day, you do just have to accept you are not going to have the answers..."* (52, 236-237), *"...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."* (77, 950-952), *"...I think my husband feels...I think he almost mourns the loss of our life, as much...as he mourned X. Because it's changed us forever."* (78, 989-991). 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 changed their lives completely and eternally. There is also a wide belief that this type of bereavement is in some ways unique: *"...losing someone to suicide is so much different to losing someone by another...circumstance."* (146, 2967-2968). In terms of 'Medical consequences' the effects were regarded as far-reaching and some participants reported their own suicidal thoughts, which ties in with prior research in terms of the increased risk: *"...has a huge impact on you emotionally and physically..."* (49, 148-149), *"...I was diagnosed with PTSD. I had all the symptoms of that...hypervigilance, being easily*

*upset, unable to concentrate, sleep disruption...irritable and panicky.” (77, 953-955). This cluster also encompasses ‘Sense of guilt and/or blame’: “She [mother] said, ‘I probably wasn’t but I didn’t feel that I could talk about my losses because of the ways, the way boys died’, and...‘I felt that I would be judged on it as a, as a parent’.” (98, 1564-1566), “Even though they were getting on with their lives, I always felt that I should have been doing more and supporting and protecting.” (94, 1467-1469),*

*“...you almost feel guilty...whenever you do try to get back to the way things were, and you feel guilty about that because you think...I’m just living my life like nothing happened...you feel terrible but you learn, to sort of, accept that...” (62, 498-501).*

The conflict of 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. Mental health issues, in the bereaved, were commonly related along with broad feelings of guilt, both in terms of the suicide but also resuming enjoyable activities or, in some cases, the inability to do so, especially for the sake of other family members. Guilt can also extend to a level of relief, with respect to the cessation of the challenges faced pre-bereavement. ‘Survivors’ perception of others’ appeared to be significantly shaped by their loss(es): *“And, I have very close friends, but now I just feel a bit distant from them and...it’s so different. It’s so different because things that they talk about just don’t interest in me anymore.” (48, 119-121), “...I’ve been a hard person to help because...I don’t want to be bothered with anybody.” (78, 967-968); with a sense of vulnerability being frequently reported alongside, often, a tendency to self-isolate to avoid the perceived trivia that those not affected consider important. That said, many reported that their experience had resulted in them becoming more accepting and less judgmental of others. Another aspect was ‘Focus’: “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.” (79, 1019-1020), “I had to keep my mind busy all the time, even when I was watching anything on TV, I had to have my laptop with me all the time just to do things.” (50, 153-155),*

*“...I’ve found distracting myself is the only thing I can try and do really and I find going to, to sleep...I have to try and distract myself before bedtime with something totally banal because all this stuff in your head and...that horrible waking up in the morning to reality.” (87, 1242-1245),*

*“And performing and singing, and I think that really sort of helped work through it. Yeah, almost using it as a cathartic tool as well.” (118, 2152-2153). Combined, the traumatic aspects impacted participants’ focus, with some struggling to function while others heavily engaged in activities to distract from their*

intense grief. Given the complex dynamic of the relationship between those lost and survivors, in terms of connection and rapport, the mental health, age, gender, historical events and so on, of both parties, it's difficult to discern an absolute pattern in terms of a cycle of grief. However, subjectively, there did appear to be a correlation with time proximity to the death and the intensity, severity and frequency of the trauma experienced.

The third theme cluster identified was 'Perceptions of Bereavement by Suicide' with a key component being 'The survivor's perspective': *"I do think having...felt suicidal at the really lowest points, consideration for other people goes out the window!"* (130, 2483-2484), *"...I think it's gotten easier just like talk about her more...being more open, and, you know 'I always remember X'...'Oh, she loved this song'..."* (73, 824-826), *"And things that I find tough will be, for example, my son, Y, never knowing my brother. The fact that X wasn't at our wedding, etc. I find those things tough!"* (109, 1888-1890). In those that lost parents, and to a lesser extent in those that lost siblings, a sense of abandonment was common. Survivors typically have a desire to diminish their sense of loss but, at the same time, a yearning to hold onto memories and retain a strong connection to the individual(s) that passed. There is a general understanding that those left behind cannot fully comprehend how those they lost felt at the time of their death(s). Survivors also acknowledge that their own perceptions, of who the person they were bereaved by was, may be somewhat different from other members of the family or friends. Moreover, this cluster comprises survivors' beliefs on the perspectives, regarding suicide, from broader, larger groups, taking in 'Society's view on suicide': *"...it's obvious and evident that stigma is still very much...associated to suicide. I think we're aware of that. Importance of language around suicide, I think, is one of the key components that are going to make those changes."* (101, 1659-1662),

*"But we do need to be really open and, and frank about our language...and talking about suicide and not being afraid to say the word, but letting children understand what that means, because it can be quite flippant. You know, kids saying things 'I will just go and kill myself'. 'Do you know what that really means?' So...it's as adults and as educators we need to...make sure people are aware of that. But also another key component is, is creating awareness around the importance of support after suicide, because ultimately...it's prevention."* (101, 1674-1680),

*"...the figures show it as £1.7 million, I think is the economic impact every suicide, whereas I think 60 or 65% of that can be attributed to those that are actually bereaved by suicide through illnesses, absences."* (102, 1693-1695). While there is a general belief that suicide is being talked about more openly, participants reported a continued sense of a lack of societal appreciation of both the suffering of survivors

and the broader impact, including that on the economy. There is a broad view that the way in which society engages with the concept of suicide needs to significantly change. This involves a focus on the specific language used and also reaching young people, to raise awareness on the challenges of the modern world, and inform them of where help is available. With respect to the 'Government's focus on suicide', the bereaved consider 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: *"...in terms of raising awareness, the government could be doing an awful lot more, I think so much falls to the third sector and I find...I'm personally of the opinion that our health services are massively underfunded and, and require much more support than they get."* (114, 2063-2065). A number of participants raised concerns regarding the potential impact of the 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!"* (147, 2984-2986); plus, general concerns as to genuine governmental efforts to facilitate real change; *"But I do think that, whilst there's an awful lot of lip service given to, suicide not being a taboo, and let's talk about it...I think, really the government should take...a more leading role on that."* (115, 2066-2068), *"...in terms of...the government being able to provide a pot, specifically for those bereaved by suicide...it needs to be more widely available, across the country, not just in individual counties."* (102-103, 1712-1714). Lastly, this super-ordinate theme involves 'Portrayal of suicide in the 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'."* (113, 2028-2031),

*"I...see sensationalist headlines. And so...I don't find the media to be supportive or helpful...in their reporting of suicide."* (114, 2060-2061), *"...it glamorises it all a bit and isn't sensitive or realistic."* (121, 2250). Even though suicide may be more often spoken about, the bereaved consider the taboo 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. Conversely, there is a concern that some social media avenues are misused, especially in the context of celebrity deaths. Extending that to the wider media, survivors welcome 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.

Another super-ordinate theme derived was ‘Organisational Challenges’ involving the ‘Healthcare system’. The provision of counselling appears to be highly variable with some people finding it readily available, while others struggled to find NHS support in this respect if any at all. Some individuals were forced, or chose, to consult private counsellors but, for some, this avenue was not available due to cost. In some instances, charities also provided counselling assistance. Where counselling was undertaken, while most participants reported overall positive experiences: *“I had it [counselling] for a few months...I could definitely feel the benefits, the confidence.”* (64, 566-568); some found it, or at least certain counsellors, not to be useful. A facet that was not related universally but, given the nature of our healthcare system it does apply to all, is the issue of siloed care. 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 X 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 X passed away in the June, and during that time he tried to enrol at a GP and wasn't able to.”* (55-56, 330-334);

*“But there isn't any information sharing, so if somebody engages with talking therapies...for example, it is entirely up to them whether they disclose any aspects of their physical health or their circumstances.”* (132, 2536-2538). This cluster also covers the ‘Legal system’: *“...because they contacted me in December [2020] saying...it was going to be reviewed, with the coroner, and I've not heard from them since.”* (55, 309-311), *“...they should have accepted what was said...in [Country X] 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...”* (77-78, 947-950). Some noted being blocked by the legal framework, due to their status in law with respect of the person lost, regardless of their role. Others found the legal bureaucracy challenging, and lacking empathy, when dealing with the recently bereaved and traumatised. Reflective of modern geographic mobility, some participants noted significant legal, and financial, hurdles regarding repatriation of their loved ones that had died abroad; *“...we had the additional trauma then of having to repatriate her.”* (76, 926-927).

Lastly, ‘Support Network’ is a theme cluster which embraces the theme ‘Family and friends’: *“Although...we all still love each other very much and we always get comfort from being together...nothing will ever be the same again.”* (79, 998-999), *“...there was a natural assumption that we would be closer*

*together as siblings. But that, that really didn't...happen.” (93, 1422-1423), “...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 a little bit like...you give the show...but it's not...meaningful.” (112, 1980-1983), “...my friends were fantastically supportive.” (129, 2442). Survivors related mixed experiences both with respect to specific family members, or friends, and over time: “...it's fractured...some relationships, strengthened some.” (119, 2174-2175). This super-ordinate theme also related to broader ‘Organisations’ covering people’s work or academic backdrop: “...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.” (53, 250-251). Experiences in the context of work/academia appeared to be highly variable, with some feeling a strong sense of support: “...work were very kind and said, ‘Take as long as you need’.” (129, 2445); while others indicated that they had mixed responses from colleagues/teachers; “...I wouldn't say it was massively great. There were some teachers that were really brilliant...and really showed a lot of care. But...other teachers...weren't so much.” (119, 2180-2182); while, in some situations, there was a sense of outright neglect and rejection; “...I didn't really have any support to speak of when it...when they pensioned me off. I didn't even get a letter of thanks for all the years I've worked for them. It's been my whole career...” (80, 1027-1028). Religious support was mentioned briefly, in a couple of interviews, but did not emerge as a strong theme. Finally, this cluster addressed support groups such as Survivors of Bereavement By Suicide (SoBS): “...the main thing that's helped me through this, is meeting people through SoBS who've lived through this experience.” (54, 292-294), and ‘Gaps’, that is, where participants felt that there is room for improvement in the awareness of SoBS (or similar): “...I just went online and sought out SoBS of my own...accord...” (51, 185-186), “I had never heard of SoBS.” (91, 1362), “It was just so much going on and yet nothing happening and no support, no GP support, nothing.” (90, 1319-1320), “...But the doctors themselves seem to be at a loss. They weren't able to signpost or, you know, suggest anything.” (97, 1558-1560); and also where they had thoughts on how Survivors of SoBS operates: “...I think sometimes it would be helpful to have a meeting, or a group, just for parents, just for siblings, just for spouses...” (84, 1150-1151), “...I feel that SoBS has a lot of potential...SoBS obviously does great work, in terms of supporting people, but I don't feel that the organisation is organised enough, at the moment, to really get the work that they do out there!” (115, 2084-2087),*

*“...I don't know how people are coping without that [in-person meetings] during COVID because the Zoom meetings just don't feel the same...I just...I didn't find it helpful. And I think it was because it was triggering, because new people were there, and you weren't able to support them in the way you normally would...and also being unable to support yourself, because after our meetings*

*we'd go to the pub and have a little debrief and a bit of a laugh...but you can't do that then...you pressed the leave button and then you're left with...all that heaviness, to kind of sift through it yourself.” (51, 195-201)*

*“...the dynamic maybe shifts and SoBS is no longer quite the support it was, when you're a facilitator.” (110, 1937-1938).* The implication is that, as the bereaved adapt, they home in on support measures that work for them plus are consistent and reliable. 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 the SoBS organisation and the work it performs. Individuals noted that attending meetings had kept them going, changed their lives for the better or even saved their lives: *“...like lots of SoBS members say...I felt for the first time...everyone in the room understood my grief essentially.” (109, 1895-1896).* There was also a frequent indication of the desire to help others bereaved by suicide via involvement in SoBS volunteering or other means: *“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.” (132, 2529-2530).* Survivors recognised that support groups have a wide range of needs to cater for but did have strong feelings about some modifications that they felt would benefit the majority, if not everyone involved. Key operational facets that emerged, related to awareness of SoBS, as an organisation and its signposting, plus, from a volunteers' perspective, greater clarity, and efficiency.

## Discussion

The purpose of this study was to elicit key themes pertaining to suicide survivors' perceptions of how losing their loved ones has affected various facets of their lives, and interactions, plus how those aspects impinge upon their attitudes towards relationships, entities, and succour available to them. By utilising Interpretative Phenomenological Analysis (IPA), themes were clustered into several super-ordinate themes relating to factors prior to the suicide(s) (Pre-bereavement Issues), after-effects (Consequences), how they, and others, view both suicide and its aftermath (Perceptions), administrative issues encountered (Organisational Challenges), and assistance provided to them (Support). In line with prior studies, even though some pre-suicide behavioural issues were noted with, in some cases, medical intervention, critical mental health difficulties were not evident in many cases. Even where a history of mental health problems was known, the act of suicide often came as a complete shock, seemingly totally out of keeping with the person survivors knew and loved. Where there had been medical intervention in the lives of those lost, the view of participants was that neither drug nor talking therapies had helped and had, perhaps, contributed to the ultimate suicides. The heterogeneity of suicide risk makes assessment and prediction challenging, and some participants were fatalistic about prevention whereas others firmly held the belief that something could, and often should, have been done to intervene. Research does suggest that suicide can be prevented (Turecki & Brent, 2016) and has also shown that a lack of awareness of the suicidality of the person lost can have a strong influence on the mental health and regard survivors have for their own lives (Pitman et al., 2017). As expected, per Nakajima (2018), survivors described experiences indicative of 'Complicated Grief' (CG) including powerful longing, anguish, consuming thought patterns and recollections, incredulity, plus trouble contemplating a meaningful life going forward. These issues often occur as part of acute grief but usually fade after approximately six months. Such symptoms not only continue for an extended period, with CG, but it can also lead to problems with socialisation, dysfunctional choices, mental health issues and physical health implications such as cancer and heart disease. Global CG rates span from a low in Japan (2.4%) to a high in Germany (6.7%), amongst the general population, with traumatic events causing a significant rise, such as murder (22%) and extremist assaults (43%) per Nakajima (2018). By contrast, suicide survivor levels of CG have been assessed as being in the range 62.8% (Bellini et al., 2018) to 78% (Dyregrov & Dyregrov, 2005). One survivor, in this study, reported a history of mental health issues which has been found to increase the likelihood of CG (Levi-Belz & Levi-Ari, 2019) and another noted the trans-generational nature of 'The Troubles' in Northern Ireland, impacting both the survivor and the individual lost, that has been found to increase suicide risk (O'Neill & O'Connor, 2020). In most cases, participants felt a typical sense of having a life prior to their loss and

beginning a new, distinct one, post-bereavement. The concept has been in place for a considerable time with it being stated that the person taking their life “...puts his psychological skeleton in the survivor’s emotional closet.” (Shneidman, 1969, p. 22, cited in Andriessen, 2014, p. 338). Participants strongly represented the opinion that bereavement by suicide is distinct from other types, reflecting some other studies (Nam, 2016; Sheehan et al., 2018), plus experiences of feeling guilty, rejected, angry, stigmatised, a strong desire to comprehend the choice of suicide and, occasionally, relief that pre-bereavement struggles were alleviated, which have also been previously described (Andriessen & Krynska, 2012). There was a typical sense of a lack of understanding of what survivors endure (Pitman et al., 2018). Survivors expressed a keen sense of responsibility, regardless of their ability to influence the actions of the person that took their own life, which is in keeping with prior research (Young et al., 2012). Different experiences, regarding the emergency services, healthcare professionals and coroners seem understandable, given localities and jurisdictions. Unfortunately, when at their most vulnerable, some survivors had to deal with instances of lack of care and empathy, exacerbating their distress, which has been noted elsewhere (Ross et al., 2018). One participant noted an interaction with a healthcare professional who use the term ‘committing suicide’ which has been frowned upon for many years, given the connotation of illegality.

Considering the profile of participants, unsurprisingly they were all very positive regarding the Survivors of Bereavement By Suicide (SoBS) organisation and the benefit they have derived from the self-disclosure opportunities the peer support groups provide, which matches the findings of studies on this approach (Levi-Belz, 2016; Levi-Belz & Lev-Ari, 2019). Several participants noted that the study interview process was also beneficial to them. Despite the interviews being a mix of face-to-face and online meetings, there was no discernible difference in the quality and the openness of the discussions. The intensity of the trauma did seem to have reduced with elapsed time, with those most recently bereaved describing more frequent and impactful symptoms of CG, as has been observed previously (Nakajima, 2018). There also seemed to be a trend of the severity of the suffering being greater the younger the person that took their life was, as might be expected (Schneider et al., 2011). It should be noted that, to an extent, these two factors likely balanced out. For instance, two of the younger people lost had also taken their lives more than 20 years ago. An unpredicted, but understandable in the modern world, issue noted by two of the participants was the challenge of repatriating the person lost where they died abroad. The complexities involved add significant burden in an already fraught situation plus a considerable financial overhead. Assistance for this aspect can come from the voluntary sector, in terms of covering costs and dealing with the administrative challenges, and such aid was provided to one participant. While

there has been research into repatriation of those that have died overseas in general, there does not seem to have been any assessments of the bearing this has on those bereaved by suicide.

From the narrative analysis, there is a strong indication that the trauma associated with bereavement by suicide is long-lasting and results in a highly complex emotional scenario for survivors. In contrast to the perceptions of the participants in this study, plus suicide survivors and their clinicians in general, some studies have concluded that there are only minor dissimilarities to other forms of bereavement (Carmassi et al., 2013). However, it has been suggested that this may be due to selection approaches, with those affected by CG more likely to consult doctors than those recruited for surveys, and procedural aspects including the limited timeframe of assessment, small samples, and an absence of controls (Andriessen & Krynska, 2012). The Dual Process Model, which describes the balance of survivors' focus on their loss and coping mechanisms, does seem to apply to the cohort interviewed and it has been shown to be highly sustainable (Fiore, 2019). In Western culture, women tend to focus on feelings and emotions while men are more likely to deal with losses as challenges to be resolved, although it has been noted that teaching each gender the approach typically adopted by the other, is beneficial to both. In other cultures, the gender difference is less distinct and, in all cases, the prevalence of each shift over time. Both are regarded as natural components of grieving, but it was noted that an imbalance can be problematic to individuals adapting to their loss (Stroebe & Schut, 2010). Although the ratio of female to male participants (7:1) and individuals lost to suicide (2:7) both reflect trends in those seeking help (Pitman et al., 2018) and suicides (Turecki & Brent, 2016), membership of SoBS suggests the former have a desire to share emotions and feelings, regardless of gender.

While not explicitly solicited, several participants did share the method of suicide employed by those they lost, which included hanging, drugs, carbon monoxide poisoning, stabbing and self-immolation. Figures for 2020 from the UK government "Office for National Statistics" (ONS, 2021a), indicate the most common means are hanging and poisoning (all types) with sharp object usage being less common. Self-immolation is not called out separately and falls under 'other'. In the West, this method is most often used by males (as in this case) but is very rare. In some poorer countries, such as India and Iran, self-immolation accounts for almost a third of suicides and is mostly implemented by females, reflecting distinct patterns of cultural variation (Pridmore & Pridmore, 2020).

Most suicide survivors are beleaguered by a drive to comprehend what led their loved one to take their own life. Self-recrimination is also common, especially where the bereaved is a parent. Feelings of rejection, by the person that took their own life, may occur, particularly with those that lost a parent.

They can also feel angry with the deceased for the choice they made or for not reaching out, even though survivors tend to recognise that those they lost were suffering greatly at the time they made their decision (Hanschmidt et al., 2016; Young et al., 2012). All these aspects were relayed during this study.

Loss of a parent to suicide has been linked to social impacts such as poverty, criminality, and single status (Erlangsen et al., 2017). These factors could be linked to major depression and alcohol or substance abuse, typical in surviving children (Brent et al., 2009). Both participants' parental losses herein were of their father, whereas the greater likelihood of negative sequelae is where a mother is lost. The deaths came when they were adolescents, with one experiencing severe anxiety and the other reporting self-harm. In both instances, these aspects occurred a considerable time ago but not immediately after their bereavements, which in keeping with the patterns observed by Brent et al. (2009). That said, the participants indicated that, until they reached 18, no peer support organisation was available to them. In the case of siblings lost to suicide, younger survivors have been shown to harbour more anger towards those lost, as opposed to older surviving siblings. Guilt was also engendered in about a third of the younger ones, due to them having some knowledge of their lost sibling's suicidality that they did not share. Overall, it was found, based partly on admissions from parents, that the bereaved siblings were 'forgotten' for a considerable time following the family's loss. Many siblings considered the bereavement to have had more impact on their parents, adding to their feelings of neglect (Dyregrov & Dyregrov, 2005). All three of the participants, in this study, that had lost siblings demonstrated a high level of concern regarding the impact the events had on their parents. The sample only contained one individual that had lost a partner. In a Danish study, where partners took their lives, it was noted that mood disorders in the surviving partner occur at a frequency of 1/200, compared to 1/500 in the population at large, and that contact with healthcare professionals is reduced despite the increased likelihood of physical and mental health conditions, and overall mortality (Erlangsen et al., 2017). The authors concluded that provision of support needs to be via active contact and follow-up. In bereaved parents, Post-Traumatic Stress Disorder (PTSD), and increased alcohol consumption, have been observed more in bereaved mothers, but fathers may under-report symptoms and behaviours. Conversely, fathers with PTSD were found to have an increased risk of physical health problems (Murphy et al., 1999). In this study, displacement activities were commonly recounted, and some found returning to work helpful by providing both a distraction and purpose. Others had trouble focussing on work and, in one case, was unable to continue with their job. The termination of their career was felt as an additional source of grief. One participant shared that they had received a diagnosis of PTSD while others related some typical symptoms. Research on parents who have lost children, and been diagnosed with PTSD, found that more than a quarter of them had absences

from work and more than half considered their job performance to be below par (Murphy et al., 1999). Generally, parents demonstrate a strong tendency to maintain a bond with the lost child but also a lack of regard for their own mortality, seeing death as a liberation from their suffering or, where religious beliefs are held, an opportunity to reunite. The presence of surviving children has been shown to be a moderator for suicidality, but mothers also worried about their sorrow's impact on their ability to attend to others (Harper, O'Connor, Dickson & O'Carroll, 2011). According to Testoni et al. (2019), a tendency towards self-recrimination negatively impacts on coping mechanisms. Although the impact of suicide seems to pervade lives for many years, with depression potentially lasting 10 or more, there are indications that parents tend to adapt to a 'new normal' within five to six years after a child's suicide (Feigelman et al., 2018).

Survivors share a sense of vulnerability after their losses and guiltiness, accountability, and humiliation have all been found to be more frequent amongst those bereaved by suicide than other types of sudden death (Pitman et al., 2016). While survivors relayed a tendency to be more understanding and accepting since their bereavement, there was commonly a lack of tolerance for aspects of day-to-day life that others considered important but the bereaved now deem trivial. This approach could negate an avenue for sharing and result in solitude and seclusion (Levi-Belz & Lev-Ari, 2019; Ross et al., 2018). A common frustration was that, despite help and support being available, the mindset of those that took their lives was so maladjusted at the time that they could not perceive a different outcome. Where parents were lost there was not only a sense of abandonment but also a level of longing for growing up with the father lost and curiosity regarding a different life that could have been. Similarly, those that lost younger people, offspring, and siblings, mourn the loss of the future lives they could potentially have had, spanning absence at major family events, them not being an uncle/aunt, and not having their own children to provide nieces/nephews and grandchildren. This is an aspect that appears to have been neglected in the literature. There was also a strong sense of survivors' desire to keep the memories of those they had lost alive and close to them. This, though, has been found to prolong grief in some instances (Harper, O'Connor & O'Carroll, 2015) while others suggest it can be an adaptive strategy (Ross et al., 2018).

Participants related a sense that, generally, people don't perceive suicide as something that can happen in their families and the families where it does occur are somehow blighted, which is a characteristically scornful attitude (Peters et al., 2016). In some cases, within and outside this study, pressure to keep the suicide a secret was reported along with unsupportive stances from the workplace, neighbours, friends and even healthcare professionals or religious leaders. There are even indications

that the public regard survivors to be “contaminated by their loved one’s suicide” (Sheehan et al., 2018, p. 340). It was noted by a participant that, post loss, someone remarked that the person they lost was not a ‘candidate’ for suicide, demonstrating a marked lack of understanding as to the complexities involved. One person in the study noted a sense of ‘toxic masculinity’ within our society, reflecting the pressure on young men to behave in certain ways which impacts their ability to cope with mental health issues and all those around them. Survivors susceptible to taking on perceived stigma can feel a reduced sense of self-worth, depression, limitation of capabilities and resignation (Sheehan et al., 2018). A direct correlation of trauma, amongst suicide survivors, has been observed in association with perceived stigma (Scocco et al., 2017). There seemed to be a general sense that the stigma associated with suicide is declining, and this may reflect recent coverage of high-profile cases but, at the same time, there’s a fear that a media bandwagon is highlighting those cases at the expense of a wider understanding of how suicide affects the general population. Several participants experienced newspaper hype, and untruths, regarding coverage of their own losses. The so-called ‘Werther effect’, named after a German author, that wrote about suicide, has been found to perpetuate with media coverage of suicide often causing an uptick in suicides, where the report covers a celebrity and especially where details of the method were included (Niederkrötenhaler et al., 2020).

Regarding the role of government, opinions ranged from a belief that human behaviour cannot be significantly influenced by policy, to a more frequent feeling that the government should be much more proactive in addressing the prevalence of suicide in the UK. In England, the government proposes to provide more than £10 million to mental health and bereavement charities in respect of the COVID-19 impact, and £5 million specifically for suicide prevention, as part of overall £500 million fund for mental health services, to reduce the backlog of needs, in 2021-22. Public Health England has been allocated £1.2 million, for this period, to develop “a national real-time suicide surveillance system” (Department of Health, 2021, p. 22). For context, figures published by the “ONS” (2021b) show that there were 5,224 registered suicides in 2020 alone, across England and Wales. As remarked upon by one participant, the economic impact of each suicide, by someone of working age, in England, covering emergency services, funeral expenses and lost productivity, plus some intangibles, is estimated at £1.67 million per incidence, at 2009 costs (Knapp et al., 2011). Using that figure suggests a financial impact of over £8.72 billion. The “ONS” (2021b) figures show a statistically significant reduction in suicide rate from 2019 (11/100,000) to 2020 (10/100,000) put down to delays in registrations plus a fall in male suicides when the pandemic began (England & Wales). Males still made up three quarters of those lost to suicide, a trend noted to have been in place for several decades. Per the government’s plan, a National Suicide Prevention Alliance

Lived Experience Network was set-up, in September 2020, to offer online support to those at risk. Whilst those involved provided very positive views of its impact, the reality is that the program is largely unknown. This contrasts with the government document's aim to deliver improved communication and assistance to the bereaved. It has also been noted that such programs should include the active participation of the bereaved within them and not be the sole purview of academics (Andriessen & Krynska, 2012). 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). Funding models likely drive the lack of an integrated approach, and this was, ironically, noted to be an issue for SoBS in that specific lottery funding carries with it an expectation of a pattern of spending that may not dovetail with other charitable organisations.

While some received strong support from relatives, and friends, several noted that the suicide caused discord and acrimony. There was also, often, a sense that those that promised assistance, immediately after the loss, frequently did not follow through resulting in a feeling of being let-down. In general, it has been found that suicide survivors are not substantially assisted by family and friends (Pitman, 2018). There was also a difference indicated in terms of wanting people to acknowledge the loss, versus preferring not to be treated any differently than before. Generally, though, there was a sense that, where people clearly knew about the bereavement, it is better to talk about it rather than avoid the topic. These reactions are in accordance with observations made elsewhere (Pitman et al., 2018). Some find work colleagues very supportive, but it was noted that behaviours can also betray a lack of understanding and empathy. A clear difference has been found in the ability of some survivors to communicate to others how their loss has affected their lives, which can lessen post-bereavement recovery (Levi-Belz, 2016). Overall, survivors strongly identify with others that have experienced the same trauma and disruptive fallout. But not only are they at greater risk of mental health problems, and can find themselves isolated from family members, in this study survivors indicated that they feel that there is a lack of signposting, in that they must seek out help, at a time when their ability to do so is significantly reduced. This included participants not being made aware of SoBS, by any professional or group, and coming across it via internet searches. It has been found that survivors are often unaware of the frequency of their situation (Feigelman et al., 2018). That said, survivors report a strong sense of community, within SoBS, and the unique ability of their fellow bereaved to comprehend their suffering in a way those not affected can never fully understand. 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 (Jordan, 2020) such as increased resilience, being non-judgemental, optimism and benevolence. These attributes are typical of those that have found themselves ready and able to volunteer with SoBS, with them reporting that helping others provides satisfaction and a sense of progression. Religiosity was not a major factor in any of the interviews, with no reports of any change in belief system post-bereavement. Consistently it was remarked that SoBS 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. Research has indicated the largest numbers affected by suicide are the friends of those lost but that support groups are primarily constituted of first-order relatives (Feigelman et al., 2018). “ONS” (2021b) figures, for 2020, show London as having the lowest suicide rate in England (7.0/100,000). With a mid-2020 London population recorded at about nine million, the suicide deaths would be approximately 630. Estimates of those deeply impacted, per event, vary from 10 (Pitman et al., 2017) to 60 (Pitman et al., 2018). Using the figure of 25, from Levi-Belz and Lev-Ari (2019), those profoundly affected in London would number 15,750 for last year alone. There are eight SoBS groups in and around London with the central London SOBS group being the largest and approaching 250 active members. This reflects the literature in that only a small proportion of those bereaved by suicide attend peer support groups (Andriessen & Krysinska, 2012). Some voiced a desire to have meetings dedicated to certain types of loss or breakouts from main meetings to address the need. At the same time, it was acknowledged that logistically this may be difficult. It has been found that such delineations are rare (Andriessen et al., 2017). The same authors suggest that peer support groups would benefit from research education to better enable them to provide services in practical terms. There was also a sense that volunteers could be better prepared for the shift in emphasis from being a general SoBS member as the overhead of the responsibility, to handle calls or run meetings, was generally felt to somewhat diminish the personal benefit.

### Strengths and Limitations

Much prior research has been carried out on students from academic establishments in Western countries. This study sampled people from a somewhat broader pool however, it was still localised to England and Wales plus, since over half the participants are SoBS volunteers, their perspective may be somewhat different from those bereaved by suicide that are not in that role or part of the organisation. The ethical considerations were fully explored by all parties, given the highly sensitive nature of this research and the approach is in keeping with previous studies (Andriessen, 2014). Aspects not specifically addressed include the background, education, economic status, and personality traits of those lost, and survivors, which could be important factors affecting both those that take their own lives and how those left behind deal with their bereavement. It's possible pre-existing trauma, prior to the bereavement by suicide, could impact participants' perceptions (Murphy et al., 1999) and this was not explicitly investigated.

A limitation to the study could be, as the researcher is a fellow SoBS member, and volunteer, already known to half of the participants, that they may have held back on relating some of the more emotional and traumatic aspect of their losses, assuming it to be understood. Conversely, the researcher's own experience of bereavement by suicide likely put participants at ease and facilitated openness during the interviews; other studies have found that participants may be guarded (Peters et al., 2016). Additional reflexivity considerations include potential bias in terms of those the researcher asked personally to participate (four of eight) and a possible sub-conscious leaning towards those with similar experiences, and perspectives, based on historical sharing at SoBS meetings. It should also be noted that while a review of prior research is normal, and expected, in and of itself that exercise could have primed the researcher's approach. Also, there may have been a level of interpretation, during the analysis, that reflects an unconscious tendency to draw out aspects that the researcher identified with, above those factors less familiar due to differing circumstances.

### Conclusions

Suicides have a devastating impact upon whole families. The effects are far-reaching, radically, and permanently changing the lives of those left behind. In the case of recognised problems pertaining to those lost, survivors felt as if they were not sufficiently educated, or warned, as to the potential consequences and that there should be more openness regarding the real risks rather than healthcare professionals looking to placate families and reassure them that 'it'll be alright'. The healthcare system partitioning of medical information, between practices and professionals, negates any individual having a

complete overview of the health, and associated hazards, of someone who may be considering taking their own life. This includes instances where planning has been divulged or even prior attempts confessed to or handled. While survivors seem to share a core set of responses to their loss(es), there are distinct aspects pertaining to the relationship(s) prior to bereavement. Coping does appear to get better over time, but the adjustment is far from linear.

Survivors perceive a widespread mindset of denial, in that the public considers suicide within families as something that happens to ‘other people’ rather than it being a very real risk to everyone. Many survivors acknowledge 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. In that respect, there is a high level of frustration that the UK government seems to acknowledge the seriousness and pervasiveness of suicide, as a severe problem in society, but does not follow through with leadership, proper funding, or a structure to tackle the issue. The requirements of handling the aftermath of a death can never be easy but those bereaved by suicide are usually in deep shock, confused and overwrought when they need to deal with the mechanistic aspects. Generally, there is no assistance available, and survivors’ trauma is often exacerbated by encounters with officialdom and some unsympathetic individuals within. Similarly, for core, long-term, meaningful support, survivors rely to the very greatest extent on the voluntary sector. SoBS has been very beneficial to all participants and an overwhelming sense of camaraderie and gratitude permeated the interviews. That said, most noted they stumbled across SoBS 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. Several noted that organisations like CALM, Mind and The Samaritans are well-known and widely identifiable, but that SoBS remains a niche organisation with very little awareness outside of its staff and membership. There is a common drive to help others bereaved by suicide with the vast majority of those in this study either already active within SoBS 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. In terms of the execution of peer support meetings, several people would like to see dedicated sub-groups relating to the loss of specific relationships, reflecting a greater sense of kinship and empathy where the bereavement is more alike. Some have found the pandemic shift to online meetings detrimental to the value they can derive themselves and to their ability to assist others. The change in

dynamic, from SoBS member to volunteer, was not apparent to many until they had taken on their duties, and this should be more transparent and handled in the training.

Overall, there is a pervading thread that too many aspects of suicide bereavement are isolated and that a more cohesive approach, including government, media, healthcare and legal systems, emergency services and the voluntary sector, would be beneficial to addressing the significant public health issue all parties acknowledge exists. Key to this is a major contribution by survivors. Specifically, regarding SoBS, while it could be argued that greater awareness may alleviate concerns about their potential actions, in those that are potentially suicidal, a strong counterargument is that an understanding of the devastation caused could be protective.

Future studies could look to gain input when the trauma is at its most raw, adding important background information. Gathering data on any pre-existing trauma would provide context. Neglected areas of research include impacts on non-family bereaved, a sense of loss of the future that could have been, and repatriation of those lost abroad. COVID-19 was mentioned by participants but the pandemic's impact, both in terms of the increased risk of potential suicides, and lockdown's impact on the mental health of the bereaved, was not explicitly covered in the current study. Further, the shift to greater levels of online support, because of the pandemic, is worthy of additional research. Based on the lived experiences of the small number of suicide survivors in this study, it should be possible to better understand the major factors impacting bereavement of this type. This would facilitate targeted focus groups, for example lower income, non-English speaking individuals, thereby expanding on the theme themes/clusters identified. A quantitative study, collecting data on those lost and those bereaved, could provide important context with respect to factors such as socio-economic status, education, personality traits and the impact of the pandemic. This could then feed into an extended IPA study to further the understanding of how survivors of suicide can most effectively be supported in practical terms.

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