GRIEF AFTER SUICIDE: A HEALTH PERSPECTIVE ON NEEDS, EFFECTIVE HELP, AND PERSONAL GROWTH

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GRIEF AFTER SUICIDE: A HEALTH PERSPECTIVE ON NEEDS, EFFECTIVE HELP, AND PERSONAL GROWTH

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Editorial: Grief After Suicide: A Health Perspective on Needs, Effective Help, and Personal Growth

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Editorial on the Research Topic

Grief After Suicide: A Health Perspective on Needs, Effective Help, and Personal Growth

Experiencing the suicide of a close person often signifies a major disruptive stressor, exacerbating the risks of social, physical, and mental health problems, and suicidal behavior in the bereaved individuals (Pitman et al., 2014). Common grief reactions after any death include feelings of sadness, longing, guilt, and anger. Compared to other forms of bereavement, people bereaved by suicide may experience more shock or trauma related to the unexpected or violent nature of the death, and more feelings of abandonment, rejection, and shame (Jordan and McIntosh, 2011a). They may struggle more with meaning-making and "why" -questions, and experience less social support (Feigelman et al., 2009; Castelli Dransart, 2013).

Compared with the general population, people bereaved by suicide have a higher risk of suicidal behavior, and mental health problems such as depression, anxiety, posttraumatic stress disorder (PTSD), and substance abuse (Erlangsen et al., 2017). Suicide bereavement also represents a risk factor for complicated grief (Bellini et al., 2018). Those bereaved who have a personal or family history of mental health and/or suicidal behavior appear to be more vulnerable to the negative psychosocial outcomes (Andriessen et al., 2016; Pitman et al., 2016). Despite these challenges, people bereaved by suicide can also experience personal and posttraumatic growth (Castelli Dransart, 2016; Genest et al., 2017; Levi-Belz et al., 2020). Research has shown that ∼1 in 5 people may experience a suicide during their lifetime highlighting the public and mental health importance of loss by suicide (Andriessen et al., 2017c).

This Research Topic aimed to broaden our understanding of grief after suicide, with regards to the needs of bereaved individuals and communities, and how to best help the bereaved, within a health psychology context. As such, the Research Topic expands the focus of previous work in this field (Jordan and McIntosh, 2011b; Andriessen et al., 2017b). The 16 published studies fall into three broad categories: (a) the experience of suicide bereavement (8 studies), (b) the impact of a death by suicide on professionals (3 studies), and (c) interventions (5 studies).

EXPERIENCES OF SUICIDE BEREAVEMENT

Regarding the experience of suicide bereavement, Feigelman and Cerel (USA) conducted a survey investigating feelings of blameworthiness in bereaved parents. Blameworthiness related to participants' perception of what they may have done (or not done) that could have contributed to their child's death, including suicide. The study found that feelings of blameworthiness strongly correlated with grief difficulties and mental health problems, such as complicated grief, PTSD, and depression.

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Levi-Belz and Gilo (Israel) explored the moderating role of self-forgiveness regarding emotional distress in people bereaved by suicide. The study found that accepting one's mistakes and fostering positive emotions, thoughts, and behaviors toward oneself can be a protective factor against depression and suicidality in people bereaved by suicide. The study findings indicated the possible efficacy of forgiveness-based interventions in this population.

Two qualitative studies focused on suicide bereavement in the context of older adults. Hybholt et al. (Denmark) studied older adults' conduct of everyday life during the first 5 years after the death. The study identified age-related issues in the participants' bereavement process. Life was no longer as expected ("the broken notion of late-life living") and participants perceived limited possibilities and time to restore their life project. Age-related factors affected their possibilities to adjust to their new life conditions.

Michaud-Dumont et al. (Canada) explored the experience of family members bereaved by the suicide of a close elderly relative. This small pilot study revealed how participants searched explanations for the suicide. Despite the perceived inevitability of death in older age, participants reported that the suicide was shocking and unexpected, and triggered strong emotions, such as anger and guilt, as well as family conflicts. The pilot study elucidated important methodological issues for future studies, for example, regarding recruitment.

Two studies looked at suicidal behavior in people bereaved by suicide. Westerlund et al. (Sweden) conducted a survey with women bereaved by suicide. It appeared that the self-reported rates of suicidal thoughts, plans, and attempts were considerably higher in this group than the rates reported in the general population. Having lost a child (as compared to another family member), shame, and experiencing family avoidance increased the risk of suicidality, leading the authors to conclude that postvention activities should target these factors.

Based on the Integrated Motivational-Volitional Model of Suicide (O'Connor and Kirtley, 2018), del Carpio et al. (Scotland/UK), examined bereavement by suicide or other death as a longitudinal predictor of self-harm in adolescents. The study reported on the prevalence of suicide bereavement and self-harm in adolescents, as well as various risk factors. Neither bereavement by suicide nor by non-suicide did predict self-harm in the bereaved adolescents.

Pitman et al. (UK) conducted a mixed methods study on self-reported use of alcohol and unprescribed drugs following loss by suicide or other sudden deaths in young people. There was no increase in alcohol or drug use in more than half of the bereaved young people. Nonetheless, young people bereaved by suicide or non-suicide unnatural deaths were more likely to report higher substance use than those bereaved by sudden natural causes.

De Leo et al. (Italy) systematically reviewed the literature on how a death can be communicated. The review found that death notification is a complex and stressful experience both for those who provide the information and for the bereaved individuals who receive the news. This process requires high-quality training and flexible protocols tailored to particular sets of circumstances.

IMPACT OF SUICIDE IN HEALTH PROFESSIONALS

Three studies focused on the impact of a suicide death on professionals in mental health and health settings. In a qualitative study, Nelson et al. (UK) explored the perspectives of ambulance staff on attending to deaths by suicide. The study revealed that responding to suicide can have professional and personal impact on the ambulance staff, including job-related strain and long-term traumatic memories. Training regarding how to respond to people bereaved by suicide and debrief opportunities were rare, pointing at a need for training and support for ambulance staff.

Rothes et al. (Portugal) interviewed prehospital health professionals regarding their experiences with emergency patients dying by suicide. Participants reported that the suicide of a patient had intense negative impacts, such as intrusive thoughts and images, and doubts about professional competence and liability. However, participants also spoke of potential positive effects, such as professional growth and increased awareness. The study stressed the importance of training for prehospital health staff.

Leaune et al. (France) presented a protocol for a mixed methods collaborative and participatory action research, the "SUPPORT-S" study. This study will evaluate the implementation and effectiveness of the SUPPORT postvention program, which provides comprehensive support to mental health and social work professionals impacted by exposure to patient suicide.

INTERVENTIONS

Five studies dealt with postvention interventions in different settings. Andriessen et al. (Australia) systematically reviewed the peer reviewed and gray literature, and presented an overview of recent models and guidelines for suicide postvention services, as well as components that may contribute to their effectiveness. The review recommended adopting a public health framework to tailor support to bereaved individuals according to the impact of suicide on their lives. Such support may range from information and awareness raising to specialized psychotherapy.

Berardelli et al. (Italy) presented a weekly group program for people bereaved by suicide, facilitated by trained psychologists. The program aimed to provide support, normalize grief reactions, and integrate the loss, and was well received by the participants. The psychoeducational approach allowed participants to interact with each other, helped them resume the course of life and place the suicide of a close person in a broader perspective.

Hagström (Sweden) qualitatively investigated how a theater play might counteract the stigmatized trauma of suicide bereavement. The study concluded that research-based theater can resonate well with the experiences of the bereaved individuals and is a promising cost-effective means of creating new meanings around suicide, both for individuals bereaved by suicide and the broader cultural context from which stigma originates.

Geležėlytė et al. (Lithuania) in a mixed methods study explored factors contributing to seeking professional psychological help by people bereaved by suicide. The findings indicated that those bereaved who experienced more stigmatization and guilt might contact professionals more often. Attitudes toward mental health specialists was the strongest predictor of help-seeking in participants. Conversely, gaps in the health care system was identified as a main barrier.

Jordan (USA) shared "lessons learned" over 40 years of his work as a grief therapist with people bereaved by suicide. This insightful paper identified a series of psychotherapeutic tasks regarding the psychological integration of the loss, such as containment of the trauma and restoration of a sense of psychological safety, psychoeducation about suicide, trauma and grief, repairing the continuing bond with the deceased, and rebuilding an assumptive world that has been shattered by the suicide. The paper concluded with clinical implications for the work with people bereaved by suicide.

CONCLUSIONS

The published papers have clearly advanced the knowledge and insights in postvention. They addressed many priority topics identified by those working in this field, such as theory-driven and longitudinal research, suicide bereavement in the contexts of older adults and helping professionals, suicidal behavior in suicide bereaved individuals, and evaluation of postvention programs (Andriessen et al., 2017a). The studies also highlighted important targets for interventions, such as self-blame and self-forgiveness, alcohol and substance use, suicidality in the bereaved, and facilitation of personal growth. Adopting a public health approach would allow tailoring interventions to the needs and the level of impact of the grief in those bereaved.

This Research Topic constitutes the largest open access peer-reviewed collection of studies regarding grief after suicide and is a testament to the substantial progress that has been made over the last years. We are grateful to the authors for submitting their manuscripts and for sharing their expertise. We are convinced that the published studies will be highly useful for clinicians, peer supporters, researchers and anyone involved in this field. These studies will inform further research and evidence-based training and interventions in postvention.

AUTHOR CONTRIBUTIONS

KA, KK, and DC have written the editorial together and have agreed on the final version. All authors contributed to the article and approved the submitted version.

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SYSTEMATIC REVIEW
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Suicide Postvention Service Models and Guidelines 2014–2019: A Systematic Review

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Background: Suicide bereavement can have a lasting and devastating psychosocial impact on the bereaved individuals and communities. Many countries, such as Australia, have included postvention, i.e., concerted suicide bereavement support, in their suicide prevention policies. While little is known of the effectiveness of postvention, this review aimed to investigate what is known of the effects of postvention service delivery models and the components that may contribute to the effectiveness.

Method: Systematic review and quality assessment of peer reviewed literature (Medline, PsycINFO, Embase, EBM Reviews) and gray literature and guidelines published since 2014.

Results: Eight studies and 12 guidelines were included, with little evidence of effectiveness. Still, providing support according to the level of grief, involvement of trained volunteers/peers, and focusing the interventions on the grief, seem promising components of effective postvention.

Conclusions: Adopting a public health approach to postvention can allow to tailor the service delivery to needs of the bereaved individuals and to align postvention with suicide prevention programs.

Keywords: bereavement, guidelines, mental health, postvention, suicide, systematic review

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INTRODUCTION

Rationale

Suicide is a major public and mental health problem in Australia. Over the last 10 years the country has witnessed a 33% increase of the annual number of suicides, from 2,341 in 2008 to 3,128 in 2017 (Australian Bureau of Statistics, 2018). The age-standardized suicide rate (per 100,000 persons) increased from 10.9 in 2008, to 12.6 in 2017, which is higher than the global age-standardized suicide rate of 10.5/100,000 persons (Australian Bureau of Statistics, 2018; World Health Organization, 2018). While the increasing suicide mortality has fueled calls for evidence-based suicide prevention, concern has also increased for the many bereaved family members, friends and community members (Department of Health, 2017). Indeed, experiencing bereavement by suicide can be a major stressor, increasing the risks of social, physical, and mental health problems, and suicidal behavior in the bereaved individuals (Pitman et al., 2014; Andriessen et al., 2017a). The impact of suicide on society can be far-reaching. Studies have shown that, on average, five immediate family members and up to 135 individuals can be exposed to the impact of an individual's suicide (Berman, 2011; Cerel et al., 2018). A recent meta-analysis determined that approximately one in 20 people (4.3%) are impacted by a suicide in any 1 year, and one in five (21.8%) during their lifetime (Andriessen et al., 2017b).

Grief is the natural reaction to the loss of a close person such as a family member or a friend (Stroebe et al., 2008). As with grief due to other causes, grief after suicide can include diverse psychological, physical, and behavioral responses to the death (Andriessen et al., 2017a). Feelings of sadness, yearning, guilt and anger, and physical reactions such as crying, are common grief reactions (Stroebe et al., 2008). People exposed to a suicide death can be affected to varying degrees. Those who were psychologically close to the person who has died are likely to be more strongly affected than those whose relationships were more distant. Cerel et al. (2014) proposed a theoretical continuum of suicide survivorship ranging from those who are merely exposed to a suicide without experiencing an impact on their life, to those who feel affected or distressed, to those who experience intense short or long-term grief reactions.

The course and duration of the grief process after a suicide death seem similar to grief processes after other causes (Sveen and Walby, 2008; Jordan and McIntosh, 2011). However, people bereaved by suicide may experience more shock or trauma related to the unexpected or violent nature of the death, and more feelings of abandonment, rejection, shame, and struggles with meaning-making and "why"-questions. They may also experience less social support compared to other forms of bereavement, which may be due both to limited help-seeking or sharing by the bereaved individuals and the inability of the social network to support them (Andriessen et al., 2017a; Pitman et al., 2017).

Suicide bereavement is a risk factor for complicated or prolonged grief (Mitchell et al., 2004). This is expressed through persisting characteristics of acute grief, such as intense longing and ruminative thoughts about the deceased, avoidance of situations related to the loss, and difficulty finding meaning in life (Zisook et al., 2014; Malgaroli et al., 2018; Mauro et al., 2019). Compared with the general population, people bereaved by suicide have a two- to three-fold risk of suicidal behavior, and psychiatric problems, such as depression, anxiety, posttraumatic stress disorder, and substance abuse (De Groot and Kollen, 2013). Having a personal or family history of mental health and/or suicidal behavior increases the risks of these problems (Pitman et al., 2014; Erlangsen and Pitman, 2017). People bereaved by suicide are also susceptible to physical illnesses, possibly due to the levels of stress or an unhealthy lifestyle (e.g., poor diet, smoking) (Erlangsen and Pitman, 2017; Erlangsen et al., 2017; Spillane et al., 2018).

Recent research has also started to shed light on the phenomenon of personal (or posttraumatic) growth in suicide bereavement (Levi-Belz et al., under review). This has been defined as the positive psychological changes experienced by an individual as the result of inner struggles after a traumatic experience (Tedeschi et al., 2018). While the research into positive personal transformations in the context of suicide bereavement is still new, it reveals that the aftermath of suicide is not always simply deleterious, and personal growth is possible.

In summary, loss by suicide can have serious and lasting psychosocial effects on the bereaved individuals and communities. Their needs are complex and variegated, necessitating a concerted provision of support.

Policy Response

The Commonwealth and the state/territory suicide prevention policies and documents in Australia recognize the importance of postvention in the overall suicide prevention efforts and the involvement of the bereaved in shaping these actions. According to the Fifth National Mental Health and Suicide Prevention Plan (Department of Health, 2017), suicide prevention efforts call for a broad approach involving a range of sectors, and targeting various settings, populations, and risk groups. Postvention, i.e., an improved response to and caring for people affected by suicide, is an element of a systems-based approach informing the Fifth Plan (Department of Health, 2017), originally based on the World Health Organization's seminal Preventing suicide: A global imperative report (World Health Organization, 2014). The Fifth Plan promises that "there will be improved postvention support for carers, families and communities affected by suicide" (Department of Health, 2017, p. 25).

The voices of people bereaved by suicide have been included in the development of the Strategic Framework for Suicide Prevention in NSW 2018–2023 (Mental Health Commission of NSW, 2018). Postvention programs and services which are "co-designed, inclusive, coordinated and integrated" (Mental Health Commission of NSW, 2018, p. 11) are included under one of the five goals of the Framework, along with suicide prevention and intervention initiatives. The Framework's Priority Area 2 involves strengthening the community response to suicide and points out to the needs of communities to be able to respond to people bereaved by the death. People bereaved by suicide may be at increased risk of suicide themselves and require timely and effective support, such as grief counseling and advice on how to find relevant services. Promotion of "community-based postvention support, tools and resources for families and communities" (Mental Health Commission of NSW, 2018, p. 26) after a suicide is one of the important actions that require immediate attention of the NSW Government. Further, the NSW Framework recognizes the potential of professionalized suicide prevention peer workforce, comprising people bereaved by suicide, in reducing the number of suicides (Mental Health Commission of NSW, 2018).

Postvention Services

It has long been recognized that people bereaved by suicide have diverse psychosocial and health needs (Shneidman, 1973) and effective postvention, i.e., suicide bereavement support, is seen as a major public and mental health challenge. Andriessen (2009, p. 43) defined postvention as: "those activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behavior."

Since the 1960 various forms of postvention services and support programs have been developed. These include group support, grief counseling, outreach by agencies, and online support (McIntosh et al., 2017). Some postvention programs are focused on specific settings, such as schools (Cox et al., 2016), workplaces (Spencer-Thomas and Stohlmann-Rainey, 2017), and faith communities (Krysinska et al., 2017), while other initiatives aim to provide support to the broader community (Andriessen et al., 2017c). Historically, most postvention services were initiated by the bereaved people themselves, followed by involvement of professionals (Farberow, 2001). Originally scarce, in recent years, progress has been made regarding the availability of postvention services both internationally and in Australia (https://postventionaustralia.org/finding-support/; http://www.supportaftersuicide.org.au/find-related-organizations) (McIntosh et al., 2017).

Suicide bereavement support groups are the most widely available postvention services. Frequently initiated by people bereaved by suicide, they are often based on the principles of sharing experiences and offering mutual assistance, thereby reducing distress and risk of mental and emotional problems (McIntosh, 2017). Support groups can be facilitated by survivors, mental health professionals, or a combination of both (McIntosh, 2017). While "open" groups are ongoing and accept new members, "closed" groups meet for a predetermined number of times with the same participants (Farberow, 2001; McIntosh, 2017).

Some people bereaved by suicide experience emotional (e.g., shame) or physical barriers (e.g., limited availability of services) to contacting a support group. Anticipating such barriers, some organizations have developed an outreach approach in which the service contacts the bereaved person after being notified of a suicide by the police or the coroner's office (McIntosh et al., 2017; Mowll et al., 2017). Such a pro-active approach has a potential to improve the collaboration between first-responders (e.g., police) and suicide bereavement services. It may also decrease the time elapsed between the suicide and the start of support received, though the effect of the outreach approach on the grief process remains unknown (Cerel and Campbell, 2008; Comans et al., 2013).

The Internet has become a major source of suicide bereavement information and support provided via websites, discussion forums, social media, and online memorials (Krysinska and Andriessen, 2017). Compared to face-to-face support, users of online services may have more control over the process and content of the interventions, which may be particularly important for people who feel stigmatized or are reluctant to access other forms of support. However, dropout rates tend to be higher online relative to interventions provided face-to-face (Karyotaki et al., 2015). As in face-to-face support groups, participants in online forums or groups can share personal stories, which may help to normalize their grief experiences (Krysinska and Andriessen, 2017). They can also find and provide empathy, mutual support and hope through the exchange of resources or advice (Schotanus-Dijkstra et al., 2014).

In some countries, support groups and/or other suicide bereavement services have created national networks or associations, such as the Suicide Loss Division of the American Association of Suicidology in the USA (https://www.suicidology.org/), the Support After Suicide Partnership in the UK (http://supportaftersuicide.org.uk/) (Lascelles et al., 2017), and Postvention Australia (https://postventionaustralia.org/) (Ceramidas et al., 2017). There is also increasing international collaboration, for example, through the Special Interest Group on Suicide Bereavement and Postvention of the International Association for Suicide Prevention (https://www.iasp.info/). Some of these organizations have developed guidelines on how to facilitate a support group (World Health Organization and International Association for Suicide Prevention, 2008), or national guidelines for suicide bereavement support (Jordan, 2017).

Overall, there is a tension between the need for psychosocial services for people bereaved by suicide (Sanford et al., 2016; Pitman et al., 2018) and what is known about their effectiveness (McDaid et al., 2008; Szumilas and Kutcher, 2011; Linde et al., 2017). Indeed, despite the devastating and lasting effects a suicide can have on people bereaved by suicide, and the number of people affected, little is known about what services and supports are effective. Postvention has been recognized as an important suicide prevention strategy in Australia and worldwide (World Health Organization, 2014; Department of Health, 2017). Still, most research has been focused on the characteristics of suicide bereavement rather than on effectiveness of interventions (Andriessen, 2014; Andriessen et al., 2017d; Maple et al., 2018). Our recent systematic review of grief and psychosocial interventions for people bereaved through suicide, which included only controlled studies, found mixed evidence of effectiveness of interventions (Andriessen et al., 2019). Clearly, further examination of the quality of postvention research, levels of evidence, and potentially effective postvention components, is needed.

Research Questions

This review was designed to answer the following two research questions.

Question 1

Which suicide postvention service models have been shown to be effective to reduce distress in family, friends and communities following a suicide?

Question 2

From the models identified in Question 1, what components of suicide postvention services have been determined to contribute to effectiveness?

We defined "suicide postvention service model" as a "coordinated approach to providing support to people impacted by the death of a family member, friend or person in a network (such as a school, nursing home, workplace, etc.) through suicide." As we were interested in current service models, we focused the review on peer reviewed literature, gray literature and guidelines published over the last 5 years.

METHODS

Peer Review Literature

Search Strategy

We developed the search strategy of this review based on experiences of our team in conducting rapid and systematic reviews (e.g., Krysinska et al., 2018; Andriessen et al., 2019). In line with the PRISMA guidelines (http://www.prisma-statement.org/) (Moher et al., 2009), we conducted systematic searches of the following databases: Medline, PsycINFO, Embase, and EBM Reviews. All databases were accessed through Ovid. The search string in Medline comprised a combination of MeSH and keywords: (bereavement/ OR bereavement.mp OR grief/OR grief.mp OR mourning.mp) AND (family/OR friends/ OR friends.mp OR acquaintance.mp OR students/OR student.mp OR schools/OR school.mp OR survivor.mp OR suicide survivor.mp) AND (counseling/OR counseling.mp OR intervention.mp OR postvention.mp OR psychotherapy/OR psychotherapy.mp OR support group.mp OR self-help groups/ OR social media/OR social media.mp OR internet/OR internet.mp) AND (suicide/OR suicide.mp OR suicide cluster.mp). We applied the same search string in the other databases using subject headings and keywords.

The search was undertaken in April 2019, was not limited by language, and comprised the years 2014 to 2019. Two researchers (KA, KKr) independently assessed titles and abstracts for eligibility. We resolved any disagreement through discussion. Potentially relevant studies were examined against the inclusion/exclusion criteria. The references of retrieved papers and existing reviews were hand searched to identify additional studies. **Figure 1** presents the search and selection process.

Inclusion and Exclusion Criteria

Original studies published in peer-reviewed journals were included if: (1) the study population consisted of people bereaved by suicide, (2) the study applied quantitative, qualitative or mixed-methods, and (3) the study reported data regarding effects of interventions or service delivery to the study population. The review excluded studies: (1) not on suicide bereavement, (2) not providing original data (such as review papers), (3) not reporting on suicide postvention services, and (4) full-text not available (i.e., conference abstract).

Data Extraction

Two researchers (KA, KKr) independently extracted the following data from the selected studies: study reference including author, year and location (country), study design, assessments, sample size, participants' age and sex distribution, participants' relationship to the deceased and time since the bereavement, type (individual, family, group), characteristics and setting of the intervention, outcome measures and names of the instruments used, main outcomes of the study, and study limitations. Any disagreement was resolved through discussion. The data extraction informed the synthesis and report of the data.

Quality Assessment

We assessed the quality of the included studies using two instruments: the (National Health and Medical Research Council, 2009) NHMRC Levels of Evidence, and the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998).

The NHMRC Levels of Evidence comprises six levels of evidence based on the design of the study (**Supplementary Table 1**) (National Health and Medical Research Council, 2009). Systematic reviews of randomized controlled trials (RCTs) are considered the highest level of evidence (Level I). Case series, with post-test or pre- and post-test outcomes are at the bottom of the evidence hierarchy (Level IV). The NHMRC instrument also requires a summary of the body of evidence of five components: evidence-base (e.g., number and quality of the studies), consistency of findings across studies, clinical impact, generalizability of findings, and applicability in the Australian or local context (**Supplementary Table 2**). Two researchers (NR, KA) independently assessed the levels of evidence, and settled any disagreement through discussion.

The Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998) comprises six components (selection bias, study design, confounders, blinding, data collection methods, and withdrawals and dropouts) which are scored as "strong," "moderate" or "weak." Complying with the instructions of the instrument, the total rating of a study was "strong" if none of its components were rated "weak." We rated a study as "moderate" if only one of its components was rated "weak," and rated a study as "weak" if two or more of its components were rated as "weak" (Effective Public Health Practice Project, 1998). In addition, the instrument assesses the integrity of the intervention and analyses (e.g., analysis by intention to treat status). Two researchers (KKr, KA) independently assessed the quality of the included studies and settled any disagreement through discussion.

Gray Literature and Guidelines

Search Strategy

Guidelines are usually defined as information on how something should be done (AGREE Next Steps Consortium, 2017). More specifically, clinical practice guidelines are defined as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (AGREE Next Steps Consortium, 2017). As such, guidelines differ from general advice or a list of resources.

We developed a search strategy based on previous experiences of our team (Krysinska and Andriessen, 2010; Krysinska et al., 2018) and indications from the literature (Eysenbach and Köhler, 2002; Morahan-Martin, 2004; Jansen and Spink, 2006). The searches were conducted in April 2019 in Google Chrome. For each search term we opened a new page using Guest Mode to avoid that browser history affected the results. We used the following search terms: "suicide bereavement support," "suicide loss support," "suicide survivor support," "effective suicide bereavement support," "effective suicide loss support," "effective suicide survivor support," "suicide bereavement service," "suicide loss service," "suicide survivor service," "effective suicide bereavement service," "effective suicide loss service," "effective suicide survivor service," "postvention

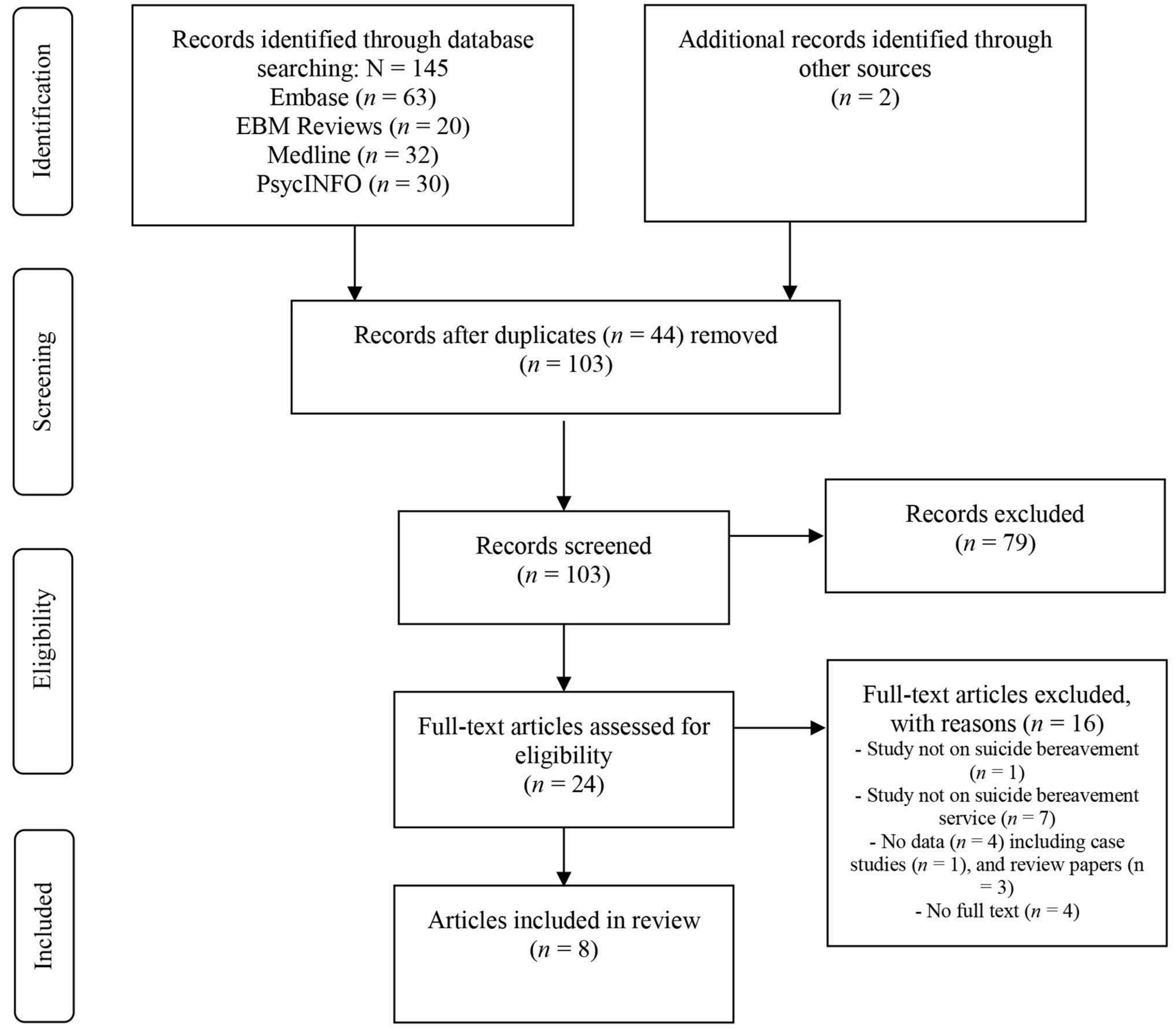

FIGURE 1 | PRISMA flow diagram.

support," "postvention service," "effective postvention support," "effective postvention service," "support after suicide," "help after suicide," "effective support after suicide," "effective help after suicide," "postvention guidelines," "suicide loss guidelines," and "suicide bereavement guidelines."

Research regarding how people search for health-related information on the Internet shows that most people only access links provided on the first page (Eysenbach and Köhler, 2002; Morahan-Martin, 2004), and the proportion of people viewing the first page only, has increased over the years (Jansen and Spink, 2006). To capture the research on services and guidelines that are readily available to the public, and to be thorough in the gray literature searches, we retained the results of the first two pages per search term. As such, the searches aimed to identify as many research publications and best-practice guidelines as possible, while confining the leads to a manageable number.

In addition to the Google Chrome searches, we consulted the following national repositories of suicide prevention resources in English-speaking countries: The Suicide Prevention Hub, Australia (https://suicidepreventionhub.org.au/), National Office for Suicide Prevention, Ireland (https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/), Support After Suicide Partnership, UK (http://supportaftersuicide.org.uk/), Suicide Prevention Resource Center, USA (https://www.sprc.org/resources-programs), Centre for Suicide Prevention, Canada (https://www.suicideinfo.ca/), Mental Health Foundation, New Zealand (https://www.mentalhealth.org.nz/). Two researchers (KKo, KA) independently assessed the leads for eligibility.

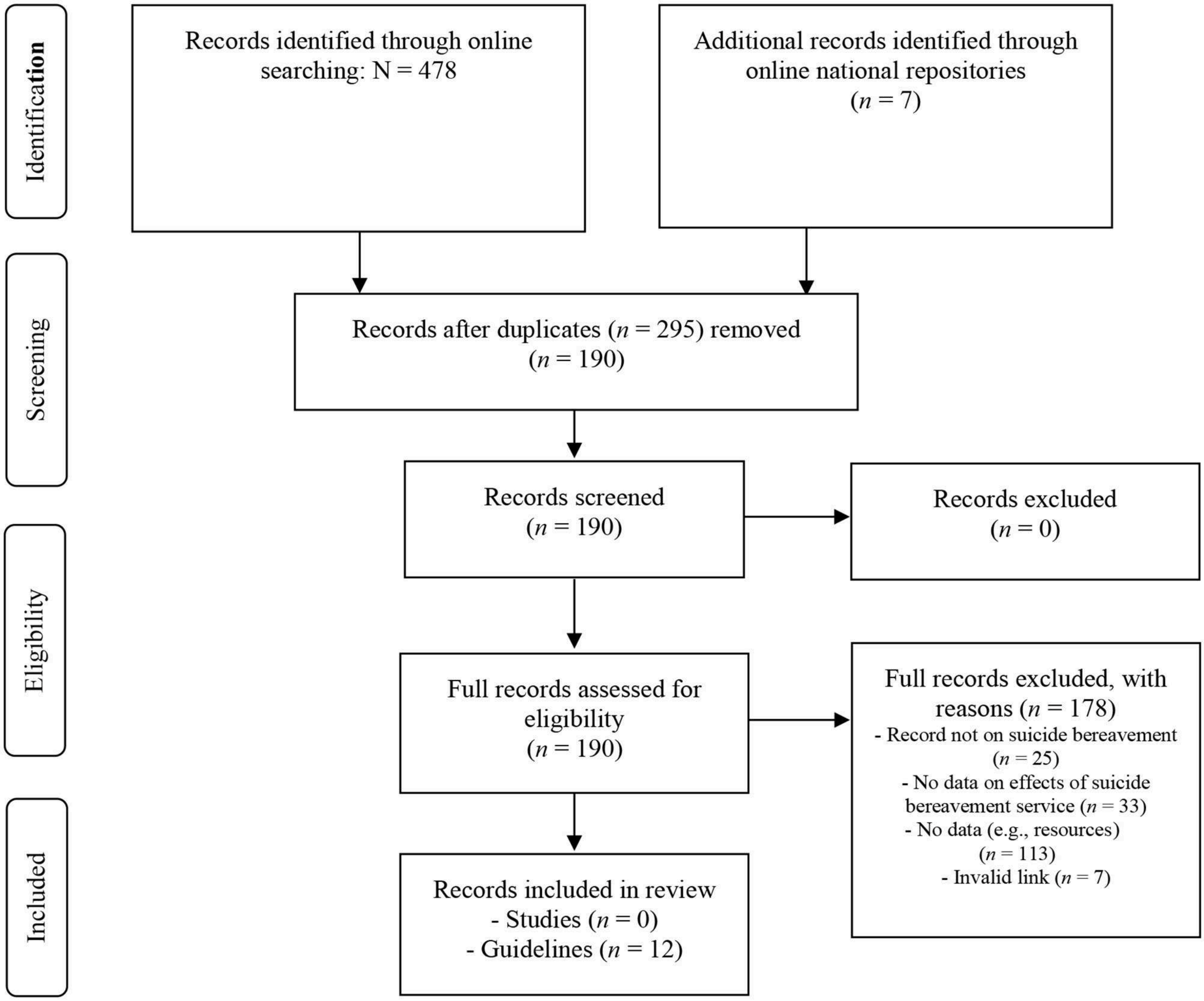

FIGURE 2 | PRISMA flow diagram: gray literature.

Any disagreement was resolved through discussion and/or involvement of a third researcher (KKr). **Figure 2** summarizes the search and selection process for the gray literature.

Inclusion and Exclusion Criteria

We adapted the inclusion and exclusion criteria of the peer-reviewed literature (above) to the search of the gray literature. Studies in webpages were included if: (1) they reported on a study population consisting of people bereaved by suicide, (2) the study applied quantitative, qualitative or mixed-methods, and (3) reported data regarding effects of interventions or service delivery to the study population. The review excluded studies: (1) not on suicide bereavement, (2) not providing original data of effects of interventions (e.g., presenting case histories or description of services), (3) not reporting on suicide postvention services (e.g., webpages limited to written resources, links, or referral addresses), and (4) invalid links.

The gray literature review included guidelines published since 2014 if: (1) they self-identified as "guidelines" and/or (2) comprised a structured set of statements on how an organization or a service can provide help to individuals bereaved by suicide. The review excluded documents (1) comprising a collection of resources, (2) providing general advice on how to support a person bereaved by suicide or self-care information for the bereaved.

Data Extraction

The gray literature search did not identify any studies not previously identified through the peer-review literature searches. Based on the criteria provided in the "Appraisal of Guidelines for Research and Evaluation II" instrument (AGREE Next Steps Consortium, 2017), two researchers (KA, KKr) independently extracted the following data from guidelines included in the review: reference including title, author, year and location (country), target users, target population, whether objectives and methods of development were described, if target users were involved in the development, whether the evidence-base of the guidelines and the theoretical model of postvention were described, and whether key recommendations or sample material, such as templates, were included. We resolved any disagreement through discussion. The data extraction informed the synthesis and report of the data.

RESULTS

Study Characteristics

Eight papers published since 2014 met the inclusion criteria and were included in the review (**Table 1**). Two studies were conducted in Australia (Visser et al., 2014; Peters et al., 2015), two in the USA (Supiano et al., 2017; Zisook et al., 2018), two in Belgium (Wittouck et al., 2014) (including one also conducted in the Netherlands, Kramer et al., 2015), and one in Korea (Cha et al., 2018) and Italy (Scocco et al., 2019), each. There were two RCTs (Wittouck et al., 2014; Zisook et al., 2018), two pre- and post-designs without control group (Kramer et al., 2015; Scocco et al., 2019), two prospective designs without control groups (Supiano et al., 2017; Cha et al., 2018), and two retrospective descriptive, cross-sectional studies (Visser et al., 2014; Peters et al., 2015).

Seven studies (Visser et al., 2014; Wittouck et al., 2014; Kramer et al., 2015; Peters et al., 2015; Supiano et al., 2017; Zisook et al., 2018; Scocco et al., 2019) focused on adult populations, and one on young people (high school students) (Cha et al., 2018). While some studies (e.g., Supiano et al., 2017; Zisook et al., 2018) included older adults, no study specifically focused on them. Apart from the study of Cha et al. (2018), female participants outnumbered male participants, with the proportion of female participants ranging from 80 to 91%. The study populations consisted mainly of first-degree family members (Visser et al., 2014; Wittouck et al., 2014; Kramer et al., 2015; Peters et al., 2015; Zisook et al., 2018; Scocco et al., 2019), though most studies also included other relatives and/or non-relatives (Visser et al., 2014; Wittouck et al., 2014; Kramer et al., 2015; Cha et al., 2018; Zisook et al., 2018; Scocco et al., 2019). Time since loss in study participants varied considerably between studies, ranging from 1 week (Cha et al., 2018) to between 3 months and 30 years (Scocco et al., 2019). Reported mean time since loss ranged from $M = 9.8$ months (*SD* 5.7) (Wittouck et al., 2014) to $M = 5.96$ years (*SD* 3.7) (Peters et al., 2015).

The interventions were conducted in a variety of settings: clinical (Wittouck et al., 2014; Supiano et al., 2017; Zisook et al., 2018), community-based (Visser et al., 2014; Peters et al., 2015), residential (Scocco et al., 2019), school (Cha et al., 2018), and online (Kramer et al., 2015). Three studies involved a group intervention (Wittouck et al., 2014; Peters et al., 2015; Supiano et al., 2017), three studies an individual intervention (Visser et al., 2014; Kramer et al., 2015; Zisook et al., 2018), and two studies a combination of group and individual interventions (Cha et al., 2018; Scocco et al., 2019). Two interventions were described as manualized (Supiano et al., 2017; Zisook et al., 2018). Three interventions targeted individuals early in the grief process (Visser et al., 2014; Wittouck et al., 2014; Cha et al., 2018). Duration of intervention and the timing of participant assessment varied considerably between studies, ranging from assessment shortly after the intervention (e.g., Peters et al., 2015; Scocco et al., 2019) to assessment at 12-months follow-up (Kramer et al., 2015).

Studies differed regarding outcomes measured and instruments used. Most studies applied mental health measures, three studies (Visser et al., 2014; Kramer et al., 2015; Zisook et al., 2018) measured suicidality, and three studies did not assess grief (Visser et al., 2014; Peters et al., 2015; Scocco et al., 2019). No single measure was used in more than one study.

Study Quality Assessment

Tables 2, **3** summarize the rating of the reviewed studies according to the NHMRC levels of evidence (National Health and Medical Research Council, 2009). There were two level II studies, two level III-3 studies, and four level IV studies (**Table 2**). Looking at the five components in detail, three were rated as "poor" (evidence-base, consistency, and clinical impact), and two were rated as "satisfactory" (generalizability and applicability) (**Table 3**).

Table 4 summarizes the study quality according to the six components of the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998). The overall study quality was weak. One study received a rating of "strong" on four components (Wittouck et al., 2014), one study on three components (Zisook et al., 2018), and one study on two components (Supiano et al., 2017). The other studies were rated "strong" on only one component (Visser et al., 2014; Kramer et al., 2015; Peters et al., 2015; Cha et al., 2018; Scocco et al., 2019). Selection bias, blinding, and withdrawals and dropouts were the weakest components across studies. Two studies used randomized designs (Wittouck et al., 2014; Zisook et al., 2018); however, no studies reported the use of an intention-to-treat analysis. All studies appeared to have used valid and reliable measures. However, it is unknown if studies measured consistency of intervention (except for Supiano et al., 2017 and Zisook et al., 2018) and controlled for effects of other treatments (for example, by a family doctor) which participants might have been receiving.

Guidelines Characteristics

The gray literature searches identified 12 guidelines published since 2014 (**Table 5**). Seven were published in the USA (Higher Education Mental Health Alliance, 2014; Survivors of Suicide Loss Task Force, 2015; California Mental Health Services Authority, 2016; New York City Fire Department, 2016; Active Minds, 2017; National Center for School Crisis and Bereavement, 2017; American Foundation for Suicide Prevention, 2018), three in Australia (Headspace School Support, 2015; Department for Education and Child Development, 2016; Australian Institute for Suicide Research and Prevention, 2017), one in Canada (Centre for Suicide Prevention, 2019), and one in the UK (Public Health England, 2016). Seven guidelines were targeted at schools (Headspace School Support, 2015; Department for Education and Child Development, 2016; Active Minds, 2017;

TABLE 1 | Summary of included studies.

Study reference, location	Study design, assessment	Level of evidence (NHMRC grade)	Sample intervention/control $N = \ldots$ Age: M (SD) or range Sex: F/M: n/n (%/%)	Intervention, setting	Outcome measures	Main outcomes	Limitations
Cha et al. (2018) Korea	Prospective cohort study Assessment: -Baseline: 1 week after suicide -Follow-up at 5 months	III-3	$N = 956$ F/M: 506/450 (53%/47%) Trauma-symptom group (CROPS ≥ 19) $N = 83$ Age: $M = 17.1$ (SD 0.8) F/M: 57/26 (69%/31%) Non-trauma group (CROPS < 19) $N = 873$ Age: $M = 16.9$ (SD 0.8) F/M: 449/424 (51%/49%)	A school-based crisis intervention program conducted 1 week after a peer suicide. Program included screenings, educational sessions, and further interview with psychiatric specialists for the trauma-symptom group. Setting: School	Posttraumatic stress symptoms: Child Report of Posttraumatic Symptoms (CROPS) The University of California at Los Angeles posttraumatic stress disorder (PTSD) reaction index (UCLA-PTSD-RI) Anxiety symptoms: Korean-Beck Anxiety Inventory (K-BAI) Depressive symptoms: Korean-Beck Depression Inventory-II (K-BDI-II) Complicated grief: Inventory of Complicated Grief (ICG)	Significant differences in CROPS, UCLA-PTSD-RI, K-BAI, K-BDI-II, and ICG scores between baseline and follow-up in both groups. Scores of the "trauma" group dropped more compared to the non-trauma group. At follow-up 2.9% of students were in the "trauma" group vs. 8.6% at baseline. A higher proportion of female students showed posttraumatic stress symptoms than male students.	Timing of follow-up determined by school circumstances Various psychosocial factors not examined, such as level of psychological closeness between the deceased and the students, social support, family functioning, or pre-existing psychopathology No unexposed control group
Kramer et al. (2015) Belgium, and The Netherlands	Pre-/post study Mixed methods: self-reported measures and interviews Assessment: -Baseline -Follow-up at 6 and 12 months -Interviews with selected sample after 12 months	IV	$N = 270$ Age: $M = 42.9$ (SD 12.4) F/M: 238/32 (87%/13%) Interview subgroup: $n = 29$ Age: $M = 45.3$ (SD 10.8) F/M: 26/3 (90%/10%)	Two government-funded web-based peer support forums for the bereaved by suicide. Site visitors can read and/or post messages about a specific topic. The two forums were similar in terms of layout, structure, and most of the predefined sub-forums. Setting: Online	Well-being: WHO-Five Well-being Index (WHO-5) Symptoms of depression: Center for Epidemiological Studies Depression Scale (CES-D) Complicated grief: Inventory of Traumatic Grief (ITG) Suicide risk: subscale of the MINI-International Neuropsychiatric Interview (MINI-Plus) Semi-structured interview about experiences with forum	Significant improvement in well-being and depressive symptoms (both $p < 0.001$). Small to medium pre-post effect sizes for well-being (6 months: $d = 0.24$, 12 months: $d = 0.36$), and small for depressive symptoms (6 months: $d = 0.18$, 12 months: $d = 0.28$). No change in grief symptoms ($p = 0.08$, 6 months: $d = 0.05$, 12 months: $d = 0.12$). No change in suicide risk (baseline: 20.8%. 12 months: 17.2%) Main reasons for visiting online fora: sharing with peers, finding recognition	Sample: online help-seeking, self-selected, mostly female Self-report measures subject to recollection bias High drop-out rate (43%) Dutch forum was launched 1 month before recruitment started, was not yet at its full capacity No control group

(Continued)

TABLE 1 | Continued

Study reference, location	**Study design, assessment**	**Level of evidence (NHMRC grade)**	**Sample intervention/control *N* = … Age: M (SD) or range Sex: F/M: n/n (%/%)**	**Intervention, setting**	**Outcome measures**	**Main outcomes**	**Limitations**
Peters et al. (2015) Australia	Retrospective study Mixed-methods: self-reported measures (online or hard copy) and interviews Assessment: shortly after intervention	IV	*N* = 82 Age: 75% over age 45 F/M: 75/7 (91%/9%) Interview subgroup: *n* = 30	The Lifekeeper Memory Quilt Project, implemented by the Suicide Prevention-Bereavement Support Services of the Salvation Army in 2008 to provide support for the bereaved by suicide and to create greater public awareness of suicide. Setting: Community-based	Participants' Evaluation of Quilt (PEQ-16): 16-item scale developed for the study to measure participant satisfaction Semi-structured interview about participants' experiences with project	High participant satisfaction (M 69.6; SD 9.1) According to 48%, 1 year after the loss was the best time for participating Approx. 92% rated the Quilt project as helpful or extremely helpful Qualitative analysis of the interviews found four themes: healing, creating opportunity for dialogue, reclaiming the real person, and raising public awareness.	Sample: mostly female, self-selected (55% response rate) People who participate in Quilt projects not necessarily representative Grief was not assessed Descriptive study No control group
Scocco et al. (2019) Italy	Pre-/post study Assessment: -Baseline: 4–6 days before intervention -Post: 4–6 days after	IV	*N* = 61 Age: *M* = 49.5 (*SD* 11.0) F/M: 49/12 (80%/20%)	A support program of mindfulness-based residential weekend retreats, including emotion- and grief-oriented exercises Setting: Residential, group	Mindfulness experiences: Five-Facet Mindfulness Questionnaire (FFMQ) Self-Compassion Scale (SCS) Dimensions of affect: Profile of Mood States (POMS)	Significant improvement over time in almost all dimensions of the POMS (mood states). No change in the dimensions of the SCS and FFMQ Compared with first-time participants, the multiple-participation group showed significant improvements over time on the Self-kindness subscale of the SCS and Non-judging subscale of the FFMQ	Sample: mostly female, help-seeking, self-selected participants Preferable, participants had attended self-help group/counseling Unclear if observed effects were related to intervention or group effects Grief was not assessed No follow-up data No control group
Supiano et al. (2017) USA	Prospective, observational study Analysis of the process of individual participant change in three complicated grief therapy groups	IV	*N* = 21 Age: *M* = 53 (range 34–73) F/M: 15/6 (71%/29%)	Complicated grief group therapy (CGGT): a multimodal, manualized group psychotherapy, with 2-h sessions over 16 weeks Setting: Clinical, group	Meaning reconstruction in grief: Meaning of Loss Codebook (MLC) Grief and Meaning Reconstruction Inventory (GMRI)	Therapy facilitated resolution of complicated grief symptoms and integrated memory of the deceased The MLC codes captured most of the statements of participants, helped articulating the therapeutic process, and showed that CGGT facilitated grief. Some participants continued to experience physical distress, depression or anxiety, even with improved self-care.	Sample: small and mostly female Sample limited to people bereaved by suicide with complicated grief Findings may only be generalizable to persons seeking intensive psychotherapy No control group

(Continued)

TABLE 1 | Continued

Study reference, location	Study design, assessment	Level of evidence (NHMRC grade)	Sample intervention/control $N = \ldots$ Age: M (SD) or range Sex: F/M: n/n (%/%)	Intervention, setting	Outcome measures	Main outcomes	Limitations
Visser et al. (2014) Australia	Retrospective cross-sectional study Assessment: after intervention (unspecified)	III-3	Intervention: $N = 90$ Age: $M = 45.7$ (SD 15.8) F/M: 73/17 (82%/18%) Control: $N = 360$ Age: $M = 40.1$ (SD 13.4) F/M: 311/49 (88%/11%)	Face-to-face outreach and telephone support provided by a professional crisis response team. The service then develops a customized plan, referring clients to other community services matched to their needs. The service is provided only to people who request it. Setting: Community-based	Quality of life: EQ-5D$^{\text{TM}}$ ICECAP index of capability Psychological distress: Kessler Psychological Distress Scale (K6) Suicidality: Suicidal Behaviors Questionnaire-Revised (SBQ-R) Work performance: World Health Organization Health and Work Performance Questionnaire (HPQ) Health care usage questions	Standby clients scored better on levels of suicidality ($p = 0.006$) No significant differences on other scales or health care usage	Sample: self-selected, mostly female Low response rate of clients (23%) Significant sociodemographic differences between the two groups Grief was not assessed Observational design, no control of confounding variables such as age of bereaved, time since death, and other treatments sought by participants
Wittouck et al. (2014) Belgium	Cluster RCT Assessment: Baseline 8-months after study entrance	II	Intervention: $N = 47$ Age: $M = 49.3$ (SD 13.8) F/M: 38/9 (81%/19%) Control/No treatment: $N = 36$ Age: $M = 47.6$ (SD 12.8) F/M: 25/11 (69%/31%)	Cognitive-behavioral therapy-based psychoeducational intervention, facilitated by clinical psychologists at participants' home 2 h sessions, 4 sessions, frequency not reported Setting: Clinical, group/family	Complicated grief: Inventory of Traumatic Grief, Dutch version (ITG) Depressive symptoms: Beck Depression Inventory (BDI-II-NL) Hopelessness: Beck Hopelessness Scale (BHS) Secondary outcomes: -Grief Cognitions Questionnaire (CGQ) -Utrecht Coping List (UCL)	No significant effect on the development of complicated grief reactions, depression, and suicide risk factors Secondary outcomes: Decrease in intensity of grief, depression, passive coping style, social support seeking and behavioral expression of negative feelings in intervention group only (all $p < 0.05$)	Sample: small, mostly female sample, possibly subject to selection bias Findings may only be generalizable to bereaved persons at-risk of complicated grief and/or seeking psychotherapy
Zisook et al. (2018) USA	RCT Assessment: -Baseline -Monthly -At week 20	II	Total: $N = 395$ -Suicide bereaved (SB): $n = 58$ -Accident/homicide (AH): $n = 74$ -Natural causes (NC): $n = 263$ Randomized in 4 groups: medication, placebo, CGT + medication, CGT + placebo Age: SB: $M = 47.2$ (SD 14.1) AH: $M = 51.6$ (SD 14.8) NC: $M = 54.6$ (SD 14.2) F/M: SB: 48/10 (82%/17%) AH: 56/18 (76%/24%) NC: 204/59 (78%/22%)	Manual-based structured Complicated Grief Therapy (CGT), facilitated by social workers, psychiatrists, psychologists Antidepressant medication (citalopram) with individual follow-up CGT: 16 sessions over 20 weeks Medication: 12-week with 2–4 weekly visits until week 20 Setting: Clinical, individual	Psychiatric symptoms: Structured Clinical Interview for DSM-IV-TR Axis 1 (SCID-1) Complicated grief: Complicated Grief Clinical Global Impressions Scale-Improvement (CG-CGI-I) Inventory of Complicated Grief (ICG) Structured Clinical Interview for Complicated Grief (SCI-CG) Grief-Related Avoidance Questionnaire (GRAQ) Suicidality: Columbia Suicide Severity Rating Scale-Revisited (C-SSRS-R) Impaired relationships: Work and Social Adjustment Scale (WSAS) Cognitions: Typical Beliefs Questionnaire (TBQ)	CGT was effective in all bereaved groups regarding CG symptom severity, suicidal ideation, grief-related functional impairment, avoidance and maladaptive beliefs. Lower improvement on clinician-rated CG-CGI-I in SB vs. AH and NC groups ($p < 0.5$) CGT seemed acceptable treatment in all groups Low acceptability of medication-only treatment	Sample: Underpowered to examine cause of death as a moderator and other possible interactions, for example related to socio-demographic variables High dropout rate in medication only subgroup Heterogeneity within cause of death subgroups No no-treatment control group

National Center for School Crisis and Bereavement, 2017; American Foundation for Suicide Prevention, 2018; Centre for Suicide Prevention, 2019) or colleges/universities (Higher Education Mental Health Alliance, 2014). Four guidelines aimed to assist (community) organizations and/or professionals helping all those bereaved by suicide (Survivors of Suicide Loss Task Force, 2015; California Mental Health Services Authority, 2016; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017), and one guideline specifically focused on a workplace environment (firefighters) (New York City Fire Department, 2016). All guidelines described their objectives. Seven guidelines described the methods of their development (Higher Education Mental Health Alliance, 2014; Headspace School Support, 2015; Survivors of Suicide Loss Task Force, 2015; California Mental Health Services Authority, 2016; New York City Fire Department, 2016; Australian Institute for Suicide Research and Prevention, 2017; American Foundation for Suicide Prevention, 2018), and the users were involved in the development of eight guidelines (Higher Education Mental Health Alliance, 2014; Headspace School Support, 2015; Survivors of Suicide Loss Task Force, 2015; California Mental Health Services Authority, 2016; New York City Fire Department, 2016; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017; American Foundation for Suicide Prevention, 2018). The evidence-base, described in ten guidelines mostly comprised a combination of references to literature and an expert advisory group or a consensus procedure, such as a Delphi study (Higher Education Mental Health Alliance, 2014; Headspace School Support, 2015; Survivors of Suicide Loss Task Force, 2015; California Mental Health Services Authority, 2016; New York City Fire Department, 2016; Public Health England, 2016; Active Minds, 2017; Australian Institute for Suicide Research and Prevention, 2017; American Foundation for Suicide Prevention, 2018; Centre for Suicide Prevention, 2019). Three guidelines described their theoretical model of postvention, i.e., a public health model (Survivors of Suicide Loss Task Force, 2015; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017). While three guidelines (California Mental Health Services Authority, 2016; Department for Education and Child Development, 2016; Active Minds, 2017) provided key recommendations, six provided sample material such as templates of letters (Higher Education Mental Health Alliance, 2014; California Mental Health Services Authority, 2016; Department for Education and Child Development, 2016; Active Minds, 2017; National Center for School Crisis and Bereavement, 2017; American Foundation for Suicide Prevention, 2018).

Research Question 1

Which suicide postvention service models have been shown to be effective to reduce distress in family, friends and communities following a suicide?

Research Studies (N = 8)

Research studies have found little evidence of effectiveness of interventions. Only five studies reported a positive outcome of their intervention (Visser et al., 2014; Kramer et al., 2015; Supiano et al., 2017; Cha et al., 2018; Zisook et al., 2018). A school-based intervention (Cha et al., 2018) and two intensive grief psychotherapy programs (Supiano et al., 2017; Zisook et al., 2018) found improvement in grief scores, including complicated grief (Zisook et al., 2018). School-based intervention (Cha et al., 2018) and an online support forum (Kramer et al., 2015) reported an improvement in mental health scores. A community-based crisis intervention program and an intensive grief therapy program reported decreases in suicidality (Visser et al., 2014; Zisook et al., 2018). In contrast, other measures in these studies, as well as the measures in the other studies (Wittouck et al., 2014; Peters et al., 2015; Scocco et al., 2019), including one RCT (Wittouck et al., 2014) yielded mixed results regarding grief, mental health or suicidality. Hence, while some evidence is emerging, this review found little evidence of effective models of postvention service delivery.

TABLE 2 | NHMRC levels of evidence.

Study	NHMRC level of evidence
Cha et al. (2018)	III-3
Kramer et al. (2015)	IV
Peters et al. (2015)	IV
Scocco et al. (2019)	IV
Supiano et al. (2017)	IV
Visser et al. (2014)	III-3
Wittouck et al. (2014)	II
Zisook et al. (2018)	II

TABLE 3 | NHMRC matrix to summarize the evidence base.

Component	Rating
Evidence base	D (Poor)
Consistency	D (Poor)
Clinical impact	D (Poor)
Generalizability	C (Satisfactory)
Applicability	C (Satisfactory)

Guidelines (N = 12)

Most guidelines ($n = 7$) focused on postvention activities in school or college (Higher Education Mental Health Alliance, 2014; Headspace School Support, 2015; Department for Education and Child Development, 2016; Active Minds, 2017; National Center for School Crisis and Bereavement, 2017; American Foundation for Suicide Prevention, 2018; Centre for Suicide Prevention, 2019). School postvention guidelines can play an important role in service provision considering that students bereaved by suicide might be at-risk of contagion. Furthermore, schools might be able to link at-risk students with counselors or mental health services. While most school guidelines were based on the literature, there were notable differences in their depth. Most guidelines covered the immediate period after death, including crisis response; while

TABLE 4 | Summary of study quality.

Quality criteria	Cha et al. (2018)	Kramer et al. (2015)	Peters et al. (2015)	Scocco et al. (2019)	Supiano et al. (2017)	Visser et al. (2014)	Wittouck et al. (2014)	Zisook et al. (2018)
A. Selection bias								
Representativeness	Somewhat likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely
Percentage agreed	Can't tell	Can't tell	<60%	Can't tell	Can't tell	<60%	80–100%	Can't tell
Rating	Moderate	Weak	Weak	Weak	Weak	Weak	Weak	Weak
B. Study design								
Study design type	Cohort	Cohort	Other	Cohort	Other	Other	RCT	RCT
Described as randomized?	No	No	No	No	N.a.	No	Yes	Yes
Method of randomization described?	N.a.	N.a.	N.a.	N.a.	N.a.	N.a.	Yes	Yes
Method appropriate?	N.a.	N.a.	N.a.	N.a.	N.a.	N.a.	Yes	Yes
Rating	Moderate	Moderate	Weak	Moderate	Weak	Weak	Strong	Strong
C. Confounders								
Pre-intervention differences?	Yes	N.a.	N.a.	N.a.	N.a.	Yes	Yes	Yes
Percentage confounders controlled for	<60% (few or none)	N.a.	N.a.	N.a.	N.a.	<60% (few or none)	80–100%	<60% (few or none)
Rating	Weak	N.a.	N.a.	N.a.	N.a.	Weak	Strong	Weak
D. Blinding								
Outcome assessors were blinded?	No	No	No	No	Can't tell	No	No	Yes
Participants were blinded?	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Yes
Rating	Weak	Weak	Weak	Weak	Weak	Weak	Weak	Strong
E. Data collection methods								
Valid measures?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Reliable measures?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rating	Strong	Strong	Strong	Strong	Strong	Strong	Strong	Strong
F. Withdrawals and dropouts								
Numbers and reasons reported per group?	No	No	N.a.	No	Yes	N.a.	Yes	No
Percentage completing study?	80–100%	<60%	N.a.	80–100%	80–100%	N.a.	80–100%	<60%
Rating	Weak	Weak	N.a.	Weak	Strong	N.a.	Strong	Weak
Total A-F:	WEAK	WEAK	WEAK	WEAK	WEAK	WEAK	WEAK	WEAK
Number of "strong" ratings	1/6	1/6	1/6	1/6	2/6	1/6	4/6	3/6
G. Intervention integrity								
Percentage participants received intervention?	80–100%	80–100%	80–100%	80–100%	80–100%	80–100%	80–100%	60–79%
Intervention consistency measured?	Can't tell	Can't tell	Can't tell	Can't tell	Yes	Can' tell	Can't tell	Yes
Confounding unintended intervention?	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell
H. Analyses								
Unit of allocation	Individual	Individual	Individual	Individual	Individual	Individual	Individual	Individual
Unit of analysis	Individual	Individual	Individual	Individual	Individual	Individual	Individual	Individual
Appropriate statistical methods?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Analysis by intention-to-treat status	No	No	No	No	No	No	No	Can't tell

TABLE 5 | Summary of guidelines[a] ($n = 12$).

Title Author Country, Year	Target users	Target population	Objectives described	Development methods described	Target users included in development	Evidence-base described	Theory of postvention described	Key recommendations included	Sample material included	Source
After a campus suicide: A postvention guide for student-led responses Active Minds USA, 2017	Students leading a campus-wide response to suicide	Schools after a student suicide	Yes	No	Unknown	Yes (Literature)	No	Yes	Yes (Social media postings)	https://www.activeminds.org/programs/after-a-campus-suicide-postvention-guide/
After a suicide: A Toolkit for schools, 2nd Ed. American Foundation for Suicide Prevention, Suicide Prevention Resource Center, Education Development Center USA, 2018	School administrators, staff, parents, communities	Schools after a suicide in the school community	Yes	Yes	Yes	Yes (Consensus procedure and Literature; Ref to NSSP)	No	No	Yes (Various letters, meeting agendas)	http://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf
After rural suicide: A guide for coordinated community postvention response California Mental Health Services Authority USA, 2016	Local public health, law enforcement, suicide prevention coalitions	Local community after a suicide	Yes	Yes	Yes	Yes (Consensus procedure and Literature; Ref to NSSP)	No	Yes	Yes (Various checklist, letters, flyers)	https://www.cibhs.org/sites/main/files/file-attachments/after_rural_suicide_guide_2016_rev.docx
A suicide prevention toolkit: After a student suicide Centre for Suicide Prevention Canada, 2019 (update from 2016)	Schools	Schools after a student suicide	Yes	No	Unknown	Yes (Literature)	No	No	No (link to AFSP 2018 guidelines, above)	https://www.suicideinfo.ca/wp-content/uploads/2016/03/After_a_student_suicide_web.pdf
Guidelines for schools responding to a death by suicide National Center for School Crisis and Bereavement, USC Suzanne Dworak-Peck School of Social Work USA, 2017	School administrators, teachers, and crisis team members	Schools after a suicide in the school community	Yes	No	Unknown	No	No	No	Yes (Various letters via link)	https://www.schoolcrisiscenter.org/resources/guide-responding-suicide/
Guidelines for suicide postvention in fire service (Standard Operating Procedure) New York City Fire Department USA, 2016	Firefighters peer support	Firefighters affected by suicide	Yes	Yes	Yes	Yes (Expert and Focus Groups consensus study)	No	No	No	https://www.tandfonline.com/doi/pdf/10.1080/07481187.2015.1077357?needAccess=true

(Continued)

TABLE 5 | Continued

Title Author Country, Year	Target users	Target population	Objectives described	Development methods described	Target users included in development	Evidence-base described	Theory of postvention described	Key recommendations included	Sample material included	Source
Postvention: A Guide for response to suicide on college campuses Higher Education Mental Health Alliance USA, 2014	Colleges, universities	Campuses after a death by suicide	Yes	Yes	Yes	Yes (Literature, Expert review)	No	No	Yes (One sample letter)	https://adaa.org/sites/default/files/postvention_guide-suicide-college.pdf
Postvention Australia guidelines: A resource for organizations and individuals providing services to people bereaved by suicide Australian Institute for Suicide Research and Prevention, and Postvention Australia Australia, 2017	Organizations and individuals providing services	People bereaved by suicide	Yes	Yes	Yes	Yes (Literature, Focus Groups, and expert review)	Yes	No	No	https://www.griffith.edu.au/__data/assets/pdf_file/0038/359696/Postvention_WEB.pdf
Responding to grief, trauma, and distress after a suicide: U.S. national guidelines Survivors of Suicide Loss Task Force, National Action Alliance for Suicide Prevention USA, 2015	All professionals and peers wishing to help those impacted by suicide loss	People bereaved by suicide	Yes	Yes	Yes	Yes (literature, Taskforce, Expert Group review, Ref to NSSP)	Yes	No	No	https://theactionalliance.org/sites/default/files/inline-files/NationalGuidelines.pdf
Responding to suicide in secondary schools: A Delphi Study headspace School Support Australia, 2015	School communities	Schools after a student suicide	Yes	Yes	Yes	Yes (Literature and Delphi consensus study)	No	No	No	https://headspace.org.au/assets/School-Support/hSS-Delphi-Study-web.pdf

(Continued)

TABLE 5 | Continued

Title **Author** **Country, Year**	**Target users**	**Target population**	**Objectives described**	**Development methods described**	**Target users included in development**	**Evidence-base described**	**Theory of postvention described**	**Key recommendations included**	**Sample material included**	**Source**
Suicide postvention guidelines: A framework to assist staff in supporting their school communities in responding to suspected, attempted or suicide death Department for Education and Child Development, Catholic Education SA Association of Independent Schools of SA, Child and Adolescent Mental Health Services SA Australia, 2016	Schools	Suspected, attempted, and suicide death	Yes	No	Unknown	No	No	Yes	Yes (Various letters and scripts)	https://www.education.sa.gov.au/sites/g/files/net691/f/suicide-postvention-guidelines.pdf
Support after a suicide: A guide to providing local services: A practice resource Public Health England, and National Suicide Prevention Alliance UK, 2016	Commissioners, local health and wellbeing boards, others	People bereaved by suicide	Yes	No	Yes	Yes (Literature, Advisory group, Ref to national suicide prevention strategy)	Yes	No	No	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

[a]*Based on the criteria of the "Appraisal of Guidelines for Research and Evaluation II" (AGREE Next Steps Consortium, 2017).*

others focused more widely from preparations for potential suicides to ongoing support and monitoring. Also considered were the importance of (social) media and use of language. The most comprehensive examples would include "After a suicide: A toolkit for Schools" (American Foundation for Suicide Prevention, 2018), "Responding to suicide in secondary schools: A Delphi Study" (Headspace School Support, 2015), and "Suicide postvention guidelines" (Department for Education and Child Development, 2016).

The remaining five guidelines (Survivors of Suicide Loss Task Force, 2015; California Mental Health Services Authority, 2016; New York City Fire Department, 2016; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017) were diverse with four focusing on postvention in the wider community (such as "After rural suicide," California Mental Health Services Authority, 2016), and one targeting a specific workplace (fire fighters) (New York City Fire Department, 2016). Three guidelines focused mainly on postvention service delivery: "Support after a suicide: A guide to providing local services" (Public Health England, 2016) provided a general overview; "Postvention Australia guidelines" (Australian Institute for Suicide Research and Prevention, 2017), concentrating on principles of postvention service provision for different organizations; The "US National Guidelines" (Survivors of Suicide Loss Task Force, 2015) provided an extensive literature review and a set of strategic directions. These three guidelines adopted a theoretical model of postvention service delivery, based on a public health approach (Survivors of Suicide Loss Task Force, 2015; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017).

Research Question 2

From the models identified in Question 1, what components of suicide postvention services have been determined to contribute to effectiveness?

Given the limited evidence found in the research studies included in this review, one must be cautious in identifying components that may have contributed to effectiveness of interventions. However, some potentially effective components are highlighted here. These can be understood in the context of a public health approach to postvention, as described in some of the guidelines (Survivors of Suicide Loss Task Force, 2015; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017).

Level of Support

In studies showing evidence of effectiveness there is a distinction between help offered to all individuals bereaved by suicide and help for those with higher levels of grief or mental health symptoms. Cha et al. (2018) distinguished between educational support for all bereaved students and a psychotherapeutic approach to those with high bereavement-related symptoms. Visser et al. (2014) distinguished between face-to-face early outreach to all suicide bereaved individuals and referral to treatment as needed, and Supiano et al. (2017) and Zisook et al. (2018) offered manualized intensive grief therapy to individuals with high levels of grief symptoms.

Peer Support and Involvement

Qualitative data reported by participants in online discussion forums (Kramer et al., 2015) and a community-based program (Peters et al., 2015) pointed to the importance of finding recognition of one's grief, sharing experiences, and providing and receiving peer-support. Also, the positive effects found in a residential treatment program might be attributed, at least partly, to the social support experienced during the residential stay (Scocco et al., 2019).

Grief Focus

Another common factor of the effective interventions seems a focus on the grief of the individuals bereaved by suicide. While this seems obvious, three studies did not measure grief in participants (Visser et al., 2014; Peters et al., 2015; Scocco et al., 2019).

Correspondingly, three guidelines described their theoretical model of postvention (Survivors of Suicide Loss Task Force, 2015; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017), i.e., public health models taking into consideration the notion of a continuum of survivorship (i.e., needs of help of the bereaved individuals may differ depending on the experienced level of impact of the suicide). The US national postvention guidelines (Survivors of Suicide Loss Task Force, 2015) were based on the framework used by the US National Strategy for Suicide Prevention (U.S. Department of Health and Human Services, 2012), comprising universal, selective, and indicated strategies, and research and evaluation. The UK Support after a Suicide guidelines (Public Health England, 2016) also referred to the public health model developed by the UK national suicide prevention strategy. It differentiates four levels of help that are offered to all the bereaved by suicide, to those in need of social support, to those who are strongly affected, and those who need specialized psychotherapy. Also the Postvention Australia guidelines (Australian Institute for Suicide Research and Prevention, 2017) adopted a similar four-level model of service delivery. **Table 6** summarizes these three models (Survivors of Suicide Loss Task Force, 2015; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017). It is understood that the number of bereaved people is largest in the lowest level (universal interventions) and smallest in the top level (indicated interventions). Together these guidelines also stress the need for training of service providers and rigorous surveillance, research and evaluation of interventions and service delivery.

Of note, the guidelines that did not refer to a theoretical model of postvention, such as the school-oriented guidelines (Higher Education Mental Health Alliance, 2014; Headspace School Support, 2015; Department for Education and Child Development, 2016; Active Minds, 2017; National Center for School Crisis and Bereavement, 2017; American Foundation for Suicide Prevention, 2018; Centre for Suicide Prevention, 2019) seem mostly based on a crisis intervention model, including immediate response after a suicide, follow-up and referral of at-risk students, and links with external services. Such crisis intervention approaches can be incorporated in a larger public health approach.

TABLE 6 | Postvention service delivery according to level of impact of suicide.

Level of postventive interventions according to actions recommended in guidelines	Responding to grief, trauma, and distress after a suicide: U.S. national guidelines Survivors of Suicide Loss Task Force (2015)	Support after a suicide: A guide to providing local services: A practice resource Public Health England (2016)[a]	Postvention Australia guidelines: A resource for organizations and individuals providing services to people bereaved by suicide Australian Institute for Suicide Research and Prevention (2017)	
Indicated interventions for people with mental health problems and disordered grief	Indicated interventions: evidence-based treatments, communication between service providers	In-depth therapy, one-to-one psychological help provided by qualified practitioners	Psychotherapy	Surveillance, research and evaluation
Selective intervention for people with severe grief reactions, strongly impacted	Implementation of guidelines, training of service providers, availability of services	Therapeutic/psychoeducational, one-to-one support, and facilitated "closed" groups provided by qualified practitioners and trained facilitators	Counseling	
Selective interventions for people with moderate grief reactions, mildly impacted		Self-help, peer support, "open" groups, and remembrance events organized by voluntary and peer groups	Support services, support groups, self-help groups, helplines, community and educational support	
Universal interventions for people with low levels of grief, little impact of suicide	Information and awareness of postvention in general public, professionals and organizations	Information on grief and bereavement by suicide and signposting to sources of support by local or national organizations	Information including leaflets, books, booklets, factsheets, posters and online information	

[a] *Two resources "Support after a suicide: Developing and delivering local bereavement support services" (http://www.nspa.org.uk/wp-content/uploads/2017/01/NSPA-postvention-framework-20.10.16.pdf) and "Support after a suicide: Evaluating local bereavement support services" (http://www.nspa.org.uk/wp-content/uploads/2017/01/NSPA-postvention-evaluation-24.10.16.pdf) complement the guideline.*

DISCUSSION

Discussion of Main Findings

This review was concerned with support for people bereaved by suicide and addressed the following two questions: (1) Which suicide postvention service models have been shown to be effective to reduce distress in family, friends and communities following a suicide? (2) From the models identified in question 1, what components of suicide postvention services have been determined to contribute to effectiveness?

A thorough search of the peer-reviewed and gray literature identified eight studies (**Table 1**) and twelve guidelines (**Table 5**) published since 2014. Overall, the studies included in this review involved diverse populations, settings, interventions, and measures, limiting the comparability of the findings. Most studies lacked a control group (Visser et al., 2014; Kramer et al., 2015; Peters et al., 2015; Supiano et al., 2017; Cha et al., 2018; Scocco et al., 2019), and overall study quality was weak. Still, five interventions resulted in positive outcomes regarding grief (Supiano et al., 2017; Cha et al., 2018; Zisook et al., 2018), mental health (Kramer et al., 2015; Cha et al., 2018), and suicidality (Visser et al., 2014; Zisook et al., 2018). The reviewed guidelines hold promise to inform and support suicide postvention services. However, except for three guidelines (Survivors of Suicide Loss Task Force, 2015; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017), all documents lacked a theoretical background, and no evaluations have been reported.

As this review was limited to publications since 2014 it is useful to consider additional evidence from earlier publications. A recent systematic review of effectiveness of controlled studies of interventions for people bereaved by suicide identified 11 studies published between 1984 and 2018 (Andriessen et al., 2019). That review found some evidence of effectiveness on grief outcomes of an 8-week support group program facilitated by a mental health professional and a trained volunteer (Farberow, 1992). A study comparing effects of a professionally led group psychotherapy and a social group program for widows bereaved through suicide found that grief symptoms reduced in the therapy group (Constantino and Bricker, 1996), although effects did not differ in a larger replication study (Constantino et al., 2001). A study comparing the effects of a death-related writing task intervention with a neutral writing task control condition yielded a significant reduction in grief levels in both groups, but more in the intervention group than in the control group (Kovac and Range, 2000).

Regarding psychosocial outcomes, the previous review (Andriessen et al., 2019) found that a 10-week psychologist-facilitated group therapy program for children reduced anxiety and depression but not posttraumatic stress of social adjustment at 12-weeks follow-up (Pfeffer et al., 2002). A psychoeducational component for parents may have contributed to the positive effects. A study of a series of three church-based support meetings following a suicide in the community found modest positive effects in the intervention group in terms of greater self-efficacy, social acceptance and job competency, up to 2 months after the intervention (Sandor et al., 1994). Together these studies suggest that social support in the community (Sandor et al., 1994), and a professionally led (with involvement of trained volunteers) support group or therapy group program for adults (Farberow, 1992) and for children (Pfeffer et al., 2002) might be helpful.

The components that might have contributed to positive effects of interventions in this review, were concerned with the different levels of grief or distress experienced by the bereaved, which is in line with public health models of postvention service delivery (**Table 6**). For example, informal, social support could be beneficial for all bereaved (Scocco et al., 2019). Those who are affected by suicide without symptoms of posttraumatic stress could benefit from an educational approach (Cha et al., 2018). Peer support, mutual recognition and sharing might be helpful for those mildly affected (Kramer et al., 2015), while those highly distressed and/or at-risk of disordered grief or ill mental health might benefit from specialized psychotherapy (Supiano et al., 2017; Zisook et al., 2018).

The recent systematic review identified additional potentially effective ingredients (Andriessen et al., 2019). The involvement of trained volunteers who serve as positive role models and peer supporters along mental health professional might contribute to effectiveness of support or therapy group effectiveness (Farberow, 1992). Pfeffer et al. (2002) suggested that psychoeducation of parents contributed to the effect of the intervention for bereaved children, as it enabled them to better support their children. Similarly, involvement of the wider community might contribute to the effectiveness of an intervention (Sandor et al., 1994). Also, it seems beneficial to deliver interventions over time (e.g., over 8–10 weeks) (Farberow, 1992; Pfeffer et al., 2002) or to use manuals or guidelines for the intervention (Kovac and Range, 2000; Pfeffer et al., 2002; Supiano et al., 2017; Zisook et al., 2018). Overall, grief specific interventions seem to yield stronger effect than interventions targeting other outcomes (Andriessen et al., 2019).

Most guidelines, especially school-based guidelines (Higher Education Mental Health Alliance, 2014; Headspace School Support, 2015; Department for Education and Child Development, 2016; Active Minds, 2017; National Center for School Crisis and Bereavement, 2017; American Foundation for Suicide Prevention, 2018; Centre for Suicide Prevention, 2019) are based on a crisis intervention approach. Callahan (1996) reported that an isolated school crisis intervention after a suicide might result in iatrogenic effects, such as increased distress and attempted suicide in students. Also, student suicide has a strong impact on school staff, who often feel ill-equipped to deal with it (Kõlves et al., 2017). Hence, it is recommended that school interventions are embedded in a whole-school approach, including suicide prevention and postvention training (Mackesy-Amiti et al., 1996; Robinson et al., 2016), and collaboration with specialized community mental health services (Rickwood et al., 2018).

Given that postvention is considered an important aspect of suicide prevention in Australia (Department of Health, 2017; Mental Health Commission of NSW, 2018) and internationally (World Health Organization, 2014), it seems logical to apply the same public health models to suicide postvention and prevention alike (Andriessen and Krysinska, 2012; World Health Organization, 2012). For example, the stepped-care model incorporated in the Fifth National Mental Health and Suicide Prevention Plan (Department of Health, 2017) fits well with the postvention models presented in the guidelines (**Table 6**) (Survivors of Suicide Loss Task Force, 2015; Public Health England, 2016; Australian Institute for Suicide Research and Prevention, 2017).

Limitations

Regarding evidence from research, important gaps exist regarding effectiveness of interventions for different age and gender groups of the bereaved individuals. Only one study targeted young people (Cha et al., 2018), no study specifically focused on older adults, and men are underrepresented in almost all studies (Visser et al., 2014; Wittouck et al., 2014; Kramer et al., 2015; Peters et al., 2015; Supiano et al., 2017; Zisook et al., 2018; Scocco et al., 2019). No study addressed Indigenous populations.

Only one study evaluated the effectiveness of help offered through the Internet (Kramer et al., 2015). Given the omnipresence of the Internet and social media, more research in this area could identify potentially effective postvention interventions and their components. Also, only one study addressed early outreach (Visser et al., 2014) and the effect of this approach on suicide bereavement remains unclear. Further, while two psychotherapy studies reported positive findings (Supiano et al., 2017; Zisook et al., 2018), one psychotherapy RCT failed to find evidence of effectiveness in comparison to the control group (Wittouck et al., 2014).

Due to lack of control groups, little is known of effectiveness of potentially effective components, such as psychoeducation, finding recognition of one's grief, sharing experiences and receiving/providing peer support. While suicide bereavement support groups are widely available, no study in this review examined their effectiveness. Moreover, many services for people bereaved by suicide have been founded by the bereaved themselves. However, it is unknown if these services are now more accessible to bereaved individuals than statutory services. The studies and guidelines included in this review involved both types of services. There may also be differences across countries. A future study might shed light on similarities or differences in service delivery according to the type of organization.

All the reviewed guidelines have great potential to inform, support, and complement existing services. Nevertheless, there is a need to evaluate their implementation and effectiveness. Inclusion of target groups and service providers in guideline development should ensure the feasibility and acceptability of guidelines. Adopting a theoretical (e.g., public health) model of postvention, training of service providers, and scientific evaluation of guidelines should maximize their impact and efficacy.

CONCLUSIONS

This review found limited evidence of effectiveness of postvention interventions and service delivery, mainly due to a relative shortage of research, particularly high-quality research involving control groups. Systematic searches of the peer-reviewed and gray literature identified eight research studies reporting on a variety of individual and group interventions, and 12 guidelines targeted at schools or the wider community. While this review identified serious gaps in the knowledge, it also identified several potentially effective components of postvention, such as involvement of trained volunteers/peers, and focusing the interventions on the grief.

Adopting a public health framework for postvention service delivery offers the opportunity to tailor support to bereaved individuals according to the impact of suicide on their lives. This can range from information and awareness raising targeting all people bereaved by suicide to specialized psychotherapy for those bereaved people who experience high levels of grief and symptoms of poor mental health. Such a framework might also align postvention with suicide prevention and mental health programs.

AUTHOR CONTRIBUTIONS

KA and KKr searched the peer reviewed literature and extracted the data. KA, KKr, and NR conducted the quality assessment. KKõ and KA searched the gray literature and guidelines, and KA and KKr extracted the data. KA drafted the manuscript. All authors contributed to the design of the study, revisions of the draft, and agreed with the final draft.

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SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2019.02677/full#supplementary-material

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*References of studies and guidelines included in the systematic review.

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BRIEF RESEARCH REPORT
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Factors of Seeking Professional Psychological Help by the Bereaved by Suicide

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Background: Studies show that people bereaved by suicide often feel a strong need for professional help. It is hypothesized that aspects related to suicide bereavement, such as stigmatization, shame or guilt, hinder help-seeking process of the bereaved. However, little is known about help-seeking behaviors of people who has lost someone due to suicide.

Aims: This study was conducted to attain a better understanding of the contributing factors, including the specific features of grief following suicide, to help-seeking behaviors of the bereaved by suicide.

Methods: The sample consisted of 82 adults bereaved by suicide (64 female; average age 37.79, *SD* = 14.33). Instruments assessing stigmatization, shame, guilt levels, well-being, tendency to disclose emotional distress and attitudes toward seeking professional psychological help were used. The participants were also asked an open-ended question what professional help-seeking barriers they had encountered. Comparisons between the groups, logistic regression analysis and thematic analysis of the qualitative data were performed.

Results: The findings revealed that bereaved participants who sought professional psychological help reported experiencing stigmatization and feeling guilty after the loss significantly more often. Also the results showed that attitudes toward mental health specialists had the highest prognostic value in predicting help-seeking behaviors of the bereaved. The participants themselves identified the gaps in the health care system as main barriers to seeking help.

Conclusion: The results challenge previously spread notion that stigmatization, guilt and shame after suicide can act only as help-seeking barriers.

Keywords: suicide, bereavement, help-seeking, professional help, stigmatization, guilt

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INTRODUCTION

Studies show that although part of grief reactions might be seen as similar among various types of losses, the levels of perceived stigmatization, shame and guilt are usually higher among the bereaved by suicide (Harwood et al., 2002; Pitman et al., 2016). Until the 19th century, suicide was treated as a crime as well as a sin and the suicide bereaved had to suffer not only the loss of a loved one but also some ways of punishment for the suicide (Knieper, 1999). A lot has changed since then, but at least subtle ways of stigmatization, such as avoidance or rejection of the suicide bereaved, still exist (Cvinar, 2005; Hanschmidt et al., 2016). It has been shown that stigmatization contributes to mourning problems after suicide (Feigelman et al., 2009) and affect suicide-bereaved individuals' ability to express their grief sincerely and openly (Chapple et al., 2015). Frost (2011) explains that the processes of stigmatization might vary from distant to the self to internalized ones referring to the application of negative meanings of stigma to a self-concept. Internalized stigma can be operationalized as feelings of shame (Hanschmidt et al., 2016) that are often related to defensiveness, self-hatred (Fisher and Exline, 2010), experiences of inadequacy or unworthiness (Wiklander et al., 2003) and mental distress (Bos et al., 2013). Such experiences motivate avoidance behaviors such as impulses to hide, flee or conceal oneself (Wiklander et al., 2003). Guilt might be defined as "a remorseful emotional reaction in grieving, with the recognition of having failed to live up to one's own inner standards and expectations in relationship to the deceased and/or the death" (Li et al., 2014, p. 166). Self-blaming thoughts and feelings that the bereaved should have done something to prevent the death are common among those who experienced suicide (Tal et al., 2017). According to Clark (2012), guilt can have negative psychological consequences, when it is too much for a person to bear. Excessive or chronic feelings of guilt can also lead to acts of self-punishment (Fisher and Exline, 2010).

As people bereaved by suicide might face many difficulties, they are often in need of help and support from their social network or from professionals (Provini et al., 2000; Dyregrov, 2011). Some studies found that even up to 95% of the suicide bereaved are in need of professional help in managing their grief (Wilson and Marshall, 2010). It was found that the bereaved by suicide might be in greater need for professional help than relatives of natural deaths (De Groot et al., 2006). Receiving appropriate professional support, if it is needed, diminishes the risk of experiencing negative consequences such as emotions of sorrow, lack of energy and abandonment (Schneider et al., 2011).

However, there are some discrepancies between suicide bereaved people needing and receiving help. The main problem arises when those who are in need of professional help do not seek it. For example, in Wilson and Marshall's (2010) study discussed before, only 44% of the suicide bereaved received professional help. Among mentioned barriers to seeking support are self-reliance, distrust of professionals, fear of being judged, reluctance to ask for help, concern for what others would think, lack of available information, poor mental health literacy, thinking no one could help or time, cost, distance (Provini et al., 2000; McMenamy et al., 2008; Wilson and Marshall, 2010; Andriessen et al., 2018).

Poor psychological condition is one of the most motivating factors to approach a professional. On the other hand, poor health, lack of energy are also mentioned among help-seeking barriers. In the study of McMenamy et al. (2008) depressed mood and lack of energy were identified as important obstacles to seeking help. Meanwhile, Wilson and Marshall (2010) found that the bereaved who were most in need of help received it. So the question if those bereaved who are most in need of help approach it remains open. It has also been claimed that more favorable attitudes toward mental health professionals are positively related to intention to seek help and to actual help-seeking behavior (Fischer and Farina, 1995; Elhai et al., 2008; Picco et al., 2016). However, we know very little about what attitudes people bereaved by suicide hold toward seeking professional help (Drapeau et al., 2015). Another factor often associated with the pursuit of psychological support is the tendency of a person to reveal personally relevant information related to distress (Kahn and Hessling, 2001; Kahn et al., 2012). Studies confirm the significance of the tendency to disclose distress to the attitudes and intentions to seek professional psychological counseling (Vogel and Wester, 2003; Nam et al., 2013). Research reveals that opening up emotions related to complicated bereavement can help to unblock the grief process (Wagner et al., 2006) and a tendency to openly discuss the death accounts for less grief difficulties (Feigelman et al., 2018). Sharing intimate information can be beneficial for growth processes following a traumatic event of suicide in the family (Levi-Belz, 2016).

It is often hypothesized that aspect related to suicide bereavement also hinder help-seeking process. Authors suggest that social stigma or shame might become serious help-seeking barriers of suicide-bereaved individuals and people after suicide attempt (Wiklander et al., 2003; Reynders et al., 2014; Skruibis et al., 2015). In their meta-analysis Hanschmidt et al. (2016) claim that stigma might lead survivors to manage it by concealment and social withdrawal. However, the understanding of these mechanisms is still theoretical. Most of the hypotheses come from other studies investigating, for example, help-seeking and stigma among those with mental health disorders. But little is known regarding help-seeking behaviors of people bereaved by suicide (Drapeau et al., 2015). Some results from previous research could as well contradict formerly mentioned ideas as the bereaved who go to therapies could also be those who feel more guilt or stigmatization. Studies show that those bereaved who receive sufficient professional support report less feelings of guilt (Schneider et al., 2011). What is more, professional help can help to reduce tension related to stigma (Miller and Kaiser, 2001).

Taking this into account, we find it important to investigate the role of the aspects related to suicide bereavement to seeking help from professionals in the context of other potentially relevant factors. More knowledge in this field would ensure that scientifically based practical recommendations that best fit the needs and interests of the bereaved could be provided. Furthermore, such studies are especially relevant in Lithuania that has one of the highest suicide rates, underdeveloped postvention resources (Klimaite et al., 2017) and extremely little scientific research in this field (Andriessen, 2014).

We raise the hypothesis that those suicide-bereaved who (1) feel less stigmatized, ashamed, guilty after the loss, (2) have lower scores of well-being, (3) are more inclined to reveal distressing information to others and (4) have more positive attitudes toward specialists, are more prone to seek help from mental health professionals. Also we want to investigate whether the mentioned constructs have significant value in predicting if a person had been seeking professional psychological help after the suicide. In addition, we aimed to reveal which barriers to seeking help from professionals the participants identify themselves.

MATERIALS AND METHODS

Participants and Procedures

The sample consisted of 82 adults bereaved by suicide: 64 females (78%) and 18 males, mean age 37.79 years (*SD* = 14.33; range = 19–70 years). 56 (68%) participants lived in a big city, 14 (17%) – in a city, 12 (15%) – in a town/village. Distribution of participants by education: 23 (28%) – primary/secondary, 18 (22%) – vocational, 41 (50%) – university degree; marital status: 14 (17%) – single, 45 (55%) – married/in a long term relationship, 5 (6%) – divorced, 17 (21%) – widow/widower, 1 (1%) – other.

The average time since suicide was 12.23 months (*SD* = 6.52; range from 5 to 36 months). Distribution of participants by the type of relation with the deceased: 55 (67%) lost a member of the nuclear family (10 – father/mother, 4 – sibling, 12 – spouse, 6 – child), 22 (27%) lost another relative, 5 (6%) lost a friend or acquaintance.

Participants were divided into two subsamples by usage of professional psychological help after suicide. It was considered that a participant used professional psychological help if he or she had at least one consultation with a psychologist/psychotherapist, psychiatrist or participated in a support group led by a professional psychologist. No other information regarding help received was required (e.g., the number of therapy sessions). The first subsample consisted of 38 (46%) persons who reported seeking professional help after the suicide.

Participants were recruited nationally via associations of the bereaved by suicide, social media websites, e-mail groups, mental health professionals and snowball sampling. To ensure higher response rates participants could choose between filling in online survey or getting a printed copy by mail. All the participants were contacted by a member of the research team (by e-mail or phone) who explained the aim of the study, participation conditions (voluntary basis, confidentiality, prerogative to refuse participation at any time) and agreed on participation type (online or paper). Then the participants were provided a link to the self-administered survey site or sent a paper questionnaire by mail, which both contained the study consent form. Research team was prepared to provide participants with information about professional help contacts if needed. Up to two reminder e-mails were sent or phone calls were made if participants failed to respond. 18% of the participants who were initially contacted by the research team did not fill in or return the questionnaires. In total, 22 (27%) paper and 60 online questionnaires were filled in.

Measures

Grief Experience Questionnaire (GEQ) (Barrett and Scott, 1989) is a self-administered instrument measuring various components of grief, including those that have been more associated with grief after suicide. From the original GEQ scale Bailley et al. (2000) found it consists of eight factors. For the purposes of the study we used Stigmatization (10 items), Shame (seven items) and Guilt (six items) subscales of the GEQ. Responses to items in each subscale have a Likert scale from 1 = "never" to 5 = "almost always." Total scores range from 10 to 50 for the Stigmatization subscale, from 6 to 30 for the Guilt and from 7 to 35 for the Shame subscales, with higher scores indicating higher levels of the perceived stigma, guilt or shame. The reliability evaluations in Cronbach's alphas for the Stigmatization, Guilt and Shame subscales in our sample were: 0.88,0.87, and 0.81, respectively.

The World Health Organization Well-Being Index (WHO-5) is a 5-item Likert-type scale (from 0 = "at no time" to 5 = "all of the time") that assesses various aspects (mood, activity, etc.) of psychological well-being during the previous 2 weeks (Psychiatric Research Unit, and WHO Collaborating Centre in Mental Health, 1999). Total score of the scale varies from 0 to 100, where a percentage score of 0 represents worst possible, whereas a score of 100 represents best possible quality of life. The Cronbach's alpha of WHO-5 in this study was 0.90.

The Distress Disclosure Index (DDI) (Kahn and Hessling, 2001). The 12-item DDI measures the degree to which a person discloses (vs. conceals) emotionally distressing information. Participants respond to items on a five-point scale ranging from 1 = "strongly disagree" to 5 = "strongly agree." Higher scores indicate a higher willingness to disclose personal information to others. Among the present data, coefficient alpha for scores from the DDI was 0.91.

The Attitudes Toward Seeking Professional Psychological Help – Short Form scale (ATSPPH-SF) (Fischer and Farina, 1995) assesses help-seeking attitudes of the respondents. It consists of 10 items on a four-point Likert-type scale (from 1 = "never" to 5 = "almost always"). Total score ranges from zero to 30, with higher score indicating more favorable attitudes toward seeking professional help. The Cronbach's alpha of total ATSPPH in this study was 0.83.

The participants were also asked an open-ended question what professional help-seeking barriers they had encountered. Questions measuring demographic, loss-related and help-seeking variables were included in the analysis too.

Data Analysis

Data were analyzed using SPSS 25.0. Categorical data are reported as percentages, and continuous variables are reported as means and their standard deviations. Pearson correlation analysis was used to investigate the relationship between variables. The comparison analyses of the study groups were carried out using MANOVA. A binary logistic regression analysis was used to evaluate the impact of chosen factors on the likelihood that respondents would report that they contacted a mental health professional after suicide of a loved one. A p-value < 0.05 was used as criterion for statistical significance evaluation.

An open-ended question was analyzed by performing thematic analysis based on the steps singled out by Braun and Clarke (2006). The double-coding procedure was chosen to ensure the reliability in this study. If coding discrepancies were found, they were discussed with the help of additional experts in suicidology, final decisions were made.

RESULTS

There were no statistical differences between the two groups of bereaved people who sought and those who did not seek professional psychological help by participant gender [help-seeking group = 87% female, non-seeking group = 70% female; $\chi^2(1,82) = 2.31$, $p = 0.128$]; age [help-seeking: $M = 36.50$, $SD = 12.99$, non-seeking: $M = 38.91$, $SD = 15.46$; $t(80) = 0.76$, $p = 0.451$]; education [$\chi^2(2,82) = 0.05$, $p = 0.977$]; place of residence [$\chi^2(2,82) = 1.47$, $p = 0.479$]; previous professional psychological help experience [help-seeking group = 41% had previous experience, non-seeking group = 30%, $\chi^2(1,81) = 0.64$, $p = 0.423$]; time since suicide (help-seeking: $M = 11.93$ months, $SD = 5.28$, non-seeking: $M = 12.49$, $SD = 7.47$; $Z = -0.30$, $p = 0.762$) and type of the relationship with the deceased (help-seeking group = 71% first-degree relative, 29% second-degree relative, friend and others, non-seeking group = 64% first-degree relative, 36% second-degree relative, friend and others) [$\chi^2(1,82) = 1.42$, $p = 0.491$]. Such results indicate that described characteristics were not significantly important in predicting help-seeking behaviors in this sample.

Among those participants who sought professional help, 32 (84%) consulted psychologist or psychotherapist, 18 (47%) – a psychiatrist and 13 (34%) participated in a support group lead by a professional. 21 (55%) of the participants used more than one kind of professional help for mental health problems due to suicide. Respondents who approached professionals indicated that it was partly to highly helpful as measured on a 1 ("harmful") to 4 ("very helpful") ($M = 3.47$, $SD = 0.63$) scale.

Results indicated that stigmatization was positively associated with guilt and shame, and negatively related to well-being. As well as, more positive attitudes toward help-seeking were positively associated with a tendency to disclose oneself (**Table 1**).

A MANOVA was conducted comparing levels of stigmatization, shame, guilt, well-being, self-disclosure and attitudes toward help-seeking for groups of help-seekers and non-help-seekers. We performed Wilks' Lambda test which showed significant results, Wilk's $\Lambda = 0.735$ $F(6,75) = 4.50$, $p = 0.001$, $\eta^2_p = 0.27$. Moreover, the results demonstrated significant differences between groups: help-seeking group experienced higher levels of stigmatization and guilt, as well as had more positive attitudes toward seeking help (**Table 2**).

TABLE 1 | Relationship between the study variables.

	1	2	3	4	5	6
(1) Stigmatization	–					
(2) Shame	0.47***	–				
(3) Guilt	0.44***	0.30**	–			
(4) WHO-5	−0.45***	−0.18	−0.28*	–		
(5) DDI	0.07	−0.12	0.12	0.06	–	
(6) ATSPPH-SF	0.21	0.12	0.26*	0.07	0.39***	–

*WHO-5, Well-Being Index; DDI, Distress Disclosure Index; ATSPPH-SF, Attitudes Toward Seeking Professional Psychological Help – Short Form Scale. *p < 0.05, **p < 0.01, ***p < 0.001.*

Binary logistic regression was performed to assess the impact of factors that were found significant in previous analysis on the likelihood that respondents would report that they sought professional psychological help after the suicide. The model contained three independent variables (stigmatization, guilt and attitudes). It was statistically significant $\chi^2(3,82) = 24.67$, $p < 0.001$, as a whole explained between 25 and 33% of the variance in help-seeking behaviors, and correctly classified 71% of cases. As shown in **Table 3**, only the attitudes toward seeking help from professionals had significant predictive value.

Themes on help-seeking barriers identified by the participants themselves are shown in **Table 4**. Many of the participants indicated no obstacles. The most frequently mentioned obstacles were related to the gaps in the health care system.

DISCUSSION

In our hypothesis we claimed that suicide bereaved people who feel less stigmatized, ashamed and guilty after the suicide of a loved one should be more prone to seek help from mental health professionals. Our results did not confirm it. On the contrary, it revealed that those bereaved who sought professional support had higher stigmatization and guilt levels. Although the regression analysis did not show the prognostic value of the constructs, differences between the groups of individuals who were and were not seeking help might indicate that stigma and guilt can even act as factors motivating the decision to seek support from professionals. What could be some potential explanations for such findings?

Some studies show that social support can be one of the factors influencing seeking help from mental health professionals. Maulik et al. (2009) found that increased social support was related to less frequent use of formal mental health services. Therefore, the loss of support after the death can encourage the bereaved to look for other ways of getting it. Also, we know that people develop different coping and support strategies to resist stigmatization (Frost, 2011; Hanschmidt et al., 2016). Seeking help from professionals might be one of them. Mental health specialists can create a safe environment for expressing emotions related to prejudice and stigma (Miller and Kaiser, 2001). Furthermore, search for explanation is common among the suicide bereaved (Lindqvist et al., 2008). It might also serve as endeavor to reduce guilt feelings by finding other convincing reasons why the loved one died by suicide (Klimaitė, 2015). For such purposes the bereaved might be hoping for psychoeducation about suicidal processes from mental health professionals as it is noted that information about suicidal and grieving processes facilitate mourning (Klimaitė, 2015). Schneider et al. (2011) found that those bereaved who received sufficient professional support reported less feelings of guilt. So those who feel more guilt about the suicide might have more reasons to take advantage of professionals in reducing those unpleasant feelings.

Another possible explanation is the impact of stigmatization and guilt to the health outcomes of the bereaved. As we discussed earlier, it is found that stigma is related to

TABLE 2 | Results of comparing the scores of the variables by help-seeking behaviors of people bereaved by suicide.

Suicide bereavement group	**Help-seeking (n = 38)**	**Non-help-seeking (n = 44)**			
Outcome measures	**Mean score (*SD*)**		***F***	***p***	η_p^2
Stigmatization	25.58 (9.23)	20.34 (7.32)	8.20	0.005**	0.09
Shame	17.63 (6.05)	16.16 (6.07)	1.20	0.276	0.02
Guilt	21.18 (5.43)	17.68 (6.24)	7.24	0.009**	0.08
WHO-5	35.68 (20.55)	44.73 (23.66)	3.36	0.071	0.04
DDI	42.13 (7.61)	38.43 (10.89)	3.08	0.083	0.04
ATSPPH-SF	32.82 (4.39)	27.18 (6.99)	18.41	<0.001***	0.19

WHO-5, Well-Being Index; DDI, Distress Disclosure Index; ATSPPH-SF, Attitudes Toward Seeking Professional Psychological Help – Short Form Scale. $^{**}p < 0.01$, $^{***}p < 0.001$.

TABLE 3 | Logistic regression predicting likelihood of seeking professional psychological help after the suicide.

Variable	***B***	***SE***	**Wald**	**OR**	***p***	**95% CI**
Stigmatization	0.07	0.04	2.71	1.06	0.100	0.99–1.14
Guilt	0.04	0.05	0.75	1.04	0.387	0.95–1.14
ATSPPH-SF	0.16	0.05	10.16	1.17	0.001**	1.06–1.30

ATSPPH-SF, Attitudes Toward Seeking Professional Psychological Help – Short Form Scale. $^{**}p < 0.01$.

mourning difficulties (Feigelman et al., 2009), intense guilt feelings can have negative psychological consequences too (Clark, 2012). In our study stigmatization and guilt were negatively associated with well-being of the participants. This means that people who feel more stigmatization or guilt also can have more complicated grief and intense unpleasant mourning reactions. Testing hypotheses about indirect effects of stigmatization and guilt to help-seeking would require future research.

The study revealed that the only significant factor in predicting whether a person sought help after the suicide was attitudes toward seeking professional psychological care. The role of attitudes toward seeking help was found to be important in previous research too (Picco et al., 2016). The results confirm the significance of programs targeted at changing attitudes toward seeking help from mental health professionals.

We did not find statistical differences of shame levels between the groups. According to some authors, external shame (in this case, perceived stigmatization) is more important to humans than the internal one because of our evolutionary based need for belonging to a group (Kim et al., 2011). It would explain our results. However, as shame can be seen as internalized stigma (Hanschmidt et al., 2016) we hypothesize that the relation between professional help-seeking and shame might be more complicated and more difficult to capture.

Adaptation to the changes after the loss was evaluated by analyzing the index of well-being. No significant differences were found between the subjective well-being (WHO-5) of the bereaved who sought professional help and those participants who did not seek it. Of course, the survivors had already received or had been receiving help before the moment of participation in the study. So it is likely that those bereaved who got treatment were less depressed than before the intervention. However, the results did not reveal that health condition act as a help-seeking barrier. It was mentioned by the participants themselves only once too.

We also found that participants who contacted specialists were more inclined to disclose distress to others, but the difference was

TABLE 4 | Themes on help-seeking barriers identified by the participants.

Generalizing theme	**Sub-themes**
No obstacles indicated (51)	No obstacles (41); no need for help (8); did not seek professional help (2)
Health condition (1)	Shock (1)
Personal beliefs and feelings (11)	Stigma of seeking help (2); disbelief that help can be effective (2); fear of speaking with a stranger about sensitive topics (1); preference to cope by oneself (1); guilt due to the loss (1); other undefined internal barriers (4)
Negative experience (5)	Negative previous experience (2); inappropriate specialist (3)
Disappointment in specialists due to suicide (1)	
Gaps in the health care system (33)	Too much effort needed to get an appointment (1); it takes a long time to get help (3); lack of help sources at the place of residence (4); received only short-term help (1); dissatisfaction with medical treatment (2); need for specialists working in private practice (5); financial difficulties (7); Need for active approach from professionals (10): need for specialists' active role in offering help (2); lack of information on help available (8)
Other individual barriers (3)	Lack of time (2); other individual obstacles that impede access to help sources (1)
Use of other sources of help (4)	

The number of times the theme was introduced by the participants is shown in brackets.

not significant. Although some studies show that a tendency to reveal emotionally relevant information to others is related to the attitudes or intentions of seeking help (Nam et al., 2013), it can be that in the face of severe emotional stress even those people who are not open about their emotional problems in their everyday life seek support from professionals. We also did not find significant differences between the groups regarding receiving professional psychological help before the death. These results also confirm that the bereaved sought new ways of help resources independently from their previous experiences.

The participants themselves highlighted the gaps in the health care system as main barriers to seeking help from mental health professionals. A need for active approach from professionals and lack of information on help available were mentioned the most often. The participants noted financial difficulties as barriers and a need for specialists working in private practice. The idea that the participants did not see seeking help from public mental health specialists (that is free of charge in Lithuania) as an option might imply mistrust in public mental health care system. Individual factors were mentioned less often. Such results reflect the importance of improving health care system to ensure proper and easily approachable help resources. However, it is also a reminder that the position of "I do not need help" might mask other important individual factors that cannot be easily captured by qualitative methods.

One of the limitations of our study was that participation percentage of men was much lower. Although, there were no differences in our sample, some studies find that help-seeking behaviors of men and women might be variant (Vogel et al., 2007). However, male non-response bias is very often in suicide bereavement research (Pitman et al., 2016). Also, the inclusion of the participants into our sample was not random. High participation avoidance was noticed in previous suicide bereavement studies in Lithuania too (Klimaitė, 2015) so investigating help-seeking behaviors of people who do not seek or are even against mental health professionals remains a challenge. Another limitation is that in our study we did not differentiate between seeking help from distinct professionals (ex. psychologists and psychiatrists) and did not have more detailed information about help received. Although, some studies show that attitudes toward mental health specialists are shared at least to some degree (Barney et al., 2006), it would be important to apply more nuanced measures of help-seeking process than we were able to use in our broad-based survey. Furthermore, in our study we had retrospective evaluations of respondents' previous experiences. As it was not a longitudinal study design we did not have a chance to capture changes in measured constructs before and after the professional intervention.

Vogel et al. (2007) notice that help-seeking does not constitute of a single act or choice, it is a process that often encompasses conflicts between various approach and avoidance factors, so it is not easy to evaluate general tendencies of peoples' help-seeking behaviors. As one bereaved by suicide illustrated the complexity of the phenomena by identifying guilt as a barrier ("The hardest thing was to get over myself, accusations of myself appeared to be very reasonable at first") as well as the reduction of it as one of the main advantage ("My psychologist introduced me with the process of bereavement. I especially needed to become aware of the fact that this was not my responsibility") of help-seeking (Geležėlytė, 2019).

It is also worth mentioning that cultural context is important in studies investigating such culturally sensitive phenomena as guilt, shame, stigmatization and grief itself (Li et al., 2014; Pitman et al., 2016). Lithuania is among countries with highest suicide mortality that might have culturally ingrained reasons too (Gailienė, 2015).Authors also claim that there are specific reasons for stigmatization of suicide in the country due to the history of occupations and cultural trauma (Klimaite et al., 2017). Having in mind that comparison of help-seeking behaviors of suicide bereaved people is novel, it is crucial to continue such studies and compare the results in different cultures.

CONCLUSION

Despite limitations, the results of the study challenge previously spread notion that stigmatization, guilt and shame after suicide of the loved one can act only as help-seeking barriers. The findings indicate that those bereaved who feel more stigma and guilt might contact professionals more often. Also the results showed the attitudes toward mental health specialists had the highest prognostic value in predicting help-seeking behaviors of the bereaved. The participants themselves identified the gaps in the health care system as main barriers to seeking help.

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available on request to the corresponding author.

ETHICS STATEMENT

Approval for the current study was obtained from the Psychology Research Ethics Committee of Vilnius University. The participants provided their informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

OG and DaG designed and carried out the study. SD and DoG collected the data and contributed to the writing of the manuscript. OG, JL, and EM-R performed the initial analyses, and contributed to the writing of the manuscript. DaG and PS assisted in the writing of the manuscript and supervised the study. All authors revised and approved the submitted version.

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'We're the First Port of Call' – Perspectives of Ambulance Staff on Responding to Deaths by Suicide: A Qualitative Study

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Introduction: Exposure to suicide is a known risk factor for suicide. Ambulance staff are exposed to work-related stressors including attending suicides, which may elevate their risk for mental health problems/suicide. Little is known about ambulance staff's perspectives on how they experience these events and whether they feel equipped to respond to bereaved families at the scene of death. This study explores the perspectives of ambulance staff about responding to deaths by suicide.

Materials and Methods: A convenience sample of ambulance staff recruited from one ambulance service in England. In-depth, qualitative, semi-structured face-to-face interviews conducted with nine ambulance staff (six male, three female) to explore experiences of responding to suicide. Data analyzed using thematic analysis.

Results: Participants reported the experience of job-related strain including exposure to the suicide/suicidal ideation of colleagues; they described suppressing their distress despite significant emotional impact. All participants had been personally bereaved by suicide and responding to suicide was a common part of their job. They were often the first professionals at the scene, and undertook varied and often conflicting roles: negotiating with patients in crisis; informing individuals of the death of a loved one; preserving the body/potential crime scene; dealing with the intense emotional reactions of bereaved individuals. Participants reported long-term, salient memories of these events; however, there was a reported lack of acknowledgment in the workplace that suicides may be traumatic and no guidance for staff on how to cope. Opportunities to debrief were reportedly rare, and there was reluctance to access work-based liaison services. Training in how to respond to individuals bereaved by suicide was also lacking.

Discussion: The study is the first to reveal the complex challenges faced by ambulance staff in responding to suicide without adequate training and support. It demonstrates the potential impact that responding to suicide can have personally and professionally on staff, and emphasizes the need for employers to support staff wellbeing in better ways. Training and postvention support could enable better coping among staff, more effective support for bereaved individuals and reduce the risk of death by suicide both in those bereaved by suicide and in ambulance staff.

Keywords: suicide, suicide bereavement, postvention, ambulance staff, emergency services, first responders, grief, training

INTRODUCTION

Each year worldwide, over 800,000 people die by suicide (World Health Organisation [WHO], 2014), more than 6,000 of these in the United Kingdom (Office for National Statistics, 2019). As first responders, ambulance staff who attend deaths by suicide may be exposed to multiple such events and are expected to respond to bereaved individuals at the scene.

For over three decades there have been indications in the literature that the effects of exposure to such events on first responder staff can be distressing, leading to raised mental health issues among these professionals (James, 1988; Beaton et al., 1995; Clohessy and Ehlers, 1999; Alexander and Klein, 2001; Bennett et al., 2004). A more recent US-based survey among first responders revealed that 14% reported either moderate or severe symptoms of depression, 28% moderate or severe symptoms of anxiety, 26% significant PTSD symptoms, 31% harmful alcohol use and/or alcohol dependence, 93% significant sleep disturbance, and 34% high risk for suicide (Jones et al., 2018). Unsurprisingly, it has been known for some time that levels of sickness absence among ambulance staff are higher than among other groups of National Health Service (NHS) staff (Bennett et al., 2004) and indeed, five times the national average (NHS Information Centre for Health and Social Care, 2012). Work-related stress has been indicated as a potential reason (Mildenhall, 2012).

Exposure to suicide is a known risk factor for further suicide (Pitman et al., 2016). Research with other first responders such as the police and firefighters demonstrates that these staff may be exposed on average to 30 such events during their working lives (Cerel et al., 2018), with higher levels of suicidality than other professionals (Stanley et al., 2016). Such cumulative exposure may increase the risk of suicide among first responders (Kimbrel et al., 2016). Indeed, in recent Australian and United States studies, first responders had a significantly higher likelihood of death by suicide compared to other occupations (Milner et al., 2017; Vigil et al., 2019). In addition, suicide risk is higher in males (Office for National Statistics, 2019) and as the majority of ambulance staff are men, gender is a further group characteristic that may potentially increase their suicide risk. Research with ‘second responder’ professionals who come into contact with suicide suggests that this experience can be profoundly distressing for some (Seguin et al., 2014), that they may be unsure how to respond to the bereaved, may feel powerless to help and are unaware of other resources (Halligan and Corcoran, 2001; Foggin et al., 2016). Additionally, a lack of training in suicide bereavement has been commonly reported among professionals exposed to suicide (Foggin et al., 2016; Gibbons et al., 2019).

The perspectives of first responders about their experiences of suicide-related work are absent from the literature (Maple et al., 2019). As well as scant published literature, there is little guidance available to direct practice (National Institute For Health And Care Excellence, 2018). Consequently little is known about the experiences of front-line ambulance staff about their exposure to fatal and near fatal suicide events in the course of their work and whether they feel equipped to respond to bereaved individuals at the scene of death. The aim of this exploratory study was to illuminate the experiences of ambulance staff in relation to attendance at a suicide, including interaction with families bereaved by suicide at the place of death.

MATERIALS AND METHODS

As the aim was to explore the experiences of ambulance staff from their own perspectives, the study took a qualitative approach.

Ethical approval was obtained from an NHS research ethics committee in North West England (reference 11/NW/21047). A convenience sample of self-selecting participants from one ambulance service in England was recruited to take part in semi-structured exploratory interviews. Those ambulance staff who could recollect their experiences of responding to a suicide (involving contact with individuals bereaved by suicide at the place of death) were eligible to take part.

Information about the study was advertised in a regional staff bulletin, on the staff intranet and by poster displayed on ambulance station notice boards. Potential participants were invited to contact the research team directly by email or phone to express their interest in taking part. Further information about the study was provided to those expressing interest in a more detailed information sheet, verbal clarification was also offered and staff had the opportunity to ask questions before deciding whether or not to participate.

If participants confirmed their willingness to take part in the study a convenient date, time and interview location was arranged. Participants provided informed, written consent before any data collection took place in in-depth, semi-structured, face-to-face interviews in their homes or workplaces. A topic guide developed from the literature guided the interviews to explore experiences of responding to suicide (see **Table 1**).

TABLE 1 | Interview topic guide.

Questions	Prompts
Tell me about your experiences of attending a suicide/suicide attempt as part of your job.	Rare/common occurrence?
How does attending a suicide impact upon you?	
Describe your experiences of responding to bereaved individuals at the scene of a death by suicide?	Challenges/opportunities?
How equipped do you feel to respond to bereaved individuals in these circumstances?	Helpful/unhelpful aspects?
What workplace support is in place to help you with suicide-related work and what else could help?	Formal/informal support?

Interviews were conducted with participants in February 2014. Interviews were audio-recorded, transcribed, anonymized and exported to NVivo 12 software for data management and coding (QSR International Pty Ltd., 2018). Data were jointly analyzed by the first and second authors using a thematic analysis approach to enable production of pre-determined and new ideas (Braun and Clarke, 2006), focusing on similarities and differences in participants' accounts. Data were jointly discussed and refined before key superordinate themes were identified.

RESULTS

Participants

In total, nine ambulance staff (six male, three female, all white British) took part in in-depth interviews lasting between 50 and 110 min. All participants were experienced staff, working in the ambulance service between 8 and 28 years (see **Table 2** for sample characteristics).

TABLE 2 | Final sample characteristics.

Participant	Gender	Professional role
P1	Male	Paramedic
P2	Female	Paramedic
P3	Female	Advanced technician
P4	Male	Paramedic
P5	Male	Paramedic
P6	Male	Advanced paramedic and station manager
P7	Female	Paramedic
P8	Male	Paramedic
P9	Male	Paramedic

Key Themes

Three key theme sare presented using illustrative data extracts that capture participants' perspectives on responding to suicide: (1) a profession under strain; (2) responding to suicide in a professional capacity and; (3) lack of workplace support following exposure to suicide. Participants' names and some of the detail of extracts are anonymized to protect the identity of those taking part.

A profession under strain

Lack of understanding of ambulance staff's role and low professional kudos. Ambulance staff described themselves as a profession under strain. One source of pressure was a perceived lack of understanding about the role of ambulance workers (and in particular of the challenges they face in carrying out their duties), among both the public and other health professions. This was compounded by the simultaneously high expectations of service users in relation to what they imagined ambulance staff could offer at the scene of traumatic incidents such as suicides or suicide attempts:

> *. . .healthcare professionals don't know what we do; GPs [primary care doctors] haven't a bloody clue what we do.* (P5, male)
>
> *. . .I have to say, in situations like [suicide] or any other situation, people's expectations of the ambulance service is phenomenal.* (P3, female)

Many felt that even friends and neighbors did not understand their job and misunderstood them as emotionally detached when responding to intensely traumatic incidents:

> *They just seem to think we're on autopilot and. . . nothing bothers you, nothing affects you. . . I think they see us as real hard. . .very hard people and we're not. . .* (P7, female)

In relation to the many other NHS professions, ambulance workers reported feeling demoralized, forgotten and neither valued nor respected by colleagues from other disciplines:

> *We are the forgotten. . . the forgotten group the ambulance personnel.* (P9, male)
>
> *We're the service what everybody uses and abuses.* (P7, female)

Participants viewed themselves as somewhat unpopular with other parts of the NHS such as accident and emergency (A&E) and psychiatric departments, as a result of being seen to be the generators of work for other staff:

> *You walk in with a patient and [A&E staff] look at you and – 'you're here again with another one?' You know, it's like 'well, what do you want me to do, go round the block?'* (P2, female)
>
> *I won't say they don't like us, but basically, we're the person who brings them the work. So, if they've got a department that's full or nearly full and two or three ambulances pitch up outside A&E, obviously they're going to be thinking 'well is there somewhere else they could've gone?'* (P5, male)

Participants stressed that these difficulties could intensify with A&E or public services outside the NHS such as the police, if for example a suicidal patient had mental health issues or had consumed alcohol. Such responses served to increase ambulance workers' sense of isolation because the options for channeling patients appropriately were significantly narrowed in these cases; some described the added strain of often having to take up defensive positions with other services to handle these challenges:

> *In regard to the psychiatric side of things you are limited at what you can do because. . . once they've had alcohol nobody seems to want*

> *to touch them... we haven't got an avenue to go down, about half the time.* (P5, male)
>
> *You learned very, very quickly, to stick up for yourself, whether it was clinically, personally, professionally, you learned just to stick up for yourself... and I think... that's the case, because paramedics are the lowest common denominator.* (P8, male)

The high expectations of the ambulance service reported by participants combined with a perceived lack of understanding of their role and little respect from colleagues inside and outside the NHS, contributed to experiences of job-related strain among ambulance staff.

Professional and personal bereavement by suicide. A significant additional source of strain for staff was losing colleagues to suicide during their career in the ambulance service. Indeed all participants reported having lost a colleague to suicide at least once and often multiple times. Knowing colleagues who had either attempted or died by suicide was therefore not uncommon:

> *So I think roughly in that space of time [10 years], three of probably the first five paramedics in the country... are all dead or tried to take their lives.* (P6, male)

One participant described going on shift, to be informed that a member of his team had died by suicide. He and his colleagues felt they had no option but to conceal their distress and continue working, regardless of their closeness to the colleague who had died:

> *...we'd come in on the shift and we were told, and basically you manned your ambulance and went out. If you didn't go... then there'd be no ambulances going out there. So you're just... well, like robotic. You just went out.* (P5, male)

Participants often lived in the geographical area in which they also worked. As a direct result there would be occasions when, in responding to an incident, the person who had died by suicide was either a colleague or a family member of a colleague; such incidents were extremely distressing for crew members:

> *Not sure what triggered it off, but he... took a massive overdose and died, and we resuscitated him.* (P6, male)
>
> *Our crews went out to [colleague's suicide] and that, as a group, affected us really badly.* (P8, male)

Some staff had, in the course of their work, been charged with informing colleagues that members of their own family had attempted or died by suicide; others remarked that suicidality among the profession was fairly commonplace:

> *[Colleague 1] was at a job, and [Colleague 2] went. [He] was the officer running [the region] at the time and... it fell to him to go and get [Colleague 1] and tell him that [family member had made a suicide attempt], and then say to him... you need to step aside, the crew is taking over...* (P3, female)
>
> *...when you're talking to different members of staff there's been a couple that have talked to me, and they've sort of been at a very low ebb... you know... I could become a midlife statistic myself.* (P1, male)

In addition to losing colleagues to suicide, some participants had family members who had attempted or died by suicide; one had lost a close family member and attributed his own attempted suicide to this loss. Despite being bereaved by suicide, with suicidal ideation, on returning to professional duties he was expected to attend suicides as a first responder.

Exposure to the suicide or suicidality of colleagues was an added strain for ambulance workers, yet staff habitually learned to suppress their feelings of distress and continue their work despite significant emotional impact.

Responding to suicide in a professional capacity

The impact on ambulance staff of attending suicides. Ambulance staff were routinely called to suicides or suicide attempts as a '*daily*' (P7, female) part of the job, involving a range of circumstances. Staff were often the first professionals at the scene:

> *It's what we get called to, to be honest, you know, suicide goes on, we're going out to it, so if somebody's dying, finding them... whether it would be by pills, other means or anything... we're the first port of call. I've done at least four in the last 10 months probably myself... but we get that many.* (P1, male)
>
> *Well who deals with it? Well, it's a sudden death, we do, and the police – long before you get to GPs, mental health, social services... it's us and the police, no one else touches [suicide].* (P8, male)

Responding to a suicide or a suicide attempt could strongly impact ambulance staff and be emotionally demanding, more so than attending the scene of accidents or other traumas:

> *... there's quite a few [suicides] where it's been really bad. the worst one I had was the [homicide-suicide] over in Locality 2 where [parent killed family and self]. That was one of the worst ones...* (P5, male)
>
> *I can put [suicide] quite high up 'cos... I find that harder to deal with than trauma. Trauma to me is just an everyday thing what we go out to. I can deal with that – that's my job, that's what we do... seeing somebody hanging... it's the most horrendous thing ever to see somebody hanging. I mean for me that's the worst job ever.* (P7, female)

Attending a suicide could evoke personal feelings of distress and vulnerability for crew members, particularly where staff identified in some way with the deceased (for example if the person who had died by a similar age to one of their children or other relatives):

> *How... could you imagine your own child dying, you know how must that feel? It's unthinkable isn't it, and I think for some staff we have children that are at home that are probably the same age as somebody that you've just dealt with.* (P4, male)
>
> *People... will come back to the station... they ring home and make sure everyone is all right, you know, because that's how it affects you.* (P2, female)

Participants reported that it was difficult to forget what they saw in the course of their work. Some described long-term, salient memories of exposure to suicides that they could recall in fine detail, often years after the event; the most traumatic events were often etched in their memories:

> *Suicide[s] they always stick… there's always a thing which stays in the back of your mind. I could take you to the first suicide [I attended]. It's not far from here, I could take you to where we found him in the car. I can describe how we got him out of the car, how he was positioned, his size and everything.* (P9, male)

> *It would be… probably about 1990, something like that, '91. It was a nice summer's day like this… all the detail yeah… you do get flashbacks.* (P5, male)

Suicides could *'haunt'* (P9, male) thoughts and interfere with sleep and normal activities:

> *…it was horrific; it was like a horror movie! [The deceased] basically, the body had exploded… the belly and everything… I couldn't sleep. I just constantly… it was like a horror movie, I just kept seeing this [person]…* (P7, female)

> *I wouldn't believe anybody that had been to, whether it was an adult or a child suicide… if they said that it didn't affect them because it always affects you… I'll go to bed and I'll dream about it and I'll have strange dreams and I'll think about it… [suicide] affects you mentally in some other way whether you think that you're over it or not.* (P4, male)

Participants described exposure to multiple suicides in the course of their work, incidents which could be personally distressing. Attending suicides could evoke salient and detailed recollections that could impact on normal functioning and endure over the long-term. Exposure to suicide was said to induce subconscious trauma of which staff could be unaware.

Conflicting roles at the scene of suicides or suicide attempts. Ambulance staff undertook varied and often conflicting roles when responding to fatal and non-fatal suicide attempts. One role was to deal with individuals who were experiencing suicidal thoughts or who were actively suicidal. Professionals reported feeling in danger in such situations and often ill-equipped to respond appropriately to individuals in mental crisis:

> *I remember going to a woman who… said she wanted to kill herself, and I remember… talking with her and she was very distressed… and I remember looking round and taking things like pencils away… but… she ran into the kitchen and… she pulled out this massive… serrated bread knife and because she went like that [brandishes knife]… stupidly, I put my hand round the serrated knife like that and I just.* (P3, female)

> *This is what [patient] was telling me last night – 'I've had to come out of the flat because I'm searching for a rope and I know that I'm going to kill myself.' Well, I just sat there and thought 'God, what am I gonna do here? What…?' Didn't want to die, but he said he'd got somebody sitting here telling him to go and do it…* (P7, female)

Ambulance staff described fulfilling several different professional roles at once in the course of responding to suicide attempts. For example they could be functioning like '*social services*' (P3, female) by taking on a welfare role with some patients and assuming duties that they perceived to more appropriately sit with other public services:

> *I've googled things for people – where the nearest Citizens Advice is or whatever… 'cause sometimes they've got money issues as well and the landlord has wanted them out… and years ago the police used to take the violent ones, but now… because [police are] having death in custody… they're washing their hands of it… and… we mop up everything, from a drunk in the street who's just been thrown out of a pub or whatever [to] the people who can't get GPs…* (P5, male)

> *…we got a girl who was… trying to do herself in, commit suicide, and we had to pull over because… she was trying to… get out the back door as the motor's moving. So, there are two of us in the back trying to hold her down… and we were trying desperately to stop her… and all she wanted to do was jump out the doors and run in front of a car. But sometimes the police… they sometimes try and get out of that by saying 'we'll follow in the car right?'* (P1, male)

Ambulance staff as first responders had to multi-task at the scene of a suicide or suicide attempt, performing resuscitation, dealing with relatives and transporting patients to hospital. While non-fatal suicide attempts could be seen by some as less emotionally draining because the professional could actively focus on saving a life and treating injuries, such events often brought other challenges and potentially multiple patients at the scene to deal with:

> *I've been to a child death before where a child has been hanging and you know, you're trying to deal with the parent but you're trying to resuscitate the child, and for those first 20, 30 min… I'm sorry, [parent] can have some involvement but my main… your duty of care is to that child.* (P3, female)

> *It's challenging, but because you've got a patient to treat, [non-fatal suicide attempt is] not as upsetting – daft as it seems – because you're focused on the injuries and you can… you're in automatic pilot because… don't forget, you've got other people there who are potentially patients, i.e., the driver of the train 'cause he's just seen somebody jump in front of him so he's emotionally upset. And it can bring on heart attacks, it can you know, the stress.* (P5, male)

In relation to a potential suicide, ambulance staff described being expected to fulfill two conflicting roles. Initially arriving with the aim of saving life, when a person was dying by suicide (or was already dead), staff described immediately becoming custodians of a potential crime scene. It was reported that when a person had died, these scenarios may be a low priority for the police, meaning long waits at the scene of death before police attend:

> *…the police have got to be there, the body has got to be taken down after forensics have been, and then you can deal with the family after… so it then potentially becomes a crime scene, because we don't know if it's a suicide or whether it's an assisted suicide… so we have to inform the police… it's not a priority [for the police], because the person is deceased, so we can wait until the police turn up and then nothing can be done.* (P2, female)

> *Because we're now being asked to do the police's job, and… the police are taking 40 min to get to a job… it's a potential crime scene.* (P8, male)

These were potentially volatile situations in which staff could be exposed to the distress of bereaved families over a prolonged period. Staff perceived that denying people access to the body of their loved one (when they wanted to care for the deceased) could be experienced as an insensitive and even inhumane act, risking violence or verbal abuse from families. Thus, preserving the potential crime scene without adequate support, often induced feelings of helplessness in ambulance staff. As well as shielding the body of the deceased from families, conversely, staff felt it was their duty to shield families from the body. Far from being insensitive to the feelings of bereaved families, this was in an effort to protect the emotional wellbeing of the bereaved by preventing visual exposure to the deceased:

> *[Deceased by suicide had] taken a massive overdose... but, he'd been there a week and he was... hanging down the settee and we couldn't recognize the features... but... then the family had been told, and the family came down, and we couldn't let them in and see him as he was, because they wouldn't have recognized him... so we were trying to keep the family...they wanted to come in... luckily the police turned up, else we wouldn't have been able to stop them.* (P2, female)
>
> *The police come along and they become so clinical... [husband] knows his wife is still hanging in the garage, all he wants is [for her] to be able to be laid at rest. And, I'm there for another, what, hour and a half, and she's still there, because [police] have got to wait for the forensics to come, and take pictures and all this. Then, they call for the fire brigade to come and get her down, so then you've got six firemen coming in, [husband has] seen his wife in this state, they're traipsing in and out. his son comes, his son wants to see his mother but he can't...* (P9, male)

One ambulance worker who had been bereaved by suicide himself felt conflicted about what he described as the *'litigation'* culture that dictated the leaving of bodies in place after a death by suicide. He felt there should be more respect for bodies of the deceased and for the bereaved and described his own attempts at practically demonstrating such respect at the scene of suicides:

> *...it's having the respect for the dead as much as the living... like when I go out to a [suicide] if there's no reason for the [deceased] to be where they are, I want to put them so that they're at rest. So, if I can get them into a bed, or I can get them onto the settee and... put a blanket on them so they look at peace, or the... relative who wants to cuddle with them, and they want to lie with them, I haven't got a problem with it.* (P9, male)

Ambulance staff described conflicting roles and duties at the scene of suicide or suicide attempts; some that they felt ill-equipped to handle and others that they believed could be more appropriately managed by other public services.

Dealing with the reactions of people at the scene. As ambulance staff were often the first professionals at the scene of a suicide, they were tasked with informing the family or friends of the deceased that a loved one had died. This meant that staff had to contend with often *'volatile'* (P1, male) situations and deal with the intense emotions/reactions of bereaved individuals, sometimes more than one. Staff could encounter extreme distress, anger and even violence among the bereaved, mixed with strong feelings of guilt or shame that those close to the deceased had not been able to anticipate the death:

> *...by the time the [family] arrived on scene, they saw [deceased by drowning... and that was a very difficult job. you've got [family] and they turn up at the scene... and they were in pieces.* (P8, male)
>
> *...[wife of deceased] just completely blew her lid.... it was an emotional not an aggressive state, but you know, she was trying to move the body... but then once the daughter had calmed down, she did then warn us that the son was on the way and he would be aggressive. She just said he would flip, so we had to leave the property... because she said... he'll start throwing and smashing things around the house and he won't care who's here.* (P2, female)

When a person had already died, staff could feel '*absolutely helpless*' (P7, female), and often felt blamed by bereaved individuals for not being able to bring the person back. This was compounded by having to complete paperwork after a death, involving questioning the deceased relatives and friends that some staff felt was inappropriate:

> *...one of the things that the family want you to do...'why aren't you doing something?!' The fingers pointed – 'why aren't you trying to get my loved one back?', even though they probably realize that their loved one's gone. We're not just standing with our hands in our pockets, but we're trying to calm the situation... we can't do anything, because there's nothing we can do. But they vent frustrations to us because it looks like we're just standing there doing nothing for their loved ones, and our main role is to support life, and keep people alive, and the family can't understand that.* (P1, male)
>
> *...we've got to go back to the... relatives and the parents of [person who has died by suicide] and say, can I start asking you a few questions now please? [The] police [should carry out this function], I personally think we've been through enough with the resuscitation and... we have to enter the property again and come back into the situation, then start again... it's a different role then... because the person is really now deceased and then you've got to start off bombarding the relatives with questions...* (P2, female)

In addition to handling the reactions of the deceased's family and friends, ambulance staff were also called upon to deal with members of the public and other colleagues who may need support at the scene of a suicide. Staff could feel overwhelmed and often helpless when faced with these multiple responsibilities:

> *I went out to a [violent death by suicide of a young person]... I'd got a policeman saying he was ready to vomit, I'd got a student paramedic with me who couldn't cope with it, and I'm trying... to deal with [colleagues] and deal with... the [person] was dead, but [unconnected members of the public were caught up in the incident]... I couldn't, I didn't know what to do...* (P7, female)
>
> *...we had... a young girl, she was a trainee [ambulance] technician. She [was] just out on her 1st day as a tech, and that was her first sight of a dead body, and she couldn't believe how the family reacted, and she couldn't cope, she broke down crying. We had to deal with her because... the hysterics of what was happening, the daughter and then the mother coming in...* (P2, female)

At the scene of a suicide, ambulance staff reported being regularly tasked with dealing with the distress of bereaved families and members of the public/colleagues who were also present. Circumstances could be volatile when a loved one was unable to be revived, with the bereaved often venting their frustration on staff who felt powerless to help.

Lack of workplace support following exposure to suicide

Lack of formal acknowledgment of the potential impact of suicide on staff. Despite the demands placed upon ambulance staff when attending suicides there was a reported lack of acknowledgment in the workplace that this work may be traumatic and no guidance for staff on how to cope. While the opportunity for taking a break or de-briefing after traumatic incidents including suicides was reportedly offered in theory, in practice it was said to rarely happen due to time constraints, staff shortages and *'by the clock'* (P5, male) working:

> *In principle, they have it, if you want to go home you can, but I think in reality very few people ask for it… and I don't think [service managers] want you to do it, because they want you to stay available… it wouldn't be encouraged… they'll say 'can we clear now for the next [Category] A?' they want you clear for that. So in terms of me asking for counseling and time out, they'll be watching that.* (P8, male)

> *…from the moment I put on the radio 'book clear' [after a suicide] – that's when you become available – and it literally is a bump on the screen, you've got another job to go to… there's no 'oh are you okay?'… because… we're just stretched to the limits, there's not enough of us, there's not enough vehicles out on the road, and you're just literally being bombarded.* (P9, male)

In addition to time-pressured working which could discourage staff to ask for support, there was also a reported culture of *'manning up'* (P5, male) which was perceived to signal in more imperceptible ways to staff (even those personally bereaved by suicide), that needing support was not be encouraged:

> *…you can ask for time out after a bad job… and I would suspect very few ask for it. And even if you did ask for it, [management] would probably think you were pulling a fast one… I suspect.* (P8, male)

> *… the unfortunate part [is]… if you can't cope with the stress, you shouldn't be in the job. There's no such thing as stress in the ambulance [service].* (P9, male)

There was said to be a *'stigma'* (P2, female) around asking for help and a 'macho' culture which encouraged the use of '*black humor*' (P4, male) and, even for female members of staff, *'blokey things'* (P3, female) as coping mechanisms in situations of high stress. The prevailing ethos was to suppress internal distress, '*shut it down*' (P8, male), and force oneself to continue working regardless of feeling traumatized:

> *…there's a lot of new staff coming on…. and some of them might be a little bit nervous to say 'I've just seen something and I can't deal with that'… and then are they thinking 'well I'll try and work through… and think I can deal with this'.* (P1, male)

> *I wouldn't ring the SALS [staff advice and liaison service] up to get any help because I feel that people would say she knows what the job's all about…* (P7, female)

There were some isolated reports of workplace support being offered to staff who were distressed by attending suicides or being bereaved by suicide, however, the overriding representation was one of the absence of easily accessible support after trauma, including the suicide of colleagues. There was no official workplace guidance or protocol on how to respond to suicides or how to care for staff who may be affected by suicide; the onus was on staff themselves to look out for signs of distress in other colleagues:

> *…there's nothing we've been given that says, if you go to this job and then you come back in [you] have somebody to speak to.* (P2, female)

> *…we'd have to sort of rely on SALS [staff advice and liaison service] members and other staff members to keep an eye out on people who've gone to things which may trigger them, such as suicide.* (P3, female)

Even in the case of informing co-workers that a loved one had attempted suicide or taken their own life, there was no protocol in place to guide this eventuality. In light of this staff talked about coping informally among themselves, though relying on the support of colleagues alone could be problematic. The availability of peer support was affected by time pressures and increasing demand on the service which saw staff working out on the road in isolation for long periods rather than being able to connect with co-workers at ambulance stations; staff felt unsupported even when they were tasked with responding to major critical incidents such as a homicide/suicide:

> *Years ago you used to do a job and… your crew members would be coming back to station, control would ring the station if there was a crew there – 'look the crew are coming back they've had a bit of a nasty job, either a fatal, or a child, or a suicide… [just] giving you the heads up'. So as soon as they come – cup of tea, and you would sit down and you'd have a chat, and you used to self-debrief… and now… you don't even see stations because we haven't got stations no more.* (P9, male)

> *[Deceased]… had… [killed family members and self]. There was nothing in place [for staff] except just looking after yourselves and looking after your crew mates… that's your support, is your mate. but if you haven't got a good mate…* (P5, male)

The potential impact on staff of attending multiple suicides was reportedly not acknowledged and there were barriers that discouraged staff from help-seeking when needed. In the absence of formal structures and guidance on how to support staff in relation to exposure to suicide, workers relied on informal peer support, though this could be problematic.

Reluctance to access work-based support. There was a reported reluctance among staff to access work-based liaison services that were described by some participants as merely *'lip service'* (P8, male) or *'tick box'* (P3, female) because they were purportedly not used by staff:

> *…[what's] available… is not always accessed.* (P6, male)

> *…[staff] don't use it. I don't know many people that do use it.* (P7, female)

Reasons for this reluctance included worries about confidentiality and a lack of expertise among those who staffed the service. The staff advice and liaison service (SALS) was described as being staffed by '*a bunch of volunteers*' (P3, female) from within the same service as potential users, eliciting concerns about possible disclosure of private information among co-workers. Participants suggested that they would be more likely to use a service that was more independent:

> *. . .you think well, you know, if I talk to him it will go round the station, it's not necessarily confidential, so it would be better if you knew there was. . . somebody confidential or a confidential service that you could speak to.* (P4, male)

> *. . .the people who do the SALS, I know it's all confidential, but. . . you know them and they work on the road. . . and. . . that's the reason why I don't tend to use it. . . I've got this fear of going to one of them and it not being strictly confidential. If I didn't know them and it was a separate organization, I'd quite happily go and see them.* (P7, female)

There was also concern that '*[the] ambulance service doesn't really know how to cope with mental health*' (P3, female) with an accompanying lack of confidence in the expertise among SALS volunteers. The service was perceived as unable to handle staff who were suicidal:

> *I'm worried about the training, because all [SALS] are is ordinary ambulance people. . . who've done a bit of a course. And. . . they care, and they make the effort and obviously they've done the training, but I don't think they've done proper training.* (P5, male)

> *. . .if it did come to the crunch that I did decide to take my life, I'll be honest with you I wouldn't ring [SALS], because I don't. . . I really don't think that they would be able to cope at that point.* (P9, male)

Services for ambulance staff who may need support after exposure to suicide were seen as somewhat tokenistic. There was a reported reluctance among staff to access such services because they were typically staffed by volunteers from within their own ranks who were perceived to lack expertise in mental health and suicidality; there were also concerns about confidentiality and a preference for the provision of independent staff support services.

Lack of training in responding to suicide. Participants reported that they had '*no training. . . whatsoever*' (P7, female) in how to respond to relatives at the scene of suicides and described being in the position of '*feeling your way*' (P5, male) in these situations. There were reports from staff of feeling helpless in these instances leading in some cases to a lack of engagement with the bereaved:

> *It's a horrible feeling because you don't know what to say to them. What can I say to them that's gonna make them feel any better. . . what the hell do I say to these people here? I don't know what to say.* (P7, female)

> *. . .you can't say anything, you can't do anything. . . my strategy is say as little as possible. . . there's nothing you can say. . . 'you'll be all right, or, it's okay, it'll pass' because it won't pass. And it won't be all right, [they'll] mourn them for the rest of their life. So I say as little as possible.* (P8, male)

Some staff commented that the lack of training in how to respond to people who were bereaved by suicide was surprising because attending these kinds of deaths was such a common part of the job. Additionally, staff had no knowledge of how to respond to colleagues who had themselves been personally bereaved by suicide:

> *[Colleague]. . . didn't realize how my [close family member] had died at first until I broke down and told her. And then she said like. . . she didn't know how to cope with it.* (P9, male)

> *. . .it was all very much, you know, supporting each other in the duty room because we'd lost one of our colleagues, he'd killed himself.* (P6, male)

It was felt that the '*focus should be on supporting ambulance staff*' (P8, male) in how to respond to the bereaved by suicide appropriately. It was reported that '*accredited*' (P5, male) training in this area that was recognized by a paramedical professional body would be beneficial for ambulance staff to address gaps in knowledge and skills and confidence:

> *I dealt with [suicide]. . . the only way I knew how to. But, sometimes you, you get blinkered. . . [and] if somebody else says 'oh well, have you thought of it that way? Oh, never thought of that.' – so. . . [training] might. . . you know, broaden the horizons to say, yes this is another way of doing it. Because if I go to a suicide. . . I can only deal with it how I personally dealt with it. . . because I don't know how else to deal with it.* (P1, male)

> *I think any training will give staff confidence and, you know, you're never going to bring that person. . . back. but relatives and those that have been bereaved want to talk about it. . . you know, they want to talk about. . . what you've done, what you found, you couldn't do anything because of this, and you know, you did this, because it's all part of that grieving, I suppose isn't it?* (P4, male)

Participants reported a lack of training in how to respond to people bereaved by suicide (including colleagues) and feelings of helplessness which led some to disengage completely from families at the scene of death. Training that was endorsed/accredited by a professional body was viewed as potentially beneficial in equipping ambulance staff with the skills and confidence to respond more appropriately to the bereaved at the scene of fatal suicides.

DISCUSSION

Key Findings

The reportedly high expectations of the ambulance service among the public combined with a lack of understanding about their role, and a perceived lack of respect from colleagues inside and outside the NHS contributed to participants' experiences of job-related strain. Exposure to suicide or the suicidal ideation of colleagues was an additional intense source of strain for ambulance workers; staff reported learning to suppress their distress to continue working in their high-pressure professional role despite the significant emotional impact they experienced.

Participants described exposure to numerous suicides in the course of their work, incidents which they found extremely distressing. Attending suicides could evoke salient and detailed recollections of violent and distressing deaths by suicide that impacted on normal functioning and could endure over the long-term. Some participants reported feeling traumatized when they responded to such incidents, but felt under pressure to suppress their emotions, due to the lack of support within the workplace; however, exposure to suicide was also said to induce subconscious levels of trauma that staff may not be immediately aware of and that may result in delayed stress reactions/mental health issues. Ambulance staff described conflicting roles and duties at the scene of suicide or suicide attempts which could be difficult to manage. Staff reported feeling ill-equipped to carry out some of these duties, such as managing people behaving dangerously or in mental health crisis; some staff believed that these situations could and should be managed by colleagues with more appropriate expertise such as the police or mental health/social services professionals. At the scene of a suicide, ambulance staff were tasked with dealing with the distress of bereaved families and members of the public/colleagues who were also present. Circumstances could be volatile, particularly when resuscitation was unsuccessful or when they denied families access to the body. Staff were fearful that families bereaved by suicide would vent their frustration on individual ambulance workers.

The impact on staff of attending multiple suicides was reportedly not acknowledged in the workplace and there were barriers that discouraged staff from help-seeking when needed. In the absence of formal structures and guidance on how to support staff in relation to exposure to suicide, workers relied on informal peer support, though this could be problematic. Work-based services offered for ambulance staff who may need support after exposure to suicide were seen as somewhat tokenistic and there was a reported reluctance among staff to access such services. Reasons for such reluctance included that services were typically staffed by volunteers from within workers' own ranks and perceptions that volunteers lacked the necessary expertise in mental health and suicidality to appropriately handle staff's needs; there were also worries about the confidentiality of volunteer services and a preference for the provision of an independent source of staff support. There was also a reported a lack of training in how to respond to people bereaved by suicide (including colleagues) and feelings of helplessness which led some ambulance staff to disengage completely from interactions with the bereaved at the scene of such a death. Training that was endorsed/accredited by a professional body was viewed as potentially beneficial in equipping ambulance staff with the skills and confidence to respond more appropriately to the bereaved at the scene of fatal suicides.

Contribution to Current Understanding

While qualitative approaches have previously examined paramedic experiences of providing care for people who self-harm (Rees et al., 2017), to the authors' knowledge this study is the first to illuminate in depth the first-hand perspectives of ambulance staff in relation to attendance at a suicide, including interaction with bereaved families and individuals at the place of death. These qualitative insights therefore build on and extend existing knowledge to reveal how multiple and intense sources of strain and experiences of attending cumulative traumatic events such as suicides may contribute to the raised levels of mental health morbidity, distress, suicidality, and sickness absence among first responders seen in existing quantitative studies and survey data (Beaton et al., 1995; Clohessy and Ehlers, 1999; Alexander and Klein, 2001; Bennett et al., 2004; Mildenhall, 2012; Pitman et al., 2014; Kimbrel et al., 2016; Stanley et al., 2016; Milner et al., 2017; Jones et al., 2018; Vigil et al., 2019).

The accounts reveal the complex challenges faced by ambulance workers in responding to suicide, i.e., exposure to multiple suicides (including witnessing violent suicides and attending the scene after a homicide-suicide); negotiating with suicidal individuals without adequate training/support; dealing with distressed and sometimes violent individuals bereaved by suicide without appropriate training (including fulfilling the potentially conflicting role of health professional and guardian of a potential crime scene by denying bereaved families access to the deceased); responding to distressed colleagues without adequate training (including caring for trainees at the scene of death); being in potentially dangerous situations and fearing for their own safety; feeling professionally isolated, unsupported by employers, undervalued by other services and sometimes powerless to help the people they are responding to; working under relentless time pressure with blurred boundaries between their role and the roles of other public service professionals.

This study offers a first step in understanding the impact that responding to suicide has personally and professionally on ambulance staff. Given that work-based support services were reportedly not fit for purpose, there is a need for employers to support the wellbeing of first responder staff in better ways so that this high risk group (staff exposed to suicide) might respond to another high risk group (individuals bereaved by suicide) by delivering high quality care and support in profoundly distressing circumstances (McDonnell et al., 2020). In England, policy has recognized that better information and support should be provided to all those bereaved or affected by suicide (HM Government, 2012) and that such postvention support (including for staff) is a fundamental tenet of suicide prevention (HM Government, 2019; NHS England, 2019); likewise, postvention support is a key aspect of suicide prevention internationally (World Health Organisation [WHO], 2018; Andriessen et al., 2019a,b).

In line with its duty of care to staff, the NHS Staff and Learners' Mental Wellbeing Commission report in England (Health Education England, 2019) emphasizes the importance of promoting and supporting the wellbeing of NHS staff and all those learning in NHS settings. The promotion of self-care in the workplace for staff is therefore a key objective in the report, with recognition that particular professional groups such as ambulance workers and other first responders are at significant greater risk of stress and trauma (including suicide). The report's recommendations in relation to self-care for learners are particularly relevant to supporting ambulance staff trainees who, as evidenced in this study, may be attending fatal and near fatal suicides under the supervision of staff who may themselves be distressed and feeling ill-equipped to support their own and others' wellbeing in these scenarios. The 'macho' and somewhat unforgiving working culture and dispassionate management style reported in this study are in direct contrast to the ethos of respect and recognition for staff espoused in the staff mental wellbeing report (Health Education England, 2019). In other countries, job-related factors such as emotional exhaustion and bullying have been indicated as potential factors in first responder suicidal ideation (Sterud et al., 2008). It is hoped that in England at least, the recent staff wellbeing report (Health Education England, 2019) will help to drive the required change in culture so that mental health problems experienced by health professionals as a result of their occupation are avoided. Improving staff and learner wellbeing may also help to improve morale, lower the number of work days lost to services, potentially reduce the suicide rate in this high risk profession.

The study suggests that when afforded the opportunity (for example, being allowed time out for reflection and/or access to colleagues who can listen and empathize), ambulance staff attempt to support each other in times of high stress. It is known that informal support and camaraderie among colleagues is a protective factor against adverse mental health and suicide risk (Stanley et al., 2016), however, the current study suggested that the organization of ambulance services can block rather than enable this. The aim of workforce remodeling to reduce issues of staff isolation and lack of contact among team members found in the staff wellbeing report is laudable and very relevant to ambulance services (Health Education England, 2019).

Protocols are needed in the workplace to guide both the response of ambulance staff to suicide (including dealing with the deceased and the bereaved with sensitivity and respect) and the response of employers to staff who may have lost colleagues to suicide and/or attend the suicide of a colleague. Given that ambulance staff may be at the scene of death for a prolonged period before other services arrive in instances of suicide, evidence-based training in critical incident management (Everly and Mitchell, 1997; Maple et al., 2019) is needed. Other qualitative research (Foggin et al., 2016) has demonstrated the extent to which even second responders such as GPs find facing the intense distress or anger of people bereaved by suicide difficult; it has also been emphasized that first responders need continuous training in suicide intervention and skills for coping with trauma-related stress (Lygnugaryte-Griksiene et al., 2017).

The study illustrates how ambulance staff often had no opportunity to deal with their own distress in relation to suicide-related work and how this can impact on their own wellbeing as well as on how they respond to bereaved families. Some ambulance staff described feeling powerless to help the bereaved and disengaging from them at the scene of a suicide. By contrast, Genest et al. (2018) emphasize that first responder approaches can have an impact on the longer-term resilience of the suicide bereaved; thus increasing the knowledge, skills and confidence of ambulance staff could enable them to provide effective support to the bereaved at the scene of death and help also to increase the bereaved's longer-term resilience. Training in how to respond to people who are bereaved by suicide more effectively that is informed by 'self-care' approaches (Grad, 2012) has demonstrated positive results and could be offered to ambulance staff to empower them (McDonnell et al., 2020). This could not only address gaps in ambulance staff's expertise in relation to responding to suicide, but and help to meet the previously identified needs of bereaved families (Ross et al., 2019; Wainwright et al., 2019). Furthermore, staff support and training are known to be protective factors by increasing resilience (Castelli Dransart et al., 2017) and could help to reduce suicide risk among ambulance workers.

Limitations and Strengths

The study is limited by the relatively small, ethnically uniform convenience sample from one ambulance service in England. However, qualitative research seeks not to produce research that is statistically generalizable but to offer insights that are transferable to similar settings. Thus, the themes revealed in the study may be relevant to ambulance services in other parts of the United Kingdom and indeed internationally where similar circumstances are seen to exist. Despite the limited sample, the qualitative approach enabled the gathering of rich and detailed accounts which are fully presented stand as a powerful and credible first exploration of ambulance staff's perspectives in relation to attending suicides and responding to the bereaved at the scene of death.

Future Research and Service Development

Given the accounts of high-pressure working described by participants in this study, through large-scale studies, further research should aim to accurately assess the magnitude of the strain on ambulance workers in relation to responding to suicide/bereaved families. Future research could explore the training needs of ambulance staff and other first responders (e.g., police and fire service workers) across countries in relation to responding to deaths by suicide and to bereaved families. Research is urgently needed to identify how employers could support the wellbeing of first responder staff in better ways. Organizational research could explore how first responder services might work together more effectively in responding to suicide in ways that that better support the wellbeing of not only the bereaved but of staff and trainees too.

CONCLUSION

The study contributes the in-depth perspectives of ambulance staff who deal with potentially traumatic deaths by suicide. Staff were often anxious and uncertain how to respond to individuals bereaved by suicide at the scene. They also had unmet support needs themselves, were hesitant to access help and coped informally. Training and postvention support for ambulance staff could enable better coping, more effective support for bereaved individuals and reduce the risk of further deaths by suicide within and outside the profession.

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available on request to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and ethical approval was obtained from National Research Ethics Service Committee North West – Greater Manchester West. Research ethics committee reference: 11/NW/21047. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

PN led on the analysis and interpretation of the study data, drafted the manuscript, revised it critically for intellectual content, provided approval for publication of the content, and agreed to be accountable for all aspects of the work. SM designed the study, recruited participants, collected all study data, jointly analyzed/interpreted the data, revised the manuscript critically for intellectual content, provided approval for publication of the content, and agreed to be accountable for all aspects of the work. LC, NK, CC-G, and JS contributed to the conception and design of the work, revised manuscript critically for intellectual content, provided approval for publication of the content, and agreed to be accountable for all aspects of the work. SS contributed to the acquisition of data, revised the manuscript critically for intellectual content, provided approval for publication of the content, and agreed to be accountable for all aspects of the work. BM revised the manuscript critically for intellectual content, provided approval for publication of the content, and agreed to be accountable for all aspects of the work.

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Feelings of Blameworthiness and Their Associations With the Grieving Process in Suicide Mourning

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Aims: This study focuses on identifying the correlates associated with the emergence of feelings of blameworthiness associated with a suicide or other traumatic death and its associations with grief complications.

Methods: Based on a mailed questionnaire survey of 575 mostly white and economically advantaged bereaved parents, 462 who lost a child to suicide, 48 to a drug overdose, 37 to ordinary accidents, and 24 to natural causes, we utilized chi-square tests, correlations and multiple regression analysis to compare and contrast patterns in the data.

Results: Findings showed feelings of blameworthiness associated with grief difficulties, complicated grief, PTSD, depression and other mental health difficulties among suicide bereaved parents. Results among suicide bereaved parents also showed that being stigmatized by socially significant others, having a mixed or negative relationship with the deceased child prior to the death and a less happy marriage, among those presently married couples, all contributed to higher feelings of blameworthiness among these bereaved.

Conclusion: Based on these findings, feelings of blameworthiness could serve as a good shorthand indicator of grief problems since it correlates so well with other grief difficulties and mental health problem measures. The importance of peer support is essential for avoiding the downward spiral associated with feelings of blameworthiness that can occur at any time during the grieving process.

Keywords: suicide bereavement, guilt feelings, blameworthiness, complex grief, grief difficulties

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INTRODUCTION

It is almost axiomatic in the bereavement literature that the suicide bereaved will experience feelings of guilt and blameworthiness following a loved one's death. Typical of such viewpoints is a statement made by the Mayo Clinic staff which appears in one of their on-line grief support pamphlets aimed at helping the suicide bereaved.

> "When a loved one dies by suicide, overwhelming emotions can leave you reeling. Your grief might be heart wrenching. At the same time, you might be consumed by guilt – wondering if you could have done something to prevent your loved one's death." (Retrieved from mayoclinc.org website, 9/23/19, healthy-lifestyle/end of life/in-depth/suicide).
>
> (Mayo Clinic On-line Grief Pamphlet, 2019)

These expectations of feeling guilty and blameworthy in the death are so widely shared that there are few researches probing into whether there are variations in these feelings from one suicide bereaved person to another and what might explain why some of those bereaved will experience greater feelings of blameworthiness than others (Cerel et al., 2008; Hanschmidt et al., 2016; Shields et al., 2017; Sheehan et al., 2018).

Yet, it is widely known and accepted among clinicians and researchers alike that the suicide bereaved will usually be haunted by feelings of guilt, self-doubt about what they could or should have done prior to the death to avoid it, anger at the deceased and shame about the death itself that gives suicide its uniquely highly distressing elements for the bereaved, leading them to be prone to more complicated grief (Jordan, 2001; Cerel et al., 2008; Dyregrov et al., 2012). Yet, despite this widespread understanding of the importance of self-blaming and guilt in the grieving process few studies have focused precisely upon assessing the impact of blameworthiness itself upon a suicide mourners' grief.

In this report, using existing survey data from bereaved parents we examine the variations in feelings of blameworthiness as they occur at the time of the death and as they may change at the time of the research interview; we also explore which social demographic and experiential factors are associated with greater feelings of blameworthiness, among some bereaved compared to others. We also explore the variations in experiencing grief problems, such as grief difficulties, complicated grief, PTSD, psychological problems, depression and post-traumatic growth among those experiencing greater or lesser degrees of feelings of blameworthiness.

We hypothesized that suicide and drug death bereaved parents would experience greater feelings of blameworthiness compared to other bereaved parents whose children died from natural causes and or from ordinary accidents, owing to the social disapproval associated with the former types of deaths. In our previous work we found great similarities in exposures to stigmatization and grief difficulties among suicide and drug death bereaved parents, compared to other accident and natural death bereaved parents (Feigelman et al., 2011). We also anticipated that when parents had closer and more positive relationships with their children prior to the death their feelings of blameworthiness would be lessened compared to when parents had mixed or conflicted relationships with their children. We expected the latter group would feel more blameworthy since they stand in a normatively anomalous position by having negative feelings toward their child prior to the death. We also expected that feeling stigmatized by the death, more common in suicide and drug death cases, would increase feelings of blameworthiness, as these bereaved would feel less supported and less validated. In addition, we also anticipated that more grief problems, complicated grief, PTSD, psychological problems and depression would be highly associated with feelings of blameworthiness, and that this would be associated inversely with time after the loss and differences in post-traumatic or personal growth. We anticipated that a statistical testing of all these associations would support these hypotheses and yield deepened understandings on how feelings of blameworthiness emerge and their impact upon the grieving process.

MATERIALS AND METHODS

Participants and Procedures

This report is based upon a convenience sample of 575 bereaved parents drawn primarily from the ranks of peer support group affiliates from the American Association of Suicidology, the American Foundation of Suicide Prevention, the Compassionate Friends and several other smaller groups of bereaved parents, such as the Parents of Suicide Support Group, the Angels of Addiction members, Grief Recovery After Substance Use Passing affiliates, popularly known as GRASP Groups. We also asked several therapists to refer former and current bereaved parent patients to complete our surveys. All survey respondents were also requested to refer additional potential respondents, as well. Most of the surveys were collected from a mailed survey instrument during 2006 and 2007, although in 2009, an additional wave of 37 surveys were collected from drug death bereaved parents. The overall response rate was 72%. While a complete methodological procedures statement will be found in Feigelman et al. (2012, pp. 22–25) potential respondents were sent letters requesting their cooperation. Once they returned letters of interest, they were mailed surveys, consent forms and post-paid return envelopes. The survey form was 27 pages long. Surveys included a most comprehensive array of questions on their socio-demographic characteristics, detailed questions pertaining to their children's deaths, such whether they had found their child's body, their relationships to their child at the time of the death; time since the loss, etc. A wide variety of questions were asked pertaining to grief experiences, grief problems, complicated grief, mental health, psychological problems, depression, PTSD and post-traumatic growth.

Surveyed bereaved parents experienced the death of a child anywhere from less than a month after the death until as long as 40 years afterward. All respondents in this survey fit into one of four types of death losses: suicide, drug overdose, ordinary accident or natural death circumstances.

Measurements

Two questions about feelings of blameworthiness were included in the survey that were never analyzed previously: (1) "People losing loved ones sometimes feel blameworthy that things they may have done (or have not done) could have contributed to the person's death. Does this apply to you and how you felt during the first weeks after your child's death." (2) "Presently, do you feel at all blameworthy in the death." Respondents were asked to express their agreement to both statements on a five-point scale from (a) Almost completely to (e) Almost not at all.

Theoretically it appeared that lingering feelings of blameworthiness would be the most germane item for us to focus on in this investigation. We therefore directed our attention primarily on whether the respondent felt blameworthy on a five-point scale at the present time. 570 respondents answered this question, yielding a mean of 3.6, SD = 1.22, with a range of 1–5 with lower numbered responses exhibiting greater feelings of self-blame.

To measure grief difficulties, we used an abbreviated version of The Grief Experience Questionnaire (GEQ; Barrett and Scott, 1989). The original GEQ scale consisted of 55 items. Following the lead of Bailley et al. (2000) who performed a factor analysis of the scale and identified eight distinct factors within it, we selected the two highest factor-loaded items for each of the eight factors to form our 16-item abbreviated scale. Our abbreviated scale yielded an internal consistency (Cronbach's alpha) coefficient of 0.87. The brief GEQ scale was answered by 522 respondents, yielding a mean of 39.1 (SD = 11.5) with scores that ranged from a low of 16 to a high of 80.

We employed a Complicated Grief scale (Prigerson, 2002); this scale was answered by 541 respondents, yielding a mean of 27.9 (SD = 8.9), with scores ranging from 11 to 51. The 13 item scale yielded an alpha coefficient of 0.89. We also utilized the Impact of Events Scale (Horowitz et al., 1979) to measure PTSD. The Impact of Events Scales, was completed by 522 respondents showing a mean score of 33.3 (SD = 8.9) and a range of 14 to 56. The 14-item IES scale yielded an alpha coefficient of 0.89.

We utilized an eight-item measure of depression (Wethington et al., 1998). It was based on responses to an initial screening question: "During the past year, was there ever a time when you felt sad, blue, or depressed for 2 weeks or more in a row?" Those answering affirmatively were asked seven additional questions querying about loss of interest, energy, appetite, concentration, feelings of worthlessness, morbid ideation and sleep disturbance. An 8-point scale (no = 0; yes = 1) was created for responses to these eight questions. In our sample, the alpha coefficient for the scale was 0.92. The depression scale was completed by 511 respondents with a mean of 4.34 (SD = 3.1), with scores ranging from 0 to 8.

We also created an index of personal psychological problems by combining several questions that had been asked in the Midlife Development Survey. The survey asked respondents to self-rate their mental or emotional health: "How about your mental or emotional health? Is it poor, fair, good, very good, or excellent?" Then, we also counted the previously mentioned depression screening question. Survey respondents were also asked to count the number of days in the past 30-day period when they were unable to go to work or had to cut back normal household activities because of mental health difficulties. In addition, they were also asked a life satisfaction question: "At present, how satisfied are you with your life – a lot, somewhat, a little, or not at all/none at all?" These responses were associated with one another with correlation coefficients ranging from 0.20 to 0.52. Summing together responses of (a) poor or fair mental health reports, (b) self-reported depression, (c) one or more days lost to work or housework during the past 30-day period, and (d) life satisfaction reports of little or none at all, we placed respondents along a continuum from 0 to 4 on our mental health problems scale, which yielded a Chronbach's alpha of 0.70. The mean score of respondents on the personal psychological problems scale was 1.6 out of a possible 4, SD = 1.3, with an *N* of 556). We also assessed suicide thoughts with a question taken from the National Survey of Drug Use and Health, "How often during the past 12 months did you think about taking your own life? Answers were graded on a five-point scale from never to very frequently.

To assess positive growth after the loss, we also included the 7 items that had the highest factor loadings from a 12-item set of personal growth questions that formed part of the Hogan Grief Reaction Checklist, HGRC (Hogan et al., 2001). The included items were "I have learned to cope better with life; I feel as though I'm a better person; I have a better outlook on life; I have more compassion for others; I am stronger because of the grief I have experienced; I care more deeply for others; I am a more forgiving person." These 7 items yielded an alpha coefficient of 0.91 among the 536 respondents that offered useable responses to this abbreviated personal growth scale where responses ranged from a low of 7 to a high of 35, with a mean of 24.0, SD = 7.1).

To assess being stigmatized, two additive scales were summed, one measuring whether any of 11 different groups (such as spouse, ex-spouse, children, siblings, other relatives, coworkers, friends, etc.) acted helpfully or hurtfully to the respondent after the death; the other asking if any of these same 11 different groups had the respondent's relationship to the group remained the same, was strengthened or weakened after the death. A more detailed discussion of this scale can be found on pages 44 and 45 of Feigelman et al. (2012). The stigmatization scale was completed by 553 respondents, yielding a mean of 3.3, SD = 3.3, with a range from 0 to 16; higher scores meant more unhelpful and/or hurtful responses and more relations being reported as weakening from the diverging groups of intimate associates. The overall stigmatization scale yielded an alpha score of 0.76.

We also had measurements for whether the parent respondent had witnessed the death, or had found the body or not. There were also questions whether the parent had a positive, mixed or negative relationship with their deceased child prior to the death, and whether their suicide deceased child had made prior suicide attempts or not. We also queried whether the bereaved parent had obtained the support of a professional counselor during the past year and their frequency of visits. We collected data on parents' marital statuses, whether the respondent reported him or herself as happily married or not; whether their child's death had improved, worsened, or had not effected the quality of their marital relationship. The time since the loss, whether the parent had experienced anger or shock with their child's death were also investigated.

Data Analysis

In the first part of this analysis we examined feelings of blameworthiness as an independent variable, first examining its distribution and how it changed with the passage of time after a loss. Then, we examined whether the suicide and drug death bereaved showed any higher levels of feelings of blameworthiness compared to parents whose children died from other accidents or natural death causes. We examined these questions in our complete dataset of all 575 respondents. Then, as we proceeded further, throughout the remainder of this analysis, our focus shifted to the 462 suicide bereaved parents, who were the primary focus of this study. Next, we examined blameworthiness and its associations with seven different important dimensions of mental health and grief problems. In the final parts of this analysis we examined blameworthiness as a dependent variable. We conducted several cross-tabular, correlational and multivariate

TABLE 1 | Comparison of feelings of blameworthiness of participants at time of death vs. at time of research study.

Feelings of blameworthiness	At time of death (%)	At time of interview (%)
Almost completely	207 (36.19)	39 (6.84)
Mostly	107 (18.71)	65 (11.40)
Somewhat	99 (17.31)	163 (28.60)
A little bit	68 (11.89)	125 (21.93)
Almost not at all	91 (15.91)	178 (31.23)
Total sample size	572	570

analyses of blameworthiness as it may be predicted from several other leading competing predictors of grief problems, time since the loss, stigma score, whether the respondent had found the body, whether parents had a happy marriage and whether they had a positive or conflicted relationship with their deceased child prior to the death.

RESULTS

Participants

These 575 bereaved parents showed mean years since loss of 5.6 years, ranging from less than a month from after the death till 40 years afterward. Females outnumbered males in our sample by a huge margin, 85–15%. 74% of respondents were between ages 46 and 65, as sample members reported belonging to one of five different age categories. The sample over represented upper-status respondents with a third having yearly incomes of over $90,000 (during the period of 2006), 53% holding managerial or professional occupations and 41% with four years of college or greater education; religious identifications were mixed; the sample was predominately White at 95% and native born at 94%.

Feelings of Blameworthiness, Contrasts Over Time

Table 1 shows the contrasts between feelings of blameworthiness at the time of the death, contrasted with having these feelings at the time of the research interview. We can see that at the time of the death more than half (55%) of bereaved parent respondents expressed having strong to moderate feelings of blameworthiness; this shrank to only 18% having these same feelings at the time of the research interview.

Differences in Blameworthiness by Type of Loss

Table 2 shows sharply contrasting differences between suicide and drug death mourners and ordinary accident and natural death causes bereaved parents. Close to three quarters of natural and ordinary accidental death bereaved felt not at all or hardly blameworthy in the death, compared to only about half of the suicide and drug death bereaved. These differences were statistically significant with the chi-square test. We suspected these differences could have been related to differences in time since the loss between these subgroups. To test for this potentially confounding causal influence we regressed feelings of being blameworthy with differences in the subgroup death causes and years since the loss. Both remained statistically significant predictors, suggesting that both factors are significant correlates in accounting for variations in feelings of blameworthiness. These regression results are not displayed in our tables.

Associations Between Feelings of Blameworthiness, Grief Problems, and Mental Health

Next, we examined the interrelations between seven diverging measures of grief difficulties and mental health differences with feelings of blameworthiness (see **Table 3**). This analysis was conducted exclusively among the 462 suicide bereaved parents. All were significantly associated, showing greater feelings of blameworthiness associated with higher grief difficulties, greater complicated grief, higher PTSD, higher depression scores, more personal psychological problems, and less personal growth. In some instances, high associations indicating correlation coefficients above 0.40 were observed.

Examining Feelings of Blameworthiness as a Dependent Variable

In **Table 4a** we display the associations between feelings of blameworthiness and other potentially associated elements that were categorical variables such as marital status. If a respondent indicated witnessing the death (a rarity in this sample) or finding the body (n = 154), compared to those not having this experience (n = 416) there were no significantly greater feelings of blameworthiness (p = 0.22). Marital status differences and whether the child had made one or more previous attempts prior to the suicide were not associated with differences in feelings of blameworthiness. A near significant association was noted between feelings of blameworthiness and whether the respondent reported the child's death had improved their marital relationship, compared to those reporting worsened relationships (p = 0.09). **Table 4a** also shows that feelings of blameworthiness were higher when the bereaved parent had a mixed, or negative relationship with their child, compared to a positive relationship (p = 0.06).

This examination of categorical variables and blameworthiness must be done for examining marital status differences but could be substituted with correlational tests where only two categories were available, with one variable being coded as 0 and the other as 1, or in the case of positive, vs. negative or unchanged marital adjustments where the numeric categories could be −1, 0, and +1. We computed correlation coefficients for all variables in **Table 4a** with the exception of marital status. The results were as follows: finding the body, −0.06, p = 0.16; prior suicide attempts, −0.07, p = 0.12; whether the parent's relationship strengthened, weakened or remained the same, 0.16, p = 0.002; the relationship with their child, before the death, whether positive or mixed/negative, −0.139, p = 0.002. These correlation coefficients yielded potential associations that the bivariate cross-tabs did not show. However, it will be in a multiple regression analysis comparison where these bivariate

TABLE 2 | Differences in feelings of blameworthiness at time of research interview among different subgroup death cause groups.

Feelings of blameworthiness	Natural death (%)	Suicide (%)	Drug death (%)	Ordinary accident (%)
Almost completely	1 (4.17)	36 (7.81)	1 (2.27)	1 (2.70)
Mostly	1 (4.17)	56 (12.15)	6 (13.64)	2 (5.41)
Somewhat	3 (12.50)	140 (30.37)	13 (29.55)	6 (16.22)
A little bit	9 (37.50)	98 (21.26)	13 (29.55)	5 (13.51)
Almost not at all	10 (41.67)	131 (28.42)	11 (25.00)	23 (62.16)
Total	24	461	44	37

Chi-square = 29.5386 (12df), p = 0.003.

TABLE 3 | Correlations of Seven Grief and Mental Health Measures with Feelings of Blameworthiness (*n* = 462).

Measure	1	2	3	4	5	6	7	8
1. AbbrevGEQ								
2. Complicated Grief	0.7762							
3. PTSD	0.7012	0.6945						
4. Personal Growth	−0.0.3618	−0.5013	−0.2651					
5. Depression	0.5769	0.6270	0.4876	−0.3358				
6. Psych Probs	0.2031	0.2120	0.1178	−0.1150	0.3959			
7. Suicide Thoughts	0.5244	0.5602	0.3593	−0.3969	0.4763	0.2016		
8. Blame Presently	−0.5687	−0.4773	−0.3626	0.2786	−0.3458	−0.1392	−0.3732	

All were significantly associated (p < 0.05).

TABLE 4A | Associations between feelings of blameworthiness and categorical variables. *N* = 462.

Variables	Almost completely (%)	Mostly (%)	Somewhat (%)	A little (%)	Almost none (%)
Witnessing death or finding body					
No	22 (7.07)	38 (12.22)	93 (29.90)	60 (19.29)	98 (31.51)
Yes	14 (9.33)	18 (12.00)	47 (31.33)	38 (25.33)	33 (22.00)
Total	36 (7.81)	56 (12.15)	140 (30.37)	98 (21.26)	131 (31.23)
Child made prior suicide attempts					
No	24 (7.92)	33 (10.89)	85 (28.05)	74 (24.42)	87 (28.71)
Yes, one	5 (6.17)	11 (13.58)	23 (28.40)	17 (20.99)	25 (30.86)
Yes, two	7 (9.33)	11 (14.67)	31 (41.33)	7 (9.33)	19 (25.33)
Total	36 (7.84)	55 (11.98)	139 (30.28)	98 (21.35)	131 (28.54)
Current marital status					
Married	21 (6.77)	33 (10.65)	96 (30.97)	71 (22.90)	89 (28.71)
Divorced	10 (9.80)	16 (15.69)	29 (28.43)	17 (16.67)	30 (29.41)
Separated	0 (0.00)	2 (16.67)	6 (50.00)	1 (8.33)	3 (25.00)
Never	2 (33.33)	1 (16.67)	1 (16.67)	0 (0.00)	2 (33.33)
Widowed	3 (10.34)	4 (13.79)	4 (13.79)	8 (27.59)	7 (24.14)
Total	36 (7.84)	56 (12.20)	139 (30.28)	97 (21.13)	131 (28.54)
Marriage relationship changed after the death					
Weaker	12 (15.19)	11 (13.92)	25 (31.65)	16 (20.25)	15 (18.99)
Same	4 (6.56)	9 (14.75)	17 (27.87)	15 (24.59)	16 (26.23)
Stronger	9 (4.57)	21 (10.66)	63 (31.98)	41 (20.81)	63 (31.98)
Total	25 (7.42)	41 (12.16)	105 (31.16)	72 (21.36)	94 (27.89)
Relationship with deceased prior to the death					
Pos Rel	26 (6.93)	41 (10.93)	110 (29.33)	82 (21.87)	116 (30.93)
Mixed/Neg	10 (11.90)	14 (16.67)	29 (34.52)	16 (19.05)	15 (17.86)
Total	36 (7.84)	55 (11.98)	139 (30.28)	98 (21.35)	131 (28.54)

Chi-square for Witness/find and Blame association = 5.6921 (4 df), pr = 0.223; Chi square for Priorattempt and Blame association = 11.885, (8 df), pr = 0.156; Chi-square for Marital Status and Blame association = 16.0332 (16 df), pr = 0.451; Chi square for Relations Changed wSpouse and Blame = 13.6710 (8 df) pr = 0.091; Chi-square for Relsw/deceased Before Death and Blame = 9.0227 (4 df), pr = 0.061.

TABLE 4B | Correlates of feelings of blameworthiness. *N* = 462.

Factors	1	2	3	4	5	6	7
1. Saw Prof Counsel							
2. Stigma Score	0.2146*						
3. Happily married	−0.1368*	−0.2843*					
4. Shock	0.0497	−0.0537	0.0247				
5. Anger	−0.0286	−0.0735	−0.0201	0.1643*			
6. Years since loss	−0.2585*	−0.0492	0.0361	0.0401	0.0419		
7. Blame presently	−0.1156*	−0.2015*	0.2995*	0.0854	−0.0970*	0.1014*	

*$p < 0.05$.

associations can be more meaningfully investigated, in the presence of potentially competing explanations.

Table 4b presents a correlation matrix showing the relationships between feelings of blameworthiness and six different other potential associated factors: whether the respondent had sought professional counseling services during the past year and their frequency of use, stigmatization scale scores, assessments of the happiness of their marriage as measured on a ten-point scale, the degree on a five-point scale that they felt shocked by the death when it occurred; the degree on a five-point scale they felt anger from the death when it occurred and time since loss, ranging from less than a month to 40 years afterward. In **Table 4b** almost all of these hypothesized associated variables were significantly associated with feelings of blameworthiness with the exception of feeling shocked at the time of the death or at the time of the research interview. Only two associations here seemed sufficiently robust to be important: stigma scale scores with a correlation coefficient of 0.20, and marital happiness with a correlation of nearly 0.30.

Multiple Regression Analysis of Feelings of Blameworthiness and Potential Confounding Variables

We anticipated that there might be some overlapping influence between all these potential predictors of feelings of blameworthiness. To eliminate these confounding causal influences, we conducted a multiple regression analysis of all significant correlates shown in **Tables 4a,b**. This is displayed in **Table 5a**. The multiple regression analysis showed only three predictors significantly associated with feelings of blameworthiness: whether or not the respondent had a positive relationship with their child prior to the death, their total stigmatization scale score and whether or not they reported themselves as happily married. All the remaining other correlates in this regression model were redundant: whether they had currently sought help from a mental health professional, whether they were shocked at the death, time since the loss, whether spousal relations had improved or worsened since the death and the number of their child's prior suicide attempts. Although some of these factors had yielded significant associations with feelings of blameworthiness in univariate correlation analyses, in the multiple regression, these variables were found to be non-essential. The three significant variables – stigmatization scale score, whether the parents reported having a happy marriage and a parent's relationship to their child prior to the death – explained 16% of the differences in blameworthy scores.

We were somewhat surprised that time since loss, which has been shown in so many bereavement studies to be an enduring and significant correlate of grief problems could be washed out so easily in the multiple regression equation. It should be noted that the first multiple regression equation was based on only 279 cases, only those currently married. Our complete sample of suicide bereaved consisted of 462 respondents. In a second multiple regression, we re-ran all variables except those that made the analysis exclusively of the currently married suicide bereaved. In **Table 5b** we show the same regression without the two variables that narrowed the scope of the analysis to be exclusively of married couples, omitting the variables marital happiness and whether the marital adjustment had been strengthened or worsened since the death. This added 170 more cases of unmarried, divorced and/or widowed suicide bereaved parents into the analysis. Here, again the results were remarkably similar with the results shown in the **Table 5a** with two significant predictors, whether the respondent had a positive or mixed or negative relationship prior to the death and the total stigmatization score.

DISCUSSION

Our findings showed feelings of blameworthiness closely associated with grief difficulties, complicated grief, PTSD, depression and other psychological problems. These findings are probably not all that surprising. The especially high correlations between feeling of blame, grief difficulties and complicated grief derives from many similar items about feeling blame and guilt being embedded within these scales; it is therefore no wonder that there are such high levels of association. Probably the most useful take-away point from these results is that feelings of blameworthiness can serve a good short hand indicator of the presence of grieving difficulties.

Another finding meriting comment was our results showing feelings of blameworthiness surging when the bereaved had a mixed, or negative relationship with their child, compared to a positive relationship. Almost twice as many parents felt not at

TABLE 5 | Multiple regression – predictors associated with feelings of blameworthiness among married couples only.

(A) Predictor	Coefficient	Beta weight	*p*-value
Prior Relsw/decease	−0.370	−0.117	0.044**
Saw Prof Counsel	0.010	0.012	0.837
Stigma Score	−0.063	−0.177	0.004**
Happily married	0.158	0.208	0.004**
Shock	0.093	0.112	0.064
Years since death	0.028	0.103	0.082
Witness/find	−0.126	−0.047	0.404
Spouse Rels Chang	0.035	0.022	0.740
Prior attempt	−0.076	−0.049	0.436

(B) Predictor	Coefficient	Beta weight	*p*-value
Prio Relsw/decease	−0.474	−0.146	0.002**
Saw Prof Counsel	−0.037	−0.046	0.333
Stigma Score	−0.074	−0.198	0.000**
Years since death	0.012	0.045	0.333
Witness/find	−0.139	−0.052	0.251
Shock	0.071	0.083	0.069

No. of obs. = 279; F (9,269) = 5.58; Prob. > F = 0.0001; R^2 *= 0.1573. Multiple regression – predictors associated with feelings of blameworthiness among all suicide bereaved parents. No. of obs. = 449; F (6,442) = 7.12; Prob. > F = 0.0001;* R^2 *= 0.09. ***$p < 0.05$.

all blameworthy in their child's death when they had reported a positive relationship with their child (31%), compared to only 18% who reported negative or mixed relations with their child. We can see that guilt may be generated after the death from not sharing the normative expectations of having a positive relationship with one's child.

Perhaps our most noteworthy and surprising finding were in the multiple regression results showing time since loss being eclipsed by the three variable combination of stigmatization scores, levels of marital happiness and the relationship of the parent with the deceased child prior to the death. We suspected that the stigmatization scores hold the key to understanding why time since the death was easily overshadowed by this three-variable combination. Most of the negative or unhelpful comments that bereaved parents had heard following the deaths of their children were expressed by ex-spouses, parents, parent-in laws and siblings. These close family groups much more frequently reported offering unhelpful and hurtful responses rather than other groups such as, friends, co-workers, neighbors and acquaintances. Many of the comments made were critical or unsupportive comments like: "how come you didn't call him that last night?[1]" (the night of the suicide or the fatal overdose); "Couldn't you have gotten him into a better a treatment program/or have taken him to a better therapist." Much of the advice might have been "I wouldn't have done that with my child." At support group meetings, many bereaved shared these upsetting, guilt-inducing, second guessing comments that they found highly distressing. Many bereaved longed for support and empathic responses from close family members, and sometimes stood in stark disbelief that a so-called beloved close relative could say such hurtful things to them when they desperately sought approval, support and validation from close family members.

Suicide bereaved parents themselves are inclined to blame themselves in the deaths of their children, no matter what. They cannot help themselves from wondering, what if I had done this, called or visited at this time, given more aid, done this or that, just before the death, if this would have meant the difference in saving the life of their child. This wonderment, guilt, and endless speculation is especially keen among mothers. Rynearson (2011) claims that mothers are socialized to feel completely responsible for the welfare and well-being of their children. If one dies or falls sick they feel they have failed abysmally from performing their time honored role as mother, keeping their child alive at all costs. Thus, the tiniest lack of support or compassion expressed by intimate family members goes a long way toward engendering greater guilt and blame in the fragile mind of a suicide or drug death bereaved parent.

Our findings showing marital unhappiness associated with feelings of blameworthy are not at all unexpected. While many suspect that the traumatic death of a child impairs their marital adjustments our results did not confirm this speculation (Feigelman et al., 2012, Chapter 13). More than twice as many of the married respondents in our sample reported having closer relations with their partner following their child's suicide or drug death, as those reporting more impaired relationships (see **Table 4a**). In a minority of families, the child's suicide or drug death leads to a rupture in their relationship. It is likely for many, a gulf may have existed in these couple's lives prior to the deaths. When the couple experienced harmony and support with each

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[1] These comments were shared at survivor of suicide support group meetings attended by the first author from April 2017 to December 2019. Comments were made by various family members related to the support group members who were grieving their suicide losses.

other, in these cases, their children's deaths usually brought them closer together, with the additional result of lessening feelings of guilt and blame.

These findings suggest that receiving immediate and unconditional support from close family members will overshadow time since loss in determining positive bereavement outcomes. When close family members continue to second-guess and withhold support, long after the occurrence of the death, feelings of blameworthiness and guilt will emerge or persist in the mind of the bereaved, leading them to spiral downward in their adaptations. Further research confirming these results will be necessary for determining the appropriate kinds of help and services essential for these traumatically bereaved.

We should acknowledge the limitations of this study. Most importantly it was based on a convenience sample of volunteers with a high oversampling of females who remain dominant in the support groups where most respondents were selected from. It should be noted there is bound to be some over-representation of women even in socially representative samples of the suicide bereaved by virtue of the sharp disparity of men taking their lives over women, with a 3 to 1 ratio of differences (Feigelman et al., 2018). We should also note that our respondents over-represented higher status, whites which could yield diverging results from samples collected with a greater representation of minorities. Though this data was originally collected over ten years previously, we doubt that these results would vary much from what might be found in a more contemporaneous sample.

Had we foreseen this research project emerging beforehand we would have been better off having several questions devoted to measuring feelings of blameworthiness in the death of a loved one, rather than a single question. Ideally, it also would have been more advantageous to study the feelings of blameworthiness longitudinally, especially over a period of three to five years after the death to examine their transformations over time. These acknowledgments and the many fruitful nuggets of new information obtained here should inspire future researchers to further investigate this potentially rich realm of blameworthy feelings correlating ever so closely with complicated grief, grief problems and a bereaved person's mental health. Some new research by Levi-Belz and Gilo (2020) suggests that self-forgiveness represents an important component in transitioning from high self-blame after a loved one's suicide into adopting lower, healthier levels of these feelings, which demands much further investigation and study.

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available on request to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the IRB Nassau Community College. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

Both authors contributed to the development and writing of this report.

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BRIEF RESEARCH REPORT
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Emotional Distress Among Suicide Survivors: The Moderating Role of Self-Forgiveness

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Grief after suicide entails unique challenges and difficulties, such as intense feelings of anger and guilt, as well as various psychological risks. The current study examined the contribution of self-forgiveness (SF) to emotional distress (e.g., depressed mood and suicidal ideation) among suicide-loss survivors, compared with bereavement following sudden and expected death types. Bereaved individuals (N = 309; aged 18-84) completed questionnaires measuring SF, depressed mood, suicidal ideation, demographics, and personal characteristics concerning the bereavement. A significant interaction between SF and type of loss was found, in which suicide-loss survivors with low levels of SF manifested the highest levels of depression and suicidal ideation compared with other subgroups. The findings reflect the importance of SF as a protective factor against depression and suicidality among suicide-loss survivors as well as the possible efficacy of forgiveness-based interventions in this population.

Keywords: suicide-loss survivors, grief, bereavement, self-forgiveness, distress, depression, suicidal ideation

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INTRODUCTION

Suicide is one of the most disturbing public health problems. Each year, approximately 800,000 people worldwide die by suicide (1). Researchers estimate that every suicide has a direct and profound impact on roughly 60 people (2, 3), totaling between 48–500 million people who might be exposed to suicide bereavement each year (4). These people, termed *suicide-loss survivors*, are likely to be family members and spouses as well as friends and colleagues, who experience high emotional, physiological, or social distress during a lengthy period following the suicide of a significant other (5).

Accumulating evidence suggests that suicide bereavement involves unique challenges and difficulties compared with other types of bereavement. Suicide-loss survivors are more vulnerable to suffer from emotional distress and psychopathology, such as depression, PTSD, complicated grief (6–8), and even suicidal ideation and behavior (3). Moreover, suicide-loss survivors differ from other mourners in the thematic content of their grief (9–12). That is, suicide-loss survivors often face feelings of shame and stigmatization, leading to social withdrawal and concealment of the cause of death (10). Many of them are also haunted by agonizing questions, such as "Why did he do this to me?" "Did I do something wrong?" or "Could I have done something to prevent it?" (13). Thus, intense feelings of anger and guilt often become an integral part of the suicide bereavement process (9, 10). Given the magnitude of this complex struggle, it can be assumed that to make peace with past events and overcome their grief, suicide-loss survivors would be in need of certain mental resources.

Researches have indicated several personal and interpersonal characteristics that can ease the pain of suicide-loss survivors and help them to adaptively manage their grief. Recent findings have shown that self-disclosure, secure attachment, and perceived social support serve as protective factors against complicated grief (6, 14). Social support has also been shown to be associated with diminished loneliness and depression among suicide-loss survivors (15). Nevertheless, to date, the distinctions between suicide-loss survivors' unique protective factors and those of other bereaved individuals have yet to be explored. A more comprehensive understanding of the internal mechanisms that may relieve distress, especially for suicide-loss survivors, is needed in order to improve clinicians' ability to provide them with effective treatment adapted to their needs.

A personal characteristic that may play an important role in the management of distress among suicide-loss survivors is *self-forgiveness (SF)*. SF has been defined as a process in which one accepts his or her mistakes and wrongdoings, attempts to abandon anger or resentment toward oneself, and fosters positive emotions, thoughts, and behaviors toward the self (16).

The tendency to forgive oneself has been widely studied as a stable personality trait (17). It has been found to be related to various personal and interpersonal adaptive qualities, such as developed emotion regulation (18, 19), and high levels of positive relationships and social support (20, 21).

Accordingly, an extensive body of research has documented the positive contribution of SF to mental health, physical health, and well-being [(21–24); for an additional review, see (25)]. Specifically, SF has been found to be related to a decreased risk for depression and suicidal behavior among various populations (26–29). Furthermore, it has been shown that high SF serves to buffer emotional distress and psychopathological symptoms upon encountering stressors and life crises such as breast cancer (30) and traumatic events (31, 32).

Recent qualitative studies among suicide-loss survivors have shown that forgiving themselves is one of the toughest struggles in their bereavement process, yet, crucial for their recovery (33–35). Considering the strong guilt feelings and disproportionate responsibility that often characterize suicide-loss survivors, perhaps adopting some elements of SF could address their feelings and promote adaptive coping with them. To the best of our knowledge, however, no study has empirically examined the contribution of SF to emotional distress among suicide-loss survivors.

The Present Study

In light of the importance of SF in dealing with traumatic and devastating events in general, and in line with the unique difficulties of suicide-loss survivors in terms of guilt and self-anger, in the present study, we aimed to examine the contribution of SF to emotional distress in the aftermath of suicide loss. In this study, suicide loss was compared with two other types of bereavement–following sudden death other than suicide and following expected death. We operationalized emotional distress as comprising depressed mood and suicide ideation, both reflective of the emotional disturbance of the individual. We suggest that SF's contribution to relieving distress among suicide-loss survivors will be greater than among the other two bereavement groups, considering the specific suicide-related bereavement characteristics (e.g., anger, guilt, and uncertainty regarding the possibility of having been able to prevent the death). Thus, we posit the following hypotheses:

H1: Suicide-loss survivors will report higher levels of depressed mood and suicidal ideation than will those enduring other types of bereavement.

H2: Suicide-loss survivors will report lower levels of self-forgiveness than will those enduring other types of bereavement.

H3: Higher levels of SF will be negatively related to levels of depressed mood and suicidal ideation in all bereavement groups but will have the most substantial contribution to diminishing depressed mood and suicidal ideation among suicide-loss survivors.

METHOD

Participants

The sample comprised 309 bereaved individuals (269 females [87.1%], 39 males), aged 18–84 (M_{age} = 44.3, *SD* = 16.23), divided into three groups:

Suicide-Loss Survivors' Group: This group comprised 124 participants (108 females, 17 males, M_{age} = 40.22, *SD* = 13.80) who lost a loved person to suicide. Following Jordan and McIntosh (5), we defined *suicide-loss survivors* as individuals who lost a person close to them to suicide, and experienced emotional distress following the loss, regardless of their relation to the deceased. Accordingly, the participants were asked for their perceived level of closeness to the deceased, as well as for the level of distress experienced after the loss. We excluded participants who indicated no distress after the loss or absence of perceived closeness to the deceased.

Sudden Death Group: This group comprised 108 participants (98 females, 10 males, M_{age} = 53.97, *SD* = 17.06) who lost a person close to them due to a sudden death other than suicide (e.g., heart attack, car accident, terrorist attack, homicide, military combat).

Expected Death Group: This group comprised 77 participants (64 females, 12 males, M_{age} = 37.34, *SD* = 11.86), who lost a person close to them due to an expected death (e.g., old age or prolonged illness, such as cancer).

Exclusion criteria for the sample were being under age 18 at the time of the research and being under age 13 at the time of the loss. Informed consent was obtained from all participants.

General Demographic Characteristics of the Study Participants

The sample comprised 104 (33.7%) married participants, 92 (29.8%) widows, 82 (26.5%) singles, and 30 (9.7%) separated or divorced. Of the participants, 213 (68.9%) were parents. As for their religiosity, 220 (71.2%) identified themselves as secular Jews, 48 (15.5%) as traditional Jews, and 27 (8.7%) as orthodox Jews. Of the participants, 202 (65.4%) held a college degree, 50 (16.2%) had a secondary education, 54 (17.5%) had a high school education, and one participant had an elementary education.

Loss-Related Characteristics of the Study Participants

Kinship to the deceased consisted of 129 (41.7%) spouses, 77 (24.9%) children, 39 (12.3%) siblings, 19 (6.1%) parents, 17 (5.5%) friends, 10 (3.2%) grandchildren, and 10 (3.2%) other family members. The remaining nine (2.9%) participants identified themselves as acquaintances, colleagues, and 'other' kinship. Time since loss varied between 1 to 54 years (*M* = 16.59, *SD* = 13.66, Median = 15). The age of the participants at the time of the loss ranged between ages 13 and 75 (*M* = 29.61, *SD* = 11.61, Median = 26), and age of the deceased ranged between ages 14 and 94 (*M* = 39.84, *SD* = 16.4, Median = 39). Most of the sample reported suffering high (147, 47.6%) and severe (128, 41.4%) distress following the loss. Among the participants, 230 (74.4%) had sought psychological therapy after the loss, and 105 (34%) were still in treatment at the time of the study. Ninety (29.2%) participants had attended support groups following the loss, and 21 (7.8%) continued participating in them at the time of the study.

Group Differences in Demographic and Loss-Related Variables

Upon examining demographic and loss-related variables (see appendix A), several significant between-group differences were revealed: age (sudden death participants were older on average than the other two groups), time since loss (for the sudden death participants, more time had elapsed since loss), age of the participants at the time of the loss (suicide-loss survivor participants were older on average than the sudden death participants), age of deceased (the expected death participants reported older ages for the deceased), and perceived closeness to the deceased (the sudden death group reported higher levels of closeness than did the other two groups) as well as for family status, relation to the deceased and participation in support groups following the loss. Thus, these variables served as covariates in the data analysis. All other demographic and loss-related variables (e.g., gender, religiosity, psychological therapy after the loss and currently) yielded no between-group differences.

Measures

Self-Forgiveness

SF was measured by the Heartland Forgiveness Scale [HFS; (36)]. The original questionnaire comprises 18 items, divided into three forgiveness subscales: Forgiveness of Self (Items 1–6), Forgiveness of Others, and Forgiveness of Situations. For the present study, we administered only the Forgiveness of Self subscale (e.g., "Although I feel bad at first when I mess up, over time I can give myself some slack"; "I don't stop criticizing myself for negative things I've felt, thought, said, or done"). The items are presented on a seven-point Likert-type scale, ranging from 1 (*almost always false of me*) to 7 (*almost always true of me*). Higher scores reflect a greater inclination for SF. Following Thompson et al. (36), the subscale score was calculated by summing the items' values. Cronbach's alpha reliability coefficient for this sample was α = 0.70.

Emotional Distress

Emotional distress was measured by two specific and direct questions:

1. *Depressed mood* was assessed by asking the participants for the frequency of feelings of depression, moodiness, or hopelessness during the past year. The item is scored on a five-point scale, ranging from 1 (*Never*) to 5 (*Very often* [*5 times or more*]).
2. *Suicidal ideation* was assessed using the Suicide Behaviors Questionnaire-revised [SBQ-R; (37)], measuring four dimensions of suicidality. For the present study, we used only Item 2 ("How often have you thought about killing yourself over the past year?"), which assesses the frequency of recent suicidal ideation. The item is scored on a five-point scale, ranging from 1 (*Never*) to 5 (*Very often* [*5 times or more*]).

Background Information

Background information collected from the participants included demographic characteristics (gender, age, education, family status, and religiosity) and loss-related characteristics (cause of death, time elapsed since loss, age of the deceased, age of the participant at the time of the loss, kinship to the deceased, perceived closeness to the deceased, levels of distress experienced following the loss, and use of health care services).

Procedure

Recruitment of the participants transpired from September 2018 to January 2019, utilizing several platforms. Suicide-loss survivors were recruited primarily through the Facebook page of the nonprofit organization, *Path to Life*, the recognized organization for suicide-loss survivors in Israel. Participants of the other groups were recruited through Ministry of Defense organizations (*Yad LeBanim*, *IDF Widows*, and *IDF Orphans*), as well as through the snowball sampling technique (using online forums of bereavement and social media platforms).

All informants were provided a recruitment letter outlining the purpose of the study and the researchers' contact information. The participants were assured of anonymity, confidentiality, and their right to withdraw from the study at any time. All participants completed the questionnaire online in a private setting.

Data Analysis

A series of one-way ANOVA and chi-square analyses was conducted to determine group differences in demographic and loss-related variables. Then, a two-way MANCOVA analysis was conducted to examine the contribution of SF to emotional distress measures among different bereavement types, controlling for demographic and loss-related characteristics. An alpha of 0.05 was adopted for all tests of statistical significance. All analyses were conducted using IBM SPSS, version 20 for Windows.

RESULTS

Group Differences in SF and Emotional Distress Measures

Table 1 presents a comparison of the scores of the three groups on the levels of SF, depression, and suicidal ideation. Contrary to our hypothesis, no significant differences were found between the study groups in SF levels. However, as we expected, significant between-group differences were found in levels of emotional distress measures, as suicide-loss survivors reported higher levels of depression and suicidal ideation relative to the other two bereavement groups.

Additionally, to test the combined contribution of type of loss and SF to emotional distress levels, we conducted a two-way MANCOVA with time elapsed since loss, age of the participant at the time of loss, age of the deceased, and perceived closeness to the deceased serving as covariates due to their revealed between-group differences. In each MANCOVA, we examined one of the emotional distress measures as a dependent variable: depressed mood in the first and suicidal ideation in the second. To appropriately examine differences in SF levels, we recoded SF into three categories: low ($Z < -0.75$), medium ($-0.75 < Z < 0.75$), and high ($Z > 0.75$). We chose those Z scores to enable a focus on the contribution of very high levels and very low levels of SF.

Depressed Mood

As expected, we found a main effect of SF on depressed mood. As it can be seen on **Table 2**, Participants characterized by low SF

TABLE 1 | A Group differences in demographic and loss-related variables (N = 309).

Type of loss					
Measure	**1. Suicide-loss survivors (n = 124)**	**2. Sudden death (n = 108)**	**3. Anticipated death (n = 77)**	**F / X^2**	**Post hoc (Scheffé, p < 0.05)**
Age				$F = 37^{***}$	1 = 3<2
M (*SD*)	40.22 (13.80)	53.97 (17.06)	37.34 (11.86)		
Range	18–71	20-84	18–70		
Family status *N* (%)				$X^2 = 57.73^{***}$	
Single	39 (31.5%)	13 (12%)	30 (39.5%)		
Married	59 (47.6%)	30 (27.8%)	15 (9.7%)		
Separated/divorced	13 (10.5%)	13 (12%)	4 (4.2%)		
Widow	13 (10.5%)	52 (48.1%)	27 (16.9%)		
Relation to the deceased *N* (%)				$X^2 = 175.42^{***}$	
Parent	26 (21%)	18 (16.7%)	33 (42.9%)		
Sibling	36 (29%)	1 (0.9%)	1 (1.3%)		
Child	15 (12.1%)	2 (1.9%)	2 (2.6%)		
Spouse	18 (14.5%)	82 (75.9%)	29 (37.7%)		
Grandparent	1 (0.8%)	0 (0%)	9 (11.7%)		
Other relative (e.g., aunt)	8 (6.5%)	1 (0.9%)	1 (1.3%)		
Friend	14 (11.3%)	2 (1.9%)	1 (1.3%)		
Acquaintance	0 (0%)	0 (0%)	1 (1.3%)		
Colleague	1 (0.8%)	0 (0%)	0 (0%)		
Other	5 (4%)	2 (1.9%)	0 (0%)		
Years since loss				$F = 59.40^{***}$	1 = 3 < 2
M (*SD*)	11.36 (7.72)	26.43 (16.31)	11.20 (8.60)		
Range	1–34	1-54	1–46		
Age of the participant at loss				$F = 4.35^{*}$	3 = 1,2; 1 > 2
M (*SD*)	31.81 (14.32)	27.38 (8.53)	29.22 (9.86)		
Range	13–69	13–75	14-48		
Age of the deceased				$F = 35.74^{***}$	1 = 2 < 3
M (*SD*)	36.79 (15.90)	34.60 (11.02)	52.10 (17.43)		
Range	14–75	18–73	16-94		
Perceived closeness to the deceased				$F = 10.58^{***}$	1 = 3 < 2
M (*SD*)	3.74 (0.58)	4 (0)	3.82 (0.45)		
Range	1–4	4–4	2-4		
Participation in support group after loss *N* (%)				$X^2 = 6.0^{*}$	
Yes	36 (29%)	39 (36.1%)	15 (19.5%)		
No	87 (70.2%)	69 (63.9%)	62 (80.5%)		

*All values given as M (SD); *p < 0.05, ***p < 0.001.*

TABLE 2 | Means, standard deviations, and MANCOVA results of depression and suicidal ideation among the groups (N=309).

Dependent variable	Levels of Self-Forgiveness	Suicide survivors	Sudden death	Expected death	*F* Type of loss	*F* SF	*F* Type of loss * SF
		***n*=122**	***n*=106**	***n*=76**	**(2,294)**	**(2,294)**	**(4,294)**
Depression	Low	4.16 (2.2)	1.58 (1.69)	3.59 (1.58)	6.54**	10.45***	2.92*
	Med	2.8 (1.87)	2.04 (1.63)	1.92 (1.53)			
	High	2.32 (2.13)	1.61 (1.74)	1.55 (1.63)			
Suicidal Ideation	Low	2.69 (1.54)	1.13 (.46)	1.76 (1.2)	21.79***	7.1**	3.44**
	Med	2.05 (1.25)	1.13 (.43)	1.35 (.79)			
	High	1.42 (.96)	1.22 (.60)	1.1 (.29)			

*All values given as M (SD). *p<.05 **p <.01 ***p < 0.001. SF, Self-forgiveness.*

reported higher levels of depression than did participants reporting the two higher levels of SF. More central to the hypothesis and evident in **Figure 1**, we also found a significant interaction between SF and type of loss on depressed mood levels. More specifically, suicide-loss survivors having low levels of SF reported the highest levels of depressed mood relative to all other groups and conditions. The differences in levels of depressed mood between low and high levels of SF were significant only in suicide-loss survivors, as well as in the expected death group. No significant differences between SF conditions in the sudden death group were found. Group differences in levels of depression were revealed only in the low and medium SF conditions, while the high SF condition was characterized by low depression levels, regardless of the type of loss.

Suicidal Ideation

We found a main effect for SF on suicidal ideation. As seen in **Table 2** and **Figure 2**, a significant interaction between SF and type of loss was found. The differences in levels of suicidal ideation between low and high levels of SF were the most prominent among participants in the suicide-loss survivors' group. Significant SF differences in suicidal ideation levels were also found in the expected death group, but to a lesser extent. Moreover, suicide-loss survivors with low levels of SF manifested the highest levels of suicidal ideation compared with all of the other subgroups, while suicide-loss survivors with high SF reported equal levels of suicidal ideation as other loss groups. Namely, consistent with our hypothesis, low SF comprises a risk factor for suicidal thoughts, particularly for suicide-loss survivors, whereas high SF buffers such thoughts.

FIGURE 1 | Depressed mood as a function of self-forgiveness (SF) and type of loss (*N* = 309).

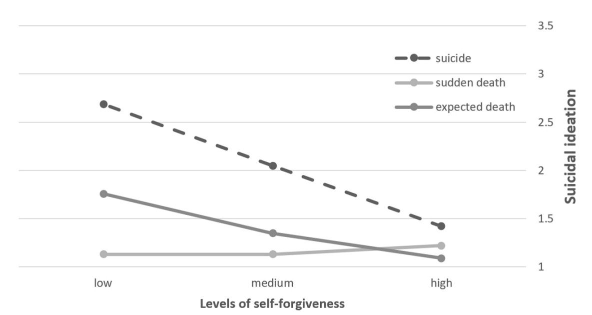

FIGURE 2 | Suicidal ideation as a function of self-forgiveness (SF) and type of loss (*N* = 309).

In order to further probe the interaction effect, we conducted a moderation analysis using PROCESS software in SPSS. To pinpoint the difference in the relation between SF and suicidal ideation among suicide-loss survivors versus other types of grief, we recoded type of loss into two categories: suicide-loss survivors, and bereaved not by suicide. As seen in **Table 3**, among suicide-loss survivors there is a significant inverse correlation between SF and suicidal ideation. However, among those bereaved not by suicide, SF was found to be unrelated to suicidal ideation.

DISCUSSION

The primary goal of this study was to examine the role of SF as a moderator of emotional distress among suicide-loss survivors in comparison with two other bereavement groups––after a sudden death and after an expected death. Whereas a growing body of research has delineated unique challenges that characterize the bereavement process after a suicide (3, 9), the data regarding factors that may relieve distress in the face of their unique struggle are scant.

Overall, suicide-loss survivors in our study reported significantly higher levels of depression and suicidal ideation in

TABLE 3 | Moderation analysis in predicting suicidal ideation among suicide-loss survivors in compare to other bereaved individuals (N=309).

Measure	*b*	*SE*	*95% CI*	*t*
Interaction SF * type of loss	−.28	.10	−.49, −.08	−2.76**
Suicide-loss survivors	−.37	.08	−.52, −.22	−4.91***
Bereaved not by suicide	−.09	.07	−.22, .05	−1.25

***p <.01 **p <.001 *** p< 0.001. SF, Self-forgiveness.*

comparison with the other bereavement groups. This finding is consistent with previous findings identifying an increased risk for a variety of psychological complications among suicide-loss survivors, especially mood disorders and suicidal behavior (3, 7, 38) as well as lower levels of posttraumatic growth (39). It is suggested that the high suicidal risk stems, among other sources, from the development of complicated grief, a common occurrence among suicide-loss survivors (40). However, other studies have revealed only minor differences concerning mental health outcomes between suicide-loss survivors and other bereaved individuals (for a review, see 12). Our findings may contribute to the resolution of this controversy by suggesting that suicide-loss survivors are indeed prone to more severe grief reactions, which may require targeted and sensitive care from professionals.

In line with our hypothesis, SF was negatively related to both depression and suicidal ideation measures. Previous studies have also highlighted the importance of SF as a facilitator of mental health and a protective factor against depression and suicidality (25, 27). Moreover, when we examined the combined contribution of SF and type of loss to depression and suicidal ideation levels, significant interactions were found. Namely, suicide-loss survivors with low SF reported the highest levels of both depression and suicidal ideation compared with all other subgroups. However, regardless of the type of loss, bereaved individuals with high SF levels reported relatively low depression and suicidal ideation levels. These findings highlight the role of SF as an internal resource that may buffer depression and suicidality among bereaved people in general and among suicide-loss survivors in particular.

Several possible explanations may be suggested for SF's role as a protective moderator for emotional distress among suicide-loss survivors. First, it has been shown that one of the pathways through which forgiveness promotes mental health is a decrease in rumination, stress, and negative emotions associated with unforgiveness, like guilt, shame, and regret (41, 42). *Intrusive rumination* (43) refers to repetitive, negative, and unwanted thoughts and relates positively to emotional distress during bereavement (44, 45). Bereaved individuals who are high in SF may be uninclined to engage excessively with their negative emotions, thus experience lower levels of distress. For individuals low in SF, however, the death circumstances may play a more prominent role in their ability to manage the bereavement process. That is, it can be suggested that among suicide-loss survivors, the combination of inevitably being occupied by questions such as 'why' and 'what if,' along with unforgiving tendencies toward themselves, may exacerbate their distress and pain.

Another possible explanation for the protective role of SF lies in its relatedness to well-developed emotional skills, such as attending to feelings, identifying internal states, and repairing negative emotions (46). Such skills may help individuals high in SF to confront and work constructively with their emotional responses following negative experiences (47). Hence, it would appear that high-SF suicide-loss survivors could benefit from those skills in order to approach, digest, and manage painful feelings concerning their loved one's suicide in adaptive ways, rather than being deterred or overwhelmed by them.

In light of the buffering effect of SF on suicide-loss survivors' suicidal ideation, it is important to discuss the potentially inverse relationship between SF and self-aggression and harm. SF embodies the abandonment of aggressive, critical, and punishing dispositions toward the self in favor of positive ones, including compassion, caring, and even love (16). As such, SF is strongly related to elevation in health-promoting behaviors, such as seeking help or treatment (48). If so, this finding may reflect the importance of SF as an internal process allowing suicide-loss survivors to actively redirect energy toward healthy and constructive behavior and away from the destructive and health-impeding state of unforgiveness.

Several limitations of the current study should be noted. First, aiming to increase the sample size, we approached several organizations that target specific bereaved populations. Such groups are relatively homogeneous and thus may not fully represent all bereavement populations. Moreover, unique characteristics of those organizations' members might have produced between-group differences that were not taken into account in the current study. For instance, members of the Ministry of Defense organizations share not only similar sudden loss circumstances, but also specific cultural scripts related to death in the course of military service and terror attacks, as well as being granted governmental financial and psychological support. The fact that suicide-loss survivors do not receive such assistance can, to some degree, account for the group differences found in distress levels. A more representative sample of bereaved individuals from the community would enhance the generalizability of the study findings and limit the chances for intergroup variability.

Second, the use of self-report measures entails the risk of reporting bias. It is also necessary to consider the shortcomings of the measures used in our study. Since emotional distress was assessed by straightforward, individual questions, our findings need to be replicated using more objective distress measures. Third, the HFS assessed merely *trait* SF, which did not necessarily reflect the participants' reactions to their specific loss (e.g., the suicide event), which might be influenced by personal and situational factors that were not evaluated. Future studies should examine both trait and state SF and compare their respective contributions to emotional distress among suicide-loss survivors.

Finally, the correlational and cross-sectional nature of this study precludes determining the sequence of the associations and inferring causality. Future research should consider a longitudinal methodology or a controlled examination of the effectiveness of a forgiveness-based intervention [e.g., (19, 49)] that could provide clearer indications as to the putative causal relationship between SF and distress among bereaved individuals. Moreover, in order to further deepen the knowledge regarding SF's role in bereavement processes among suicide-loss survivors, it is important to examine the unique and specific contribution of SF to grief distress in a sample of suicide-loss survivors exclusively, compared with other well-established correlates of grief distress and difficulties. Our findings suggest that SF can serve as a protective factor against emotional distress in the aftermath of loss, especially among individuals bereaved by suicide. This study sheds light on the unique psychological risks associated with suicide grief and reveals the potential therapeutic influence of SF on suicide-loss survivors' prospects of overcoming their pain and moving forward. Thus, the current findings suggest that interventions that promote SF, such as forgiveness therapy [FT; (49)], may be especially effective for suicide-loss survivors in managing their distress and fostering adaptive coping with their grief. This prospect is particularly invaluable, considering the lack of research demonstrating the efficacy of interventions for this population (2). From clinicians' point of view, our findings suggest that identification of self-unforgiving tendencies in suicide-loss survivors during therapy may comprise a warning sign, alerting to their level of suicide risk.

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available on request to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Ruppin Academic Center Ethical Committe. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

YL-B and TG desiged the study, recruit the participants, conducted the analyses and wrote the final vertion of the manuscript.

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Lessons Learned: Forty Years of Clinical Work With Suicide Loss Survivors

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The author has been a grief therapist in private practice for almost 40 years. The largest percentage of his clients have been suicide loss survivors, and in this article, the author reflects on the "lessons learned" about how grief therapy with survivors is both the same as, and very different from, work with clients bereaved after other types of losses. After briefly reviewing some of the empirical literature about differences between suicide bereavement and grief after other modes of death, the author argues that perhaps the most distinguishing and difficult aspect of a suicide loss is the "perceived intentionality" of the death, and the related "perceived responsibility" for the death. The author goes on to identify a number of tasks of psychological reintegration after a suicide loss that can serve as a template for treatment goals for clinicians and clients alike. These include the cultivation of a very specific type of secure and nurturing therapeutic alliance; extensive psychoeducation about suicide, trauma, and grief; the need to help the client repair the psychological continuing bond with the deceased; and providing gentle support for the survivor in rebuilding an assumptive world that has been shattered by the suicide of a loved one. Finally, the article concludes with a discussion of the clinical implications of these differences for work with suicide loss survivors.

Keywords: intervention, suicide loss survivors, grief therapy, grief counseling, suicide bereavement, grief after suicide

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INTRODUCTION

As a clinical psychologist and grief therapist in private practice for most of my career, I have had the opportunity to know and work with many people who have been bereaved by suicide. A percentage of them had already seen another mental health clinician, before they got to me. Consequently, I have heard many stories about positive and healing experiences that survivors have had with other therapists. Unfortunately, I have also heard far too many "horror stories" about therapists who (mostly out of ignorance about what is normative after a suicide), have been at best unhelpful, and at worst, overtly injurious to the survivors. As one example, I worked with a woman who lost her adult daughter to suicide. She went to see a clinician who was recommended by her primary care physician, and after three sessions with the client, the therapist stated that "You're dwelling on this too much," and began trying to administer the cognitive behavioral therapy in which she had been trained. Her goal was to help her ". . . . . .change your negative thinking about this loss." *In my opinion, this example illustrates a lack of experience, knowledge, and, quite likely, training about working with newly bereaved suicide loss survivors. A very common clinical error is to immediately try to "fix" the presenting problem with the tools available to the clinician, without establishing a secure,* *attachment based relationship with the client, and without understanding the wide-ranging and long term impact that the loss of a child to suicide can have for mothers. This type of profound loss is, in my experience, transformational for suicide loss survivors, and is virtually always a long and slow adaptational process that does not lend itself to "quick fixes."* I am writing this article with the hope of sharing with other professionals some of what I feel that I have learned over nearly 40 years of providing grief therapy to suicide loss survivors. My goal is not to critique other hard-working and well-intended caregiver peers. Nor is it to proselytize for the one true and correct way to work with survivors (indeed, the empirical evidence base for working with all traumatic losses such as suicide is, in my opinion, woefully under-researched (Jordan and McMenamy, 2004; McDaid et al., 2008; Andriessen et al., 2019). Rather, my hope is that this article will serve as a catalyst for my colleagues to approach the complex phenomena of suicide bereavement with the sense of respect and humility that the subject deserves, and to better educate themselves about what seems to be helpful in most clinical situations.

IS SUICIDE BEREAVEMENT DIFFERENT?

The question of whether, and in what ways, grief after suicide might be different from grief after other modes of death is not a new one. Several research and theoretical articles have attempted to answer this question (Jordan, 2001; Sveen and Walby, 2008; Jordan and McIntosh, 2011). Typically, the research and clinical literature has generally (although not always) found the mourning process after a suicide to differ from more normative causes of death in the following ways:

- There is a greater need to seek an explanation for the death and to make sense of the death.
- Survivors experience greater levels of guilt and felt responsibility for the death (or at a minimum, for a failure to somehow foresee and prevent the suicide).
- There is a greater level of stigmatization and shame about this mode of death, and a greater need to conceal the fact that the death was a suicide.
- Survivors receive more avoidance by, and isolation from, social support from their regular social networks.
- Exposure to the loss of a loved one to suicide increases the chances of suicidal thinking and behavior in the person exposed.

In addition, like other sudden, unexpected, and often violent deaths (such as homicides, motor vehicle crashes, and natural disasters), suicide also seems to produce higher levels of PTSD type symptoms (intrusive reliving, avoidance of triggering reminders of the death, and physiological hyperarousal; Kaltman and Bonanno, 2003; Bonanno et al., 2007; Neria et al., 2007). This is often accompanied by a significant disruption of the survivors' assumptive world (e.g., beliefs such as "my life is predictable" and "I can keep my loved ones safe from harm"; Wickie and Marwit, 2000; Parkes, 2001; Parkes, 2013).

WHAT MAKES SUICIDE BEREAVEMENT DIFFERENT? THE "WHY?" AND "RESPONSIBILITY?" QUESTIONS

There are some universals in grief, no matter what the mode of death was. For example, when we lose someone important to us through death, we yearn to have them back. Yearning can perhaps be considered the hallmark of the grief response, and its presence is usually expected by both the mourner, and those in the social network around the bereaved individual. Indeed, its unremitting persistence over time is one of the signal indicators of complicated grief, since over time, most yearning for the deceased begins to gradually subside (Pearlman et al., 2014; Mauro et al., 2018).

Beyond the aspects of grieving that apply to all bereavement situations, there are several aspects of a suicide death that can be considered to be either unique to suicide, or at least much more prominent after a suicide, and other traumatic deaths. By traumatic deaths, I mean a mode of death that is sudden, unexpected, and often times violent – and thus likely to leave the mourner in a state of shock and bewilderment.

Perhaps the element that most distinguishes a death by suicide from all other deaths is the *perceived intentionality* of the death (Survivors of Suicide Loss Task Force, 2015; Jordan and McGann, 2017). That is, most survivors seem to view suicide as a voluntary choice made by the deceased to die. This perception of self-volition *by the deceased* in the cause of death is unique to suicide (The question of whether suicide is "actually" a choice, freely made by the decedent, is a complex and debatable one, and is beyond the scope of this article. What matters here is the degree to which the mourner *perceives* the death to have been a choice, versus a behavioral act to which the individual was "driven" by circumstances beyond their control). Whenever a mourner believes that someone intended a death to happen, this belief seems likely to add an extra layer of guilt and rage to the emotional response to the death. To the degree that a suicide death is also perceived as intended, then, it raises profound meaning-making and existential questions for the mourner. Why would they choose to do this? How could they have overcome their fear of death, their responsibilities, and their love for others to engage in this behavior? If this death was chosen, then could the deceased, or myself, or someone else have prevented that choice? Why wasn't my relationship with the person enough reason to stay alive? Whose "fault" was the death, and who should be held accountable for it? To a greater or lesser degree, these are the questions with which most suicide loss survivors wrestle. They are also questions that often do not have simple or socially consensual answers, which can create a high level of angst on the part of many survivors, and misunderstanding on the part of the social network.

Closely related to the "Why?" question is the "Responsibility?" question: Who is to be held accountable for this death? This is true because, for most of the public, suicide is a mysterious and even baffling cause of death. Thus, most survivors do not have the kind of generic explanations for the death that are already socially constructed for most other modes of death. For example, the mourner can explain a death to lung cancer by the fact that the deceased was a smoker, and couldn't or wouldn't stop. Even a traumatic and violent death of a loved one, such as a homicide, might be explained by the evil or revengeful intent of the murderer. But why does someone choose to "murder" themselves (The Latin root of the word suicide literally means "self-killing or self-murder")? Most people have no easy, socially validated explanation for suicidal behavior, since it seems to violate a belief that most people take for granted, which is that *"Of course, everyone wants to keep living, don't they?"* And because we collectively do not have a commonly accepted narrative for self-inflicted death, many survivors struggle with who or what should be held accountable for the death?

While it might seem obvious that the individual who killed themselves should be held responsible, in my clinical experience, this only happens some of the time, and for only some of the survivors of a suicide loss. Instead, most survivors begin by blaming themselves for the death. Many survivors repeatedly review a litany of their own "sins of omission and commission" in trying to assign responsibility for the death. Sometimes referred to as the "if-onlys," survivors may have thoughts such as "if only I had not had an argument with him the night before," or "if only I had made him go to therapy or Alcoholics Anonymous, or church," etc. Sometimes, survivors will also assign the blame to someone else, such as other family members, friends, or professionals who are deemed to have been professionally responsible for the deceased (e.g., a therapists, doctors, or clergy persons). In my experience, it is less common for survivors to begin by blaming the deceased, although that may come in time.

TASKS OF PSYCHOLOGICAL INTEGRATION OF THE LOSS

Sometimes referred to as grief work, I have come to believe that there are several psychological tasks that most survivors need to address if they are to integrate and make their peace with the suicide. These tasks can serve as a broad guide for both the clinician and the client as to the work that needs to be done in the treatment. I will list and comment on these tasks in the bulleted list below.

- Containment of the Trauma and Restoration of a Sense of Psychological Safety and Control

Evidence suggests that exposure to the violent death of a loved one, particularly if the survivor was an eye-witness to the dying process, or found the body of the deceased, can generate trauma symptoms in the survivor (Kristensen et al., 2012; De Leo et al., 2014; Rando, 2015). *In my opinion, the core of the trauma response is elicited by exposure to a terrifying or horrifying situation, which results in intense physiological arousal, as well as a profound sense of helplessness and a loss of one's subjective sense of predictability and control over the world. This, in turn, makes the world a significantly less psychologically safe place to dwell.* Trauma symptoms can include intrusive reliving of the sensory data from the scene (sights, sounds, smells, etc.), and strenuous attempts to avoid anything that will trigger *an involuntary relieving of the original* traumatogenic experience *(a.k.a. flashbacks)*, along with efforts to suppress the physiological arousal that goes with these memories. As an example, I worked with a couple whose adolescent daughter killed herself after an intense argument with her parents. Her mother found her daughter's body in the girl's bedroom upstairs, and for several weeks after this trauma, she had difficulty leaving her own bedroom, and absolutely refused to go upstairs or to go into her daughter's bedroom, *in an obvious attempt to avoid being triggered into reliving the nightmare of finding her daughter's body in her bedroom.*

This pattern can morph into full-blown symptoms of post-traumatic stress disorder (PTSD) (Stroebe et al., 2001; Kaltman and Bonanno, 2003). It is also important to note that one does not have to have been an actual eye-witness to the suicide to develop trauma symptoms. Instead, one only needs to know the method of the suicide (e.g., gunshot to the head, hanging, etc.) to develop mental imagery about the death scene and dying process. These images then function as trauma "memories."

These hallmark symptoms of PTSD often require that some type of focused trauma reduction clinical techniques must be used, early in the therapy process, to help the client regain a sense of control over their own reactivity to the horror of the death scene as it was witnessed and/or imagined, and to keep the trauma from "spreading" into other areas of the individual's physical and psychological life space. I have found that the technique of Eye Movement Desensitization and Reprocessing (EMDR) is one empirically based trauma treatment that can help with trauma reduction in suicide loss survivors, although EMDR is not the only such method for producing relief from trauma symptoms (Kosminsky and McDevitt, 2012; Solomon, 2018). *Other promising and effective treatments for bereavement related PTSD have also been developed* (Cohen et al., 2006; Foa et al., 2009; Pearlman et al., 2014).

- Repair of the Mourner's Assumptive World

In addition to producing PTSD type symptoms, most traumatic experiences violate the assumptive world of the survivor, particularly their implicit beliefs about safety, predictability, and control in the world (Kauffman, 2002; Currier et al., 2006). One's assumptive world includes many of the "taken for granted" beliefs that we carry about who we are, who other people are, and what we can expect in terms of our relationships with them. Suicide may violate all of these beliefs for the mourner. For example, I worked with a client whose 15-year old son went upstairs and hung himself after an intense argument with his parents. The parents had no idea that their son was thinking of, let alone capable of, such an act. When I saw the mother 5 years later, she was still struggling with the meaning-making question of "was this really a suicide – or was this an accident?" I asked her what it would mean to her if she could speak with her son again, and he said that he had, in fact, intended to die. My client answered plaintively that "It would mean that I didn't know my son?" In other words, much of my client's assumptive world – what she took for granted about her son – was that she knew him well enough to know if he was in danger of suicide; that he would come to her for help if he was wanting to die; and more generally, that she could keep him safe from harm. All of these suppositions were shattered by his sudden suicide. This catastrophe had produced a long-lasting experience of distress, self-doubt, guilt, and anxiety in the client, including a fear that she was a complete failure as a mother, and that she was now in danger of misjudging whether one of her other children might be suicidal. All of this had disrupted her assumptive world, and required therapeutic work on rebuilding those beliefs in a way that would allow her to acknowledge the truth of what had happened, yet permit her to restore a positive self-image and confidence in her functioning as a parent to her other two children.

One of the most important healing tasks for suicide loss survivors is to develop a "bearable" narrative of the suicide, *one that works well enough for the survivor that they can obtain some relief from the "Why?" questions and restore a sense of coherence to their assumptive world. This usually includes construction of a narrative of the death that embraces the complexity of suicide as a kind of "perfect storm" of factors coming together (including the intentions of the deceased) that allowed the suicide to happen, rather than just the simple result of one person's mistakes or failures.*

This ideally includes a *realistic and fair* explanation of what happened, why it happened, and what responsibility the survivor should *realistically and fairly* assume for the event. Note that this does not mean that all people in a family must agree on all aspects of the story of what happened, or why it happened. Rather, each family member (or person in the social network affected by the death) must develop an explanation of the death that works well enough for them psychologically, and that allows them to begin to reinvest in their life without the deceased (see final task, Reinvestment in Living, below). This task also includes accepting the "blind spots" that are common after suicide, such as the fact that the only person who could answer these "Why?" questions is now dead, and unavailable to offer clarification of their behavior (Sands, 2009; Sands et al., 2011; Neimeyer and Sands, 2017).

- Self-Dosing – Creation of Psychological Sanctuary and Relief from the Pain

The loss of someone to suicide can be excruciatingly painful. Many survivors report that this experience is the deepest psychological anguish they have ever felt. In fact, a recent literature review has confirmed that exposure to the suicide of someone to whom we are psychologically close increases the risk that the person exposed will die by suicide as well (Jordan, 2017). The intense "psychache" (Schneidman, 1981) that suicide leaves in its wake is likely a contributing element to this elevated risk of suicide in survivors. It follows from this that one of the most important integrative tasks is to help the individual cultivate ways to find relief from the despair created by the suicide.

In the beginning, survivors typically do not have any control over their grief – in a very real sense, grief controls the survivor, rather than the other way around. The therapeutic task then becomes one of finding ways to help people more voluntarily regulate this intense pain. This allows the survivor to grieve when they choose to allow this to happen. And correspondingly, when the time and situation is not appropriate, people can usefully learn to "compartmentalize" their grief, so that they can address current challenges in their immediate environment. I have come to label this function as learning to "dose" one's grief. This idea is captured in the relatively recent model of grieving called the "Dual Process Model of Grief" Dual Process Model (DPM) (Stroebe and Schut, 2010; Stroebe and Schut, 2016). The DPM suggests that in normal, healthy mourning, people oscillate between two orientations toward grief. The first, the Loss Orientation, involves the survivor immersing themselves in the reality of the loss, and the feelings, thoughts, and behaviors that accompany that immersion. The second orientation is termed the Restoration Orientation, and it includes putting the grief on the "back-burner" while the bereaved person learns to cope with the changed world that has been created by the death. Learning to engage in this kind of "flexible attention" to their grief indicates that the mourner is evolving from a primarily involuntary to a more voluntary and "chosen" process of grieving (Kosminsky and Jordan, 2016).

- Development of Social Management Skills

Suicide frequently alters the quantity and quality of social connections between the mourner and their family and larger social networks. For example, in my clinical experience, suicide often strains the relationship between marital partners. People sometimes need to use coping mechanisms that have rarely been employed before in the relationship. To illustrate, after the death of a child to suicide, a mother may seek more or less continuous opportunities to talk about her grief and to process her loss with the child's co-parent. The partner, in turn, may need to isolate themself and retreat into a defensive "hibernation" stance. This produces a kind of coping asynchrony between the couple, wherein what one person needs to do to integrate the loss is the opposite of what the other needs to do. Moreover, the couple may have little or no experience dealing with this kind of profound emotional dysregulation within and between them. Similarly discrepant reactions can occur between parents and children, between nuclear and extended family members, and even between members of the family and others in their larger social network. Navigating this straining of routine social connections, and managing the usually well-meaning but often clumsy efforts of other people to help by offering platitudes ("they're in a better place") or advice ("pray to Jesus"; "take up Yoga") can add an additional burden of psychological work to be done at a time when the mourner is lacking in skills or energy for such an undertaking. *For example, after the suicide of her husband, a bereaved wife may find spending time with her clergyperson and friends at a Bible study class at her church to be difficult and emotionally draining. Conversations may be guarded for the widow within her church social circle, and discussions of "sin" and "punishment for immoral behavior" within the class awkwardly strained as a result of her husband's suicide. Indeed, the woman may ultimately feel compelled to leave this church and find another faith community where her background and story are not so much a focus of community members.*

It is important also to note that while in many societies the amount of outright stigma that families encounter after a suicide may be decreasing, suicide and psychiatric disorder nonetheless have a long history of being defamed and punished by most communities. Many suicide loss survivors still experience at least some of the outright avoidance, condemnation, and hostility that have historically been associated with completed suicide (Cvinar, 2005; Botha et al., 2009; Feigelman et al., 2009; Pitman et al., 2018). The social isolation produced by this shunning behavior can negatively affect some people so much that families may attempt to keep the suicide a secret. Or they may experience a rise in family tension and conflict about how to handle these "information management" challenges as a group. In addition, suicide can generate a great deal of anger or rage, some of which may be directed toward the deceased, but much of which may be targeted toward other family members (Jordan and McGann, 2017). These scapegoating processes can seriously erode family cohesiveness, and add to the emotional distress and upheaval with which family members must cope (Jordan et al., 1993). For example, one couple I saw after their young adult son had shot himself presented with enormous anger and hostility between them. The couple had a history of marital conflict, and on many occasions, one of their arguments centered on the father's refusal to get rid of his gun collection. Finally, the father agreed, but failed to actually dispose of the guns, and the son had subsequently used one of his father's guns to shoot himself – a fact that infuriated his wife.

- Repair of the Relationship with the Deceased

In a literal sense, death ends the relationship between two people, in least in its previous form. There has been an intellectual "revolution" in modern thanatology, however, with the recognition that for most of human history, most human cultures have allowed, even encouraged, the development of what have been called "continuing bonds" with the deceased (Klass et al., 1996; Klass and Walter, 2001). For example, in traditional Japanese culture, every household would have a shrine or alter to the ancestors in the family, who are symbolically treated as on-going, "living" members of the family system. It is only with the development of 20th century psychiatric thinking that the idea has emerged that mourners are supposed to "decathect" (i.e., withdraw emotional investment in) their bond with the deceased. In addition, the contemporary mental health community has historically judged the failure to do so to be an indicator of unresolved or pathological grief. In contrast, the continuing bonds movement in thanatology has suggested that the task after death is not to "say goodbye" and end the psychological relationship with the deceased. Rather, it could better be characterized as the work of transforming the nature of the attachment to the deceased from one of a relationship in physical reality to one in the psychic/spiritual reality of the mourner (Klass, 1999; Klass and Goss, 1999) – that is, finding a different way to "hold on" to the relationship. The difficulty with the mourning process after a suicide is that suicide often results in a psychological rupturing and betrayal of the relationship between the mourner and the deceased.

The "meaning" of a suicide for a given individual can vary widely from one person to another. Nonetheless, one common theme for suicide loss survivors is to perceive the death as a rejection, abandonment, or even a betrayal by the deceased. Note that how the act of suicide is experienced is "in the eye of the beholder," and for some survivors, there may be little or no feeling of disloyalty or duplicity by the deceased. But for many people, the death is perceived to be a choice with a critical interpersonal message for the survivor from the deceased about the lack of worth or value of the relationship. All of this can add to the feeling of alienation and estrangement from the deceased.

Continuing bonds theory, as well as common clinical experience, suggests that this kind of sudden breaking of a relationship extracts an even heavier toll from survivors of suicide loss in their mourning process. Correspondingly, an effort by clinicians to help the mourner to reinstate and repair the relationship with the deceased, and to make their peace with the "unfinished business" in the relationship, is often a necessary task of healing after a suicide loss. In my experience, this work often needs to be accomplished by some form of dialogue with the deceased – a dialogue that might have happened if the deceased had betrayed the survivor in some other way, and then was willing to make amends for the damage. The form this dialogue takes can include letter writing to the deceased, empty chair enactment of conversations with the deceased, and other forms of communication between the deceased and the mourner that are experienced as authentic and healing for the bereaved survivor (Jordan, 2012; Neimeyer, 2012, 2016; Botkin, 2014; Neimeyer, in press; Valdez et al., in press).

- Development of a Durable Biography of the Deceased

Walter (1996) has suggested that one of the important tasks of mourning is to create a "durable biography" of the deceased. A durable biography is a narrative of who the deceased was, what they had accomplished, and what they have left behind from their life. He argues that this process is accomplished primarily by a process of shared remembering and storytelling amongst people who knew the deceased. This process typically begins immediately at the time of death (e.g., at the funeral), and may continue on for years, or even generations within family systems. It is a universal and natural way for the community around the deceased to share their grief, and to combine and enrich each mourner's personal narratives of interaction with the deceased over the course of their life.

Suicide, however, may present special problems for the accomplishment of this important task of mourning. More specifically, because suicide is both a relatively rare and a socially stigmatized cause of death, establishing the communal narrative about the life of the deceased can become either taboo, or alternatively, almost exclusively focused around the mode of death itself. In other words, when someone dies by suicide, that fact may become the only "important" thing about their life story. Thus, mourners who wish to remember the entirety of the life of their friend or relative, not just the manner by which they died, often need to make an extra effort to share (and request that others share) memories that predate and highlight other important aspects of the deceased's identity and life story. And they also must overcome the social discouragement about talking about and remembering the deceased that comes from others in the interpersonal network, who may view the suicide as a shameful and dishonorable form of death. This implicit prohibition of the "social remembering" aspect of the mourning process can add to the emotional distress and difficulty of the survivors in integrating the loss into their own life narrative as an associate of the deceased.

- Reinvestment in Living

As Sands (2009) and Sands et al. (2011) has pointed out, suicide loss survivors often need to "try on the shoes" of the deceased, but ultimately they must decide to "take off the shoes" of the deceased". Exposure to suicide, which we know increases the risk of suicide in those who have been exposed (Jordan, 2017), seems to have the effect of raising suicide as an option for the survivor when dealing with life problems and pain, including most importantly the pain of the loss of a loved one to suicide itself. But healing after a suicide loss does require that survivors find reasons to choose to go on with their own life, despite the emotional pain and real life problems that have been left in the wake of the suicide. They also must sometimes contend with a wish for reunion with the deceased that a suicide might produce. For some survivors, their own reasons to go on living may never really be in doubt. But for others, the exposure to the suicide of a loved one creates significant psychological distress, and raises the question of "Why do I want to continue on? What are my reasons for living?" Working through those issues can be a central challenge for many suicide loss survivors, and the therapeutic relationship can be an important crucible for resolving these fundamental existential questions for the survivor.

IMPLICATIONS FOR CLINICIANS

This article has identified a number of ways that grief after suicide may be different in both quality and quantity than grief after other modes of death. I conclude this commentary with some remarks about the implications of these differences for practicing mental health professionals. Again, these recommendations come both from my study of the research literature on suicide bereavement, as well as my own extensive work with suicide loss survivors. These are the "lessons learned" from providing over 40 years of grief therapy for survivors. For additional commentary about the process of providing grief therapy to suicide loss survivors, please see some of these other publications on the topic (Jordan, 2008; Jordan, 2009; Jordan, 2011; Kosminsky and Jordan, 2016).

The first point is that my preferred model for doing the work is longer term therapy. I understand the tremendous pressure within many clinical settings to "speed-up" therapy by providing targeted, but short-term, crisis oriented work for victims of traumatic experiences such as a suicide death. I suspect, however, that this is too often driven by economic, not clinical, concerns. The existing literature suggests that, for people who have been deeply impacted by a suicide, the journey is often long term and transformational (Saarinen et al., 2002; Feigelman et al., 2012; Jordan and McGann, 2017). Therefore, I have come to believe that a "companioning" model of clinical work (Tedeschi and Calhoun, 2003), in which the therapist serves as a transitional attachment figure who helps the bereaved individual re-regulate themselves and integrate the loss over time, is best suited to the nature of the work that needs to be accomplished (Kosminsky and Jordan, 2016). Except at the very beginning of treatment, or in situations where the mourner is in immediate crisis or self-destructive, I believe that it is preferable for the clinician to provide relatively infrequent sessions, but *long term availability* to the mourner.

Second, I believe that, while important in all psychotherapy, the quality of the relationship between therapist and client is of particular importance in helping suicide loss survivors integrate and heal from the loss. Kosminsky and Jordan (2016) have outlined the foundations of an "attachment informed grief therapy" which emphasizes the crucial importance of an on-going, nurturative attachment relationship with a clinician who is empathically attuned to the experience of the client. Rooted in the robust literature on attachment theory and psychotherapy (Wallin, 2007; Berant and Obegi, 2009; Holmes, 2013; Mikulincer et al., 2013; Cozolino and Santos, 2014), this stance is backed by the robust literature on the importance the therapeutic alliance in improving treatment outcomes in all forms of psychotherapy, and of certain therapist behaviors and characteristics that are particularly helpful in fostering that alliance (Norcross and Lambert, 2018). Building on this, Kosminsky and Jordan suggest that certain "Core Capacities," or necessary interpersonal skills of the grief therapist, are the key to developing a strong therapeutic alliance in work with traumatically bereaved clients. These capacities include the clinician's skill at creating an emotionally safe relationship, their capacity for empathy, non-defensiveness and repair of alliance ruptures, their ability to tolerate the client's (and their own) emotional distress without having to "fix-it" immediately, and a deep level of mindfulness and self-knowledge. The reader is referred to the Kosminsky and Jordan (2016) volume for further elaboration and case examples of the application of these Core Capacities to clinical bereavement situations.

Third, I believe that it is important to recognize that grief therapy often involves more than simply helping the client to express and/or gain insight into their feelings. For example, most survivors come to grief therapy with a minimal understanding of psychiatric disorder, suicide, and grief after suicide. Thus, the clinician needs to play an active psychoeducational role in helping the bereaved survivor understand the factors that usually contribute to a suicide and the normality of the intense grief and trauma responses that may follow a suicide. This is important to help the client develop the "bearable narrative" that was mentioned previously.

Likewise, therapy by itself may not be sufficient in providing psychological support for survivors. The opportunity to connect with other suicide loss survivors may be a very helpful experience for many people bereaved by suicide (Feigelman et al., 2008;

Hoy, 2016). Opportunities to make their bereavement journey a communal experience can be vital in helping to reduce the sense of shame and isolation that many survivors experience. Sharing with other survivors also allows the bereaved to compare their reactions to those of other survivors, and to learn new adaptive skills by observing the coping efforts of others in similar circumstances. This social exchange can happen in a variety of settings, from face to face peer support groups, to one-on-one interactions with survivors, to new resources that allow survivors to connect with each other online (Beal, 2011; Walker, 2017). Clinicians can be tremendously useful to survivors by helping them find resources beyond the professional mental health community that may provide opportunities for peer support and education about their loss.

Lastly, since a suicide loss can lead to a host of ancillary problems, such as trauma symptoms, existential anxiety about the loss of security and predictability in the world, and disruption of the survivor's social connections, the therapist must be open to a variety of non-traditional topic areas and clinical techniques that have usually been considered beyond the range of conventional mental health treatment. For example, although many bereaved individuals wonder about the possibility of life after death, this can become an agonizing spiritual question for traditionally religious suicide loss survivors, who may fear for the whereabouts and well-being of their loved one after committing the "sin" of suicide. Some mental health professionals are uncomfortable with discussion of such important issues, having been trained that they are beyond the legitimate concerns of mental health treatment, and, at most, should be referred to a clergy person for "answers." Likewise, clinicians may also be uncertain about the appropriateness of referral of their clients to psychics or mediums in the community. It is important also for grief therapists to be very mindful of their own beliefs and values about the existential questions that suicide often raises: is there life after death; where do our loved ones go after death; can I communicate with them; and will I be reunited with them? These are necessary and legitimate questions with which survivors struggle and with which therapists should become familiar and comfortable. It is also worth the clinician's time and effort to learn about developing and unconventional therapy techniques that may help some suicide loss survivors answer such crucial questions (Botkin, 2014; Valdez et al., in press).

POST-TRAUMATIC GROWTH AFTER SUICIDE

Understandably, this article has focused primarily on the negative impact that exposure to a suicide may have on the survivors left behind. As discussed previously, there is now convincing evidence that such exposure can lead to a number of adverse sequelae on survivors, not the least of which is an elevated risk of suicide in the exposed survivor (Jordan, 2017). But it would be a mistake to assume that only bad things can follow the loss of a loved one to suicide. The recognition of what has been called Post-Traumatic Growth (PTG) in survivors after traumatic experiences (Tedeschi and Calhoun, 2008; Calhoun and Tedeschi, 2014) is a new and burgeoning field of inquiry. PTG can be manifested in a changed outlook on life (i.e., an altered assumptive world), greater resilience in the face of stress, and the development of increased prosocial feelings and behavior such as compassion, non-judgmentalness, and hope. Recent research on PTG in suicide loss survivors has suggested that some people show evidence of PTG after suicide (Moore et al., 2015; Genest et al., 2017; Drapeau et al., 2019). And we are beginning to learn some of the correlates of PTG in suicide loss survivors, which will hopefully set the stage for learning what clinicians can do to foster and enhance PTG in people bereaved by suicide. This offers hope for an improving set of methods for mitigating the injurious effects of such a devastating loss, and for promoting the growth of wiser, more compassionate survivors of this painful life experience.

AUTHOR'S NOTE

Bereavement after a suicide has been neglected in the field of suicidology. This paper reflects the nearly 40 years of clinical work by the author in providing grief therapy to suicide loss survivors. It also draws on his other publications on this topic, as well as the larger literature within thanatology on mourning processes after traumatic death.

AUTHOR CONTRIBUTIONS

The author confirms being the sole contributor of this work and has approved it for publication.

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METHODS
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The SUPPORT-S Protocol Study: A Postvention Program for Professionals After Patient or User Suicide

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Background: Exposure to patient or user suicide (PUS) is identified as a challenging occupational hazard for mental health and social work professionals. Professionals exposed to PUS may encounter several ranges of emotional, traumatic or professional impacts in the aftermath. A high proportion of exposed professionals reports a lack of support in the aftermath of PUS. SUPPORT is a postvention program designed to provide a comprehensive, adaptative and effective support to professionals impacted by PUS. The aims of the SUPPORT-S study are to (1) improve the design of the SUPPORT program, (2) evaluate the effectiveness of the program to buffer the emotional, traumatic and professional impacts and to improve the perceived social support for professionals exposed to PUS, and (3) provide more insights into the consequences of PUS on both professionals and organizations.

Method: The SUPPORT-S study is a mixed method collaborative and participatory action research. The simultaneous and complementary collection and analysis of qualitative and quantitative data will offer an in-depth evaluation of the implementation and the effectiveness of the program. The qualitative evaluation includes: (a) an ethnographic observation; (b) 25 semi-directed interviews with randomized participants; (c) an activity analysis with providers of the program; and (d) collaborative sharing of the results with providers and participants. The quantitative evaluation includes pre- and post-measures in participants of: (a) emotional impact (*Differential Emotions Scale IV*); (b) traumatic impact (*Impact of Event Scale-Revised*); (c) professional impact (non-validated questionnaire); and (d) perceived social support (*Perceived Social Support Scale for Professionals*). The action research design will rely on: (a) the cycling process of implementation/evaluation/data sharing/adjustment and (b) the participatory approach through data sharing with providers and participants. Triangulation, saturation, randomization, and participatory design will also reduce the risk of biases and will improve the generalizability of conclusions.

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Expected Results: We expect the SUPPORT-S study to evaluate and improve the design of the SUPPORT program to effectively help professionals to cope with PUS.

Conclusion: The results of the study will allow us to disseminate an effective and adaptive postvention program for professionals and institutions encountering PUS.

Keywords: suicide, postvention, institution analysis, mixed method approach, action research

INTRODUCTION

Exposure to patient or user suicide (PUS) has been identified as a frequent and challenging occupational hazard for mental health and social work professionals (Gulfi et al., 2010; Séguin et al., 2014; Castelli Dransart et al., 2017; Leaune et al., 2019a). For instance, between 51 and 82% of psychiatrists (Castelli Dransart et al., 2017), 46.9% of psychiatric trainees (Leaune et al., 2019a), between 22 and 39% of psychologists (Castelli Dransart et al., 2017), 55% of nurses (Takahashi et al., 2011) and 33% of social workers (Jacobson et al., 2004) will experience PUS during their training or career. Cerel et al. (2014) identified a "continuum of survivorship" after suicide, distinguishing those who are exposed to, affected by, or bereaved long-term or short-term by suicide. Considering PUS, all the members of the staff may encounter high levels of psychological distress and professional difficulties in the aftermath, including emotional, traumatic, and professional impacts (Séguin et al., 2014; Castelli Dransart et al., 2017; Leaune et al., 2019a,b). The emotional impact frequently includes shock, guilt, sadness, anger, failure, shame, and anxiety. Stress and traumatic reactions are also reported, including acute stress and posttraumatic stress disorders. Regarding professional impact, PUS may challenge the feelings of self-confidence and professional competence. A fear and avoidance of suicidal individuals, an impairment in professional decision-making or a decrease in work performance are notably reported. Some of the exposed professionals may also experience grief reactions or disenfranchised grief, i.e., a grief that is denied the right to exist because the impact of the loss is not recognized by peers, superiors or society (Doka, 1989). The majority of professionals will positively manage the impact of PUS through professional growth and encounter it as a learning and beneficial experience. In contrast, a minority of professionals will show high levels of impacts, with negative personal and professional outcomes. The term "second victims," proposed to designate professionals exposed to adverse medical events in patients, has thus been used in the case of professionals impacted by PUS (Scott, 2019). The negative impact of PUS is significantly associated with a closeness to the deceased, a high level of the professional–client relationship and a lack of support and training. Castelli Dransart et al. (2015) notably reported that the lack of support in the aftermath was a risk factor for higher traumatic impact in the aftermath of PUS.

Postvention refers to the activities developed in the aftermath of a suicide to prevent negative health outcomes and facilitate recovery among the bereaved (Andriessen, 2009). Despite the growing evidence on the impact of PUS, the lack of institutional support in the aftermath has been widely documented (Ruskin et al., 2004; Castelli Dransart et al., 2015; Leaune et al., 2019a,b). Moreover, the literature on postvention programs dedicated to the support of health and social work professionals remains scarce. In retrospective studies, however, the participants have reported that support from peers, superiors or their institution can be both a protective factor and a predictor for adaptative coping strategies and lower levels of emotional, traumatic, and professional impacts (Castelli Dransart et al., 2015, 2017). Only one study qualitatively explored the effects of a half-day retreat dedicated to health and social work professionals previously exposed to PUS (Figueroa and Dalack, 2013). All respondents reported that participating in the retreat was a beneficial and helpful experience, highlighting the positive effects of the group intervention design. The effectiveness of this program to reduce the emotional, traumatic or professional impact of PUS was not assessed.

Hence, research dedicated to the development and evaluation of comprehensive and adaptive programs providing support to mental health professionals and social workers exposed to PUS is needed. In line with this urgent need for social change, this article aims to describe (1) the design and implementation of a postvention program (SUPPORT) for professionals exposed to PUS and (2) the protocol of the SUPPORT-S research-action study evaluating and improving the design of the SUPPORT program to effectively help professionals to cope with PUS.

Method

Development of the SUPPORT Program

The Center for Suicide Prevention (CSP) is an ambulatory care unit located in Lyon, France, that provides several types of suicide prevention activities, including brief contact interventions for people showing suicidal ideation or those who attempted suicide, outreach interventions for people showing suicidal behaviors, postvention counseling for individuals or family bereaved by suicide and information and training on suicide prevention.

According to the model of support for professionals after adverse events developed by Scott et al. (2010) our pluri-professional team of the CSP (psychiatrists, social and work psychologists, nurses, and psychiatric residents) designed a four-stage postvention program for mental health and social work teams exposed to PUS (SUPPORT, see **Figure 1**). The Scott three-tiered integrated model (STTIM) of interventional support after adverse event was developed by Scott et al. (2010) to provide an on-demand rapid intervention, ranging from immediate first aid support through peers and superior support to professional counseling for second victims. The STTIM relies on both local

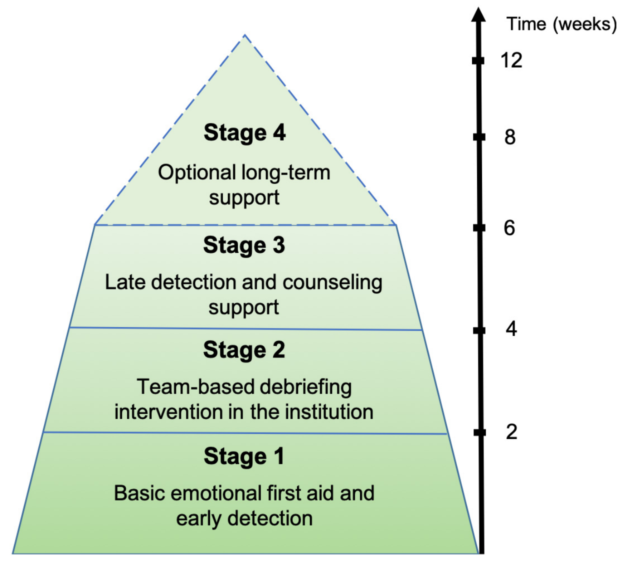


FIGURE 1 | Schematic overview of the SUPPORT program.

support from peers and superiors and supportive interventions by a trained team dedicated to the impact of adverse events on professionals.

Inspired and adapted from the STTIM, SUPPORT is a 6-week program divided into four distinct stages. The three following stages are mandatory: (a) basic emotional first aid at the local level; (b) team-based 1- to 2-h supportive intervention in the institution; and (c) follow-up, late detection. A fourth optional stage including long-term support and training or workshops on suicide prevention may be provided to professionals. The objectives of the SUPPORT program are to (1) buffer the traumatic, emotional and professional impacts in professionals, (2) improve the support perceived by exposed professionals, and 3) promote the return to normal functioning in the institution exposed to PUS.

Stage 1: Emotional First Aid

The first stage of the program includes early contacts by the CSP with the head of the exposed team (head of department, physicians, chief nurse, etc.) to provide them with an organizational framework of structured and synchronized crisis management. According to the guidelines for postvention interventions (Andriessen et al., 2019), the objective of this first stage is to build a crisis team dedicated to the management of the aftermath of PUS and the deployment of basic emotional first aid for the exposed professionals. The detection and initial support of highly impacted professionals (acute stress disorder, depressive reaction, suicidal ideation, etc.), the prevention of suicide contagion and the orientation to mental health care for those who are highly impacted are the most crucial issues of this first stage of the SUPPORT program. Individual consultations are notably proposed to the most strongly impacted professionals through a fast-track referral to the CSP. Stage 1 thus aims to promote basic emotional first aid and early detection for those who were the most impacted through local support from peers and superiors during the first days following a PUS, through the building of a crisis team.

Stage 2: Team-Based Intervention

The team-based intervention consists of a 1- to 2-h intervention in the institution where the suicide occurred, driven by two professionals (e.g., a psychiatrist or psychologist and a nurse) from the CSP in the month following a PUS. All of the exposed professionals are invited to participate in the intervention, during which a debriefing of the event and its impacts is performed. Exposed professionals are offered a supportive space to freely express their feelings about, emotions toward and experience of PUS. The intervention on the entire team aims to buffer the emotional, traumatic, and professional impacts, both in individuals and in the working team. In particular, the presence of the professionals who discovered the corpse or performed resuscitation techniques, those who were the closest of the deceased and those who were the most impacted is encouraged. Stage 2 thus aims to provide professional emotional aid at institutional level, through an in-depth team-based debriefing intervention.

Stage 3: Late Detection and Counseling

The third stage of the program seeks to perform late detection and counseling support for professionals who are strongly affected or traumatized by exposure to PUS. Those who feared attending the team-based intervention stage may notably receive individual debriefing during this stage. Stage 3 aims to promote the return to normal functioning in the institution, at both the individual and organizational levels. When stage 3 has not been effective in ensuring the recovery among professionals, a fourth stage can be added to properly support the impacted team.

Stage 4: Optional Long-Term Support

This optional stage is notably delivered if several suicides occurred or if the whole team is highly impacted by the suicide(s). The support of the management team and the close collaboration with the CSP are the most important components of this stage. A second debriefing intervention or a 3-hour suicide prevention training may be provided to the whole team. Workshops on the means and actions seeking to improve the prevention of suicidal behaviors or the support of professionals in the exposed setting are encouraged and organized, to involve impacted professionals in proactive and meaningful actions related to PUS. Stage 4 can last from one to three months and aims to provide in-depth long-term support for teams and institutions that have been strongly impacted by PUS.

The SUPPORT-S Study

Study Objectives

Primary objective

The primary objective of the SUPPORT-S study is to improve the design of the SUPPORT program through the participatory involvement of professionals who deliver the intervention and those who receive it.

Secondary objectives

The SUPPORT-S study aims to evaluate the effectiveness of the SUPPORT program to buffer the emotional, traumatic and professional impacts and to improve the perceived social support for professionals exposed to PUS. The SUPPORT-S study also seeks to provide more insights into the consequence of PUS on both professionals and the organization and to identify markers that may help in implementing programs adapted to different professional settings.

Study Setting

The SUPPORT-S study will take place in Rhône, France, which is the geographical area of intervention for the CSP. The SUPPORT program is designed to be implemented in the following institutions: psychiatric hospitals, general hospitals, nursing homes and social work institutions. The study will start in February 2020 and last 18 months. Every psychiatric and general hospitals, nursing homes and social work institutions of the geographical area will receive in February 2020 detailed information on the SUPPORT-S study. A mail and an email will be sent to all executive managers.

Inclusion and Exclusion Criteria

Every professional working in the institution in which PUS occurred are eligible for participation in the SUPPORT-S study, without any exclusion criteria. Only professionals who do not agree to participate will not be included in the study but they will receive the postvention intervention if they wish to. The eligible professionals will be informed of the concepts, design and running of the study through an information sheet and oral explanations at inclusion.

Study Design

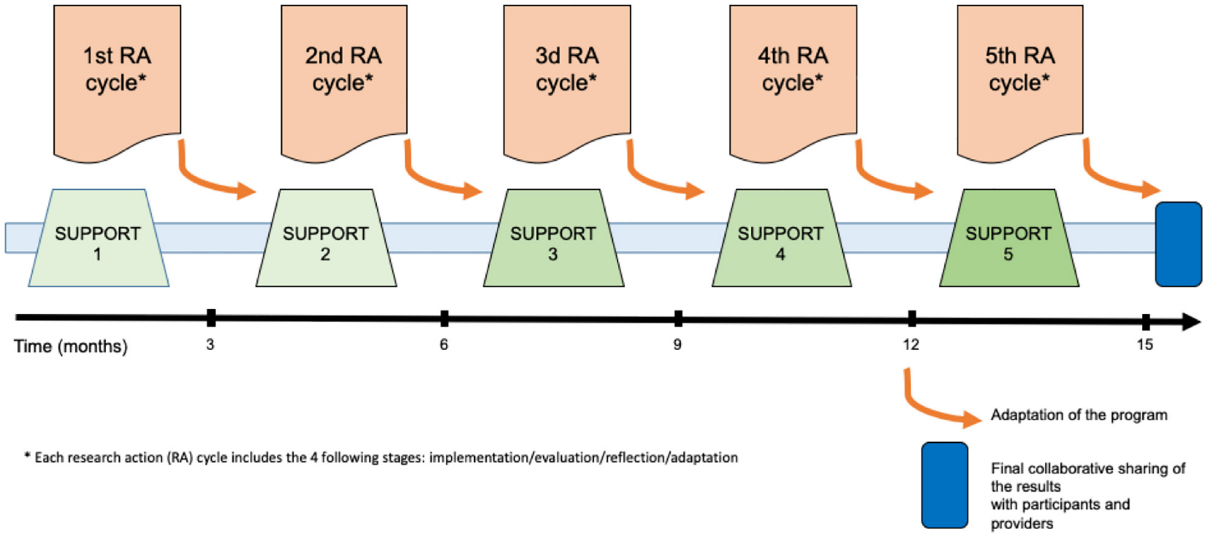
SUPPORT-S is a mixed method collaborative and participatory action research study, including a total of five SUPPORT interventions over a total of 15 months (**Figure 2**). SUPPORT-S seeks to evaluate both the effectiveness of the program from the perspective of professionals who receive the intervention (i.e., participants) and those who deliver it (i.e., providers) through an iterative participatory process.

Action research

Action research is an approach that involves active collaboration *in situ* between researchers and participants to develop a process through knowledge building and social change (Lewin, 1946). Action research gives credence to the development of powers of reflective thought, discussion, decision, action, evaluation and revision by people or professionals participating in a collective research, through active participation during iterative sequences of those who have to carry out the work in the exploration of problems that they encounter (Adelman, 1993). The affective and cognitive involvement of participants is critical for the production of empirical knowledge and social modifications in professional practices. Cordeiro and Soares (2018) identified the following four principles of action research: (1) participation and collaboration; (2) a cycle of implementation, action, reflection and adjustment; (3) knowledge building that considers participants' realities; and (4) social change and problem solving. These principles will be assumed in the SUPPORT-S study through the cycling process of local implementation/evaluation/reflection/adaptation and the active participation of professionals in the evaluation process through restitutions of the results and the conditions of the implementation. The action research process will be held through the following three main activities: (1) the collaborative sharing of results for all professionals after each SUPPORT intervention, (2) the cycling process for each SUPPORT intervention, and (3) the final collaborative sharing of results at the end of the study.

The *collaborative and participatory approach* will notably rely on the collaborative sharing of results, during which professionals (i.e., participants and providers) will be allowed to express their feelings about and experience with the SUPPORT program to propose adjustments for the program. The discussion, revision and validation of the results by the participants ensure their social relevance for the modification of practices in the institution and the implementation of new professional postures in professionals. This approach thus has a transformative role in the pluri-professional collective workforce rather than only focusing on individuals by involving them as active actors and not only participants of the research (Durif-Bruckert and Gonin, 2011; Budig et al., 2018). Moreover, the collaborative approach is based on the implications of social sciences researchers and clinical researchers who are also providers of the program. According to the notion of the "expanded scientific community" developed by Oddone et al. (1981), our participatory research action design thus involves a pluri-professional collaboration between participants, providers and researchers. This concept was developed to produce in-depth and empirically grounded knowledge on work-related psychosocial risk prevention and emphasizes the importance of the social context to improve efficacy and well-being in professionals. The lack of institutional support reported by professionals in the aftermath of PUS indicates the need to drive a substantial social change in institutional practices regarding postvention issues. The research action design of the study thus aims to allow the dissemination of a comprehensive and adaptative intervention among different institutions and professional settings. The collaborative and participatory approach of the SUPPORT-S study is understood at the same time as a way to gain effectiveness in the intervention, as a way to limit the biases related to mixed method design, and as an ethical posture in the research process and the interpretation of the results.

The *cycling process* of the SUPPORT-S study will be one of the key components of the action research design. Indeed, the local implementation of the SUPPORT program after a PUS will be performed throughout the following repeated process: (a) implementation, (b) qualitative and quantitative evaluation, (c) collaborative sharing of the results, and (d) adjustment of the program according to the restitution and evaluation (**Table 1**). Notably, the reflection on and modification of the SUPPORT program after each local implementation will ensure the cycling process of implementation/evaluation/reflection/adaptation through the active participation of both providers and participants. For each local implementation, the sequence will be repeated, and the program will be progressively modified,



* Each research action (RA) cycle includes the 4 following stages: implementation/evaluation/reflection/adaptation

FIGURE 2 | Schematic overview of the SUPPORT-S study.

revised and adapted according to the cycling process. The revision and adaptation of the SUPPORT program after each implementation, through the active participation of providers and participants, will improve its effectiveness and relevance to help professionals in coping with PUS. Moreover, the cycling process is a methodological means to ensure the collaborative and participatory approach of the study, as providers and professionals are proactively involved in the research process.

Mixed method evaluation

Mixed method studies have been shown to be effective in evaluating the implementation of new prevention programs in mental health (Palinkas et al., 2011). Mixed methods design focuses on collecting, analyzing and merging both quantitative and qualitative data into one study. According to the taxonomy of mixed method studies described by Palinkas et al. (2011), the structure of the SUPPORT-S study relies on a simultaneous collection of qualitative and quantitative data. Regarding the function, the two datasets will be collected in complementarity, e.g., qualitative data will be used to provide depth of understanding, and quantitative data will be used to provide breadth of understanding. The process of data analysis will be performed by merging the two datasets and actually bringing them together. The SUPPORT-S study is thus designed as a simultaneous complementary merging mixed method study.

Data Collection

According to the mixed method research design of the study, quantitative and qualitative data will be simultaneously and complementarily collected to obtain an in-depth evaluation of the implementation and effectiveness of the SUPPORT program (**Figure 3**).

Quantitative data

A collection of individual quantitative data will be performed before (T0) and after (T1) the SUPPORT program among professionals exposed to a PUS. Sociodemographic data and information on the therapeutic relationship with the deceased will be collected at T0. A pre/post measure of emotional, traumatic and professional impacts and perceived social support will be performed at T0 and T1.

The following sociodemographic characteristics of participants will be collected at T0: age, gender, profession, and years spent working in the organization.

The following information on the relationship between the professional and the event or the patient or user who died by suicide will be collected at T0: connection with the deceased, discovery of the corpse, resuscitation techniques used, being at work or not the day of the event, and therapeutic alliance with the deceased.

The traumatic impact will be assessed at T0 and T1 through the French version of the *Impact of Event Scale-Revised* (IES-R; Horowitz et al., 1979; Weiss and Marmar, 1997; Brunet et al., 2003). The IES-R is a 22-item self-report questionnaire assessing intrusion, avoidance and hyperarousal symptoms in the previous seven days before completion. Each item is rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely), for a total score of 88. According to previous literature, we will retain a cut-off score of 24/88 to indicate a significant traumatic reaction (Bienvenu et al., 2013) and a cut-off of 34/88 for PTSD (Asukai et al., 2002). The French version of the IES-R shows a good internal consistency (alpha coefficients ranging from 0.81 to 0.93) and satisfactory test-retest reliability (correlations coefficients ranging from 0.71 to 0.76) (Brunet et al., 2003).

The emotional impact will be obtained at T0 and T1 through the French version of the *Differential Emotions Scale IV* (DES-IV; Ricard-St-Aubin et al., 2010). The DES-IV is a 36-item questionnaire assessing the level of expression of the twelve following emotions: interest, joy, surprise, anger, contempt, disgust, sadness, fear, guilt, shame, shyness, and self-hostility. The emotions are measured through a 6-item Likert scale ranging

TABLE 1 | The cycling process of the SUPPORT-S study.

Stage of the cycling process	Actions
Implementation	The CSP is informed of a PUS through emails or phone calls by the chief department of the institution where it occurred. Through a partnership developed with the Regional Health Agency, the CSP can be informed of every PUS occurring in nursing homes or social work organizations in the area and contact the chief department. After oral and written information of all exposed professionals in the institution, the SUPPORT program is implemented in the setting
Evaluation	• Collection of qualitative data: ethnographic observation, five individual semidirected interviews with participants, activity analysis with the SUPPORT program providers • Collection of quantitative data: traumatic impact (IES-R), emotional impact (DES-IV), professional impact (non-validated scale) and perceived support (P3SP) among participants/exposed professionals • Merging of the qualitative and quantitative data • Data analysis and report
Collaborative sharing of the results	Discussion, revision and validation of the results between researchers, providers and participants (workshop). Participants and providers freely express their feelings about and experience with the SUPPORT program to propose an adaptation of the program
Adaptation	Adaptation of the SUPPORT program (content, form) according to the revisions proposed during the collaborative sharing of data, before the next implementation

CSP, Center for Suicide Prevention; PUS, Patient or user suicide; IES-R, Impact of Event Scale – Revised; DES-IV, Differential Emotions Scale – IV; P3SP, Perceived Social Support Scale adapted for Professionals.

from 1 (rarely or never) to 5 (very often), for a total score ranging from 36 to 180. The DES-IV shows good temporal stability (correlations coefficients ranging from 0.49 to 0.79) (Ricard-St-Aubin et al., 2010).

The professional impact will be assessed at T0 and T1 through a non-validated 18-item questionnaire built by our pluri-professional team and adapted from non-validated questionnaires on self-efficacy at work (self-confidence, problem-solving, and decision-making) and modifications in practice. The participants will be asked through close-ended questions about the self-perception of their effectiveness at work, the perception of modification in their professional practice and the type of modification that they perceive. Regarding the self-reported modifications in professional practice, a fear and avoidance of suicidal patients, an increased tendency to hospitalize patients, a fear of granting passes for patients and a prolonged duration of hospitalization are considered negative professional impacts. A better assessment of suicidal ideation in patients, an increased tendency to ask advice to colleagues, a better trackability of information in patients' files and an interest in suicide prevention are considered positive professional impacts. Regarding self-efficacy, the perceived loss of self-confidence or self-control and perceived difficulties in problem solving or decision-making will be considered as negative professional impacts. The presence of at least three items indicating a negative impact on professional practice or self-efficacy will be considered as a negative professional impact.

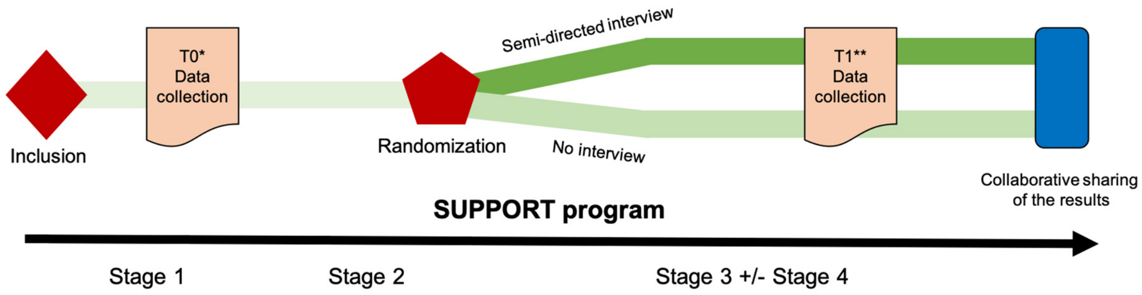
Perceived support will be assessed through the *Perceived Social Support Scale for Professionals* (P3SP; Collange et al., 2016). The P3SP is a 12-item questionnaire evaluating the following four types of perceived social support provided by peers, superiors or the institution in the context of the workplace: (1) instrumental support (e.g., material support, technical assistance), (2) emotional support (e.g., being listened to), (3) informational support (e.g., advice, information, counseling), and (4) esteem support (e.g., positive feedback, constructive appreciation). The satisfaction regarding the four types of perceived support is assessed through a 4-item Likert scale ranging from 0 (not satisfied) to 3 (very satisfied), for a total score ranging from 0 to 36. The P3SP shows good sensitivity and specificity (Collange et al., 2016). Three scores are especially measured by the P3SP questionnaire: (1) level of perceived support from peers and collaborators (from 0 to 12), (2) level of perceived support from the institution (from 0 to 12), and (3) level of satisfaction of perceived support from superiors (from 0 to 12). The P3SP shows very good internal consistency (Cronbach's alpha ranging from 0.82 to 0.93) (Collange et al., 2016).

Qualitative data

An *ethnographic observation* of the local implementation of the SUPPORT program will be performed by social sciences researchers (CD-B, MV, and BCu) to collect in-depth observational data on the implementation of the program. The observation will notably focus on the reaction of the professionals exposed to PUS, and how they manage and experience the implementation of the SUPPORT program. The interactional processes between professionals delivering the program will also be examined.

For each intervention, five exposed professionals will be randomly selected to participate in an *individual semistructured interview* at the end of the program. The semistructured interviews will last between 30 and 60 min and will be performed by one or two social researchers (CD-B, MV, and BCu) in the workplace of participants. The participants will be interviewed regarding their individual experience of the SUPPORT program, including: how they perceived the program for themselves and for their team, which mechanisms led to its effectiveness and how the program could be improved. The content of the interview will be recorded and anonymized.

An *activity analysis* will be performed with the providers of the intervention. An activity analysis is an effective means to analyze complex processes occurring in professional practices (e.g.,



* sociodemographic data, relationship with the decease, pre-test for traumatic (IES-R), emotional (DES-IV) and professional impacts, perceived social support (P3SP)
** post-test for traumatic (IES-R), emotional (DES-IV) and professional impacts, perceived social support (P3SP)

DES-IV= Differential Emotional Scale–IV; IES-R= Impact of Event Scale – Revised; P3SP= Perceived Social Support Scale for Professionals

FIGURE 3 | Participants' trajectories in the SUPPORT-S study.

professionalization processes, interactions between professionals, internalization of professional identities, etc.) (Bedny and Karwowski, 2004). We will use the methodology of auto- and allo-confrontation (Mollo and Falzon, 2004). Regarding methodological issues, in auto-confrontation, subjects are confronted with their own activity, whereas in allo-confrontation they are confronted with an activity that they practice but which is performed by someone else. Regarding purpose issues, auto-confrontation aims to reveal the cognitive processes underlying the activity, whereas allo-confrontation allows subjects to develop their knowledge by becoming aware of other types of representations (Mollo and Falzon, 2004). To perform the activity analysis, the providers of the program will be filmed during their intervention in the institution (stage 2 of the SUPPORT program). In auto-confrontations, they will be asked to comment on and to express their experience with and feelings about moments of their intervention. In allo-confrontation, the comments will be made by other providers from the CSP to enrich the discussion about professional practices and question the different ways of running the intervention.

Estimated number of participants

The inclusion of 150 exposed professionals is expected for the collection of quantitative data. Considering the five local implementations of the SUPPORT program throughout the SUPPORT-S study, the inclusion of 150 exposed professional is needed to observe a 30% decrease in the mean IES-R score between T0 and T1 with a 90% statistical power.

Of them, a total of 25 professionals will participate in the semistructured interviews. According to previous qualitative studies on professionals' experiences of adverse events in which similar (Ullström et al., 2014; Ferrús et al., 2016) or lower (Chan et al., 2018; Kable et al., 2018) samples were included, the inclusion of 25 professionals in semidirected interviews should provide sufficient saturation for the representativeness and reliability of the data. However, the sample of participants in semidirected interviews could be increased if saturation is not reached.

Data Analysis

The quantitative and qualitative data collected in the study will be separately analyzed through independent statistical and qualitative analyses.

Quantitative analysis

Data manipulation and analyses will be performed using R software (R 3.4.1). Qualitative variables will be summarized using numbers and percentages, and quantitative variables will be described using either means and standard deviations or medians and interquartiles. Quantitative variables will be analyzed with the appropriate test, depending on the application conditions. The evolution between T0 and T1 of the following four dependent variables will be measured: (1) PTSD reaction (IES-R > 24), (2) high emotional impact (DES-IV > 108), (3) negative professional impact (e.g., the presence of at least three items indicating negative impact on professional practice or self-efficacy), and 4) low perceived social support (P3SP < 12). For each variable, the total scores will be compared between T0 and T1 using paired Student's t-test or non-parametric sum rank test for matched samples, depending on the distribution of the variables. Then, the proportion of subjects above the cut-off scores will be compared between T0 and T1 using the McNemar test. For the main outcome criteria analysis (IES-R score) a multivariate analysis will be conducted using a multivariate linear mixed model to adjust for main confounders: age, gender, profession, relationship with the decease. All tests will be two-tailed and the statistical significance threshold will be set at 5%.

Qualitative analysis

Based on the narratives of the semidirective interviews, a content analysis will be performed, with several chronological phases (reanalysis, operation of equipment, and interpretation) (Bardin, 2013). According to a new method developed by Renz et al. (2018), two data analyses (i.e., manual and computer based) will be combined to enhance the trustworthiness of the results. The first method is based on a manual content analysis (Graneheim et al., 2017). Three authors (EL, BCu, and CD-B) will first look at the apparent messages through a repeated reading of the transcripts to achieve immersion and obtain a sense of the whole. In addition, this first reading will allow us to define thematic and formal categories relevant for later coding speeches. Units of meaning will then be independently identified, categorized and put into relation to identify axes of transversal meanings. This process will allow us to classify the elements and to emit a simplified representation of the raw data. The second method will use a computer-based content analysis, through the NVivo software, and will be performed by another author (MV). NVivo is a computer-assisted qualitative data analysis software that allows for qualitative inquiry beyond the coding, sorting and retrieval of data (Wong, 2008). The benefits of using NVivo are outlined in terms of facilitating teams of researchers to systematically and rigorously synthesize qualitative data.

Finally, the results issued from the two methods will be grouped and organized through a coding scheme.

Funding Sources and Ethical Approval

The SUPPORT-S study is funded by the Scientific Research Committee from the Centre Hospitalier le Vinatier and University Lyon 2. The study received ethical approval from the Ethical Review Board Sud-Est IV of Clermont-Ferrand (registration number 2019/CE67).

EXPECTED RESULTS

Although the impact of PUS on mental health professionals and social workers has been well described, the SUPPORT-S study will be the first to evaluate the effectiveness of a postvention program for professionals exposed to PUS. The mixed method and action research design will allow us to collect both in-depth qualitative and quantitative data on the effectiveness of the implementation of the SUPPORT program. The multidisciplinary approach through the collaboration of researchers and clinicians from different disciplines and theoretical backgrounds is another strength of the study, as it will improve the strength and generalizability of our conclusions. While previous studies have relied on retrospective data collection through large surveys or qualitative interviews (e.g., individual interviews or focus-groups), the longitudinal design of the current study will offer new insights and perspectives on PUS and its impact on professionals and institutions.

Our study protocol has several limitations. First, the non-controlled design prevents us from making definitive inferences on the effectiveness of the program. The use of a research-action approach may also limit the representativeness of the sample, induce selection biases and limit the ability to avoid misinterpretation in the researchers' conclusions. Second, the SUPPORT-S study is a monocentric study performed in the French context. This setting may impede the generalizability of our conclusions and results, due to the particularities of the French health system and social policies. Finally, the small number of local implementations (5) may limit the power of our results and conclusions. However, the following four main bias limitations will be used in the SUPPORT-S study: (a) triangulation, (b) randomization, (c) saturation, and (d) participatory approach. *Triangulation* refers to the use of multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena (Patton, 1999; Carter et al., 2014). Denzin (1978) and Patton (1999) identified the following four types of triangulation: (a) method triangulation, (b) investigator triangulation, (c) theory triangulation, and (d) data source triangulation. The four types of triangulation will be ensured in the SUPPORT-S study through the mixed method and action research design (method and data source triangulation) and the involvement of researchers from different disciplines and theoretical backgrounds (theory and investigator triangulation). An intramethod triangulation will also be added through the two methods of content analysis previously described in the paragraph on qualitative analysis. The *randomization* of professionals to participate in individual semidirected interviews will limit the selection bias by randomly ensuring the representativeness of the sample and avoiding the biased selection of, for instance, more motivated professionals. *Saturation* is used in qualitative designs as a criterion for discontinuing data collection and analysis (Saunders et al., 2018). According to the taxonomy developed by Saunders et al. (2018), the following four types of saturation are defined: (a) theoretical saturation (i.e., the development of theoretical categories), (b) inductive thematic saturation (i.e., the emergence of new codes or themes), (c) *a priori* thematic saturation (i.e., the degree to which identified codes or themes are exemplified in the data), and (d) data saturation (i.e., the degree to which new data repeat what was expressed in previously collected data). The saturation used in the SUPPORT-S study will focus on the data saturation and the inductive thematic saturation. The *participatory approach* is an effective means to limit the misinterpretation of the collected data by the researchers. The involvement of participants in the restitution process promotes the ability to adjust the program as well as the conclusions issued from the research through their direct comments of the results.

CONCLUSION

Health and social work professionals are frequently exposed to PUS and may encounter several ranges of emotional, traumatic or professional impacts in the aftermath. The lack of support in the aftermath of PUS has been reported by a high proportion of exposed professionals, indicating the urgent need to implement and evaluate innovative programs dedicated to facilitating recovery and preventing negative health outcomes after a PUS. The SUPPORT program is a postvention program designed to provide comprehensive, adaptative and effective support to professionals impacted by a PUS. The SUPPORT-S study is a mixed method collaborative and participatory action research project aiming to (1) improve the design of the SUPPORT program, (2) evaluate the effectiveness of the SUPPORT program to buffer the emotional, traumatic and professional impacts and to improve the perceived social support for professionals exposed to PUS and (3) provide more insights into the consequences of

PUS on both professionals and organizations. The simultaneous and complementary collection and analysis of qualitative and quantitative data will offer an in-depth evaluation of the program's implementation and effectiveness. The action research design will also improve the limitation of biases and improve the generalizability of the conclusions. The results of the study will allow us to disseminate an effective postvention program for professionals and institutions encountering PUS.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Comité de Protection des Personnes Sud-Est VI. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

EL, MP-T, NC, BCh, and EP contributed to the conception and design of the SUPPORT program. EL, BCu, MV, NC, A-FP, JH, and CD-B contributed to the conception and design of the study. EL wrote the first draft of the manuscript. BCu, AF, JH, and CD-B wrote the sections of the manuscript. All authors contributed to manuscript revision, read, and approved the submitted version.

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Self-Reported Patterns of Use of Alcohol and Drugs After Suicide Bereavement and Other Sudden Losses: A Mixed Methods Study of 1,854 Young Bereaved Adults in the UK

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Background: Bereavement, particularly by suicide, is associated with an excess risk of mortality and of physical and psychological morbidity. Use of alcohol as a coping mechanism is suggested as a contributing factor. However, studies describing substance use after bereavement rely on diagnostic data, lacking a more fine-grained understanding of patterns of substance use when grieving. We aimed to use mixed methods to compare patterns of substance use after bereavement by suicide and other sudden deaths among young adults in the UK.

Methods: Using an online survey throughout 37 UK higher education institutions we collected free text responses from 1,854 young adults who had experienced sudden bereavement. We conducted content analysis of free text responses to an open question about patterns of alcohol and drug use following the bereavement, measuring frequencies of coded categories. Collapsing these categories into binary outcomes reflecting increased use of alcohol or drugs, we used multivariable logistic regression to quantify the associations between mode of bereavement and increased post-bereavement substance use.

Results: Of 1,854 eligible respondents, 353 reported bereavement by suicide, 395 by accidental death, and 1,106 by sudden natural causes. The majority of the sample reported no increase in their use of alcohol (58%) or unprescribed drugs (85%) after the bereavement. Overall 33% had increased their alcohol use at some point after the bereavement, whilst 12% had increased their use of drugs. People bereaved by suicide were significantly more likely to describe an increase in substance use (adjusted OR = 1.29; 95% CI = 1.00–1.66; $p = 0.049$) than people bereaved by sudden natural causes, as were people bereaved by non-suicide unnatural deaths (adjusted OR = 1.32; 95% CI = 1.03–1.68; $p = 0.026$).

Conclusion: Just under half of young UK adults who experience sudden bereavement increase their alcohol use afterwards, and very few increase their use of drugs. People

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bereaved by suicide or non-suicide unnatural deaths may be more likely than people bereaved by sudden natural causes to use substances as part of the grieving process, and may have a greater need for monitoring of potential harms. Understanding the reasons for substance use will help primary care and bereavement practitioners screen and address needs appropriately.

Keywords: alcohol, drugs, substance misuse, bereavement, grief, content analysis, qualitative methods

INTRODUCTION

Although grief is a normal response to loss, there is evidence that people who lose a close contact to suicide or other violent causes of death have an increased risk of complicated grief (Lobb et al., 2010), and are more likely to perceive stigma and shame related to the loss (Pitman et al., 2014). This is likely to be related to the violent or sudden nature of the loss, its degree of unexpectedness, and the lack of anticipatory grief. Among people who experience suicide bereavement, complicated grief is associated with risk of suicidal ideation (Mitchell et al., 2005), and there is clear evidence of an increased risk of suicide, psychiatric disorder, and physical health problems after suicide loss (Erlangsen et al., 2017). The burden of grief in people bereaved by sudden unnatural causes is therefore potentially heavier than for people bereaved by natural or anticipated causes, yet we know little about coping mechanisms in this group. We also remain unclear about the explanations for the excess risk of mortality and physical health problems in people bereaved by suicide (Pitman et al., 2014; Erlangsen et al., 2017).

Worden's theory of grief suggests that bereaved people face a series of tasks, including accepting the reality of the loss, processing the pain of grief, and learning to adjust to a world without the deceased (Worden, 2018). Clinically we observe that some bereaved people use alcohol to help cope with these tasks (Stroebe et al., 2007), and there is evidence to support an increased risk of alcohol disorders after stressful life events (Keyes et al., 2011).

Data from a United States household survey data show that the unexpected death of a loved one was cited as respondents' most common traumatic experience, and was also most likely to be rated as their worst traumatic experience (Keyes et al., 2014). This same study demonstrated an association between unexpected bereavement and a range of psychiatric disorders across the life course, most commonly alcohol use disorder (36%), particularly in older age groups (Keyes et al., 2014). There is evidence to support increased alcohol use after bereavement in older adults (Byrne et al., 1999; Stahl and Schulz, 2014), and young adults (Hamdan et al., 2013), particularly men (Pilling et al., 2012). Use of alcohol to cope with emotional pain may be particularly characteristic of men (Cleary, 2012), including after bereavement (Creighton et al., 2015). However, despite being used as a coping mechanism, it may even exacerbate their psychological distress (Cleary, 2012).

These clinical and research findings identify alcohol misuse as a potential explanation for the association between suicide bereavement and adverse physical health, mental health and mortality outcomes, although there is little direct evidence to support this hypothesis (Stroebe et al., 2007). Instead, indirect support for this theory arises from the well-established association between alcohol misuse and poor physical and mental health, and with suicide (Connor et al., 2016). Finnish data show that risk of mortality due to violent causes is doubled in the first week after widowhood, and suicide mortality is increased over the first 5 years (Kaprio et al., 1987). Substance misuse is a risk factor for both accidental death and suicide (Bohnert et al., 2010). There is also evidence that mortality risk from alcohol-related causes is elevated after bereavement (Martikainen and Valkonen, 1996). However, few studies have investigated changes in alcohol use after suicide bereavement compared with bereavement by other causes, and none have tested whether substance misuse mediates risk of suicide after suicide bereavement.

The majority of epidemiological studies exploring changes in use of alcohol or drugs after bereavement have relied on diagnostic criteria for alcohol dependence or misuse. A study based on diagnostic interviews with young people found significantly higher rates of current alcohol or substance misuse disorder 21 months after parental loss due to suicide compared with bereavement by accidental death, but was not adjusted for pre-loss substance misuse (Brent et al., 2009). Population-based analyses using population registries have reliable means of adjusting for pre-loss psychopathology, but rely on individuals presenting to services and formal diagnosis being recorded. Such work has established that the risk of alcohol and drug misuse disorders is increased in people bereaved by suicide compared with non-bereaved controls (Erlangsen et al., 2017), but not when compared with people bereaved by other causes (Bolton et al., 2013; Erlangsen et al., 2017). To fully understand the range of drug and alcohol-related behaviors that might change after suicide compared with other losses, it is therefore important to go beyond diagnostic criteria and use alternative data collection approaches to gain a more in-depth understanding of this phenomenon.

In this study we aimed to use mixed methods in order to gain a better understanding of any changes in patterns of use after suicide bereavement compared with other sudden unexpected deaths. We were interested in self-reported patterns rather than formal diagnostic classification systems for substance use (World Health Organisation [WHO], 1992; American Psychiatric Association [APA], 1994) or alcohol use screening tests (Rumpf et al., 2002). This was to gain a sense of the wider role that drugs or alcohol played in bereaved people's lives, how this relates to their social functioning or physical and mental health, and any motivations for changes in use. Our first objective was to use content analysis of qualitative accounts to gain an understanding of how substance use might be affected by sudden loss, and to investigate whether patterns differ by type of bereavement. Our second objective was to use the results of our content analysis to test the hypothesis that people bereaved by suicide would be more likely to describe increased substance use after bereavement than people bereaved by sudden natural causes of death. We also wished to test whether people bereaved by non-suicide unnatural causes of death would be more likely to describe increased use of substances than those bereaved by sudden natural causes of death.

MATERIALS AND METHODS

Study Design and Participants

We used email sampling and a closed online survey to collect cross-sectional data on young adults working or studying at British higher education institutions (HEIs). This sampling frame was judged to be the most accessible and low-cost means of recruiting a hard-to-reach population of young adults (Pitman et al., 2015), minimizing the biases involved in using a help-seeking sample. Recruitment has been described in detail elsewhere (Pitman et al., 2016). Briefly, in 2010 we invited all 164 HEIs in the UK at that time to participate in an online survey, following-up non-responding HEIs to encourage broad socio-economic and geographic representation. Over 20% of HEIs (37/164) agreed to take part, providing an estimated sampling frame of 659,572 staff and students (a minority of whom were assumed to have experienced sudden bereavement). All participants were invited to take part in a survey of “the impact of sudden bereavement on young adults.” The majority of participating HEIs agreed to send an individual email invitation to each staff and student member, as per study protocol. For reasons of sensitivity, 10 HEIs modified this strategy, for example by sending the study to students and not staff, or using differing combinations of their weekly news digest email or intranet advertisement for staff or students.

Inclusion criteria were as follows: people aged 18–40 who had experienced sudden bereavement of a close friend or relative after 10 years of age. This age range was chosen to reflect an under-researched group of great interest in suicide prevention policy. Early childhood bereavements (prior to age 10) were excluded to reduce recall bias and capture adult cognitive processing of a life event. We used the age of 10 as this was the threshold for criminal responsibility in England and Wales at the time of sampling and therefore represented the threshold for adult cognition. Sudden bereavement was defined as “a death that could not have been predicted at that time and which occurred suddenly or within a matter of days.” Type of bereavement was sub-classified by self-report as: bereavement by suicide, bereavement by sudden natural causes (for example cardiac arrest), and bereavement by sudden unnatural causes (for example accidental death). In the case of exposures to more than one mode of sudden bereavement, we applied a hierarchy such that all those bereaved by suicide were classified as such, regardless of other exposures. Those bereaved by deaths due to sudden natural causes and those due to sudden unnatural causes were asked to relate their responses to whichever person they had felt closest to, and exposure status was classified accordingly. For people bereaved by more than one suicide, respondents were asked to relate their responses to the person they had felt closest to.

Procedures

Each email invitation contained a link to the online survey. This questionnaire (Pitman et al., 2016). was designed in consultation with a group of young bereaved adults and bereavement counselors, who identified important domains to cover in relation to the impact of bereavement and appropriate wording. It was piloted in an open online survey for individuals accessing support from four national voluntary sector organizations providing bereavement support (Cruse Bereavement Care, Samaritans, Survivors of Bereavement by Suicide, Widowed by Suicide).

The first 120 questions elicited quantitative data on socio-demographic and clinical characteristics (Part 1). These were followed by 20 open questions eliciting free text qualitative data (Part 2) on specific domains affected by the bereavement, such as relationships, spirituality, and finances. Part 2 questions were worded to be non-leading and neutral (i.e., not assuming only negative outcomes of bereavement), and were derived from the literature describing lived experience (Wertheimer, 2001; Simone, 2008) and input from the consultation group. There was no upper word limit, and respondents were invited to give as much or little detail as they wished, or to skip the question if it did not apply to them.

The question relating to use of drugs and alcohol was worded as follows: “*In what way, if any, has the bereavement affected your drinking habits or your use of unprescribed drugs? (Unprescribed drugs include illicit drugs as well as medications used above their prescribed limits).*” To avoid ambiguity in phrasing this question, we chose to use the term unprescribed drugs to cover use of illegal drugs, legal highs, over-the-counter drugs, or prescribed drugs used above advised limits.

Ethics

The study was approved by the UCL Research Ethics Committee in 2010 (ref: 1975/002). The participant information sheet indicated that the study was being conducted by a research team at UCL, that the results would be analyzed and compiled into a publically available report, and that no individual respondent would be identifiable from this information. All participants provided online informed consent by ticking a box to indicate they had read the participant information leaflet and consent form and agreed that the anonymized results would be used for research purposes.

Content Analysis

Given the nature and quantity of the data, we chose the approach of content analysis to analyse large volumes of brief free text responses to this question. This is a qualitative research method used to interpret the content of text data through a systematic classification process involving coding and identifying themes (Krippendorff, 2004). In conventional content analysis, the researcher does not start with preconceived ideas about what kinds of codes or categories of codes will be found but uses the data to drive the coding (Hsieh and Shannon, 2005). However, we aimed to use directed content analysis to capture perceived increases or decreases in substance use, as well as perceptions of no change. This approach allowed us to measure the frequency of these codes, and link them to quantitative variables such as exposure, socio-demographic characteristics and time since loss (Ritchie et al., 2013). We deliberately avoiding attempting diagnostic categorization or estimates of the quantity of substances used due to the inherent difficulties using an online survey. The analytic team included a medical sociologist (FS) and clinical academic psychiatrists (AP, MK, DO) to balance clinical and non-clinical perspectives.

Qualitative Component of Content Analysis

We imported online responses to the question on substance use into Microsoft Excel, which allowed us to process and code large volumes of relatively brief free text data. We coded free text responses to create a set of codes corresponding to respondents' perceptions of any changes in patterns of substance use. After familiarization with the first 100 data lines, the first two authors noted that respondents often described any change in their habits in terms of perceptions of helpfulness or harms. They developed an initial coding framework of five categories, which was agreed by all co-authors for face validity. This was as follows:

1. no change
2. Increased use – perceived as harmful.
3. Increased use – perceived as helpful.
4. Decreased use – perceived as harmful.
5. Decreased use – perceived as helpful.

The familiarization process also resulted in a team decision to separate out three separate substances used (alcohol, unprescribed drugs, and cigarettes) given that reported patterns of use varied by substance. Cigarette use had not been specifically inquired about in the survey question, but as some respondents included information about smoking patterns in their responses, this was considered as a separate entity.

The first author then proceeded to code the first 500 responses, further elaborating the set of codes to create new categories and sub-categories of existing codes. These sub-categories reflected temporal changes in patterns of substance use (for example transient increases) as well as perceptions of harm or benefit. This coding was conducted in collaboration with the second author (FS) rather than independently, and involved discussions within the wider team. After coding 500 of responses the coding framework was expanded as follows:

1. No change in substance use.
2. Brief temporary increase (within the week of the death) but then resumed pre-loss pattern of use.
3. Stopped.
4. Reduced.
5. Increased (unclear if perceived as helpful or harmful).
6. Increased (perceived as helpful).
7. Increased (perceived as harmful).
8. Increased (unclear if perceived as helpful or harmful) but then resumed pre-loss pattern of use.
9. Increased (perceived as helpful) but then resumed pre-loss pattern of use.
10. Increased (unclear if perceived as helpful or harmful) but then stopped.
11. Unable to classify.

Responses describing the appropriate use of prescribed medication (for example "*Been prescribed citalopram for depression for the past 3 years*") were regarded as no evidence for substance misuse and were classified as no change.

Following team agreement on this coding framework, the first author then recoded all datalines using this framework, in discussion with the second author. This provided opportunities to check validity of codes against data, clarify where meaning was uncertain, and encourage reflexivity. Text was analyzed with the researchers blinded to the cause of death, except in 15 cases where the text made this explicit. After a final review of the 11 category coding framework against the full dataset, the team agreed on its conceptual coherence and did not feel there was a need to elaborate coding further.

Quantitative Component of Content Analysis

1. Frequencies.

Once all responses had been coded, we derived frequency counts for the 11 substance use categories to describe patterns of use by substances used. We did not include cigarette use due to small numbers, and because our research question did not directly address this.

1. Hypothesis-testing.

We imported our coded data into Stata together with variables describing socio-demographic and clinical characteristics, and characteristics of the bereavement, as collected in Part 1 of the online questionnaire.

To test the hypothesis that people bereaved by suicide, and people bereaved sudden unnatural (non-suicide) causes of death, were more likely to describe an increase in substance use than people bereaved by sudden natural causes of death we collapsed our 11 codes into a binary measure of substance use: increase in use post-bereavement vs. no increase. To separate these out by substance used, we also created two binary measures: any increase in alcohol use post-bereavement and any increase in drug use post-bereavement. Again, we did not include cigarette use.

We used descriptive statistics (counts and percentages) and chi-squared tests to describe the socio-demographic and clinical characteristics of our sample, including the following variables:

- Socio-economic status, derived from a question about own occupation (for university staff) or parental occupation (for students), using the five categories from the Office for National Statistics (ONS).
- Pre-bereavement depression using the Composite International Diagnostic Interview (CIDI) screen for lifetime depression (Robins et al., 1988), qualified by whether this was before or after the sudden bereavement, to derive a pre-exposure measure.

- Family history of psychiatric problems (including drug and alcohol problems), using responses to the question "Has anyone in your family suffered from an anxiety disorder, a depressive disorder (including postnatal depression), had drug or alcohol problems, or other psychological or emotional difficulties?

We used multivariable logistic regression to test for an association between type of bereavement and likelihood of increased substance use. We pre-selected the following socio-demographic and clinical characteristics as potential confounders of any association, based on the literature and our clinical experience: age, gender, time since bereavement, socio-economic status, pre-bereavement depression, and family history of psychiatric problems (including drug or alcohol problems). We fitted binary models using *xtlogit* commands in Stata, with HEI as random effect (Rabe-Hesketh and Skrondal, 2012), to take into to account any clustering effect at institutional level. Our statistical analyses were conducted using Stata version 15 (StataCorp, 2017).

RESULTS

Participant Response

A total of 5,085 people of the 659,572 sampled responded to the questionnaire by clicking on the survey link, with 91% (*n* = 4,630) consenting to participate. Of all those consenting, 1,855 (40%) responded to the open question on substance use. Bereavement status for this group was as follows: 1,106 reported bereavement by sudden natural causes, 395 by sudden unnatural causes, and 353 by suicide. We excluded one case in which exposure was not specified. Our final sample for this analysis was therefore 1,854 individuals. There was no accurate way of measuring overall response to the survey, as the denominator of bereaved people could not be ascertained.

Content Analysis: Frequency Counts

Frequency counts for the patterns alcohol or drug use identified are shown in **Table 1**. Just over half the sample (58%) reported no change in their use of alcohol, the large majority (85%) reported no changes in use of unprescribed drugs. These categories included those who had not used those substances previously. A minority had increased their alcohol use (33%) or their drug use (12%) at any point since the loss. A small minority (*n* = 94; 5%) of respondents reported having found it helpful to increase their alcohol use after the bereavement, of whom 24 (26%) had since reduced down to their pre-bereavement pattern of alcohol use. Only 47 (3%) of the sample reported finding it helpful to have increased their use of unprescribed drugs after the loss, of whom 8 (17%) had since reduced down to their pre-bereavement pattern of drug use.

A small proportion had completely stopped their use of alcohol (2%) or drugs (1%). Quotes to illustrate responses coded in each category are given in **Table 2**, edited only for spelling errors.

Table 1 also presents three basic summary measures, namely: no impact of bereavement on substance use (except initial week); increase in use (at any point beyond the first week after the loss); and decreasing or stopping use. We found no significant between-group differences on these categories using simple chi-squared tests for alcohol (*p* = 0.973) but a borderline significant group difference for drug use (*p* = 0.046).

Although not presented in this table, and not specifically probed in the question, 39 respondents (2%) mentioned a change in their smoking habits. Of these, five had stopped smoking since the bereavement, three had cut down on smoking, and 31 had increased their smoking (for whom this had been temporary in eight cases).

Participant Characteristics

The characteristics of the sample of *n* = 1,854 individuals included in the current analysis are presented in **Table 3**.

The sample was primarily female (81%), and of white ethnicity (91%), with the majority representing social classes 1 and 2 (62%) and educated to degree level or above (59%). The age range of respondents was 18–40 years as per eligibility criteria (mean = 25.6; *SD* = 6.3). Length of time since the index bereavement ranged from 1 day to 28 years (mean = 4.9 years; *SD* = 5.2; IQR = 6 years). The majority of the sample (68%) reported a family history of mental health problems, including drug and alcohol problems. The majority of those bereaved by sudden natural mortality causes (85%) reported the death of a relative, but those bereaved by sudden unnatural causes and suicide were split equally between those bereaved by the death of a relative or a non-relative. Overall 21% of the sample had a personal history of depression pre-dating the bereavement, but this was significantly more common in those bereaved by suicide (26%) than in those bereaved by sudden natural losses (21%) or other unnatural losses (18%).

Association Between Bereavement Exposure and Changes in Substance Use

Our multivariable logistic regression found that, compared with people bereaved by sudden natural causes, both those bereaved by suicide and those bereaved by sudden unnatural causes were significantly more likely to describe increased use of alcohol or unprescribed drugs post-bereavement (**Table 4**). This was the case in unadjusted and adjusted analyses, although this was of borderline significance in people bereaved by suicide (*p* = 0.049).

When separated out into alcohol and drug use, only the group bereaved by sudden unnatural causes were significantly more likely to describe increased alcohol use post-bereavement. There was no evidence for between-group differences in post-bereavement use of unprescribed drugs. However, these sub-group analyses may have been underpowered to detect any differences, and the magnitudes of the odds ratios for these individual measures were very similar. Although we did not directly compare bereavement by suicide and non-suicide unnatural causes, in all models confidence

TABLE 1 | Frequency counts for content analysis (11 category coding).

Type of bereavement	Sudden natural mortality causes (*n* = 1,106)		Sudden unnatural mortality causes (*n* = 395)		Suicide (*n* = 354)		Total (*n* = 1,854)	
Coding category	**Alcohol**	**Drugs**	**Alcohol**	**Drugs**	**Alcohol**	**Drugs**	**Alcohol**	**Drugs**
No change in use n (%)	671 (61)	963 (87)	210 (53)	330 (84)	190 (54)	288 (82)	1,071 (58)	1,581 (85)
Brief temporary increase (<1 week) n (%)	4 (<1)	1 (<1)	3 (1)	0 (0)	2 (1)	0 (0)	9 (1)	1 (<1)
Stopped n (%)	18 (2)	9 (1)	7 (2)	10 (3)	9 (3)	8 (2)	34 (2)	27 (1)
Reduced n (%)	60 (6)	10 (1)	27 (7)	3 (1)	21 (6)	10 (3)	108 (6)	23 (1)
Increased (unclear if perceived as helpful or harmful) n (%)	189 (17)	64 (6)	78 (20)	21 (5)	69 (20)	24 (7)	336 (18)	109 (6)
Increased (perceived as helpful) n (%)	49 (4)	21 (2)	10 (3)	10 (3)	11 (3)	8 (2)	70 (4)	39 (2)
Increased (perceived as harmful) n (%)	7 (1)	1 (1)	4 (1)	0 (0)	2 (1)	2 (1)	13 (1)	3 (<1)
Increased (unclear if perceived as helpful or harmful) but then resumed pre-loss pattern of use n (%)	92 (8)	31 (3)	46 (12)	17 (4)	42 (12)	12 (3)	180 (10)	60 (3)
Increased (perceived as helpful) but then resumed pre-loss pattern of use n (%)	11 (1)	4 (<1)	8 (2)	3 (1)	5 (1)	1 (<1)	24 (1)	8 (<1)
Increased (unclear if perceived as helpful or harmful) but then stopped n (%)	2 (<1)	1 (<1)	0 (0)	0 (0)	0 (0)	0 (0)	2 (<1)	1 (<1)
Unable to classify (%)	3 (<1)	0 (0)	2 (1)	0 (0)	2 (1)	0 (0)	7 (<1)	0 (0)
No mention of illicit drug use n (%)	0 (0)	1 (<1)	0 (0)	1 (<1)	0 (0)	0 (0)	0 (0)	2 (<1)
Summary measures of above								
No change (excluding initial week) n (%)	675 (61)	964 (87)	213 (54)	330 (84)	192 (54)	288 (82)	1,080 (58)	1,582 (85)
Increased at any point beyond initial week n (%)	350 (32)	122 (11)	146 (37)	51 (13)	129 (37)	47 (13)	625 (33)	220 (12)
Reduced or stopped n (%)	78 (7)	19 (2)	34 (9)	13 (3)	30 (9)	18 (5)	142 (8)	50 (3)
Total	1,106 (100)	1,106 (100)	395 (100)	395 (100)	354 (100)	354 (100)	1,854 (100)	1,854 (100)

intervals for the odds ratios for each group overlapped, suggesting no differences.

DISCUSSION

Main Findings

The findings of our content analysis suggest that in a sample of people who had experienced sudden bereavement, the majority had not changed their pattern of drug or alcohol use. This sample had been bereaved for an average of 5 years, capturing both short-term and longer-term effects over a period of grieving. However, a third of the bereaved sample had increased their alcohol use at some point, whilst a fifth had increased their use of unprescribed drugs. Our content analysis identified that an awareness of benefits or harms was apparent in some respondents' accounts of any changes in their patterns of use. A perception of benefits was more common than that of harms, although only a small number expressed such judgments.

We found that people bereaved by suicide or other unnatural deaths were significantly more likely than those bereaved by sudden natural deaths to describe an increase in substance use. However, this finding was of borderline significance for people bereaved by suicide, and our analyses may have lacked power when separating out drugs and alcohol use. An increase in substance use after bereavement by suicide or other unnatural losses is in keeping with the clinical understanding of unnatural losses as more traumatic for the bereaved than deaths due to natural causes, and the potential for the bereaved to cope with

TABLE 2 | Examples of free text responses by coding category.

Code	Example quote (type of bereavement in brackets)
1 No change in use	"It has not altered my drinking habits or my used of drugs. I would say that I am a social drinker and still am. I used to be also a social drug user as well, mainly weed, but I have not taken drugs in a very long time" (sudden natural causes).
2 Brief temporary increase (<1 week)	"It hasn't affected me in the long term, but the night I found out what had happened I drank to try and forget about it, but instead I became more miserable and ended up going home in a ridiculous, drunken state" (suicide).
3 Stopped	"Stopped drinking alcohol immediate aftermath of bereavement as felt numb, alcohol appeared to have no effect on me and I was afraid to drink too much as I know alcohol is a depressant (I was depressed enough!)" (sudden unnatural causes)
4 Reduced	"I was more dedicated to not using drink or drugs for fear any use would tempt me to use them to drown my sorrows and lead to addiction" (suicide).
5 Increased (unclear if perceived as helpful or harmful)	"I have hit alcohol quite hard at certain times since the bereavement, sometimes I can go weeks without a single drop, but other times I could get drunk 5 days in a week" (sudden natural causes).
6 Increased (perceived as helpful)	"I definitely drink to numb myself and physically relax, and I would say I've drunk more heavily since Dad died" (sudden natural causes).
7 Increased (perceived as harmful)	"My drinking increased significantly and was self-destructive. Even though it was a death from natural causes I carried a lot of guilt about being alive when he wasn't and this carried on to my 30th birthday (when I became older then he was) but I had managed to get a hold of and sort my drinking out a few months before this time. I never indulged in drugs" (sudden natural causes).
8 Increased (unclear if perceived as helpful or harmful) but then resumed pre-loss pattern of use	"For the couple of months following his death, I definitely drank more, but I think it was more a case of making sure I was out and busy all the time. Now my drinking habits are pretty much as they were" (sudden natural causes). "I drank a fair bit in the first year, whilst going out partying hard and trying to find oblivion. I now socially drink only" (suicide).
9 Increased (perceived as helpful) but then resumed pre-loss pattern of use	"In the first month following his death I was drinking excessively and smoking marijuana a lot to try and numb myself from the reality of what had happened" (sudden unnatural causes).
10 Increased (unclear if perceived as helpful or harmful) but then stopped	"After the bereavement I drunk a lot of alcohol and went out a lot but now I don't drink at all" (sudden unnatural causes)
11 Unable to classify	"I feel guilty about drinking" (sudden unnatural causes) "Whenever I drink too much I become depressed and cry a lot about the death" (sudden natural causes).

the loss by using drugs or alcohol, even if transiently. It is possible that people bereaved by suicide and other unnatural causes are more likely to respond behaviorally to their loss by using substances to cope. This may meet a need to escape from the work of grief, to palliate symptoms of depression or anxiety, or to find a release. Such substance use may be within safe limits, but in some cases likely to be hazardous (Public Health England, 2016).

It is also possible that people bereaved by suicide or other unnatural deaths have genetic similarities to the people they grieve, for whom substance use may have contributed to the death, and therefore a genetic vulnerability to substance misuse after a traumatic life event. Individuals diagnosed with alcohol dependence have a greater risk of death by unnatural causes, whether due to suicide, homicide or accidental death (Markkula et al., 2012). They leave behind partners and friends who are genetically similar, based on theories of assortative mating (Agerbo, 2005) and assortative relating (Joiner, 2003) and therefore also at risk of substance misuse. Whether bereavement by suicide or other unnatural death triggers substance use in those with or without genetic vulnerabilities, it is important that we are aware of these needs. Our findings suggest that people bereaved by suicide or other unnatural deaths may have a need for primary care monitoring of substance use, to identify any emergent harmful use and offer support to address this. They also suggest that clinicians should be mindful of the perceived beneficial effects of substance use as part of the normal process of grief, and balance this against the potential for harmful effects.

Results in the Context of Other Studies

No other studies have used mixed methods to investigate the impact of bereavement on self-perceived substance misuse in a sample of young adults in Britain bereaved suddenly by the death of a family member or a friend. In relation to existing quantitative research, our findings using self-reported accounts conflict with studies using diagnostic categories, perhaps due to the greater detail we explored. A Canadian registry-based study used routine clinical data to identify ICD-9 and ICD-10 codes for alcohol abuse or dependence in parents bereaved by the suicide or the motor vehicle death of a child (Bolton et al., 2013). This found that each group's probability of drug abuse/dependence or of alcohol abuse/dependence did not significantly increase after the loss (Bolton et al., 2013). Although this was methodologically more stringent in its use of strict thresholds for diagnosis, it did not account for a range of behaviors within and beyond those diagnostic criteria, as ours did. One other British study investigating alcohol use after suicide bereavement was an uncontrolled study of 85 people bereaved by the suicide of an older adult using semi-structured interviews. This found that alcohol intake had increased in 14%, although the measure used was not specified. Self-reported consumption in terms of units of alcohol indicated that 7% were drinking at hazardous levels (Harwood et al., 2002). The same study also collected data on change in alcohol use in the group bereaved by suicide and a control group of those bereaved by natural causes, but did not report these findings (Harwood et al., 2002), and those data are no longer available.

TABLE 3 | Sociodemographic characteristics of survey respondents (*n* = 1,854).

Bereavement exposure	**Sudden natural causes (*n* = 1,106) n (%)**	**Sudden unnatural causes (*n* = 395) n (%)**	**Suicide (*n* = 353) n (%)**	**Total (*n* = 1,854) n (%)**	***p*-value**[a]
Socio-demographic characteristics					
Gender†					
Male	217 (20)	68 (17)	67 (19)	352 (19)	0.579
Female	889 (80)	327 (83)	286 (81)	1,502 (81)	
Missing	0	0	0	0	
Age of participant (years)†					
Mean (SD)	25.5 (6.4)	25.8 (6.4)	25.6 (6.0)	25.6 (6.3)	**0.006**
Aged 18–21	412 (37)	133 (34)	112 (32)	657 (35)	0.119
Aged 22–40	694 (63)	262 (66)	241 (68)	1,197 (65)	
Relationship status					
Single	759 (69)	277 (70)	231 (65)	1,267 (68)	0.132
Within a relationship	347 (31)	116 (29)	121 (34)	584 (32)	
Missing	0 (0)	2 (1)	1 (<1)	3 (<1)	
Self-defined ethnicity					
White	994 (90)	362 (92)	323 (92)	1,679 (91)	0.242
Non-white	112 (10)	32 (8)	30 (9)	174 (9)	
Missing					
Socio-economic status†[b]					
Social classes 1.1 and 1.2	680 (62)	252 (64)	222 (63)	1,154 (62)	0.802
Social classes 3 –7 and 9	402 (36)	132 (33)	124 (35)	658 (36)	
Missing	24 (2)	11 (3)	7 (2)	42 (2)	
Educational status					
Attained maximum A level equivalent	473 (43)	156 (40)	128 (36)	757 (41)	0.187
Attained degree level or above	630 (57)	238 (60)	225 (64)	1,903 (59)	
Missing	3 (<1)	1 (<1)	0 (0)	4 (<1)	
Clinical characteristics					
Pre-bereavement depression†[c]					
Yes	230 (21)	72 (18)	92 (26)	384 (21)	**0.037**
No	876 (79)	322 (82)	260 (74)	1,458 (79)	
Missing	0 (0)	1 (<1)	1 (<1)	2 (<1)	
Family history of any psychiatric problems (including drug and alcohol problems)†					
Yes	727 (67)	270 (69)	255 (72)	1,262 (68)	0.287
No	368 (33)	124 (31)	98 (28)	590 (32)	
Missing	1 (<1)	1 (<1)	0 (0)	2 (<1)	
Characteristics of the bereavement					
Kinship to the deceased					
Blood-related	168 (15)	199 (50)	170 (48)	537 (29)	**<0.001**
Non blood-related	934 (85)	193 (49)	183 (52)	1,310 (71)	
Missing	4 (<1)	3 (1)	0 (0)	7 (<1)	
Years since bereavement†					
Mean (SD)	4.8 (5.3)	5.1 (5.2)	5.1 (5.0)	4.9 (5.2)	0.066
less than2 years	376 (34)	106 (27)	98 (28)	580 (31)	**0.009**
Over 2 years	730 (66)	289 (73)	255 (72)	1,274 (69)	
Missing	0	0	0	0	

†Covariates included in adjusted model. [a]p-values for univariate associations of characteristics with loneliness scores. [b]Socio-economic status using the five categories from UK Office for National Statistics. [c]Measured using CIDI screen for depression. p-values in bold indicate those below the threshold for statistical significance.

In relation to other qualitative research, our own thematic analyses of these data specifically for people bereaved by suicide (Eng et al., 2019), and non-suicide unnatural deaths (Drabwell et al., 2020), identified that for both groups struggles over control with alcohol or drugs were prominent and many used substances for specific ends. For those bereaved by non-suicide unnatural causes these ends included gaining a release, escaping reality, and achieving emotional openness (Drabwell et al., 2020). For those bereaved by suicide, they included coping with overwhelming emotions, and honoring the memory of the deceased (Eng et al., 2019). For both groups there was a clear awareness of the harmful effects balanced against these perceived benefits, which for many drove efforts to control their use (Eng et al., 2019; Drabwell et al., 2020). A thematic analysis of interviews with 57 young British men aged 19–35 who had been bereaved by non-suicide unnatural causes found many similar themes (Creighton et al., 2015). In this sample many men explained that they drank to anesthetize themselves from the pain, whilst others used alcohol to release feelings of despair. Many of the older participants felt that the positive effects of alcohol outweighed the negative effects over the short-term, whilst also recognizing negative effects in longer-term use, whereby ingrained habits could lead to risk-taking and dependence (Creighton et al., 2015). Together this body of work suggests that an understanding of the perceived benefits and risks is important when discussing with a bereaved person their use of alcohol or drugs as part of their grief. Their needs for substance misuse support should therefore be considered and discussed in the context of the balance of risks and benefits they perceive.

Strengths and Limitations

We believe this to have been the largest-scale qualitative study comparing self-reported use of alcohol and unprescribed drugs after sudden bereavement, and comparing suicide to non-suicide losses. Other studies using national registries have achieved larger sample sizes, but used recorded diagnoses of substance misuse or dependence rather than self-reported changes in patterns of use, and these may result in under-ascertainment of harmful or hazardous substance use. Although our categories had no diagnostic validity, they had face validity from the perspective of a bereaved person and emphasized any potential benefits perceived as well as perceived harmful consequences. Our models were not adjusted for pre-bereavement substance misuse, due to the lack of a validated measure in our survey, but our outcomes were based on a perceived change in use rather than diagnostic criteria *per se*. Covariates were chosen for our model *a priori*, using a theory-driven approach based on the scientific literature. However, we acknowledge the possibility of residual confounding. Our sample comprised specific subgroups warranting closer investigation, including those who had never used alcohol or drugs as part of their coping repertoire, those using alcohol and prescribed drugs within safe limits, and those using them at hazardous levels. These groups are likely to have very different cognitive profiles, but again we were not able to explore these using our data.

We used a novel but systematic approach to test a specific research question. Face validity and external validity were enhanced by using minimal dimensions during coding, namely a perceived increase or decrease in use, and any perception of the change being helpful or harmful. The advantage of using content analysis was that we were able to organize complex free text data into clear themes and relate these to quantitative variables of clinical interest. Use of an anonymous online questionnaire for this sensitive topic enhanced disclosure (Joinson, 2001) and reduced the potential for social desirability bias effects (Joinson, 1999) but it remains possible that denial or shame may have resulted in under-reporting of substance use. This is despite accepting attitudes toward alcohol in some cultures (Sudhinaraset et al., 2016), particularly among young British

TABLE 4 | Associations between substance use and type of bereavement.

Exposure to bereavement by:	Sudden natural deaths (n = 1,106)		Sudden unnatural deaths (n = 395)			Suicide (n = 353)			Total (n = 1,854)
Outcome	**Prevalence n (%)**	**Odds ratio**	**Prevalence n (%)**	**Prevalence n (%)**	**Adjusted^a odds ratio (95% CI)**	**Prevalence n (%)**	**Unadjusted odds ratio (95% CI)**	**Adjusted^a odds ratio (95% CI)**	**Prevalence n (%)**
Any increase in substance use post-bereavement	394 (36)	1	160 (41)	700 (38)	1.32 (1.03–1.68) **(p = 0.026)**	146 (41)	1.30 (1.01–1.67) **(p = 0.038)**	1.29 (1.00–1.66) **(p = 0.049)**	700 (38)
Any increase in alcohol use post–bereavement	350 (32)	1	146 (37)	625 (34)	1.35 (1.05–1.73) **(p = 0.017)**	129 (37)	1.26 (0.97–1.62) (p = 0.081)	1.25 (0.96–1.61) (p = 0.096)	625 (34)
Any increase in drug use post-bereavement	122 (11)	1	51 (13)	220 (12)	1.31 (0.91–1.88) (p = 0.147)	47 (13)	1.30 (0.90–1.87) (p = 0.157)	1.28 (0.88–1.86) (p = 0.190)	220 (12)

[a]Adjusted for age, gender, socio-economic status, time since bereavement, pre-bereavement depression, and family history of psychiatric problems (including drug and alcohol problems); threshold for significance for all models was p = 0.05. p-values in bold indicate those below the threshold for statistical significance.

people (Cooke et al., 2019). The wording of the question used may have resulted in the under-reporting of legal psychoactive drug use, which has become more prevalent in this age group in Britain (Bowden-Jones, 2013), and of changes in tobacco use, which were reported unprompted by 2% of the sample. Given the age group and student status of many respondents it was possible that changes in substance use were influenced more by peer groups or educational transitions than the bereavement itself. However, given the nature of the data collection it was not possible to disentangle this further.

Our sample was derived from higher education institutions in the UK, with a bias toward those in higher social classes. This and the non-response from men suggests that the sample may not be generalizable to all young bereaved adults in the UK, but instead may have more resonance to female, white, highly-educated groups. However, this approach was preferable to that of recruiting a help-seeking sample, which risked introducing selection biases. Our sampling method also allowed access to a large community sample of young adults who tend not to be represented in health research. As only 40% of those consenting to participate in the wider survey answered the question on substance use, this is likely to have introduced a response bias from those with the time to provide more detailed responses and/or those with potentially the strongest views on this issue. This again limits the generalizability of our findings. Online data collection meant that we were unable to probe the motivations for respondents' patterns of substance use, as might have been possible in an interview study. Although our data were collected in 2010, Global Burden of Disease data show that alcohol remained the leading risk factor for ill-health, disability and early mortality among people aged 15–49 years over the period 1990–2013 (Forouzanfar et al., 2015). No other study to our knowledge has collected similar data, so this constitutes the best available evidence. Our thematic analyses of data for people bereaved by suicide (Eng et al., 2019), and by accidental death (Drabwell et al., 2020), were conducted with lead researchers blind to the coding used in this study, and provide further insights into the reasons for underlying behavior change in this sample.

Clinical, Policy, and Research Implications

Our findings provide clinically valuable information for primary care practitioners and bereavement counselors encountering bereaved young adults in clinical settings. A third of our sample had increased their alcohol use, whilst a fifth had increased their drug use. This appears to be one method of coping with sudden bereavement, but places them at theoretical risk of harm, with the possibility of short-term harms (through disinhibition, vulnerability to violence, and toxicity) as well as longer-term organ damage if use becomes hazardous or dependent. Substance misuse is likely to be a correlate of other putative risk factors for early mortality after bereavement, such as psychological distress, loneliness, and loss of a confidant(e), as well as changes in social ties, living arrangements, and economic support (Byrne et al., 1999; Stroebe et al., 2007). Use of drugs or alcohol should therefore be viewed and discussed in this wider psychosocial context. Overall 2% of respondents stopped using alcohol completely, and 1% stopped using drugs. This is a small but clinically important behavioral response to sudden bereavement, with potential health benefits, and likely explanations are as follows. Our previous thematic analysis of qualitative data from the sub-sample of those bereaved by suicide identified a tendency in some people to respond to the loss by developing their own safeguards against suicide (Pitman et al., 2017). These included avoiding all medications for fear of accidental overdose. The attitudes underlying complete cessation of alcohol or drugs after sudden bereavement in the current study might therefore relate to a desire to protect oneself from a similar death, whether due to sudden cardiac causes, accidental death, or suicide. Our more in-depth thematic analyses of this dataset also suggested that some people bereaved by unnatural causes stopped using drugs or alcohol because alcohol made them depressed (Drabwell et al., 2020), alcohol made it harder for them to control their emotions (Eng et al., 2019), or because drugs or alcohol were thought to have contributed to the death (Eng et al., 2019). The attitudes underlying complete cessation of alcohol or drugs after sudden bereavement across a broader sample of people bereaved by sudden natural or unnatural causes are likely to relate to a desire to protect oneself from a similar death, and to avoid the negative effects.

Our results suggest that all young adults exposed to sudden bereavement should be screened for substance use, particularly after bereavements due to suicide and other unnatural causes, as part of an inquiry about methods of coping. Not all will be in touch with bereavement counselors, particularly as provision of bereavement support varies greatly geographically. However, some will consult their primary care teams, perhaps for the physical and mental health problems that are more common after sudden bereavement (Erlangsen et al., 2017). Bereavement counselors and primary care practitioners should inquire non-judgmentally about current substance misuse, and explore whether the bereaved person would like any help to cut down. Targeting such screening at those bereaved by suicide and other unnatural causes would be indicated given the findings of this study, but should not be punitive (Eng et al., 2019; Drabwell et al., 2020). Given that bereavement services are often disconnected from health services, and bereavement counselors may not feel skilled to screen for substance use where they suspect it, appropriate liaison between the two services would be helpful. Our separate more fine-grained analyses of free text responses for people bereaved by suicide (Eng et al., 2019) and by other sudden unnatural deaths (Drabwell et al., 2020) provide clinicians with a more nuanced understanding of the reasons for drug or alcohol use. An awareness of these reasons would help clinicians broach the issue in a more acceptable way, increasing the likelihood of successful intervention. It would also help concerned friends and relatives know how to offer support without appearing judgmental.

CONCLUSION

Among young adults in the UK who experience the sudden death of a friend or relative, a third describe an increase in their use of alcohol or unprescribed drugs, whether transiently or permanently. This is significantly more likely in people bereaved by suicide or other unnatural deaths. Despite the perceived advantages in helping them cope with grief, substance use carries a risk of short-term harm and permanent organ damage, and may not be identified by professionals offering bereavement support. Our coding identified that some bereaved people perceive benefits in using drugs or alcohol as part of their adjustment to the loss, particularly in the immediate aftermath, suggesting that a non-judgmental approach from professionals is important. A discussion of coping mechanisms at different stages after a traumatic loss may help identify those who are relying on drugs or alcohol more than they are comfortable with, or more than is safe, and who might need extra support.

DATA AVAILABILITY STATEMENT

The dataset generated for this article is not publically available due to the threat to confidentiality. However, requests for collaboration to analyze these data can be made to the lead author, subject to departmental review of proposal and honorary contract.

ETHICS STATEMENT

The study was approved by the UCL Research Ethics Committee in 2010 (ref: 1975/002). The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

AP, DO, and MK conceived and designed the study and the recruitment strategy. AP, DO, MK, and FS contributed to questionnaire design. AP recruited participants, managed the survey, collected data, developed the coding framework, ran the regressions, drafted the manuscript with input from all authors, had full access to all the data in the study, takes responsibility for the integrity of the data, and was the guarantor. AP and FS independently coded data.

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A Theory-Based Longitudinal Investigation Examining Predictors of Self-Harm in Adolescents With and Without Bereavement Experiences

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Background: Research has demonstrated that exposure to suicide can lead to increased vulnerability for self-harm or suicide. As a result, ideation-to-action models of suicide (e.g., the Integrated Motivational-Volitional Model of Suicide; IMV) recognise exposure as a significant risk factor which may be implicated in the translation of thoughts into actions. However, few studies have tested this theoretical link explicitly within an adolescent population, and examined how it compares to other types of bereavements.

Methods: A 6-month prospective questionnaire study was conducted with 185 Scottish adolescents aged 11–17 (113 adolescents also completed the questionnaire at follow-up). The questionnaire included measures on experiences with bereavement and lifetime engagement in self-harm, as well as measures of defeat, entrapment, social support, coping, and other psychological variables.

Results: At baseline, 12% of young people reported exposure to a suicide death, and 61% to a non-suicide death. In addition, 21% of pupils reported ever engaging in self-harm, while 23% had experienced self-harm ideation without engaging in it. Cross-sectional multivariate logistic regressions showed that family social support, glorifying/normalising beliefs about suicide, and family self-harm were significantly associated with self-harm group membership (control, ideation, or enactment groups). At follow-up, 10% of pupils reported exposure to a suicide death and 16% to a non-suicide death for the first time. A total of 26% of the sample reported self-harm at T2 (11% of participants for the first time), and 24% reported self-harm ideation without engaging in it. Multivariate analyses found that self-harm ideation and family self-harm at baseline were the only variables to predict self-harm group membership prospectively, in the expected directions. Bereavement experiences, whether by suicide or non-suicide, did not predict self-harm group status at baseline nor at follow-up.

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Conclusions: This study provides support for the validity of a theoretical model of suicide, even though predictive ability over the 6-months period was limited. Although difficulties with recruitment may have limited the statistical power, this study provides insight into the prevalence and experiences of suicide bereavement among adolescents and the factors related to the onset and maintenance of self-harm.

Keywords: adolescence, self-harm, suicide, bereavement, theory, IMV model

INTRODUCTION

Suicide is a major public health problem across the globe, representing the second leading cause of death among young people from 15 to 29 years old worldwide (World Health Organization [WHO], 2014). The most recent data from Scotland reveals that 784 people took their own lives in 2018 (Scottish Public Health Observatory, 2019). The rate of young people aged 15–24 dying by suicide in 2018 was at its highest since 2007, at a rate of 15.1 per 100,000 population, an increase of over 50% since the previous year.

Research has found that over half of young people under 20 years old who died by suicide had a history of self-harm (University of Manchester, 2017), and evidence consistently shows that one of the strongest predictors of suicide is self-harm, irrespective of the intention (Hawton et al., 2012). Research has also frequently demonstrated that the vast majority of young people who self-harm do not present to hospital, and consequently it is important to go beyond clinical studies to examine the prevalence and causation of adolescent self-harm (Geulayov et al., 2018).

In Scotland, research examining self-harm within community samples suggests that up to 14% of young people have engaged in (enacted) self-harm (O'Connor et al., 2009b, 2012), and a further 22.8% have thought (ideated) about self-harm (Russell et al., 2018). These findings are comparable to other studies in the United Kingdom (Hawton et al., 2002; McMahon et al., 2010). This research highlights that self-harm is a significant issue affecting young people, and understanding the risk and protective factors for self-harm is therefore imperative to reduce the potential negative outcomes associated with this behaviour. National suicide prevention strategies also recognise self-harm as a crucial component of suicide prevention (Scottish Government, 2018b; HM Government, 2019), emphasising the need for evidence-based interventions to reduce self-harm at the community level.

Suicide Bereavement: Risk Factor for Self-Harm and Suicide

Exposure to the fatal and non-fatal self-harm of others has been cited as a predictor of future suicidal or self-harming thoughts and behaviours (SSHTBs; O'Connor et al., 2009a; Hawton et al., 2012; O'Connor and Nock, 2014; Mars et al., 2019a). Regarding non-fatal self-harm, De Leo and Heller (2004) analysed responses from 3,757 secondary school pupils as part of the Child and Adolescent Self-Harm in Europe (CASE) study. They found that exposure to the self-harm of others significantly predicted one's own self-harm; self-harm among friends was associated with a higher odds of self-harm than self-harm among family members (*OR* = 4.07 vs. 3.22). Similarly, McMahon et al. found that approximately one third of adolescents in Ireland had been exposed to a friend or family member's self-harm or suicide, and these individuals were almost eight times more likely to report self-harm compared to those without such exposure (McMahon et al., 2013). Evidence of the association between fatal self-harm (i.e., suicide) and adverse outcomes is less clear. This is partly due to the uncertainty about how many adolescents are dealing with a suicide bereavement. It is known that bereavement is a common experience among young people; Harrison and Harrington (2001) found that up to 77.6% of adolescents from 11 to 16 years old in England had experienced the death of a first or second-degree relative or close friend. In Great Britain, one study found that 3.5% of children and adolescents (5–16 years old) reported being bereaved by a parent or sibling, 6.3% being bereaved of a friend, and 0.3% of both (Fauth et al., 2009). However, no known studies have determined the proportion of young people in Scotland who are bereaved by suicide. This is significant given that many people are known to be affected by each suicide, with estimates ranging from 6 people (Shneidman, 1972), to 10 (Andriessen and Krysinska, 2012), 80 (Berman, 2011) and up to 135 (Cerel et al., 2018) individuals affected by every suicide. A recent meta-analysis predicted that 21.83% of individuals are exposed to suicide at some point in their lives, with 4.31% in the past year (Andriessen et al., 2017). Identifying how many adolescents in Scotland are bereaved by suicide will therefore aid in understanding its impact.

The sequelae of bereavement or exposure to a suicide (i.e., experiencing the suicide death of someone important to oneself, such as a family member or friend) may extend beyond that of other types of deaths. Those bereaved by suicide may face a number of additional challenges as a result of the manner of death, including increased perceptions of rejection, shame, stigma, blame, and a need to conceal the cause of death (see Sveen and Walby, 2008 for a review). An elevated risk of mental and physical health problems, particularly depression, anxiety, and posttraumatic stress disorder (Pitman et al., 2014; Erlangsen and Pitman, 2017), as well as prolonged grief reactions (Young et al., 2012), have also been indicated. Empirical evidence of increased risk of SSHTBs is less consistent, and may be the result of varying methodological approaches, the quality or type of relationships being investigated, or age groups in question.

Within the adolescent literature, family suicide is a strong risk factor for subsequent SSHTBs. Guldin et al. (2015) showed that suicide bereaved children had a greater incidence of suicide than children bereaved by accidental or other deaths, and the risk persisted for decades. Similar patterns were reported by Wilcox et al. (2010) and Kuramoto et al. (2013), who highlight childhood and adolescence as a vulnerable time. It is also suggested that parental sex may play an important role, with adolescents more likely to die by suicide if their same-sex parent died by suicide (Cheng et al., 2014), and the risk is independent of family history of psychiatric illness (Qin et al., 2002). Despite evidence to suggest that family suicide is a risk factor for adolescent SSHTBs, less is known about the influence of other non-familial suicide deaths. Cross-sectional research (e.g., Pirelli and Jeglic, 2009) has been more likely to find an association between peer exposure and suicidality, compared to longitudinal research (Andriessen et al., 2016). However, there is a dearth of control-group studies looking at adolescents' experiences with bereavements outside of the immediate family, and prospective research in this area is particularly scarce. Longitudinal work is valuable in that it allows for the prediction of future behaviours, and thus provides particularly strong evidence for identifying risk factors for self-harm (Ribeiro et al., 2016).

Suicide Theory: The IMV Model of Suicidal Behaviour

There has been a call for more theoretically driven work in order to develop a cumulative evidence base which can inform suicide intervention development going forward; however, at the moment there is a paucity of theoretically informed work in this field. Theoretical conceptualisations recognise exposure to suicide as a risk factor for SSHTBs. The Integrated Motivational-Volitional (IMV) Model of Suicide (O'Connor, 2011; O'Connor and Kirtley, 2018) offers a framework to understand the development of thoughts and their translation into behaviours, which are seen as distinct processes within an ideation-to-action framework (Klonsky and May, 2015). Applicable to self-harm as well as suicide, it proposes that a convergence of biological, psychological, and environmental risk and protective factors contribute to suicide. Importantly, factors, which predict the formation of suicidal ideation, are thought to be distinct from those which predict behavioural enaction. Background vulnerability factors and triggering events are said to predispose a person to feel defeated and humiliated. This can result in perceptions of entrapment, which may result in suicidal thoughts. These transitions are facilitated by Threat to Self (TSM) and motivational moderators (MM), which increase/decrease the likelihood of a person moving between each of these key stages. A number of factors, or volitional moderators (VMs), subsequently increase or decrease the likelihood that a person will go on to engage in suicidal behaviours after experiencing thoughts.

Within the IMV model, exposure to the SSHTBs of others is recognised as a key volitional factor in the transition from ideation to attempts. The model proposes that people who engage in self-harm behaviours are more likely to have been exposed to self-harm or suicide than those who only experience thoughts of self-harm or those with no history of self-harm. Research specifically testing the IMV model finds support for this notion (Dhingra et al., 2015; Mars et al., 2019b), although the evidence base for adolescent experiences of losing someone to suicide is limited. Studies investigating this relationship would also benefit from taking into account other factors which impact adjustment after a loss.

One factor purportedly relevant to the development of SSHTBs within the TSMs is one's coping style. Research has shown that coping ability is related to levels of suicidality (after controlling for depression), and may interact with levels of defeat and entrapment to elevate or reduce risk of suicide (Gooding et al., 2015). Studies also demonstrate that suicide bereaved youth engage in increased risk taking behaviours to cope with a loss, such as alcohol and drug misuse and risky sexual behaviours (Bartik et al., 2013a), and may utilise more avoidant coping strategies, such as distraction and social diversion (Bartik et al., 2013b). Relatedly, self-esteem has been associated with vulnerability to suicide, where low levels of self-esteem were associated with high suicide probability (measured through the constructs of hopelessness, suicidal ideation, hostility, and negative self-evaluations) even after controlling for depression (Gooding et al., 2015). Among adolescents, Seguin et al. (2004) showed that individuals who attempted suicide and experienced suicidal ideation differed from controls (with no history of self-harm), but not each other, on levels of self-esteem. Self-esteem was also predictive of subsequent depression among adolescents bereaved by parental death (Brent et al., 2009), suggesting it may buffer the impact of a bereavement on young people.

The social context of an individual is recognised within the proposed MMs of the model. Studies have consistently found that social support is associated with suicide risk (Kleiman and Liu, 2013; O'Connor and Nock, 2014), as well as adjustment after a death (Andriessen et al., 2015). Perceptions of loneliness and altered social roles may explain why suicide bereavement leads to increased vulnerability for self-harm (Pitman et al., 2014). In addition, attitudes and stigma surrounding suicide (as another possible MM) have been highlighted as important in mental health and suicide outcomes. Bartik et al. (2015) found that young people who had experienced a suicide bereavement were less likely than a general population sample to view suicide as resulting from isolation and depression, and more likely to view those who die by suicide with stigma and in glorifying or normalising terms. Ultimately, endorsing stigmatising beliefs about suicide may prevent individuals from talking about it or seeking help when needed, and therefore increase their vulnerability to adverse outcomes.

To further our understanding of the link between bereavement experiences and subsequent self-harm behaviours, research is needed to understand the interrelationships between bereavement and other factors which may be relevant to self-harm. By providing testable hypotheses, theory-based investigations can ultimately guide suicide prevention efforts by providing an evidence-base for interventions that reduce known risk factors for self-harm. Effective postvention, or the support offered to people bereaved by suicide, is an area that requires further empirical research given that it is a key target for suicide prevention and policy (Scottish Government, 2018b; Andriessen et al., 2019). As an emerging theoretical model, the IMV model requires further testing, particularly with diverse populations and age groups, to better understand the mechanisms underpinning suicide. Its evaluation would be of specific value to researchers, practitioners and policymakers given its potential to inform practice.

The Current Research Study

While evidence points to suicide bereavement being a risk factor for subsequent SSHTBs, this association requires specific testing among adolescent populations. Research needs to quantify how many young people are bereaved by suicide, and how this experience is related to other factors important in the development of SSHTBs. Discussion about why exposure to suicide may increase the likelihood of self-harm behaviours in some but not others may be usefully informed by reference to theories such as the IMV. Longitudinal research is also necessary, as much of the literature to date has been cross-sectional. Prospective work is required, which can aid in identifying future targets for community-based interventions for self-harm.

The current study aimed to explore whether exposure to suicide or other deaths is associated with self-harm behaviours cross-sectionally, and longitudinally over a 6-month follow-up, and examines whether 11 relevant IMV model variables may be important in this relationship. This was achieved by examining factors highlighted in the existing literature as being relevant to the emergence of suicidal or self-harming behaviours among adolescents, within the context of an ideation-to-action framework. Specifically, the following hypotheses rooted in the IMV model were proposed:

(a) Ideation and enactment groups will differ from controls, but not each other, on motivational phase measures (defeat, entrapment, social support, coping, self-esteem, and attitudes to suicide).

(b) Ideation and enactment groups will differ from controls, as well as each other, on volitional phase measures (exposure to suicide deaths, family self-harm, and friend self-harm). Exposure to non-suicide deaths will not differentiate groups (control, ideation, or enactment).

In order to examine cross-sectional associations as well as longitudinal predictions, analyses were conducted twice, with variables predicting self-harm outcomes at baseline (T1) as well as approximately 6-months later (T2).

MATERIALS AND METHODS

Participants

A total of 185 pupils (aged 11–17, $M = 13.17$, $SD = 1.49$) were recruited at T1 from nine secondary schools across Scotland. This sample consisted of individuals retained after removing participants with >50% missing data ($n = 2$) or who did not provide data on any of the SSHTB outcome measures ($n = 22$), and including participants from T2 who only provided data once and not at baseline (i.e., were absent at the first time point, or baseline data was removed due to missingness but T2 questionnaire was complete; $n = 15$). Of the T1 sample, 84 stated they were male, 98 female, 2 other, and 1 did not respond. Approximately half were in Year 1 (predominantly aged 12–13) of secondary school ($n = 91$, 49.2%) and described their ethnicity as White ($n = 167$, 90.3%), consistent with the last Scottish Census (96.1%; National Records of Scotland, 2011). The percentage of pupils entitled to free school meals, as a proxy measure of Socioeconomic Status (SES), ranged from 4.74 to 20.99% between schools ($M = 14.10$, $SD = 5.31$), slightly lower than previous Scottish studies (e.g., mean of 17.8% in Russell et al., 2018), though comparable to the national average of 14.4% (Scottish Government, 2018a).

One hundred and thirteen individuals (aged 12–18, $M = 13.58$, $SD = 1.52$; 45 male, 65 female, 2 other, 1 did not respond) provided data for T2, which could be matched to corresponding baseline data. This sample was retained after removing data from respondents whose T2 participant identifier codes could not be confidently matched to their baseline data ($n = 31$), who had >50% missing data ($n = 5$), or who did not respond to any of the outcome measures ($n = 5$).

The retention rate of 61.08% is similar to other longitudinal studies using adolescent samples (Boergers and Spirinto, 2003; O'Connor et al., 2009a; Hasking et al., 2013, 2015; Rasmussen et al., 2016).

Measures

An anonymous self-report questionnaire was created using measures selected on the basis of previous literature, which have been used, or deemed appropriate for use, with adolescents. Only those which are pertinent to the current study are reported here; a full list of measures used can be obtained from the authors.

Demographic and Control Variables

Demographic characteristics

Demographic characteristics included age, gender (male/female/other), and ethnicity. The SES of participants was determined by the percentage of pupils in their school entitled to free school meals, as reported by official Scottish Government (2018a), which has been used as a measurement of SES in previous schools-based research (O'Connor et al., 2009b; Russell et al., 2017).

Depression

Depressive symptoms were assessed using the Short Mood and Feelings Questionnaire (SMFQ; Angold et al., 1995), which consists of 13 items describing how a person may have felt or acted in the past 2 weeks. Responses are given on a 3-point scale from 0 (not true) to 2 (true), e.g., "*I thought I could never be as good as other kids.*" Internal consistency is high in the published literature (e.g., $\alpha = 0.85$; Angold et al., 1995), and was 0.93 in this study.

Anxiety

The Generalised Anxiety Disorder (GAD-7; Spitzer et al., 2006) scale was used to measure symptoms of anxiety, and can be used as a screening tool for generalised anxiety disorder. Seven items describe common anxiety symptoms, and participants are asked to respond whether they have felt bothered by the problems over the last 2 weeks, using a 4-point scale from 0 (not at all) to 3 (nearly every day), e.g., "*Becoming easily annoyed or irritable.*" Cronbach's α was 0.92 in this study, comparable to previous research (e.g., α = 0.92; Spitzer et al., 2006).

Self-Harm and Suicidal Ideation or Behaviours

Self-harm

Self-harm was measured using five items from the CASE study questionnaire (Hawton et al., 2006). The original questionnaire was developed through an international collaboration of researchers and experts in self-harm and school-based research, and extensively piloted before use with adolescents across several European countries and Australia. Participants in this study were asked, "*Have you ever deliberately taken an overdose* (e.g., *of pills or other medication*) *or tried to harm yourself in some other way* (*such as cut yourself*)*?*" Those responding 'Yes, once' or 'Yes, more than once' comprised the "Enactment" group.

Self-harm ideation

Non-suicidal self-injury (NSSI) thoughts were assessed using an item from the Self-Injurious Thoughts and Behaviours Interview (SITBI; Nock et al., 2007), namely, "*Have you ever had thoughts of purposely hurting yourself without wanting to die?* (*for example, cutting or burning*)." Suicidal thoughts were assessed with the SITBI item, "*Have you ever had thoughts of killing yourself?*" A participant who answered 'Yes' to either NSSI or suicidal thoughts, and 'No' to the self-harm behaviours question, was considered to be in the "Ideation" group used for all further analyses. Therefore, this group consisted of all individuals with previous thoughts of self-harm or suicide, irrespective of their intent or motivation (similar to the enactment group with regards to the intent or motivation of their behaviours). Individuals responding "No" to all self-harm behaviours and NSSI or suicidal thoughts questions were considered "Controls" with no history of self-harm thoughts or acts. The SITBI has been shown to be a valid and reliable measure of a wide range of self-harm related constructs (Nock et al., 2007).

Whether a participant had engaged in first-time or repeat self-harm or self-harm ideation over the study period could be ascertained by changes in their responses to these questions across the two time-points. Although self-harm group was the outcome measure in the main analyses (T1 self-harm group for cross-sectional analyses, and T2 self-harm group for prospective analyses), self-harm ideation at baseline was also inputted as a predictor variable within the motivational phase test in the prospective analyses, given research suggesting it is a strong predictor of future self-harm (O'Connor, 2011; Ribeiro et al., 2016; O'Connor and Kirtley, 2018).

Motivational Phase Variables

Defeat

Defeat was assessed via the Defeat Scale (Gilbert and Allan, 1998), measuring perceptions of failed struggle and loss of rank or status experienced over the last week. Participants respond to 16 items using a 5-point scale, ranging from 0 (Never) to 4 (Always), indicating their agreement with the items, e.g., "*I feel that I have given up.*" Cronbach's α for this scale was high at 0.95.

Entrapment

Entrapment was measured using the Entrapment Scale (Gilbert and Allan, 1998), which evaluates perceptions of being unable to escape from one's current situation or circumstances. Sixteen self-report items, e.g., "*I have a strong desire to escape from things in my life,*" are rated on a 5-point scale from 0 (never) to 4 (always), reflecting how frequently they have been experienced. The scale showed high internal consistency at α = 0.95.

Coping

Coping was assessed using the Brief COPE (Carver, 1997), measuring the degree to which a person uses a specific strategy to deal with difficult or stressful situations. The 28-item measure covers various strategies, e.g., "*I have been using alcohol or other drugs to make myself feel better,*" which are evaluated using a 4-point scale from 1 (I haven't been doing this at all) to 4 (I've been doing this a lot). Several scoring methods have been proposed. As per Moore et al. (2011) and Blomgren et al. (2016), we differentiated between adaptive coping (16 items covering active coping, planning, positive reframing, humour, acceptance, religion, use of emotional support, and use of instrumental support) and maladaptive coping (12 items on self-distraction, denial, substance use, behavioural disengagement, venting, and self-blame). Cronbach's α was high for both the adaptive and maladaptive subscales, at 0.84 and 0.77, respectively.

Self-esteem

The Rosenberg Self-Esteem Scale (Rosenberg, 1965) was used to measure self-esteem by asking about self-worth and positive or negative feelings about oneself. Ten items are answered on a 4-point scale from 0 (Strongly Agree) to 3 (Strongly Disagree), with higher scores indicating greater self-esteem, e.g., "*I take a positive attitude toward myself.*" Internal consistency was high at α = 0.90.

Social support

The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) was used to assess the perceived adequacy of social support that an individual receives from family, friends, and significant others. Each of the three categories is assessed with four items, given on a 7-point scale ranging from 1 (very strongly disagree) to 7 (very strongly agree), e.g., "*I can talk about my problems with my family.*" A total overall score or three subscale scores for the different sources of support can be calculated by summing the relevant items. Subscales were used here to differentiate the influence of different sources of support; internal consistency was high (family α = 0.89, friends α = 0.90, and significant others α = 0.89).

Stigma

Attitudes toward people who die by suicide were measured using the Short Form of the Stigma of Suicide Scale (SOSS; Batterham et al., 2013b), which asks participants to rate how much they agree or disagree with words describing people who take their own lives. Sixteen items, e.g., "*irresponsible,*" "*lonely,*" "*noble,*" are rated on a 5-point scale from Strongly Disagree to Strongly Agree. Subscales of stigma, isolation/depression, and glorification/normalisation can be calculated by summing the relevant items for each subscale; internal consistency for the respective subscales was α = 0.83, α = 0.83, and α = 0.70.

Volitional Phase Variables

Bereavement

In order to inquire about adverse life events, including bereavements, that may have occurred in young people's lives, a 20-item Life Events Checklist (LEC) from the CASE Study Lifestyle and Coping Questionnaire (Hawton et al., 2006) was utilised. This measure asks about potentially traumatic life events occurring within the past 12 months and/or more than a year ago, and has been used in several countries with adolescent samples (e.g., Madge et al., 2011; Hasking et al., 2013). Although participants were presented with all 20-items, only five are relevant and discussed here; three items inquired about experiences with the death of someone close. Specifically, "*Has anyone among your immediate family* (*mother, father, brother, or sister*) *died?*," "*Has anyone close to you died?*", and "*Has anyone among your family or friends committed suicide?*" Although we acknowledged the outdated language used in this question, wording of items was left as in the original measure to allow for comparisons with the extant literature.

Self-harm of family or friends

Two additional questions from the Life Events Checklist inquired about self-harm behaviours among one's friends or family: "*Has anyone among your [family]/[close friends] attempted suicide or deliberately harmed themselves?*" As with all LEC items, possible responses included 'Yes, in the past 12 months,' 'Yes, more than a year ago,' or 'No.'

Procedure

Ethical approval was granted from the University of Strathclyde Ethics Committee, and approval was given from 14 local education authorities across Scotland to carry out the study in their area. 153 secondary schools in participating areas were contacted and invited to take part. An information sheet detailing the nature of the investigation and consent form were sent out to all parents/guardians of pupils in participating year groups. Parental/guardian consent as well as participant consent was obtained.

The researcher then visited each school and spoke to pupils to explain the procedures and address any questions in person. Pupils were given information sheets to take away with them and read in their own time, which explained that the research would ask about past experiences of bereavement as well as self-harm or suicide. Approximately 2 weeks later, pupils were invited to complete the questionnaire during a class period. Two versions of the anonymous questionnaire with counterbalanced measures were distributed so as to avoid order effects, and ensure that respondents could not gauge the responses of their peers in answering sensitive questionnaire items and thus maintain a level of confidentiality. Participants completed them individually after providing informed consent. Completion of the questionnaire took approximately 30 min, and the researcher was present throughout to address any questions or issues arising. Pupils were provided with blank sealable envelopes to return their completed forms at the end, and were debriefed and given an information pamphlet with follow-up sources of support should they feel they need it, which was tailored to each school. Approximately 6 months later, pupils were invited to complete the questionnaire for a second time under the same conditions, and informed consent was obtained again.

Data Analytic Plan

Missing data was dealt with using multiple imputation, as Little's MCAR test was non-significant, $\chi^2(5) = 9.23$, $p = 0.100$, and data was deemed to be most likely missing completely at random. A total of $m = 67$ imputations were generated based on 67% of cases having incomplete data (as suggested by White et al., 2010). Analyses were conducted using SPSS Version 25, which supports pooled analyses based on imputed datasets for several statistical tests; however, some analyses are not supported by this function. In such cases, parameter estimates were manually averaged across the 67 imputed datasets, an approach also taken by Jones et al. (2014) when dealing with imputed data in SPSS. Microsoft Excel 2013 was used to manually pool parameter estimates where necessary.

Prevalence rates of SSHTBs, as well as bereavement experiences, were reported through descriptive statistics. Hierarchical multinomial logistic regressions were used to investigate which variables were associated with self-harm outcomes at baseline and at follow-up. Two separate regressions for each time point (baseline and follow-up) were conducted in order to test the motivational and volitional phases of the model. All analyses controlled for age and gender, given the established differences with respect to self-harm (Hawton et al., 2012). We also controlled for baseline mood, in line with previous research (e.g., O'Connor et al., 2012; Hasking et al., 2013; Dhingra et al., 2015) and given that depression and anxiety were both significantly associated with self-harm group status at T1 and T2. Odds ratios and confidence intervals were obtained from univariate analyses. Variables which were significantly associated with self-harm group status in univariate analyses were entered into multivariate analyses to determine their relative contributions. Holm–Bonferroni corrections were applied to correct for multiple comparisons.

RESULTS

Prevalence of Bereavement and Self-Harm at Baseline (T1)

A comparison of those who took part at baseline only and those who participated at both time points revealed no significant differences on any of the demographic or studied variables. Descriptive statistics of continuous study variables for all participants across all self-harm groups are shown in **Table 1**. At baseline (n = 185), 134 (72.43%) young people reported that someone among their immediate family and/or someone else close had died; 22 (11.89%) of which knew someone who had died by suicide (making up the suicide exposed group), while the remaining 112 (60.54%) people were exposed to a non-suicide death.

TABLE 1 | Descriptive statistics for continuous scale variables for participants at both time points, within each self-harm group.

	Total (*M, SD*)		**Control (*M, SD*)**		**Ideation (*M, SD*)**		**Enactment (*M, SD*)**	
	T1 (*n* = 185)	**T2 (*n* = 113)**	**T1 (*n* = 103)**	**T2 (*n* = 57)**	**T1 (*n* = 43)**	**T2 (*n* = 27)**	**T1 (*n* = 39)**	**T2 (*n* = 29)**
Age	13.17 (1.49)	13.58 (1.52)	12.90 (1.42)	13.29 (1.40)	13.44 (1.50)	13.93 (1.69)	13.59 (1.55)	13.83 (1.51)
SES	14.10 (5.31)	13.93 (4.86)	14.85 (4.87)	13.95 (4.84)	12.14 (5.83)	12.98 (5.30)	14.29 (5.41)	14.76 (4.48)
Depression	7.92 (7.21)	8.20 (7.58)	4.39 (4.90)	3.27 (4.05)	9.57 (6.43)	10.00 (5.27)	15.41 (6.89)	16.21 (7.23)
Anxiety	6.92 (6.27)	7.52 (6.96)	4.10 (4.89)	3.30 (4.44)	9.23 (6.00)	10.59 (6.27)	11.85 (5.82)	12.97 (6.44)
Defeat	17.91 (14.80)	20.42 (16.36)	10.56 (8.99)	11.25 (9.22)	21.38 (13.36)	22.10 (10.88)	33.51 (15.38)	36.88 (18.33)
Entrapment	13.99 (14.81)	15.86 (16.12)	6.43 (8.49)	5.84 (7.35)	17.89 (13.24)	21.65 (14.05)	29.63 (15.85)	30.17 (17.30)
Adaptive coping	33.92 (8.98)	33.48 (8.85)	32.48 (8.61)	32.00 (9.65)	35.17 (10.03)	35.99 (7.57)	36.35 (8.15)	34.06 (7.94)
Maladaptive coping	22.06 (6.10)	21.58 (6.18)	19.11 (4.75)	18.42 (4.38)	24.23 (5.30)	24.09 (5.62)	27.47 (5.45)	25.46 (6.57)
Self-esteem	21.37 (5.89)	21.98 (6.22)	18.68 (4.71)	18.44 (4.71)	23.24 (5.37)	23.74 (3.72)	26.40 (5.22)	27.32 (6.29)
SS – family	5.62 (1.49)	5.52 (1.61)	6.16 (1.08)	6.20 (0.94)	5.23 (1.48)	5.45 (1.34)	4.63 (1.78)	4.25 (2.08)
SS – friends	5.21 (1.59)	5.41 (1.58)	5.40 (1.42)	5.59 (1.42)	4.98 (1.82)	5.51 (1.62)	4.97 (1.71)	4.95 (1.80)
SS – significant other	5.49 (1.54)	5.76 (1.42)	5.74 (1.32)	5.90 (1.22)	5.43 (1.64)	5.95 (1.41)	4.87 (1.81)	5.31 (1.73)
SOSS – stigma	2.07 (0.73)	1.96 (0.78)	2.17 (0.72)	2.00 (0.80)	2.04 (0.73)	2.27 (0.82)	1.84 (0.74)	1.60 (0.53)
SOSS – Iso/Dep	3.63 (1.01)	3.58 (1.05)	3.46 (1.00)	3.17 (1.09)	3.71 (0.95)	4.04 (0.91)	3.99 (1.01)	3.96 (0.75)
SOSS – Glo/Nor	2.53 (0.88)	2.61 (0.88)	2.46 (0.90)	2.55 (0.93)	2.79 (0.88)	2.45 (0.88)	2.42 (0.78)	2.88 (0.75)

SES, socioeconomic status; SS, social support; SOSS, Stigma of Suicide Scale; Iso/Dep, isolation/depression subscale; Glo/Nor, glorification/normalisation subscale.

39 (21.08%) pupils reported having ever engaged in self-harm behaviours during their lifetime (enactment group), while a further 43 (23.24%) reported past self-harm ideation with no history of behaviours (ideation group). Thus, the control group at baseline consisted of 103 (55.68%) individuals with no history of self-harm or suicidal thoughts or behaviours.

Prevalence of Bereavement and Self-Harm at Follow-Up (T2)

At follow-up, 81 participants of the T2 sample of $n = 113$ reported that someone among their immediate family and/or someone else close had died. Eighteen (15.93%) individuals overall reported knowing someone who had died by suicide (suicide exposed group), of which 11 (9.73%) were reported for the first time since T1. A further 65 (57.52%) individuals were exposed to a non-suicide death, with 18 (15.93%) reported for the first time since baseline. It is worth noting that two individuals responded ‘no’ to the death of an immediate family member or anyone close, but ‘yes’ to experiencing a suicide death of family or friends.

At follow-up, 29 (25.66%) adolescents reported ever engaging in self-harm, with 12 (10.62%) of these for the first time between Time 1 and Time 2. A further 27 (23.89%) individuals reported having experienced self-harm ideation (with no actions) at follow-up. The control group at T2 therefore comprised of 57 (50.44%) individuals who reported no history of self-harm ideation or behaviours at follow-up.

Cross-Sectional Associations Between Motivational and Volitional Phase Variables and Self-Harm at Baseline (T1)

Motivational Phase Variables

A hierarchical multinomial logistic regression was conducted to examine whether motivational phase variables were associated with self-harm group status at baseline. In univariate analyses, those in the ideation group reported higher levels of defeat (OR = 1.07, 95% CI = 1.01–1.13, $p = 0.02$) and entrapment (OR = 1.07, 95% CI = 1.02–1.12, $p = 0.007$), were more likely to employ maladaptive coping strategies (OR = 1.15, 95% CI = 1.03–1.28, $p = 0.01$), and report less available social support from family members (OR = 0.63, 95% CI = 0.47–0.85, $p = 0.003$) compared to controls, as expected (**Table 2**). Comparisons between the enactment group and controls showed similar patterns on the same variables (defeat: OR = 1.12, 95% CI = 1.05–1.19, $p = 0.001$; entrapment: OR = 1.10, 95% CI = 1.05–1.16, $p < 0.001$; maladaptive coping: OR = 1.22, 95% CI = 1.07–1.38, $p = 0.002$; family social support: OR = 0.54, 95% CI = 0.38–0.76, $p = 0.001$). As predicted, the ideation group did not differ from the enactment group on any motivational phase variable, apart from the enactment group being less likely to endorse glorifying/normalising beliefs about suicide (OR = 0.40, 95% CI = 0.21–0.76, $p = 0.005$).

Significant univariate predictors associated with self-harm were entered into a multivariate analysis (**Table 3**), which found that two factors continued to be associated with self-harm group membership: ideation (OR = 0.60, 95% CI = 0.43–0.83, $p = 0.002$) and enactment (OR = 0.58, 95% CI = 0.38–0.89, $p = 0.012$) groups were both more likely to report lower family social support compared to controls as predicted, and the enactment group were also less likely to hold glorifying/normalising beliefs about suicide than the ideation group (OR = 0.35, 95% CI = 0.18–0.70, $p = 0.003$).

Volitional Phase Variables

A similar logistic regression analysis was conducted to examine volitional phase variables and their association with self-harm group status at baseline. Univariate analyses showed that ideation and enactment groups did not differ from controls on any

TABLE 2 | Univariate multinomial logistic regression of the association between motivational phase variables and self-harm group status at baseline (controlling for age, gender, depression, and anxiety).

Motivational phase variable		*B*	*SE*	OR	95% CI for odds ratio	*p*
Defeat						
Control	Ideation	0.07	0.03	1.07	1.01–1.13	**0.020**
Control	Enactment	0.11	0.03	1.12	1.05–1.19	**0.001**
Ideation	Enactment	0.05	0.03	1.05	0.99–1.10	0.094
Entrapment						
Control	Ideation	0.07	0.02	1.07	1.02–1.12	**0.007**
Control	Enactment	0.10	0.03	1.10	1.05–1.16	**<0.001**
Ideation	Enactment	0.03	0.02	1.03	0.99–1.08	0.144
Adaptive coping						
Control	Ideation	0.01	0.02	1.01	0.96–1.06	0.709
Control	Enactment	0.03	0.03	1.03	0.97–1.09	0.302
Ideation	Enactment	0.02	0.03	1.02	0.97–1.08	0.447
Maladaptive coping						
Control	Ideation	0.14	0.05	1.15	1.03–1.28	**0.010**
Control	Enactment	0.20	0.06	1.22	1.07–1.38	**0.002**
Ideation	Enactment	0.06	0.06	1.06	0.94–1.19	0.325
Self-esteem						
Control	Ideation	0.13	0.05	1.13	1.02–1.26	0.021
Control	Enactment	0.14	0.07	1.16	1.02–1.31	0.027
Ideation	Enactment	0.02	0.06	1.02	0.90–1.15	0.756
SS – family						
Control	Ideation	−0.46	0.15	0.63	0.47–0.85	**0.003**
Control	Enactment	−0.63	0.18	0.54	0.38–0.76	**0.001**
Ideation	Enactment	−0.16	0.15	0.85	0.63–1.15	0.287
SS – friends						
Control	Ideation	−0.07	0.13	0.94	0.73–1.21	0.619
Control	Enactment	0.04	0.16	1.04	0.75–1.43	0.816
Ideation	Enactment	0.10	0.15	1.11	0.82–1.50	0.501
SS – significant other						
Control	Ideation	−0.17	0.14	0.84	0.64–1.11	0.224
Control	Enactment	−0.31	0.17	0.73	0.53–1.01	0.061
Ideation	Enactment	−0.14	0.16	0.87	0.63–1.19	0.374
SOSS – stigmatisation						
Control	Ideation	−0.32	0.30	0.73	0.40–1.32	0.290
Control	Enactment	−0.72	0.38	0.49	0.23–1.03	0.059
Ideation	Enactment	−0.40	0.38	0.67	0.32–1.40	0.291
SOSS – Iso/Dep						
Control	Ideation	−0.12	0.23	0.89	0.56–1.40	0.606
Control	Enactment	−0.03	0.32	0.97	0.52–1.81	0.931
Ideation	Enactment	0.09	0.32	1.10	0.59–2.04	0.770
SOSS – Glo/Nor						
Control	Ideation	0.34	0.25	1.41	0.87–2.30	0.167
Control	Enactment	−0.57	0.32	0.57	0.30–1.06	0.076
Ideation	Enactment	−0.91	0.33	0.40	0.21–0.76	**0.005**

Holm–Bonferroni corrections were applied; only the comparisons in bold remain significant at the adjusted significance level. SES, socioeconomic status; SS, social support; SOSS, Stigma of Suicide Scale; Iso/Dep, isolation/depression subscale; Glo/Nor, glorification/normalisation subscale.

TABLE 3 | Multivariate multinomial logistic regression of the association between motivational phase variables and self-harm group status at baseline (controlling for age, gender, depression, and anxiety).

Motivational phase variable		*B*	*SE*	OR	95% CI for odds ratio	*p*
Defeat						
Control	Ideation	0.03	0.03	1.04	0.97–1.10	0.280
Control	Enactment	0.08	0.04	1.08	1.00–1.16	0.045
Ideation	Enactment	0.04	0.03	1.04	0.98–1.11	0.204
Entrapment						
Control	Ideation	0.04	0.03	1.04	0.98–1.10	0.198
Control	Enactment	0.05	0.03	1.05	0.99–1.12	0.123
Ideation	Enactment	0.01	0.03	1.01	0.96–1.07	0.621
Maladaptive coping						
Control	Ideation	0.14	0.06	1.15	1.02–1.30	0.022
Control	Enactment	0.18	0.08	1.20	1.03–1.39	0.019
Ideation	Enactment	0.04	0.07	1.04	0.91–1.20	0.566
SS – family						
Control	Ideation	−0.52	0.17	0.60	0.43–0.83	**0.002**
Control	Enactment	−0.55	0.22	0.58	0.38–0.89	**0.012**
Ideation	Enactment	−0.03	0.19	0.97	0.68–1.40	0.875
SOSS – Glo/Nor						
Control	Ideation	0.43	0.27	1.54	0.90–2.64	0.114
Control	Enactment	−0.61	0.37	0.54	0.27–1.11	0.096
Ideation	Enactment	−1.04	0.35	0.35	0.18–0.70	**0.003**

Holm–Bonferroni corrections were applied; only the comparisons in bold remain significant at the adjusted significance level. SES, socioeconomic status; SS, social support; SOSS, Stigma of Suicide Scale; Glo/Nor, glorification/normalisation subscale.

variable. The ideation group differed from the enactment group only on family self-harm (OR = 0.11, 95% CI = 0.05–0.25, p = 0.007), where those who self-harmed were more likely to report this experience (**Table 4**). Neither experiencing a suicide nor a non-suicide death were associated with self-harm group membership. A multivariate analysis was not conducted as only one variable emerged as a significant predictor in this analysis.

Longitudinal Associations Between Motivational and Volitional Phase Variables and Self-Harm at Follow-Up (T2)

Motivational Phase Variables

A hierarchical multinomial logistic regression examined whether motivational phase variables were associated with life-time self-harm group 6-months later. In univariate analyses, participants in the ideation group were significantly more likely than controls to have reported self-harm ideation at baseline (**Table 5**; OR = 0.12, 95% CI = 0.03–0.46, p = 0.002). Those in the enactment group did not differ from controls nor from the ideation group on any motivational phase variable. A multivariate analysis was not conducted as only one variable was significant in this model phase.

Volitional Phase Variables

Another analysis was conducted to examine volitional phase variables and their association with self-harm group status prospectively. In univariate tests, the ideation group did not differ

TABLE 4 | Univariate multinomial logistic regression of the association between volitional phase variables and self-harm group status at baseline (controlling for age, gender, depression, and anxiety).

Volitional phase variable		*B*	*SE*	OR	95% CI for odds ratio	*p*
Suicide death						
Control	Ideation	0.25	0.79	1.29	0.27–6.09	0.749
Control	Enactment	−0.99	0.72	0.37	0.09–1.52	0.170
Ideation	Enactment	−1.24	0.68	0.29	0.15–0.57	0.067
Non-suicide death						
Control	Ideation	0.01	0.44	1.01	0.43–2.38	0.977
Control	Enactment	0.34	0.51	1.40	0.52–3.81	0.507
Ideation	Enactment	0.33	0.50	1.38	0.52–3.70	0.516
Family self-harm						
Control	Ideation	1.43	0.88	4.16	0.75–22.90	0.105
Control	Enactment	−0.79	0.64	0.46	0.13–1.61	0.223
Ideation	Enactment	−2.21	0.82	0.11	0.05–0.25	**0.007**
Friend self-harm						
Control	Ideation	−0.58	0.44	0.56	0.23–1.33	0.190
Control	Enactment	−1.07	0.51	0.34	0.13–0.94	0.037
Ideation	Enactment	−0.49	0.50	0.61	0.23–1.62	0.329

Holm–Bonferroni corrections were applied; only the comparisons in bold remain significant at the adjusted significance level.

TABLE 5 | Univariate multinomial logistic regression of the association between motivational phase variables and self-harm group status at follow-up (controlling for age, gender, depression, and anxiety).

Motivational phase variable		*B*	*SE*	OR	95% CI for odds ratio	*p*
Defeat						
Control	Ideation	0.02	0.03	1.02	0.96–1.09	0.463
Control	Enactment	0.02	0.03	1.02	0.96–1.08	0.499
Ideation	Enactment	0.00	0.03	1.00	0.94–1.06	0.954
Entrapment						
Control	Ideation	0.02	0.03	1.02	0.97–1.08	0.367
Control	Enactment	0.01	0.03	1.01	0.96–1.06	0.735
Ideation	Enactment	−0.01	0.03	0.99	0.93–1.04	0.596
Adaptive coping						
Control	Ideation	0.04	0.03	1.04	0.98–1.10	0.237
Control	Enactment	−0.04	0.03	0.96	0.90–1.02	0.200
Ideation	Enactment	−0.08	0.04	0.93	0.86–0.99	0.032
Maladaptive coping						
Control	Ideation	−0.03	0.07	0.98	0.86–1.11	0.710
Control	Enactment	−0.07	0.07	0.93	0.81–1.07	0.303
Ideation	Enactment	−0.05	0.07	0.96	0.83–1.10	0.520
Self-esteem						
Control	Ideation	0.05	0.06	1.05	0.93–1.19	0.427
Control	Enactment	0.11	0.07	1.12	0.99–1.27	0.084
Ideation	Enactment	0.06	0.07	1.07	0.93–1.22	0.355
SS – family						
Control	Ideation	0.00	0.18	1.00	0.70–1.43	0.997
Control	Enactment	−0.14	0.18	0.87	0.61–1.23	0.419
Ideation	Enactment	−0.14	0.19	0.87	0.60–1.25	0.442
SS – friends						
Control	Ideation	−0.09	0.17	0.91	0.65–1.27	0.580
Control	Enactment	−0.26	0.17	0.77	0.55–1.07	0.118
Ideation	Enactment	−0.17	0.17	0.84	0.60–1.18	0.323
SS – significant other						
Control	Ideation	−0.23	0.17	0.79	0.57–1.11	0.178
Control	Enactment	−0.37	0.17	0.69	0.50–0.97	0.032
Ideation	Enactment	−0.14	0.17	0.87	0.63–1.21	0.416
SOSS – stigmatisation						
Control	Ideation	0.07	0.34	1.08	0.55–2.11	0.831
Control	Enactment	−0.09	0.37	0.92	0.44–1.90	0.818
Ideation	Enactment	−0.16	0.41	0.85	0.38–1.90	0.698
SOSS – Iso/Dep						
Control	Ideation	−0.15	0.28	0.86	0.50–1.50	0.601
Control	Enactment	−0.13	0.31	0.88	0.48–1.62	0.687
Ideation	Enactment	0.02	0.35	1.02	0.52–2.02	0.948
SOSS – Glo/Nor						
Control	Ideation	−0.03	0.30	0.97	0.54–1.75	0.915
Control	Enactment	−0.56	0.33	0.57	0.30–1.09	0.091
Ideation	Enactment	−0.53	0.35	0.59	0.30–1.18	0.136
Self-harm ideation at T1						
Control	Ideation	−2.12	0.69	0.12	0.03–0.46	**0.002**
Control	Enactment	−0.81	0.69	0.45	0.12–1.72	0.241
Ideation	Enactment	1.31	0.78	3.70	0.80–17.19	0.095

Holm–Bonferroni corrections were applied; only the comparisons in bold remain significant at the adjusted significance level. SES, socioeconomic status; SS, social support; SOSS, Stigma of Suicide Scale; Iso/Dep, isolation/depression subscale; Glo/Nor, glorification/normalisation subscale.

from controls nor from the enactment group on any variable. The enactment group differed from controls on the experience of family self-harm, where they were more likely to report having had this experience, as predicted (**Table 6**; OR = 0.11, 95% CI = 0.03–0.47, *p* = 0.003). Neither experiencing a suicide nor a non-suicide death predicted self-harm group membership. A multivariate analysis was not necessary given only one variable emerging as significant in this analysis.

Overall, cross-sectional analyses showed that family social support and endorsing glorifying/normalising beliefs about suicide (motivational phase variables) and family self-harm (volitional phase variable) were significant predictors of self-harm group status. Longitudinally, self-harm ideation at baseline (motivational phase variable) and family self-harm (volitional phase variable) predicted self-harm group at follow-up.

DISCUSSION

This study aimed to investigate whether experiences of bereavement and other theoretically derived variables were associated with self-harm group status. These relationships were examined both cross-sectionally and over a 6-month period, given that longitudinal work is crucial for establishing causal relationships and constitutes particularly strong evidence. As suggested by the IMV model, participants in the ideation and enactment groups were expected to differ from controls, but not each other, on motivational phase variables, namely: defeat, entrapment, social support, coping, self-esteem, and attitudes to suicide. In addition, as predicted by the volitional phase of the model, it was expected that the ideation and enactment groups would differ from controls and each other on exposure to suicide

TABLE 6 | Univariate multinomial logistic regression of the association between volitional phase variables and self-harm group status at follow-up (controlling for age, gender, depression, and anxiety).

Volitional phase variable		*B*	*SE*	OR	95% CI for odds ratio	*p*
Suicide death						
Control	Ideation	−0.86	0.87	0.42	0.08–2.30	0.323
Control	Enactment	−1.19	0.84	0.31	0.06–1.57	0.158
Ideation	Enactment	−0.32	0.77	0.72	0.16–3.28	0.675
Non-suicide death						
Control	Ideation	0.08	0.52	1.08	0.39–2.99	0.884
Control	Enactment	−0.35	0.58	0.71	0.23–2.19	0.546
Ideation	Enactment	−0.42	0.62	0.66	0.20–2.19	0.492
Family self-harm						
Control	Ideation	−0.80	0.81	0.45	0.09–2.19	0.321
Control	Enactment	−2.21	0.74	0.11	0.03–0.47	**0.003**
Ideation	Enactment	−1.40	0.72	0.25	0.12–0.50	0.050
Friend self-harm						
Control	Ideation	0.29	0.57	1.34	0.44–4.02	0.611
Control	Enactment	−0.49	0.55	0.61	0.21–1.80	0.371
Ideation	Enactment	−0.78	0.61	0.46	0.14–1.48	0.203

Holm–Bonferroni corrections were applied; only the comparisons in bold remain significant at the adjusted significance level.

deaths, family self-harm, and friend self-harm, but not exposure to non-suicide deaths.

Results partially supported the hypotheses cross-sectionally. Although several variables (defeat, entrapment, maladaptive coping, family social support, and endorsing glorifying/normalising beliefs about suicide) predicted self-harm group membership in univariate analyses, only social support from family members and endorsing glorifying/normalising beliefs about suicide remained significant multivariate predictors within the motivational phase of the model. Defeat and maladaptive coping were approaching significance in the final model. Family self-harm was the only predictor among the volitional phase variables to predict self-harm group cross-sectionally. Results of longitudinal analyses showed that self-harm ideation (motivational phase test) and family self-harm (volitional phase test) at baseline predicted self-harm group membership 6-months later: the ideation group at T2 were more likely to report baseline self-harm ideation than controls, and the enaction group more likely to report family self-harm than controls.

Bereavement Experiences as Predictors of Self-Harm

Contrary to model predictions, bereavement did not predict self-harm group at either time point. Wetherall et al. (2018) reported on cross-sectional data from the Scottish Wellbeing Study of 18–34 year olds, and found that having a friend who attempted suicide differentiated ideation from enactment groups as expected, but having a family member or friend die by suicide did not. This study was based on a comparatively large sample (suicide attempt $n = 403$, suicidal ideation $n = 498$, control $n = 2{,}534$) and similarly did not find evidence to support an effect of loss to suicide. Future investigations should examine other features surrounding the death, such as the time elapsed since the death, closeness/quality of the relationship, or mental health history (Pitman et al., 2014; Andriessen et al., 2016).

It is worth noting that the rates of suicide and non-suicide death exposure reported in this sample reflect rates from previous research with young people. Harrison and Harrington (2001) reported that 77.6% of 11–16 year olds were bereaved of a relative or close friend. Madge et al. (2011), using data from the CASE Study which utilised the LEC measure, found that 59.7% of adolescents had experienced the death of someone close, and 30.4% had experienced a suicide death *or* self-harm of others (the authors did not differentiate fatal from non-fatal self-harm). However, it is worth noting that the LEC measure may not be reflective of the number of adolescents who consider themselves suicide bereaved. Indeed, two individuals at T2 reported no deaths of immediate family members or other close persons, but simultaneously reported a death to suicide of a family member or friend at the same time point. Based on the information gathered in this study, it is unclear whether this was due to the wording of the question, recall bias, or whether those reporting a family member or friend who died by suicide would consider themselves *bereaved by* suicide or *exposed to* suicide, given that follow-up information could not be ascertained regarding the extent to which they were impacted. This relates to the issue of terminology discussed by Cerel et al. (2014), who propose a continuum of suicide bereavement, where an individual can be exposed, affected, or bereaved (short/long-term) by suicide; these categories reflect varying levels of emotional attachment and adjustment after the loss. It has been said that simply being exposed to a suicide death does not constitute someone being deeply affected by the death (Andriessen et al., 2017). While limited conclusions can be made on this based on the data collected, it is nonetheless apparent that a large proportion of adolescents reported a suicide death of someone they knew.

IMV Model Psychological Variables as Predictors of Self-Harm

Our cross-sectional findings reflect previous research (Kleiman and Liu, 2013; O'Connor and Nock, 2014) and theory (O'Connor, 2011; O'Connor and Kirtley, 2018) showing that levels of social support are significantly associated with suicide risk. In a recent large-scale study, Wan et al. (2019) found that lower social support was significantly associated with self-reported NSSI, suicidal ideation and suicide attempts among young people aged 10–20 years old. Our finding that only family social support was associated with self-harm group membership is consistent with Cheng and Chan (2007); using a translated version of the MSPSS, they found that the impact of family social support was stronger than that of friends in predicting suicidality among adolescents. Similarly, Tabaac et al. (2016) reported that social support from family and significant others was associated with suicidal ideation, but only family social support was associated with suicide attempts. They suggest that family members may represent a closer and more permanent source of support than other social groups, particularly for adolescents dealing with stressful life events.

The finding of a significant association at baseline in the motivational phase variable of glorifying/normalising beliefs about suicide was contrary to IMV model predictions, as ideation and enactment groups were not expected to differ. The ideation group were more likely to endorse glorifying or normalising beliefs about suicide than the enactment group. Previous research using the same SOSS measure (Batterham et al., 2013a) also showed that suicidal ideation was associated with greater glorification of suicide, as well as less stigma toward suicide, whereas suicide attempts were not associated with any attitude subscale (stigma, isolation/depression, or glorification/normalisation). One possible explanation is that individuals who self-harm are more likely to have been exposed to similar behaviours in others (Dhingra et al., 2015; Mars et al., 2019b), and increased exposure has been shown to reduce stigma (e.g., in relation to mental disorders; Jorm and Wright, 2008); in this study, experiencing self-harm of family members was indeed associated with self-harm group status, which may account for the lack of an association with glorifying/normalising beliefs among the enactment group. Interestingly, self-harm group status was not associated with suicide bereavement. Given the small numbers of young people bereaved by suicide it was beyond the scope of this research to compare different bereavement groups. However, Bartik et al. (2015) found that those bereaved by suicide were more likely than the general population to perceive suicide as stigmatising and in glorifying or normalising terms, and less likely to attribute it to isolation and depression. Future research should therefore endeavour to assess how attitudes impact help-seeking among those who are suicide bereaved, to better understand the relationship between attitudes and self-harm.

The finding that baseline self-harm ideation predicted self-harm group at follow-up is consistent with past research (Ribeiro et al., 2016) and the theoretical assertion that ideation/intention is a proximal predictor of engagement in behaviours (O'Connor, 2011; O'Connor and Kirtley, 2018). We also found that self-harm among family members could predict self-harm group membership both at baseline as well as prospectively. In a United Kingdom population-based cohort study, Mars et al. (2019a) showed that exposure to family self-harm was a predictor of future suicide attempts among adolescents who reported suicidal thoughts (but not those who engaged in NSSI). O'Connor et al. (2009a) found that adolescents who engaged in repeat self-harm over a 6-month period were also significantly more likely to have family and friends who self-harmed than those who did not report self-harm; however, only family self-harm remained a significant predictor in multivariate analyses. These findings may be explained by familial transmission of suicidal behaviour (O'Connor et al., 2009a; Pitman et al., 2014), possibly through increased risk from shared environmental stressors or genetic factors, or transmission of psychopathology and impulsive aggression (Brent et al., 2002; Melhem et al., 2007). On the other hand, the finding that self-harm of friends did not predict self-harm group status here may also be attributed to a lack of statistical power, as numerous studies have suggested a role for social modelling of self-harm among non-family members. Self-harm among peers significantly predicted future suicidal behaviour in four large-scale studies across various countries (De Leo and Heller, 2008), where the sample sizes ranged from n = 731 to 11,572, depending on the study time point. This effect is observed in studies specifically with adolescents (Hawton et al., 2002; Doyle et al., 2015). Given the small sample in this study, further work is required to test this using a larger dataset.

Overall, some support for the IMV model was found. That several factors did not predict self-harm group membership cross-sectionally nor longitudinally may likely be the result of limited statistical power. The baseline self-harm groups consisted of 39 people in the enactment group, 43 in the ideation group, and 99 controls. At follow up, there were only 29 individuals in the self-harm enactment group, 27 in the ideation group, and 57 controls. While the sample sizes were deemed adequate for the analyses chosen, they may not have been sufficient to detect group differences if these existed, where cell sizes were small (e.g., there were only two non-bereaved individuals in the enactment group at T2). Risk factors for self-harm can vary significantly over time and even within a day (Kashyap et al., 2015), so estimating future outcomes from measures taken 6 months earlier is particularly challenging, especially when using a small sample. It is also possible that the IMV model does not appropriately model the relationship between certain variables, or may not be applicable to young people in a Scottish context. Given the absence of an association between various established risk factors (including defeat and entrapment) and self-harm in multivariate analyses, additional research is needed to determine whether these findings hold with a larger sample, and ultimately whether the model requires further refinement. Future research should also examine the difference between internal and external entrapment; we refrained from exploring this due to the small sample size.

Strengths and Limitations

This study contributes important knowledge regarding rates of adolescent bereavement in Scotland, by suicide and generally, and the results show that rates are similar to previously published research. It also adds to the growing body of evidence testing the IMV model with adolescent community samples, showing the potential utility of this theoretical framework. A major strength of this study is its longitudinal design. While there is existing cross-sectional research demonstrating associations between bereavement and self-harm thoughts or behaviours, this has yet to be properly investigated prospectively, especially with adolescent community samples. Most longitudinal studies have been based on hospital records or national health registers (e.g., Kuramoto et al., 2013; Rostila et al., 2013; Li et al., 2014), which can be advantageous in their levels of accuracy and completeness, but do not generally capture community-occurring self-harm which seldom presents to clinical settings. Second, the variables of interest were all chosen on the basis of theory, and the specific measures were selected due to their suitability for use with adolescents. Measures were also counterbalanced to avoid order effects. The main analyses adjusted for demographic and mood variables, consistent with previous research and thereby reducing the chance of confounding. Schools were recruited from areas across the country with varying degrees of socioeconomic deprivation. As a result, the sample was reflective of the demographics of the wider population.

We recognise there are limitations to this study, particularly related to the small sample size and statistical power. Challenges with recruitment for various reasons (including school unease about the nature of the study, low response rates from schools or parents, and attrition over the study period) meant that study uptake was slow. The criteria for participation also excluded pupils who had been bereaved within the last 6 months, as suggested by previous research (Dyregrov et al., 2011), however, this period of particular risk may reflect specific experiences and needs that could not be captured here. Future research may also benefit from investigating a time period of greater than 6 months, to understand the longer-term effects of suicide bereavement. In addition, missing data in quantitative studies is often inevitable and a rate of 15–20% can be typical of educational and psychological research (Dong and Peng, 2013). In this case, the rate of missing data across individual items in the study was relatively low, at 6.13%, and data was deemed to be missing completely at random. Nevertheless, this may have reduced the statistical power and led to biassed parameter estimates, despite that multiple imputation was used to address missing values. Finally, although age, gender and mood were controlled for in all analyses, we cannot discount the possibility of residual confounding.

Implications

These findings offer an important contribution to the limited literature on adolescent bereavement experiences and their relation to self-harm. Results highlight that self-harm ideation and behaviours are prevalent among Scottish youth, and a large proportion of adolescents have also been bereaved or exposed to the death of someone close to them. Given the potential consequences of bereavement, and particularly suicide bereavement with its association to adverse outcomes, understanding the extent and nature of this experience among adolescents is essential. As a test of a theoretical model, support is promising for some aspects of the IMV model, in particular identifying self-harm ideation and family self-harm as predictors of future behaviours. At the same time, evidence which was not wholly consistent with regards to the role of other variables within the IMV model, such as the impact of experiences of suicide loss, requires further investigation with larger samples to assess their placement within the model. In addition to guiding future research and theory refinement, our findings have implications on targets for clinical interventions and postvention. Efforts aimed at increasing family cohesion and social support, reducing unhelpful beliefs and attitudes about suicide (such as viewing suicide as glorifying), and targeting self-harm ideation before it becomes severe, may be especially effective.

Future research is needed to establish whether these results replicate with a larger group and with other types of bereavements. Further qualitative work would also be beneficial to understand the impact of surviving a loss beyond what questionnaire-based methods can provide. Research which includes people bereaved more recently (e.g., within the first 6 months after a death) would also help understand whether these results are applicable to all young people regardless of their length of bereavement, and would help inform immediate postvention responses according to need. Taken as a whole, this study provides novel insight into the experience of bereavement among young people in Scotland, and within the context of an emerging theoretical model of suicide, offers potential avenues for effective intervention.

DATA AVAILABILITY STATEMENT

The data underpinning this research are available on request. Anonymous data will be archived and made available from the United Kingdom Data Service, and linked to the University of Strathclyde's Research Data Repository. Some data will be removed in order to ensure participant confidentiality and privacy.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by University of Strathclyde Ethics Committee. Informed consent to participate in this study was provided by the participants' legal guardian/next of kin.

AUTHOR CONTRIBUTIONS

LC, SR, and SP contributed to the conceptualisation and design of the study. LC was involved in the acquisition of data. LC and SR contributed to the analysis of data. LC, SR, and SP were involved in the interpretation of results and writing of the manuscript.

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Suicidal Thoughts and Behaviors Among Swedish Suicide-Bereaved Women: Increased Risk Associated With the Loss of a Child, Feelings of Guilt and Shame, and Perceived Avoidance From Family Members

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Previous studies have shown that suicide-bereaved individuals may suffer increased risk of suicidal thoughts and behaviors (STBs) due to traumatic grief. In this paper, we present the self-reported rate of STB among Swedish suicide-bereaved women (*N* = 293). Data was collected in a cross-sectional anonymous survey on the homepages of Sweden's leading suicide survivor organization, SPES. We used logistic regression to evaluate risks (of any STB event) related to losing a child compared to other relatives and the experience of social avoidance from family members, as well as feelings of shame and guilt. The self-reported rate of suicidal thoughts, plans, and attempts was 60, 24, and 5 percent, respectively, considerably higher than in the general population. Results showed that all of the investigated variables were independent risk factors for STB (ORs ranged between 1.29 and 2.69). Women who had both lost a child and experienced family avoidance reported the highest STB rate (87.5%), and we found an interaction effect between these two risk factors (OR = 3.45; 95% CI = 1.05–11.32) that was related to self-reported shame. It is concluded that perceived responsibility for someone else's suicide, and the social avoidance associated with it, may play an important role for suicide survivors and should be targeted by postvention activities.

Keywords: suicidal thoughts and behaviors, bereavement, child bereavement, social avoidance, guilt, shame, postvention, women's health

INTRODUCTION

In Sweden, suicide is one of the most common single causes of death. With a population of 10 million people, approximately 1,500 individuals die by suicide every year (National centre for suicide research and prevention, 2019). Every death to suicide has a ripple effect and is estimated to deeply affect at least 6 to 14 relatives and close friends (Clark and Goldney, 2000; Jones and Meier, 2011; Jordan and McIntosh, 2011). Looking beyond the immediate group of bereaved family members and close friends, up to 135 individuals are in some sense affected by a single suicide (Cerel et al., 2018).

Various studies have pointed to the linkage between suicide bereavement and severe psychosocial stress and ill-health (e.g., Wilcox et al., 2010; Bolton et al., 2013; Heeke et al., 2019), and that people bereaved by suicide are at severe risk of suicidal behavior themselves (e.g., Diekstra and Garnefski, 1995; Crosby and Sacks, 2002; Runeson and Åsberg, 2003; Jordan, 2008; Erlangsen and Pitman, 2017). In a recent study, Erlangsen et al. (2017) showed that suicide-bereaved spouses have a six to eight times higher risk of completed suicide compared to the general population and also a significantly increased risk compared to individuals bereaved by other reasons (e.g., accidents and natural causes).

Bereavement after suicide seems to differ from other forms of grief (due to "other causes of death") regarding certain characteristics. Especially strong feelings of guilt, shame, stigmatization, social rejection, and isolation have been put forward as such characteristics (e.g., Bailley et al., 1999; Jordan, 2001; Harwood et al., 2002; Ratnarajah and Maple, 2011; Bell et al., 2012). Shame and stigma have historically, culturally, and religiously surrounded the suicide subject *per se* but also many of the underlying causes of suicide, such as psychiatric illnesses, drug abuse, and social problems (Westerlund, 2018). Guilt and blameworthiness may be due to that suicide-bereaved people in part see themselves as responsible for their close one's death (Jordan, 2001) and may feel that they should have recognized the signs and prevented the suicide (Lester, 2012).

Further, the social and cultural taboo and stigma surrounding suicide (Joiner, 2005: 6) may prevent the grief from being socially sanctioned, thereby causing bereaved individuals to withdraw and isolate themselves from their sociocultural context (Bailley et al., 1999; Jordan, 2001; Sveen and Walby, 2008; Feigelman et al., 2009; Peters et al., 2016). The taboo and stigma may also lead other people to avoid social contact with grieving suicide-bereaved individuals (Wagner et al., 2005). McMenamy et al. (2008) reported moderate-to-high levels of guilt among three quarters of suicide-bereaved subjects, and moderate-to-high levels of shame or stigma among one third. Moreover, a majority of the suicide-bereaved subjects in this study had severe difficulties in social contacts, especially with regards to communicating about suicide and sharing their grief with family members. This process of "disenfranchised grief" (Doka, 1989) can lead to an incapacity to accept the loss and create strong feelings of hopelessness and purposelessness about one's life and future (Neimeyer et al., 2009). The unresolved, traumatic, and prolonged grief, which has also been labeled as "complicated grief" (Stroebe et al., 2001; Latham and Prigerson, 2004; Mitchell et al., 2005; Tal Young et al., 2012), may lead to adverse psychosocial reactions and suicidal behavior (Hollander, 2001; Crosby and Sacks, 2002; Bell et al., 2012).

Other studies have also indicated that social isolation and avoidance—and related psychosocial factors such as loneliness, alienation, and lack of social support—could pose a serious risk for suicidal ideation, planning, and acts (Feigelman et al., 2008; King and Merchant, 2008; McMenamy et al., 2008; van Wijngaarden et al., 2014; McKinnon et al., 2016; Stickley and Koyanagi, 2016; Beutel et al., 2017). In a recent narrative review of 40 studies on suicide and social isolation (primarily systematic reviews, meta-analyses, narrative reviews, and original studies on larger samples), Calati et al. (2019) concluded that a vast majority of studies reported a positive association between social isolation and suicidal outcomes. The authors also concluded that both the objective dimension of social isolation (living/being alone) and the subjective dimension (feeling alone/loneliness) were related to suicidal thoughts and behavior.

The prevalence of self-reported suicidal thoughts and attempts among Swedish women is 15 and 5 percent, respectively (Public Health Agency of Sweden, 2018), but the exact risk among Swedish suicide-bereaved women has hitherto been unknown, and few risk factors have been established in a Swedish context. However, some studies imply that grief processes may be particularly difficult for parents whom are losing their children to suicide (e.g., Hollander, 2001; Jordan, 2001; Bailey et al., 2015). A possible hypothesis is that both society and mothers themselves perceive a greater sense of responsibility toward their children than they do toward parents, partners, or friends. If this were the case, their own sense of failing to take responsibility could turn into feelings of guilt and shame after their child's suicide, which in turn could add an additional layer of risk toward their own suicidality. At the same time, society's view of the mothers' responsibility may also exacerbate the complicated grief if it leads to greater social avoidance and a higher degree of "disenfranchisement," especially if the mother is already experiencing feelings of guilt and shame.

In this paper, we investigate (1) the prevalence of suicidal thoughts and behaviors (STB) among Swedish suicide-bereaved women, (2) the suicide risk related to losing a child compared to losing other kin, and (3) if such an elevated suicide risk can be explained by perceived social avoidance from family members and feelings of guilt and shame.

METHODS

Study Design

An anonymous cross-sectional web-based survey was constructed and addressed to individuals (over 18 years) who had lost a relative, a close friend, or a significant other to suicide. The survey was announced and made accessible to users on the official website and Facebook groups of Sweden's leading suicide survivor organization, SPES[1]. Data was collected and stored on a secure server between March 18 and September 04 in 2016 and allowed only one submission per IP address. Permission was granted from the administrator of the SPES website and Facebook groups. Ethical approval for the study was granted by the Regional Ethical Review Board in Stockholm 2016-02-11. A more detailed account of the design and methods has been described elsewhere (Westerlund, 2018).

Materials

The survey contained single item questions to measure gender, age, suicidal thoughts, plans, and attempts, the relationship/kinship to the person who had died by suicide, the perceived avoidance from family members, and feelings of

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[1] www.spes.se

guilt and shame. All participants (100%) also reported the time (number of years) that had elapsed since the death event (<1, 1–2, 2–3, 3–4, 4–5, 5–6, 6–10, or >10 years). Avoidance from family members was measured by a single item on a three-point scale (1 = Never; 2 = Sometimes; 3 = A lot). Feelings of guilt and shame was measured by single items on a five-point scale (1 = Not at all; 5 = Very much). The other items were Yes or No questions. All questions were phrased in such a way that they referred to psychological experiences occurring as a consequence of being bereaved by suicide; either soon after the event or during a process of prolonged grief [e.g., "Have you experienced that other people (in your family) have been clearly avoidant, unappreciative, or unhelpful with regards to your sorrow and pain, after the suicide of your relative/friend?"].

Statistical Analysis

A total of 327 responses were collected. Due to a very low percentage of males, we excluded participants who reported male gender (n = 31) or had missing data on gender (n = 3), to increase the likelihood of representativeness for females. Limited statistical power precluded analysis of suicide attempts alone (see **Table 1**). Therefore, suicidal thoughts, plans, and attempts were indexed into a single binary measure of suicidality ("Any STB"). The measures of guilt and shame were treated as continuous variables. All other items were originally categorical or ordinal variables and were transformed (dichotomized) to simplify the interpretation of the results. All analyses were performed in IBM SPSS version 25 with a significance level of 0.05 (two-tailed). Bivariate associations were estimated using Chi-square tests, Pearson correlations, and independent samples t-tests.

In the main analysis, we modeled STB using a three-step hierarchical logistic regression, always controlling for the effect of age (N = 275, after listwise exclusion of missing cases). We modeled the effects of losing a child versus losing other kin (partner, parent, sibling, other family relative, friend, other relations), the perceived avoidance from family members (dichotomized as "Not at all" vs. "To some degree" or "A lot"), and feelings of shame and guilt (continuous scores; 1–5). Importantly, we also modeled the interaction effect between child loss and family avoidance (Child loss × Family avoidance) and examined if such an effect was contingent on the level of guilt and shame reported by participants. The first step in the regression included age, child loss, and family avoidance; the interaction term was included in the second step; and guilt and shame were included in the third step. This specific sequence of entering predictors to the model enabled us to examine whether any interaction effect was contingent guilt and shame.

TABLE 1 | Rate (%) of self-reported suicidal thoughts, plans, and attempts (STB) in the total sample and separately for child-bereaved participants.

Group	Thoughts	Plans	Attempts	Any STB
All women (N = 293)	60.1%	23.5%	4.8%	60.8%
Missing data (% of 293)	1.7%	6.1%	6.5%	2%
Child loss group (n = 116)	69.8%	34.5%	4.3%	71.6%
Loss of other kin (n = 177)	53.7%	16.4%	5.1%	53.7%
Group difference (Pearson Chi-square)	$\chi^2_{(1)} = 8.74$; $P = 0.003$	$\chi^2_{(1)} = 14.67$; $P < 0.001$	$\chi^2_{(1)} = 0.04$; $P = 0.837$	$\chi^2_{(1)} = 8.40$; $P = 0.004$

RESULTS

Univariate and Bivariate Analyses

In the total sample of bereaved women (N = 293), the frequency of suicidal thoughts, plans, and attempts was about 60, 23, and 5 percent, respectively, and the index of any SBT was 61 percent (**Table 1**). Forty percent of the sample reported having lost a child to suicide, and Chi-square analyses showed that these women more commonly (relative to the other 60%) reported suicidal thoughts and plans, but not attempts. The risk of any STB was also significantly higher in the child loss group (**Table 1**). The amount of time (number of years) that had elapsed since the death event was typically a few years (median value = 2–3 years), but this variable was not statistically associated with STB [$t_{(285)} = -1{,}623$; $P = 0.078$].

The mean age in the total sample was 46.8 years (SD = 13.4; range = 18–79), and the mean age was significantly higher in the child loss group [56.6 vs. 40.3 years; $t_{(290)} = -12.58$; $P < 0.001$]. About half of the sample (53.2%) reported at least some degree of family avoidance. The mean shame score was 2.35 (SD = 1.44; range = 1–5), and the mean guilt score was 3.65 (SD = 1.35; range = 1–5).

Regression Analysis

The first model step ($P < 0.001$) indicated significant main effects of both child loss (OR = 2.69) and family avoidance (OR = 2.30), in the expected direction. The interaction term (child status × avoidance status) term was entered in the second step, but this did not significantly improve the model ($P = 0.059$). The model only improved significantly at the third step ($P < 0.001$), in which the shame and guilt variables were entered into the model. In this final model, there were no significant main effects of child loss, family avoidance, or age. However, the interaction term significantly predicted suicidal outcomes (OR = 3.45), as did shame (OR = 1.29) and guilt (OR = 1.31). Age was not significantly related to suicidal outcomes in any step of the model. The detailed test results from the regression are shown in **Table 2**.

Post hoc Analyses

Tests of bivariate associations were performed *post hoc* to disentangle the regression analysis and increase the interpretability of its results. Mainly, the effects of shame and guilt were examined using t-tests (because the P-values were virtually the same, we here report the results under assumption of homoscedasticity, even if violated). Firstly, there was a moderately large correlation between shame and guilt ($r_{\text{Pearson}} = 0.50$; $P < 0.001$), but both were independently

TABLE 2 | Results from binary logistic regression model: prediction of any STB (suicidal thoughts, plans, and/or attempts).

Model entry sequence	Predictors	Odds ratio (95% CI)		*P*-value
Step 1	Child status	2.69	(1.39–5.21)	0.003
	Family avoidance status	2.30	(1.37–3.85)	0.002
Step 2	Child status	1.72	(0.77–3.83)	0.186
	Family avoidance status	1.62	(0.86–3.04)	0.133
	Interaction (Child × Family avoidance status)	2.95	(0.94–9.27)	0.065
Step 3	Child status	1.55	(0.67–3.58)	0.304
	Family avoidance status	1.32	(0.68–2.57)	0.415
	Interaction (Child × Family avoidance status)	3.45	(1.05–11.32)	0.041
	Shame	1.29	(1.02–1.62)	0.032
	Guilt	1.31	(1.05–1.64)	0.016
Overall model statistics	All models controlled for the effect of age ($P > 0.05$ in all steps) Step 1, Omnibus test: $\chi^2_{(3)} = 22.29$; $P < 0.001$; -2 Log likelihood = 342.41; $R^2_{\text{Nagelkerke}} = 0.10$ Step 2, Omnibus test: $\chi^2_{(1)} = 3.57$; $P = 0.059$; -2 Log likelihood = 338.83; $R^2_{\text{Nagelkerke}} = 0.11$ Step 3, Omnibus test: $\chi^2_{(3)} = 20.27$; $P < 0.001$; -2 Log likelihood = 318.57; $R^2_{\text{Nagelkerke}} = 0.20$ (Final model Omnibus test: $\chi^2_{(6)} = 44.13$; $P < 0.001$)			

associated with STB in the expected direction [mean shame score difference = -0.70; $t_{(282)} = -4.06$; $P < 0.001$ (heteroscedasticity indicated); mean guilt score difference = -0.67; $t_{(280)} = -4.18$; $P < 0.001$]. Secondly, there was no significant difference in shame or guilt between the child loss group and the participants [mean shame score difference = -0.02; $P = 0.902$; mean guilt score difference = -0.25; $P = 0.132$ (heteroscedasticity indicated)]. Thirdly, the group of participants that reported family avoidance had significantly higher scores on shame while there was no such group difference in guilt [mean shame score difference = -0.58; $t_{(282)} = -3.43$; $P = 0.001$ (heteroscedasticity indicated); mean guilt score difference = -0.21; $P = 0.185$]. Fourth, a Chi-square analysis showed that perceived family avoidance was not more commonly reported in the child loss group (50.0%) compared to the other women (57.2%; $P = 0.229$). Fifth, we did not find any Pearson correlation with age (Shame: $P = 0.298$; Guilt: $P = 0.541$). Lastly, the amount of time (number of years) that had elapsed since the death event had no significant impact on the regression model (coefficient statistics: OR = 1.09; $P = 0.139$; details not shown).

Together, these *post hoc* tests provide an indication of why the interaction term was not significant when shame was not included in the regression. That is, the combination of child loss and family avoidance *did* imply a multiplicative risk of STB, but this interaction was mediated by shame, which was not in itself associated with child loss. Moreover, descriptive results (shown in **Figure 1**) may suggest that the additive risk of child loss + family avoidance created a ceiling effect, as 87.5% of participants in this subgroup reported STB. Hence, shame had a relatively small impact in this group, but was more critical for STB in the other subgroups (especially A and C). **Figure 1** shows the different STB rates in different subgroups according to shame levels (dichotomized at the median; Md = 2). However, guilt levels contributed less to the understanding of this interaction effect, as it was only directly associated with STB (and with shame). This is confirmed by the fact that the results of the regression were virtually unchanged when replicated without including guilt in the model (results not shown). Guilt is therefore not displayed in **Figure 1**.

DISCUSSION

This study aimed to investigate the rate of self-reported STB among adult Swedish women who had lost someone to suicide—with particular attention to women who had lost a child to suicide. Over half of the sample reported having suicidal thoughts (compared to 15% in the Swedish general population), and about five percent reported suicidal attempts (compared to 5% of the Swedish general population) (Public Health Agency of Sweden, 2018). Overall, these numbers were even higher in the child loss group. Due to the relatively small sample size, risk of self-selection bias, and other biases, these prevalence figures cannot be generalized. Nonetheless, they can be considered high by many standards, especially in relation to healthy populations. Considering that participants accessed the survey through a suicide survivor organization (SPES), the elevated risk of STB is not entirely unexpected. However, this is the first study, to our knowledge, to report such figures for Swedish women.

About half of the sample reported that their family, at least to some degree, had been "avoidant, unappreciative or unhelpful with regards to their sorrow and pain." A main effect was found on STB in this group (a 2.3-fold increased risk). Higher shame scores (but not guilt scores) were also associated with both family avoidance and STB, but not child loss. Finally, we found an interaction effect between child loss and family avoidance, but only when shame scores were held constant (for participants who lost a child the relative odds increased from 2.69 to 3.45). In other words, the co-occurrence of both these risk factors implied not only an additive risk (where 87.5% reported STB) but also a multiplicative risk. This interaction was found when the high-risk women were compared to other participants with equal levels of shame. However, since shame was only associated with family avoidance but not with the type of loss (losing a child,

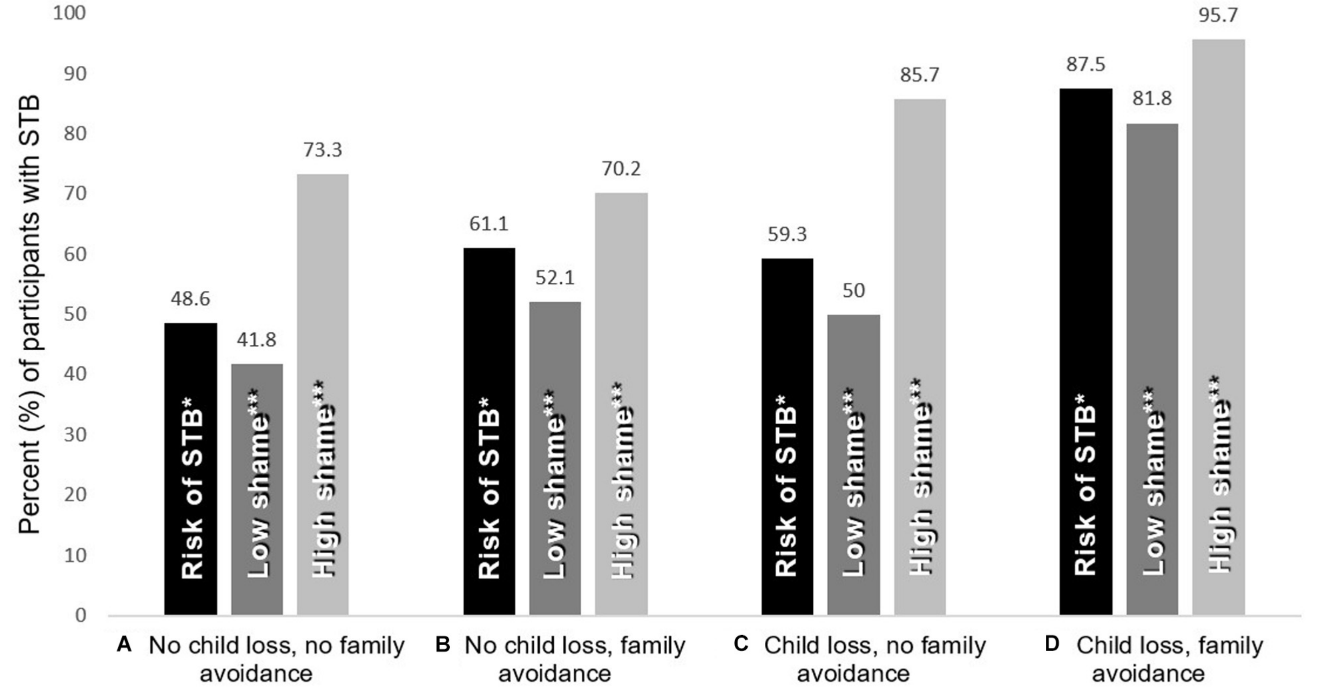

FIGURE 1 | Descriptive results for participants included in the Logistic regression analysis (*N* = 275). Rate (%) of suicidal thoughts and behaviors (STB) in various subgroups, according to variations in shame. The four groups **(A–D)** represent the 2×2 combinations of child loss and family avoidance status. *The STB risk when disregarding shame all together. **Shame levels split at median (Low=1–2; High=3–5).

spouse, parent, etc.), it remains unclear why this group is more vulnerable to STB in terms of shame. Moreover, guilt contributed less to our understanding of this interaction, as it was only directly associated with STB. In other words, participants who experienced both child loss and family avoidance evidenced the risk of STB regardless of whether they felt guilty or not. Although guilt and shame are often used interchangeably, the results of this study suggest that these are two somewhat different, even if related constructs (cf. Hastings et al., 2002). Further support of this is the finding that the items measuring shame and guilt only had 25% shared variance.

One possible understanding of why child-bereaved mothers are at increased risk for STB is that feelings of shame (poor self-image and self-blame) grow as a consequence of being socially avoided by family members (cf. Hollander, 2001; Grad, 2005; Bell et al., 2012; Bailey et al., 2015). This avoidance may be interpreted as a sign of rejection or punishment—even if it is not so intended—especially if one views the suicide as a sign of bad character and failure to take social responsibility (Jordan, 2001; Bell et al., 2012; Lester, 2012). Our data supports the notion that bereaved mothers have a particularly high risk of STB if they experience shame and/or if the family avoidance is associated with some factor that is unrelated to shame but still makes the grief process more challenging (e.g., loneliness). There are various signs of complicated grief that might discourage family members from expressing their sympathies, due to fear of negative emotional reactions (cf. Sveen and Walby, 2008; Feigelman et al., 2009; Peters et al., 2016). Poor knowledge and stigmatizing attitudes toward suicide and mental health problems might contribute to such social strains (cf. Wagner et al., 2005; McMenamy et al., 2008).

Limitations of the Study

The present study has a number of limitations, such as the cross-sectional design which precludes further investigation of temporal changes. Also, the retrospective character of the study may have caused a biased reporting, and the self-selective approach affects who chooses to participate (the most obvious example is the over-representativeness of females in the sample). However, our analysis of time (years elapsed since the suicide) indicated a neglectable effect of time, producing statistically non-significant effect in all main aspects, including the regression model. The study is also largely descriptive in its nature, as the reasons behind the suicidal acts, feelings of shame, and guilt, etc., were not investigated in further depth (e.g., we did not collect qualitative data regarding these issues). Therefore, the research questions and hypothetical mechanisms that we put forth in this paper can only be answered in terms of general statistical associations. For example, the study does not provide a clear picture of *why* some participants experienced more shame or family avoidance than others. Further, the cross-sectional nature does not allow any conclusions about the causal or temporal direction between these variables. Our conclusions are thus tentative, with regards to why child-bereaved mothers are at increased risk for STB, relative to other suicide-bereaved women.

Implications of the Study

The clinical implications of this study pertain to social support in the context of shame and self-blame. Public health-related postvention activities should aim to increase the chances of social support from close relatives, whereas psychotherapeutic interventions may target feelings of shame and guilt in an attempt to improve the grieving process. As Bell et al. (2012) have suggested, suicide-bereaved people need help and support to understand that the guilt, shame, and responsibility they feel for their relative's death in suicide is most often overestimated. However, therapeutic, psychiatric, and other interventions are probably not equally effective during all stages of a grieving process. Regardless of the statistical risk faced by this group of bereaved women, our results indicate that informal support (such as social acceptance) from one's family may be of similar protective importance. Hence, there is an imperative to longitudinally investigate critical stages in the grieving process, whereby psychological construct such as guilt and shame should be treated as targets of therapy. Qualitative studies may shed light on the psychological mechanism that should be targeted by clinical intervention. Public health initiatives should also be stimulated in order to identify bereaved individuals at risk of self-harm, using for example larger quantitative datasets and electronic health registers.

Conclusion

In this study, we found a high self-reported rate of STB among Swedish suicide-bereaved women. We also found that women who had lost a child were at increased risk of those outcomes (except suicide attempts). Although the child loss group was not more prone to report avoidance from family members, the subgroup of bereaved mothers who did experience such avoidance were at especially increased risk of STB. However, we also found that feelings of guilt and shame were important predictors of STB. Shame was particularly important in mediating the interaction (i.e., the exacerbated risk) between child loss and family avoidance. Almost all (over 95%) bereaved mothers who reported both family avoidance and high levels of shame also reported STB and should be offered appropriate postvention.

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available on request to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the Regional Ethical Review Board in Stockholm. Written informed consent for participation was not required for this study in accordance with the national legislation and the institutional requirements.

AUTHOR CONTRIBUTIONS

MW and SH were the main contributors to the production of this manuscript, to which GH made important intellectual contributions. MW conceived of the original study, designed the questionnaire, conducted the survey, and collected the data. SH conceptualized the analytic plan and conducted the statistical analysis. GH made intellectual contributions to the analytic plan and results interpretations. MW and SH authored the manuscript to which GH made substantial contributions. All authors read and approved the final manuscript.

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Research-Based Theater and "Stigmatized Trauma": The Case of Suicide Bereavement

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Background: Existing research shows that family members who suffer the loss of a loved one through suicide often experience self-blame and shame, and that this limits their grieving process. It can also lock them into stigmatized positions and the notion that either *somebody* or a *dysfunctional family* is to blame for the suicide.

Aim: This article investigates from a narrative perspective how a theater play might counteract the stigma that surrounds suicide bereavement by contributing destigmatizing understandings of suicide.

Methods: A theater play was performed in a churchyard theater in Stockholm, Sweden, in 2019. Audience members were asked to write down their free reflections on a form distributed at the theater. In particular, they were asked to assess *whether* they found the play related to their own lives and, if so, *how*; and to describe *what* they had learned. Their written reflections [$N = 41$] were analyzed from a narrative methodological perspective to investigate their responses to the play. Three categories of audience member were identified from their responses: people with their own suicide bereavement experiences; people with similar but different experiences of stigmatized trauma; and people who did not report any experiences of suicide or stigmatized trauma.

Results: The suicide-bereaved generally reported familiarity with the thematic performed, in particular the "why question," the blame and shame responses and the silenced family communication. Most of these aspects were also shared by those affected by other types of stigmatized trauma. Respondents from all categories emphasized how they had learned that suicide is a desperate rather than a deliberated act, caused by overwhelming emotional pain or depression. Ultimately, suicide was perceived as an involuntary death caused by complex interacting factors linked to both inner vulnerabilities and stressful life events, for which no one was to blame.

Conclusion: The results show that research-based theater is a time-limited and cost-effective method of introducing alternative meanings and identities to both individual mourners and the broader cultural context from which stigma originates, and how it can have destigmatizing effects on a stigmatized trauma such as suicide bereavement.

Keywords: bereavement, meaning-making, narrative, self-formation, stigma, suicide, theater

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INTRODUCTION

Rationale

It has been established in research that stigmatizing notions of suicide constitute a particular circumstance that suicide-bereaved family members need to manage during their grief, in addition to the loss itself (Sudak et al., 2008; Jordan and McIntosh, 2011). People bereaved by a suicide in the family testify in several studies how they feel ashamed and tainted by the suicide, and that their self-perception is negatively affected as a result (e.g. Sterner Demi and Howell, 1991; Cvinar, 2005; Sveen and Walby, 2008; Feigelman et al., 2009; Peters et al., 2016; Silvén Hagström, 2016). This stigmatization process has been described as dual, since a socio-cultural pressure is exerted on the suicide-bereaved from both within and without (Dunn and Morrish-Vidners, 1988; Silvén Hagström, 2013). The mourners themselves perceive suicide as a morally deviant death and ask themselves *why* their loved one *chose* to die (Loy and Boelk, 2014; Silvén Hagström, 2019). They also commonly take on the blame and shame for failing to prevent the suicide – or even for causing it (Cvinar, 2005; Peters et al., 2016; Silvén Hagström, 2016). At the same time, suicide-bereaved family members describe in research the negative responses they encounter within their social networks after the suicide (Allen et al., 1994; Chapple et al., 2015; c.f., Sheehan et al., 2018). Social insecurity (Dyregrov, 2004) or "empathic failure" (Feigelman et al., 2009) linked to stigmatizing interpretations of suicide make it difficult to acknowledge the family members' grief and offer them support. This is also known as "disenfranchised grief" (Neimeyer and Jordan, 2002). The suicide-bereaved commonly report how individuals in their social circle avoid communication about the deceased family member and the suicide, and how a tense atmosphere usually arises when such topics are initiated by the bereaved themselves. It has also been reported that people distance themselves to avoid confronting the circumstances of the suicide, and how negative responses can also be directed toward the bereaved family, such as anger, explicit accusations and outright rejection (Allen et al., 1994; Feigelman et al., 2009; Maple et al., 2010; Silvén Hagström, 2013; Peters et al., 2016). All these non-supportive responses reinforce an already stigmatized position in grief, and make it difficult for the bereaved family to *talk* about the suicide and process the loss.

The understanding of suicide as an anomalous behavior, where blame is to be attributed to an immoral individual or a dysfunctional family, is rooted in Western culture (Minois, 1999; Cvinar, 2005). In the Middle ages, suicide was conceived as a banned act; and as both a religious sin – since only God has the power to give and take away life – and a criminal offense. Suicide and suicide attempts were associated with severe penalties; for example, the deceased through suicide was not allowed to be buried in consecrated ground. Sanctions were also directed at grieving family members, who commonly had to pay an extra tax to the church and were socially excluded from the community (Cvinar, 2005). Such authoritarian practices no longer apply in contemporary Western societies, but recent research, as shown above, demonstrates how stigmatizing practices still exist. This indicates that prevailing understandings of suicide as a deviant and morally norm-breaking death caused by individual responsibility still operate in social interactions, and the question of *who* is to blame for suicide is still present in the Western cultural meaning-making of suicide (Silvén Hagström, 2016; c.f. Turchi et al., 2019).

Taken together, since suicide-bereaved family members suffer emotionally and commonly lack social contexts for support, they are particularly vulnerable to developing psychological ill-health themselves, such as complicated grief, depression and suicidal behavior – and even to suicide (Runeson and Asberg, 2003; Cerel et al., 2008; Feigelman et al., 2009). It is therefore vital to equate postvention efforts directed at relatives affected by suicide with suicide prevention (Andriessen, 2009; Jordan, 2017). This also highlights the urgency of finding new ways to understand and facilitate grieving processes among the suicide-bereaved to promote their health and wellbeing. This article assumes, based on research, that stigmatization hinders the grieving process after a suicide in the family. It aims to investigate from a narrative perspective how a theater play might counteract stigma in suicide bereavement by contributing destigmatizing understandings of suicide.

A Social Constructionist and Narrative Perspective on Suicide Bereavement

When striving to counteract the adverse health effects of suicide on mourning family members, it is important to understand the psychosocial processes of suicide bereavement. The present article is grounded in a social constructionist and narrative theoretical perspective on loss, grief and trauma (Neimeyer and Sands, 2011; Neimeyer et al., 2014). This conceptualization is based on Parkes' (1971) theory of how a traumatic experience fits into an individual's existing "assumptive worlds" and Janoff-Bulman's (1992) theory on "shattered assumptions." According to these theories, traumatic events can shatter basic, taken-for-granted assumptions about the life world and the self, as it is no longer possible to identify with them. Such basic assumptions commonly suggest that the world is a benevolent, fairly safe and predictable place, and that the individual as a member of it is meaningful and morally worthy. Non-normative deaths – and suicide in particular – are by their nature more incomprehensible and thus represent a greater challenge, and usually provide a "shock effect" to the mourner's existing world of meaning (Neimeyer and Sands, 2011; Sands et al., 2011 p. 249). The mourner's ongoing autobiography is thus disrupted and contested by the suicide event, which causes a potential *crisis of meaning* (Neimeyer and Sands, 2011; c.f. "biographical disruption" and chronic illness Bury, 1982).

Thus, grieving is mainly understood as a narrative process that aims to construct new meanings and identities in the wake of profound loss. Just as with stigmatization, such meaning reconstruction is a process that occurs both *within* and *between* people. The social aspects of this process correspond with the need to search for significant personal meaning while at the same time attempting to validate this meaning in social interactions with others. Accordingly, grieving is described as:

"a situated interpretive and communicative activity charged with establishing the meaning of the deceased's life and death as well as the post-death status of the bereaved within the broader community concerned with the loss" (Neimeyer et al., 2014, p. 485). Meaning can, however, also be searched for and negotiated outside of such immediate social networks, and through the use of artistic forms of expression such as writing, painting or participating in theater (Silvén Hagström, 2014; Thompson and Neimeyer, 2014).

From this social constructionist and narrative theoretical viewpoint, it is assumed that the meaning which mourners find through such situated, interpretive and communicative activities is either necessarily congruent with the meanings that permeate the larger sociocultural context, or represents an active form of resistance against them (Currier et al., 2006). Since the theater play analyzed contributed destigmatizing understandings of suicide, it is suggested that it should be viewed as a counter-narrative to existing prejudicial perceptions of suicide that permeate society (Andrews, 2004; c.f. Silvén Hagström, 2014). As such, it could potentially affect both an individual audience member's sense-making of suicide, and negative attitudes to suicide more generally.

Suicide as a Case of "Stigmatized Trauma"

An inhibitory factor for narrative meaning reconstruction in suicide bereavement is stigmatization (Silvén Hagström, 2016). Goffman (1963) defined stigma as a process of identification and othering, whereby individuals who are associated with a stigmatized condition through social interaction are discredited and positioned with an undesirable social status. Nowadays, the terms *stigma through association* or *associative stigma* are used with reference to an extended stigma that denotes the negative attitudes and actions taken against the family members, friends or others linked to a socially stigmatized individual (Burk, 2007; van der Sanden et al., 2015). The term *family stigma* has also been used to explain the gossip, patronizing remarks, criticism, unsolicited advice or avoidance directed at family members of individuals who belong to a stigmatized group, such as those suffering from psychological problems (Larson and Corrigan, 2008; Moses, 2014). In the case of suicide bereavement, in addition to the reported suffering of public stigma that appears in responses in the mourners' social lives, grieving family members also commonly exercise *self-stigmatization* (Dunn and Morrish-Vidners, 1988). This is a process by which the same sociocultural understandings of suicide are internalized by the bereaved and directed toward themselves as a form of self-criticism (Cvinar, 2005; Feigelman et al., 2009; Silvén Hagström, 2013; Silvén Hagström, 2016). Such dual stigmatizing processes have been discussed as a potential contributory factor to suicide (Schomerus et al., 2015). Hence, self-stigma can induce negative emotional reactions, social withdrawal and feelings of hopelessness, which in turn can lead to the individual experiencing reduced social belonging and difficulties talking about the psychological distress. In addition, both public stigma and self-stigma are associated with reduced willingness to seek professional help (Schomerus et al., 2015).

In this article, suicide is understood to result in the tentative concept of "stigmatized trauma". This concept indicates that suicide is usually perceived as a traumatic loss that induces stigmatizing responses within the suicide-bereaved family members and their social circle. In line with the above, stigma is assumed to constitute a barrier to communication and help-seeking that can negatively affect the grieving process by complicating the construction of manageable meanings and moral identities in the wake of suicide. Other cases of stigmatized trauma are substance abuse, domestic violence and sexual assault, as well as many other life- and self-changing events, that for reasons of self-blame and shame are usually surrounded by silence.

Theater as a Means of Combating Stigma

Theater has a long history of being considered a means of contributing to psychological, interpersonal and social change. Hence, from a theater theoretical perspective "theater in all its manifestations, is essentially concerned with change" (Landy and Montgomery, 2012, p. ix) [. . .] and "when applied to learning, social action and therapy, performance becomes a means for changing understanding, power dynamics, consciousness, and behavior" (Landy and Montgomery, 2012, p. xii). This implies that a theory of change exists in all theater projects regardless of whether that theory is articulated (Kushner et al., 2001), and that all projects are predicated on what someone thinks the participants need and the strategies that will enable them to meet those needs. Importantly, however, theater should not want to change *people*. Instead, as Kushner et al. put it, "theater presents information, emotions, and ideas so to create a condition in which if people wanted to change their ideas or emotional orientations, they could. But the objective is not to change but to invite certain kinds of change" (ibid., p. 66).

There are various examples of how theater has been used for therapeutic purposes to help people to process obstacles in life and strengthen their agency – so-called "therapeutic theater" (Snow et al., 2003; de Aguilera et al., 2018). In one such project, people with psychological problems contributed their narrated experiences to a theater play to be performed by actors. The study participants thus became both constructors and audience, allowing them to gain a deeper understanding of their own psychological condition and to develop coping strategies to adjust to depression, anxiety and distress (Animbom Ngong, 2017).

Theater has also been used with the aim of contributing to interpersonal and social change, not least in work to reduce stigma (Landy and Montgomery, 2012). "Playback theater" was used in a project involving people receiving care within mental health services (Yotis et al., 2017). These individuals were able to stage difficult self-experienced situations to an audience consisting of people who do not usually come into contact with those suffering from psychological ill-health. This theater format, based on the sharing of life experiences of prejudice and discrimination, was discussed as a contributory factor to people taking a stance against existing negative attitudes, and to a decrease in social distancing and the fostering of a community.

In another project, "research-based drama" was used to counteract stigma among people diagnosed with dementia (Mitchell et al., 2019). This performed drama was produced in a collaboration between researchers, theater producers and actors. Like the present study, this performance – which could also be called progressive or political theater – sought to combat stigma by contributing to a better informed understanding among the public of the complexities of the reality of living with dementia. Hence, as the authors put it: "understanding stands in defiance of stigma and can help individuals and societies to see the others' shared humanity and personhood rather than the difference and judgment" (ibid., p. 22). This research-based drama was shown to have potentially contributed to change on three different levels: first, a changed understanding through the ability to empathize with the other's perspective; second, an emotional or physical impact, such as feelings of sadness, anger and anxiety, through identification with the protagonists; and, third, changed behavior, demonstrated by reports that audience members would now respond to people with dementia in a different way (ibid.).

MATERIALS AND METHODS

Study Design and Material

Production of the theater play "The abyss: A performance about meeting one's past" was based on previous research on young people's narration of their experiences of parental suicide – so-called "research-based theater." A latent yet clear objective of the play was to inform people about suicide bereavement and to support them to construct destigmatizing understandings of suicide, by highlighting depression and emotional suffering as contributory factors rather than individual responsibility. Hence, the play was assumed to have the potential to assist with psychological processing among the suicide-bereaved and a changed attitude to suicide more generally. Ultimately, the intention was to promote health and wellbeing among those associated with suicide.

The study developed gradually and was carried out in four steps: In a first step, the playwright contacted the author for an interview on her own initiative after having read her previous articles. The playwright's aim was to inform herself further on the subject as a basis for writing a theater play. In a second step, the playwright wrote the script alone based on what were described as central elements of young people's parental suicide bereavement experiences. The author of this article had a peripheral role in the production process but was mainly a source of knowledge with no intention other than to provide ideas for inspiration. The idea of the present study, to follow up the play from an audience perspective, arose only after having read the completed script. In a third step, the theater play was organized, staged and rehearsed in collaboration between the playwright, the director and the actors. In the meantime, the author constructed a reflection form with the aim of collecting the audience members' narrated experiences and thoughts of the theater play as it was performed. In a fourth step, the analysis of the written reflections was conducted – a process that will be described more in detail in the analysis section below.

The play was performed by two female actors at an intimate churchyard theater in Stockholm, Sweden, on 13 occasions during the spring of 2019. The theater environment consisted of a bare stone house surrounded by gravestones. It contained a stripped-down scenography and plastic chairs were lined up for the audience on both sides of the stage floor. The audience consisted of about 40 people and was dominated by women in mid- to late middle age. The play was 1-h long. After the play, the playwright informed the audience about the present study and its aim: to collect and analyze the audience members' written reflections in order to investigate how they had been affected by a theater performance of this kind. The audience members who wanted to participate in the study were instructed to take an information leaflet and reflection form as they left. The written material encouraged the study participants to reflect freely as all thoughts were welcome, but also to consider *whether* they found the play related to their own lives and, if so, *how*; and *what* they had learned.

Altogether, 41 audience members aged between 37 and 75 (34 women aged 37–75, and 7 men aged 44–67) sent their written reflections to the article author. The reflections differed in length and narrative richness, but it was a rule rather than an exception for there to be a longer written text in which the content of the play was discussed in relation to the person's own life experience and perspective.

Ethical Considerations

The study participants' written reflections are understood as personal material in that they contain descriptions of emotionally sensitive life events and vulnerable situations. At the same time, the participants were informed about the purpose of the study and that the reflections would be published. As a precautionary measure, a decision was taken to alter the ages of the respondents who are quoted, as well as any personal information that might directly reveal their identities.

A Narrative Analysis of Audience Members' Storied Responses

The participants' written reflections of the theater performance were analyzed using narrative methods with the purpose of identifying the central themes and meanings of their content (Riessman, 2008). Accordingly, each reflection was read and analyzed as a narrative whole to see *what* the participants chose to communicate to an imagined reader/the article author based on the questions on the form. Of particular interest in the analysis was to examine *how* suicide was interpreted, given that this study aims to investigate the potential for the integration of alternative destigmatizing meanings of suicide.

The narrative analysis was undertaken in the following three steps. First, the writings were categorized according to the question: "Does the play relate to your own life?". In response, the participants usually set out their position in relation to suicide in their introduction, as a starting-point for their reflections. Three categories of audience member were thus identified and categorized from their writings: people with their own suicide bereavement experiences, people with experiences of other types of stigmatized trauma and people who did not report any experience of suicide or stigmatized trauma. Second, the written reflections within each category were analyzed more deeply according to the "*How*" aspect of the first question, as well as a second question: "*What* have you learned?". This analysis revealed what the participants recognized in the play from their own lives, and what they took from it in their current position in relation to suicide or other significant life experience. In the case of the final category, however, the reflections were not primarily related to personal experience. Finally, the participants' interpretations of suicide were analyzed with regard to the meaning they attributed to it in their reflections; for example, whether suicide was seen as the fault of the suicidal individual or the bereaved family, or caused by other more complex and uncontrollable factors. This was to evaluate whether the participants' understandings were consistent with a stigmatized attitude to suicide, but also to identify whether any change in attitude was described as having occurred.

The Storyline: Two Daughters Struggle to Communicate and Resolve the Question of *Why* Their Father Committed Suicide

The theater performance portrayed two sisters – Alice and Theresia – who had never talked about their father's suicide, which had occurred when they were 13 and 11 years old and led to the creation of a wall of silence in the remaining family. Their father's suicide was referred to as when he "vanished". In school and within the family's social network, the sisters told of how the suicide was surrounded by insecurity and silence.

Alice, the older sister who is portrayed as the responsible and more controlled of the two, discloses to the audience that she has always been jealous of Theresia, who was "daddy's girl." While she has only fragmented memories and no photographs of her father, Theresia has several photographs of just her and her father, and she declares that she had felt very close to him. Theresia acts the emotional, care-free and humorous one – perhaps in perceived similarity with their father. The main intrigue revolves around Alice, who is now in her 40s and has begun psychotherapy in an attempt to understand why her father committed suicide. In her search for meaning, she reaches out to Theresia and their mother to start talking about the suicide. However, the performance illustrates the barriers to finding such common ground for communication. Both sisters, in their lonely positions of grief, express deeply embedded feelings of abandonment, yearning, sadness and anger linked to the confusion around how to understand their father's suicide. The silent interpretation until now had been that their father had *chosen* to commit suicide – that he had made a deliberate decision to leave his daughters and this world behind.

Eventually, the sisters' searches for meaning are intertwined as they turn to different sources for information. Theresia goes through a bag of the father's personal belongings and visits his grave to talk to him in a "continued bond" of grief (Klass et al., 1996; Wood et al., 2012). She walks around wearing his shirt and sunglasses in an attempt to reconnect with him and in retrospect to try to read his mind. Alice, on the other hand, reads her father's hospital records and decides to ask their mother for answers. Her mother's long-lasting silent meaning-making was that her daughters' father, who had been discharged from a psychiatric ward on the day of his death, had taken his life because she wanted them to live apart. In a separate scene, the audience gets to know their father before his suicide. He is portrayed as bedridden and severely depressed with no capacity to care for his daughters – Alice almost drowns as a result. The mother is seen as a caring partner who finally reaches the limit of what she can cope with. In the new conversation with Alice, however, the mother paints a different, more amiable, picture of her father – as a funny, smart and wonderful person – when not depressed – who she had loved deeply.

A parallel intrigue emerges as the mother discloses to her daughters that a witness to their father's suicide had contacted her about giving her a letter in connection with his death, but that she had declined his visit. At the end, the remaining family members in their search for answers decide to meet "the man on the bridge" to hear his story. This now aged man tells how he had tried to convince their father not to jump, but to stay alive. He had clung on to his coat, before their father had struggled free. In the fall, a letter had fluttered out of the coat and landed next to him on the bridge. Now, almost 40 years after the suicide, the three women open the envelope. It contains only an old photograph of the three of them together. On the back is written: "Sorry, I can't manage anymore. I love you." The letter allows the daughters to renegotiate their understanding of their father's suicide: he had no conscious intention to leave them; he loved them but was suffering from severe depression and was desperate to end his emotional pain. In the final scene, the daughters stand together on the bridge. They look down into the abyss and up at the sky and speak out loud, "farewell dad, farewell dad," in a gesture of reconciliation and parting.

RESULTS

The Responses by the Suicide-Bereaved

The analysis of the written reflections by the suicide-bereaved study participants ($N = 12$) showed that their narrative thematic contained two main themes with a strong recognition of their own experience of suicide loss and its effects. These themes were silenced family communication and hindered meaning reconstruction in grief. Their interpretation of suicide was shown in their recapitulation of their lived experience, as well in the interplay with the meanings introduced through the theater performance. Some of their reported thoughts and their own experiences of suicide bereavement are set out below.

A Silenced Family Communication Linked to Suicide Being a Stigmatized Death

A major part of these participants' writings touched on their experience of restricted family communication and the effects it had on them. This 60-year old woman is a case in point. She depicted her lonely position in grief following the traumatic loss of her brother through suicide, and stressed the importance of being able to talk about it.

> Thank you, it was a very well-performed play of a trauma that follows you your entire life. Losing a loved one through suicide is so difficult and special. I lost my brother 4 years ago and life has changed a lot. I had always felt like a confident person, but no longer. The worst has happened already, but it is like I always think that something new is going to happen. I am a member of SPES [a Swedish NGO for the suicide-bereaved] and it is very good for me to share what is hard with others who have been affected. There is far too little talk about suicide. When it happened to me, I thought we, my family and friends, would talk about him and how we felt. But that was not the case. Instead, it was expected that you should move on after a while. Sure, life goes on, but it is an unimaginable pain when someone you love is unable to live. What I take with me from the performance is how suicide affects everyone in a whole family, and that you must talk about it and not hide.

In the play, the family's neighbors gathered in their gardens and chatted over the fence, as they tried to make sense of the suicide by putting all the pieces together in a somewhat sensation-seeking way. This 46-year old woman recognized how she too was affected by such gossip in her social network following her brother's suicide. In chorus with the previous writer, she emphasized the importance of open family communication, of acknowledging differences in experiences of loss and grief, and of exchanging support, but also of constructing shared memories of the life lived with the deceased.

> I think it is very important to highlight siblings' different experiences of their father's illness and suicide in this way, but also what the silence can do to you. I recognize so many things, not least the talk among the neighbors and how rumors and stories are created. I think it is very valuable to be able to talk about what happened within the family, and to find a kind of joint strength. Because it is hard to share the experience with someone who has not had the experience and/or who did not know the deceased person. To be able to share the lighter memories is important as well.

This man of the same age lost his father in an accident and later his brother through suicide. He recognized himself in the jealousy conflict between the sisters and reflected on the devastating consequences of unprocessed grief in the family – when it is not possible to reconcile with each other and exchange support.

> What I take with me are my own experiences from when my father died (46 years – accident) and how it affected my brother who later committed suicide. The importance of perceived balance and love... A family where jealousy eats you up from inside and makes it difficult to cope with and sort out relations, especially the difficult and complex ones, when they are important...before it is too late.

In the case of this 61-year old woman, her grandmother's suicide was a well-kept family secret, while her mother's psychological ill-health was a reality she needed to cope with throughout her childhood. Her reflection contains sadness and disappointment that her mother did not receive the support she needed, through open family communication or professional assistance, to create meaning after her mother's suicide. This could have prevented a complicated grief from affecting future generations.

> I grew up myself with a mother who never got to know whether her mother, my grandma, died by accident or suicide. Mum died some months ago, and her ignorance followed her to the end. The uncertainty and unprocessed grief affected her tremendously and she went through deep depressions, which affected the whole family. With my, even incomplete, knowledge about suicide and psychological trauma, I am convinced that my grandma committed suicide and made it look like an accident. My mum never got to talk to someone professional about her uncertainty and grief. This had devastating consequences, because she was only 14 when she lost her mother. [...] A play such as this can facilitate difficult conversations about suicide and help many to understand the underlying causes and thereby support grieving. Thank you!

Similarly, this 72-year old woman described how the theater play opened up closed doors to the suicide secret in her family, which had had a deep impact on her life.

> I came into contact with things that have been unmentionable for a long time. My mother's first husband committed suicide; he shot himself when my oldest sister was a couple of years old. The facade was that he had died of pneumonia. My sister found out the true history by accident. Our aunt mentioned it in passing. Of course, she thought we knew. My sister was then 45 years old. My mother suffered this trauma until her death without telling us children, which of course affected our relationships and our childhoods.

A Hindered Meaning Reconstruction in Grief and Theater as Facilitator

Like the sisters in the play, this 55-year old woman described her long struggle to make sense of her father's suicide in childhood. She underlined her need to recurrently process her paternal loss throughout her life and the healing effect the performance had had on her.

> I have my own experience. My dad killed himself when I was 7 years and 10 months old. My 5-years older sister was just 12 years old. I have tried to process the event through therapy and by seeking answers from my mother, while she was alive. It was hard, however, to reach her all the way. I have also written a monolog that was performed in a theater. STILL – this performance resonated with me at various sore points that can still cause pain. The performance did not try to hide anything, play anything or take a stand for right and wrong, which I believe contributed a lot to me being touched – despite having spent YEARS trying to understand what happened in May 1971, and how it has affected my entire life. Having to constantly carry this pain, sore spot in my heart, is and has been very exhausting. It never ends. But it was like a healing, nurturing hand – to see the performance that faced the issue so openly and sincerely. Thank you!

In some cases, it became evident how the play had contributed to an actual *change* in the participant's understanding of suicide. This 65-year old woman lost her cousin through suicide at a young age. She described how the play made her renegotiate her previous standpoint in relation to suicide; from the interpretation that a dysfunctional and secretive family caused the suicide, to a realization that suicide is caused by depression and unbearable emotional pain. This new destigmatizing interpretation has in previous studies been connected with health-promoting coping strategies, by changing the focus from *who* is to blame for suicide to *what* caused the suicide (Silvén Hagström, 2019). In this case, this new benchmark for reflection on suicide was explained as a potential starting point for reconciliation with the suicide-bereaved family.

> It was a strong and well-performed play. I was particularly moved because my cousin took her own life when she turned 20. I really took to heart the idea that you commit suicide because you are sick, under the influence of extreme anxiety and suffering. It was a relief to me. It can dissolve the feelings of guilt and shame that emerge, especially when someone takes their own life at a young age and one wonders if one could have done more to save that person's life. Perhaps a process of reconciliation has begun with me, especially toward my cousin's parents. I wanted to find the "guilty" and thought it was a dysfunctional family with secrets. It was perhaps a way to keep the "darkness" away from *me*. Thanks for the play!

This 60-year old mother attended the play with her grown-up daughter on the anniversary of her son's suicide. He is buried in the cemetery outside the theater. She recognized the experiences of self-blame in grief and said that she perceived the play as very meaningful. There was also an indication that it supported her meaning reconstruction in grief.

> So nice (drawn heart) that we could participate. It was the same day 3 years ago that we had the funeral for Lars, Anna's 3-years younger brother, our forever missed and beloved son. So terribly difficult and sad. [. . .] My son ended up in the abyss. I use the word because it feels true and it is how I have described what happened to him before. Like a steep edge. . ..He tried following persistent low moods/feelings of depression to commit suicide several times. He died June 21, 2016 and I was the last person who saw him, and also the one who found him and in vain tried to revive him. Darkness. . .pain. For me it is like his soul has been set free and gained peace. We who remain on earth are the ones who need to struggle. Seeing this play was very meaningful. It is so easy to believe that there is something wrong with you in the wake of such loss. I struggle and learn every day. It is important to take time and not hurry. It was nice for us to come together (drawn heart). Thank you!

Some of the audience members were in their late middle age or older. In some of their reflections, it was emphasized that this kind of insight would have been extra valuable in connection with a parental suicide in childhood or youth, since the majority of their life had passed and been negatively affected by the suicide. This 65-year old woman briefly stated:

> I have my own experience of suicide in my family, my father when I was 6 years old. The play felt meaningful and it would have meant a lot to me if I had got so see something similar earlier. A very good play.

In sum, the written reflections by the suicide-bereaved participants show how they felt familiar with the main themes of the play and were supported in grief by the new meaning-makings of suicide that were introduced. These were said to relieve self-accusations and finger pointing in grief. In particular, the suicide-bereaved participants described silenced family communication as the greatest impediment to grieving, since it makes it difficult to share and validate emotions within the family and to construct a common understanding of suicide.

The Responses by Those Suffering From Other Types of Stigmatized Trauma

Some of the reflections ($N = 5$) were written by people affected by other types of stigmatized trauma, such as having grown up in a family with a parent with a history of mental illness or substance abuse. In these cases, the play was interpreted more broadly as an example of how emotionally challenging and stigmatizing life events can be managed in a family context. In common with the suicide-bereaved participants, the reflections were concentrated on the main theme of a silenced family communication and the subsequent difficulties in comprehending and processing such childhood experiences. In their meaning-making of suicide, these similarities between suicide bereavement and their own traumatic and at the same time stigmatizing experiences are stressed, with reference to blame and shame responses in the family that hinder open communication and prevent access to support.

A Silenced Family Communication About Stigmatized Family Troubles

This 54-year old woman recognized the sadness of not being able to have the relationship you had hoped for with your siblings and parents due to stigmatized family troubles. In line with the meaning-making of suicide throughout the play, she underlines the involuntary nature of suicide – that it is never a free choice – and expresses gratitude for the opportunity to reflect and to be introduced to new perspectives.

> So much of people's lives in just 1 h! I recognized myself in most of it. Neither of my parents committed suicide, but they had big problems and issues with mental illness and substance abuse. I recognized myself in the position where you as an adult cannot have the relationships with your siblings and parents that you had hoped for. It feels empty and unsatisfying. As a mourning for the rest of your life where new relationships and attachments are affected. If he chose to take his life, did he also choose his previous depression? The suicide is rather a valve that becomes a permanent solution to a problem that is probably treatable and transient. I believe that the play is about reconciliation . . .. A warm thank you for this beautiful, high quality and easily accessible performance that gives us the opportunity for important reflections and new perspectives! (drawn flower).

Similarly, this 62-year old woman grew up with a father with an alcohol problem. She recognized the silenced family communication in the play – aiming to conceal the problem – and the sisters' need to search for answers in relation to their father's psychological suffering and subsequent death.

> I have carried my father's long-drawn-out suicide with me my whole life. He was an alcoholic. My family couldn't "save" him. Ola's [the father's] behavior in the play reminded me very much

> about my father's difficulties talking about his inner life and the humor that existed in parallel to the abyss. Just like Alice, I decided to request my father's hospital records. Having read them, I got a deeper explanation for and understanding of his behavior. He sought care repeatedly over several years. I was touched to see how he struggled with relapses, denial and confessions, and how he again and again was taken into custody and tried to get out of his alcohol abuse problem. He realized what was happening and said on one occasion after my parents divorced: "Take care of mum, you can't change me". He died at 58-years old. I recognize the difficulties in talking about the problem. We fought a lot but there was a lack of dialogue, which is what is most needed in such situations. It became a kind of pact of silence.

From the above, it becomes evident that the grief following a parent's death linked to long-term alcohol abuse can be likened to a slow suicide by grieving family members, and that there are similarities in the why questions that are raised and have to be addressed as part of the processing of loss. The woman also reported that she had a history of depression and burn out, and that she had been in therapy for several years.

This 45-year old woman experienced comparable family problems in her childhood that could not be talked about. She too emphasized the importance of open and honest family communication where feelings and needs are acknowledged and supported in order to be able to process such adverse childhood events.

> I have no personal experience of suicide in my surroundings, but the performance touched me strongly and I cried when the sisters and the mother finally got to say farewell to the father on the bridge. I thought of my own family, how no one spoke about anything and I became sick and felt bad about it; and when the oldest sister in the play told her mother that she was still obsessed with her father's death, and of her need to express those words and to receive validation. Not arranged, but what really happened. It confirmed me in what I have always had difficulties letting go of/processing in my own family. The importance of confirmation, to have your feelings acknowledged and of being listened to.

The reflections by the participants who had no experience of suicide, but who had suffered from other challenging and stigmatizing family problems, highlighted the similarities between these circumstances. This was particularly the case with restricted family communication – "a pact of silence" – in combination with the need to search for answers, such as the exposed child's need to process and understand the parent's psychological problems or substance abuse, which negatively affected the family. In these cases, just like with the suicide-bereaved, the performance was said to be helpful by providing an opportunity to emotionally process past life events and non-stigmatizing explanations for stigmatizing family problems.

The Responses by Those Not Affected by Suicide or Stigmatized Trauma

A majority of the participants ($N = 24$) reported no experience of suicide or of any other type of stigmatized trauma. Nonetheless, they unanimously underlined the importance of the play, first and foremost in terms of learning from the experiences of others. The narrative thematic consisted of their detailing what they had learned about the complicating aspects of suicide bereavement for the bereaved family. They also paid special attention to how suicide can and should be understood through the meanings introduced in the play as their platform reflection.

Learning About the Effects of Suicide on the Bereaved Family

Just like the participants with their own experience of suicide or stigmatized trauma, many of the participants who lacked such experiences learned that suicide can present a barrier to communication. This 57-year old woman told how through the play she had learned about the destructiveness of silence – as an "abyss" – both in relationships and to the *Self*.

> The healing and fine ending was the reconciliation between the sisters and their mother. That they could finally meet in grief. The struggle before, between them, was almost more a drama in forgetting and suppressing where they hurt each other and became very lonely, each and every one of them. The culture of silence becomes an abyss itself. Where the sorrow and pain swim like dangerous leviathans under the surface. Powerlessness and self-blame, as a letter in the mail to the family.

This 45-year old woman learned how grief can be managed differently between people – with no rights and wrongs – and how it is never too late to find new meanings in past life events.

> A moving story of how a suicide affects a family. It also shows how two siblings, similar in age, who have grown up in the same family can remember so differently. It is portrayed straight, without forcing you to decide who is right. I also take with me the idea of the suicide and the finality of death, and that it is never too late to seek answers to difficult things that have happened.

The power of theater in addressing sensitive life issues, such as suicide bereavement, was discussed by this 72-year old woman. Throughout the performance she was able to identify and empathize with the protagonists and thus process her own loss experiences, but also to become a better informed fellow human being or professional.

> I was touched by the genuine tone in the performance. Realizing the importance of theater, music and art that touches the most difficult things in our lives. I have not lost any relatives through suicide, but it is "easy" to identify with because we all experience losses of various kinds [. . .]. Having been in family conversations myself (and still sitting with people in crisis), and even for us professionals working with people who have been through traumatic events, these performances are important. A big THANK YOU for this theater play. So many of us keep our trauma inside – these performances open inner doors, which is the only path to healing. Thanks!

Learning About Non-stigmatizing Explanations for Suicide

This 47-year old man learned about the traumatic and stigmatizing aspects of suicide bereavement and reflected on how a culturally marked event – such as suicide – can hinder communication and the reconciliation that can come from shared meaning-making, as with the family portrayed in the play.

> This well-written and skillfully staged play led me to think about the traumatic effects of suicide on family members and others. The sisters have internalized these effects and need to articulate and share this experience. The play also raised questions about why people have a tendency to repress or refrain from talking about a suicide (especially if it is culturally marked as shameful, humiliating, immoral). [. . .] Finally, a hopeful ending – the father didn't just vanish; he was ill, and the daughters could begin to say farewell to him.

Similarly, this 47-year old woman reflected on the meanings of suicide that were introduced by the performance. She learned that suicide is fundamentally an involuntary act: it is not a deliberate choice to die and leave the family behind, it is just not possible to go on living. No one is therefore to blame for suicide.

> It was good from the perspective that it is a disease like cancer. It is not that someone wants to leave and die, it is just that they can't go on living. It is nobody's fault. You can get angry anyway. You are allowed.

All the participants who did not report any experience of suicide or stigmatized trauma described how through the performance, they had gained new insights into a position as fellow humans and potential support providers, or in a professional role. In line with the above, they learned about the special circumstance of self-blame and stigmatization in suicide bereavement, and several of them repeated the meaning-making that suicide is an involuntary death for which no one is to blame.

The Role of Theater in Contributing Destigmatizing Meanings of Suicide

In the above, the audience members from all categories showed how they had been made aware through the theater play of the complicating aspects of grief following suicide. In their reflections, the study participants referred to the silenced family communication and the family members' stigmatized positions in grief as hindering factors in their processing of loss. In their own words, they described how they were emotionally drawn into the plot, and in tandem with the sisters became engaged in their processing of loss and search for meaning as to "why" their father had committed the self-inflicted act of suicide. In this meaning-making process, it became apparent to the participants that all family members carried heavy loads of self-blame, while they themselves through having witnessed the sisters' struggle and self-questioning approach in grief could not blame them for the suicide. When the family members broke the silence connected to the paternal suicide and opened up to each other, a shared meaning-making became possible in which they could exchange information, liberate each other from guilt and search for shared meaning (Winchester Nadau, 2001; Kaslow et al., 2011). Together, they gathered the strength to face the "man on the bridge" and to open the letter. The study participants' written reflections revealed that the sisters' new understanding of their father's suicide – that he did not choose to leave them behind, that he loved them, but that he had suffered too much to go on living – had been integrated into their understandings of suicide.

The reflections suggest that most participants arrived at the interpretation of suicide as a desperate act and ultimately an involuntary death. Some even demonstrated how the theater play had contributed to a *change* in attitude. That no one with a genuine choice would choose to die seemed to be common ground in this reasoning, which instead focused on different kinds of emotional suffering and depression as contributing circumstances to suicide. In addition, in a dialog between Alice and the mother in the play the father's mental health problems were externalized from who he was as person. The father was depicted as deeply affected by depression during his final months, but the mother declared that this was not who their father was. Instead, he was depicted as a "funny, smart and wonderful person". In this way, the theater play not only liberated the suicidal individual and his family from responsibility for suicide, but also acknowledged the memory construction of *who* the deceased parent was separate from suicide as an important part of this liberation and the daughters' grieving process (Nickman et al., 1998). One 45-year old woman, who had not herself been affected by suicide, summed up her central understandings from the play. These are representative of most of the participants and highlight the role of and potential for theater to contribute destigmatizing meanings to counteract culturally stigmatizing notions of suicide.

> [I am] grateful for this fine-tuned and emotional play about how difficult it can be to cope with grief when a loved one commits suicide. The <u>taboo</u> aspect, common prejudices that the neighbors with their lawnmowers represent....Not daring to talk about it, not being able to mourn. The <u>disease</u> aspect, i.e. often depression....It is also difficult for psychiatry to identify. It warms the frozen landscape to also remember the deceased by suicide for his bright, fine sides.

This shows how the narrative points from the theater performance have the potential to affect culturally charged notions of suicide and help to counteract the stigmatizing attitudes that burden and complicate the grieving of suicide-bereaved family members. Many of the study participants reported that they could identify with the position of the protagonist sisters; either by being suicide-bereaved themselves or by finding themselves in a position defined by stigmatization and silence due to other family troubles. However, those who did not report any experience of suicide or other types of stigmatized trauma also seem to have empathized with the sisters as they expressed how they had been emotionally moved by the performance. This is in line with Mitchell et al. (2019) use of research-based drama. Just as in their study, the audience was introduced to alternative understandings of a stigmatized subject based on research, through an emotionally charged experience and identification with the protagonist. This theater format made a potential change in audience behavior possible. Such integrated learning through theater – between cognitive meaning reconstruction and an emotionally based experience – therefore seems to constitute a particularly favorable condition for the internalization of new understandings.

DISCUSSION

Discussion of Main Results

This article has sought to investigate how a theater play might counteract the stigmatization of suicide bereavement and contribute new understandings of suicide. The theater format analyzed was inspired by previous research about young people's experiences of grieving after a parent's suicide – so-called research-based theater. Special attention in the play was paid to the two narrator sisters' different grief responses, their concurrent preoccupation with *why* their father had committed the self-inflicted act of suicide, and their persistent struggle to search for answers. Hence, it proved difficult to construct a manageable meaning from their stigmatized family situation, where the suicide had been encapsulated in silence.

The audience members' written reflections after witnessing the play were free in nature, but at the same time structured based on the questions of *whether* the play related to their own lives, and if so *how*; and *what* they had learned. The results showed that many of the suicide-bereaved participants empathized with the mourning daughters and recognized themselves in their lonely position in grief, as well as their struggle to search for answers in relation to the suicide stigma. In their written reflections, the negative consequences of silenced or conflicted family communications after suicide were detailed from their own experiences. It was underlined how open and honest family communication – where feelings and needs can be shared and validated, and the memories and meanings of the deceased family member's life and death jointly constructed – was attributed the greatest importance to the ability to process the suicide loss (c.f. Winchester Nadau, 2001; Kaslow et al., 2011). Such family communication stands in sharp contrast to what seemed to be the dominant experience among the suicide-bereaved participants. This was something that many expressed a hope for and would probably also have benefitted from in their grief.

The experience of thwarted family communication was shared by the participants who reported experiences of other forms of stigmatized trauma, such as mental illness and substance abuse in a parent. This finding is consistent with research on the stigma connected to both mental illness and substance abuse (Kroll, 2004; Larson and Corrigan, 2008; Moses, 2014; Silvén Hagström and Forinder, 2019). Those participants also expressed a strong desire to talk about their disadvantaged childhoods, to renegotiate meaning and to restore moral identities in the wake of stigmatized trauma. In both cases, experiences of abandonment, sadness, anger and confusion dominated the childhood narratives, with the risk of long-term effects from self-blame and shame responses. The third category of participants differed from the previous two, since they did not report any experience of either suicide or other types of stigmatized trauma. However, the performance was discussed as a means of processing other types of more "normal" loss experiences in a shared community of grieving. More importantly, given the focus of this study, they also reported that they had learned something new about the distinguishing characteristics of suicide bereavement. It was said that this new knowledge would contribute to a more informed position in their future contacts with people bereaved through suicide.

Finally, participants from all categories reported how they had learned that suicide is a desperate rather than a deliberated act, mainly linked to overwhelming emotional pain or depression. In the end, suicide was thus perceived as an involuntary act caused by complex and interacting factors linked to both inner vulnerabilities and stressful life events, and an act for which no one was to blame (c.f. Silvén Hagström and Forinder, 2019). This destigmatizing interpretation of suicide is in line with the sisters' narrative meaning reconstruction in the performed theater play. Consequently, this demonstrates how these understandings have been integrated and made conscious by the audience. Sudak et al. (2008) suggests that it is beneficial for the suicide-bereaved to receive non-stigmatizing explanations for suicide in a professional contact, such as that depression is a contributory factor, to relieve self-blame in relation to the "why-question" in grief. They also recommend that such explanations are provided to educate the public in order to decrease stigma, both through a change in general attitudes and to counteract internalized stigma among the suicide-bereaved. This study represents one such educational effort to inform the public and individual mourners about suicide bereavement and non-stigmatizing explanations for suicide.

Limitations

The present study is limited in that a large proportion of the audience chose not to participate by providing their reflections. This could indicate that the results are biased in that they are only based on the reflections of the participants who were motivated enough to contribute their views on the play and their personal life experience to the research. In the case of the suicide-bereaved participants, and those affected by other types of stigmatized trauma, this would be in close conformity with the results of wider research. Hence, respondents expressed a strong desire to talk about previously silenced life experiences, and the theater performance was seen as assisting with doing just that. From this reasoning, it can be assumed that the audience members who declined to participate in the study chose to do this on the basis that the performance either touched on experiences that they still found too difficult to articulate, or that they simply wanted to see a theater play and not to participate in a research study.

CONCLUSION

Regardless of the limitations noted above, the study results contribute to the research field of suicide postvention and prevention: first, by validating previous research findings on a culturally induced suicide stigma (Cvinar, 2005; Feigelman et al., 2009; Jordan and McIntosh, 2011; Silvén Hagström, 2019); and, second, by illustrating and analyzing how research-based theater could function as a means for combating this stigma. The results point to the conclusion that research-based theater is a time-limited and cost-effective method of introducing alternative meanings and identities to both individual mourners and the broader cultural context from which stigma originates. They also show how it can have destigmatizing effects on a stigmatized trauma such as suicide bereavement. A recommendation for future research, as well as practice that includes the vulnerable group of suicide-bereaved family members or other stigmatized groups, would be to investigate further how research-based theater could be used to counter stigmatization and contribute to psychological processing of traumatic life events in other contexts. Many other initiatives and strategies are also needed to combat suicide stigma as part of a health-promotion approach to suicide bereavement. For example, there are several examples of how other narrative methods can support people individually or in groups to reconstruct meanings and identities in relation to a suicide loss in the family (see for example Sands, 2009; Stepakoff, 2009; Thompson and Neimeyer, 2014; Sather, 2015; Silvén Hagström, 2017). All such efforts to assist in the construction of destigmatized meanings and moral identities in the wake of suicide have the potential to help the suicide-bereaved to experience post-traumatic growth, and thus improved health and wellbeing (Neimeyer, 2004).

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available on request to the corresponding author.

ETHICS STATEMENT

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. The patients/participants provided their written informed consent to participate in this study. Written, informed consent was obtained from the individual(s) and/or minor(s)' legal guardian/next of kin for the publication of any potentially identifiable images or data included in this manuscript.

AUTHOR CONTRIBUTIONS

The author is the sole researcher in the project and responsible for the study process from material gathering to analysis and manuscript writing.

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Older Adults' Conduct of Everyday Life After Bereavement by Suicide: A Qualitative Study

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Background: The loss of a loved one to suicide can be a devastating experience that can have negative long-term effects on the social life and physical and mental health of the bereaved person. Worldwide, an estimated 237 million older adults have experienced suicide bereavement. As assumed in critical psychology, "the conduct of everyday life" reflects the social self-understanding by which people actively organize their lives based on their personal concerns, negotiation with co-participants in various action contexts, and their life interests. Bereaved people may change their social self-understanding as they adjust to their new roles and relationships in everyday life. The aim of this study was to investigate how older adults bereaved by suicide conducted their everyday life during the first 5 years after the loss of a loved one.

Methods: This was a semi-structured qualitative interview study carried out by a research team consisting of co-researchers (older adults aged $\geq$60 years and bereaved by suicide), professionals, and researchers. The team conducted 15 semi-structured interviews with 20 older adults bereaved by suicide. The interviews were audio-recorded and verbatim transcribed. The participants' mean age was 67.6 (range 61–79) years at the time of the loss. Data were thematically analyzed through a "conduct of everyday life" theoretical perspective.

Results: We constructed a central theme, "the broken notion of late-life living" in that late-life would no longer be as the participants had imagined. They struggled with their understanding of themselves and other people in social communities when they pursued their concerns adjusting to their broken notions of late-life living. We construed three primary concerns: (1) seeking meaning in the suicide, (2) keeping the memory of the deceased alive, and (3) regaining life despite the loss.

Conclusion: The participants' bereavement process was influenced by their stage in life. They perceived themselves as having reduced possibilities to restore their life project and limited time to re-orient their life. Age-related factors influenced their possibilities to pursue their concerns in order to adjust to their new life conditions.

Keywords: bereavement, everyday life, older adults, suicide, qualitative research

INTRODUCTION

It can be a devastating and life-disrupting experience to lose a loved one to suicide, and this may even have negative long-term influences on the bereaved person's social life and physical and mental health (Pitman et al., 2014; Maple et al., 2017). The past year and lifetime prevalence rates of adults' exposure to suicide among family, friends, or someone known personally have been estimated at 3.8 and 24.7%, respectively (Andriessen et al., 2017b). In 2017, there were 962 million adults ≥60 years in the world (United Nations, 2017). Assuming that exposure to suicide is similar for older adults, some 37 million older adults may have experienced a suicide in the past year and 237 million during their lifetime. Despite these numbers, older adults bereaved by suicide is an understudied area (Andriessen et al., 2017a), and a systematic search revealed a lack of research about this large group (Hybholt et al., 2018).

Suicide bereavement is associated with an increased risk of prolonged grief, as well as elevated risks of depression, anxiety disorders, psychiatric hospitalization, and death by suicide (Young et al., 2012; Pitman et al., 2014). Although people bereaved by sudden death and suicide experience social awkwardness and attitudes in their social environment, those bereaved by suicide experience greater stigma (Pitman et al., 2018). Stigma is associated with psychosocial distress and a higher risk of suicidal ideation and behavior (Pitman A. L. et al., 2017; Scocco et al., 2017). People bereaved by suicide also have a higher rate of sick leave and disability pension use (Erlangsen et al., 2017). They may also be affected in terms of social functioning, for instance, withdrawing from social interactions and feeling shame, embarrassment, guilt, and the inclination to conceal the death and suppress their emotions and grief (Chapple et al., 2015; Hanschmidt et al., 2016; Peters et al., 2016; Pitman et al., 2016). Uncomfortable feelings such as blame, guilt, and emptiness are enhanced by the inability to find meaning in a death by suicide (Shields et al., 2017). Additionally, young adults bereaved by suicide report a lack of informal support or delays in receiving support compared to those bereaved by sudden death (Pitman A. et al., 2017).

According to the dual-process model of coping with bereavement, bereavement is both an inner psychological condition and a social and cultural event. Bereavement may change a person's identity and self-understanding as they work on their new roles and relationships in everyday life (Stroebe and Schut, 1999). Among older adults, grief may be affected by age-related difficulties in everyday life, such as reduced/limited social interaction or challenges in restoration-oriented tasks (Hansson and Stroebe, 2007). Bereaved older adults experience higher levels of emotional and social loneliness and are at increased risk of suicide (Shah and Meeks, 2012). However, older adults also seem better prepared to cope with bereavement compared to younger age groups because they are more experienced with death and have higher emotional control (Hansson and Stroebe, 2007). People bereaved by suicide might handle the situation differently depending on their age and prior experiences with death; mature individuals who have experienced several life events receive comfort through open dialogue, while younger individuals handle difficult situations by concealing their emotions and suffering (Kasahara-Kiritani et al., 2017).

Theoretical Perspective: Conduct of Everyday Life

Losing a significant other to suicide is likely to affect everyday life on a long-term basis. In critical psychology, the notion of "the conduct of everyday life" encapsulates the actions and social self-understanding by which individuals actively organize their daily life. This is based on their personal concerns, negotiation with co-participants in various action contexts, and their life interests. The conduct of everyday life must be understood from the individual's first-person perspective (Dreier, 2008, 2011; Holzkamp, 2013, 2016; Scraube and Højholt, 2016). Everyday life is conducted with meaningful regular activities that re-occur in a seemingly repetitive manner but without actually being repetitions since the circumstances change. Daily routines such as eating breakfast are taken for granted until they are disrupted, for example, by an illness or the loss of a loved one. A person's everyday life changes many times over a lifetime with events like retirement or becoming a grandparent. Changes can be more or less profound, but when life conditions change, it may initiate substantial identity work in coming to understand oneself, other people, and collective subjectivity in the light of the new life conditions (e.g., bereaved by suicide). This subsequently influences the person's conduct of everyday life. Personal concerns refer to what really matters for an individual. An individual may pursue personal concerns across the various action contexts in their entire social practice. Action contexts are anchored in time, space, and contexts in everyday life where participants come together (e.g., family members mourning at a ritual). Action contexts are characterized by the confluence of the participants' common, differing, and conflicting concerns, and it can be difficult to find ways to pursue one's personal concerns (jointly, allied with, and in opposition to others). Thus, a person's scope of action possibilities is not solely up to the individual; it also depends on other people's activities and actions. People sometimes give up pursuing a concern and comply with circumstances if it is in the person's life interest. Life interests are the basic human interest to sustain and expand the influence on one's life conditions and life quality.

The aim of this study was to investigate how people bereaved by suicide at age ≥60 conducted their everyday lives in the first 5 years following the loss of a loved one.

MATERIALS AND METHODS

A group consisting of professionals, researchers, and older adults bereaved by suicide collaborated to explore everyday life experiences after a loss. The group co-created a qualitative semi-structured guide to interview older adults bereaved by suicide.

Study Setting

The interviews were carried out in Denmark from September 2017 to July 2018. There is a free-of-charge public health care system for all citizens in Denmark, including free access to general practitioners (GPs). A specific care plan for people bereaved by suicide is not available, but GPs can prescribe subsidized psychotherapy, thus, reducing therapist fees by 40%. Older adults bereaved by suicide might not contact their GP in relation to bereavement. In Denmark, there are two, not-for-profit non-governmental organizations (NGOs) offering support to people bereaved by suicide. The Network for the Affected by Suicidal Behaviour (NEFOS) offers home-based support to older adults bereaved by suicide based on the clinical assumption that this group is less inclined to seek help and therefore may face obstacles attending appointments outside the home (Erlangsen and Fleischer, 2017). The other NGO is the National Association for the Bereaved by Suicide, which offers peer support meetings as well as "walk and talk" events.

The interviews were part of a Co-operative Inquiry into the need for psychosocial support among the elderly bereaved by suicide with the overall aim to develop and test new psychosocial interventions (Hybholt et al., 2019). Co-operative Inquiry research is "with" people rather than "on" people, so the production of knowledge is a joint venture among an array of stakeholders who work together to create relevant and practice-oriented knowledge. This is achieved in four research steps: preparation, orientation, intervention, and evaluation (Heron, 1996; Reason and Bradbury, 2008; Berring et al., 2016). The interview study was a part of the orientation step, where the goal is to gain a deeper understanding of the subject under research. We interviewed older adults about their everyday lives and experiences with the purpose of identifying needs for psychosocial support among older adults who experience suicide bereavement. In this paper, we focused on the research question: "How do elderly persons bereaved by suicide experience their everyday life after the death of a loved one?"

Participants and Recruitment

Recruitment was based on a purposive sampling designed to create a maximum variety of habitat, gender, kinship, and civil status (Patton, 2015). We exclusively included participants who had lost to suicide within the previous 5 years. This decision was made to ensure that we learned about the participants' interactions with present day health care and social care services. Participants were recruited through the two NGOs; the mental health services in two regional health care providers in Denmark; and notices about the project at relevant meetings, websites, conferences, and on social media. None of the people who contacted the principal investigator for further information about the study refused to participate.

A total of 15 semi-structured single interviews with 20 participants were conducted across Denmark. We conducted five of the interviews with married couples. For some of the participants ($n = 7$), it was an unexpected death. Others ($n = 4$) became aware of the risk of suicide weeks or months before it happened, and some ($n = 9$) had lived with worries about suicide for years or decades due to the deceased's previous suicide attempts, severe mental illness, or other problems. The participants were 7 men and 13 women aged between 61 and 79 years at the time of the loss (mean: 67.6 years). The time between the death by suicide and the interview ranged from 7 to 66 months (mean: 25.2 months). The kinship to the deceased was parent ($n = 9$), stepparent ($n = 1$), child ($n = 1$), child-in-law ($n = 1$), spouse ($n = 4$), parent-in-law ($n = 1$), and grandparent ($n = 3$). Seventeen of the participants had retired from work, and seven lived alone (see **Table 1**).

Eleven participants had previously contacted the mentioned NGOs and had received support from them prior to the interview. The participants had had varying degrees of contact with professionals including police officers, general practitioners, psychologists, psychiatrists, and nurses in relation to the suicide death.

Interviews

A semi-structured interview guide was developed (Kvale and Brinkmann, 2014) in a collaborative working group in which the members had different areas of expertise. Older adults bereaved by suicide and professionals were experts based on their lived experience, while the researchers were academic experts in developing a qualitative interview guide with open questions. The interview guide consisted of four themes exploring: (1) what had happened in the participant's life since the loss (questions about their own thoughts and actions and their experience of other people's reactions including professionals, friends, acquaintances, and family members), (2) how they lived their everyday life, (3) their reflections on how their age might have influenced their everyday life, and 4) what kind of support they felt would have helped/could help them. All interviewers were very familiar with the interview guide. The project investigator had the task to provide the formal information, and the co-researcher would ask the first opening question in theme one. Thereafter, we emphasized to have a dialogue guided by the themes in the interview guide with no prior agreement about who asked the specific questions (see **Supplementary Material**).

Each interview was conducted by two interviewers: a Ph.D. educated female researcher (principal investigator LH) and one co-researcher. The project investigator had expertise with conducting qualitative interview about sensitive personal issues and is an expert within everyday life and learning processes. The co-researchers were retired older adults with lived experience as

TABLE 1 | Participants.

Participant number	Age at time of loss in age intervals	Gender	Living with a partner	Kinship to deceased	The time between the death and the interview in month	Contact to an not-for-profit non-governmental organization (NGO) in relation to the loss	Retired from work at time of the interview	Interview with spouse
1	60–64	Male	Yes	Father	14	Yes	Yes	Yes
2	60–64	Female	yes	Mother	14	Yes	Yes	Yes
3	60–64	Female	No	Mother	23	Yes	Yes	No
4	65–69	Female	No	Spouse	66	Yes	Yes	No
5	65–69	Female	No	Spouse	44	Yes	Yes	No
6	70–79	Male	Yes	Father-in-law	23	No	Yes	No
7	70–79	Female	No	Grandmother	12	No	Yes	No
8	65–69	Male	Yes	Son	11	No	Yes	Yes
9	65–69	Female	Yes	Daughter-in-law	11	No	Yes	Yes
10	65–69	Female	Yes	Mother	7	Yes	Yes	Yes
11	65–69	Male	Yes	Stepfather	7	No	No	Yes
12	65–69	Female	Yes	Mother	40	Yes	No	Yes
13	60–64	Male	Yes	Father	40	Yes	No	Yes
14	65–69	Female	No	Spouse	11	No	Yes	No
15	60–64	Female	Yes	Mother	39	No	Yes	No
16	60–64	Male	No	Spouse	24	Yes	Yes	No
17	70–79	Female	Yes	Grandmother	23	No	Yes	Yes
18	70–79	Male	Yes	Grandfather	23	No	Yes	Yes
19	65–69	Female	Yes	Mother	27	Yes	Yes	No
20	70–79	Female	No	Mother	45	Yes	Yes	No

bereaved by suicide [JT (male), VT (female), and EK (female)]. The interviews were conducted with the sole presence of the participants and the two researchers. As they were not familiar with each other, the interview situation was initiated by a presentation of the researcher and the co-researcher and their academic/personal background. The interviews were carried out in the participants' homes, except for one person who preferred meeting in an office provided by the research team. The interviews were audio-recorded and verbatim transcribed. The mean length of the interviews was 109.5 (range: 81–134) min. After each interview, the principal investigator made field notes with the impression of the interview and setting. The participants were offered to read the transcript. Two participants accepted the offer and had a few elaborations of the content. When we were unable to identify new issues during several interviews, we decided to end the data generation.

Analysis Strategy

All interviews were analyzed thematically (Coffey and Atkinson, 1996) with the conduct of everyday life as the theoretical perspective (Dreier, 2008, 2011; Holzkamp, 2013, 2016; Hybholt, 2015; Scraube and Højholt, 2016). The analysis was divided into seven steps. Four research teams consisting of a researcher and co-researcher carried out the first three steps of the analysis. The principal investigator, LH, conducted the last four steps in collaboration with LLB and NB, which was supported and challenged by continual dialogue with the entire research group. The seven steps were:

(1) Becoming familiar with the data: each research team read and re-read a designated portion of the interview transcripts including a short description of the interview/setting based on the field notes while noting their first impressions.
(2) Generating initial codes: each research team separately created open coding of the interviews.
(3) Describing categories in each interview: each research team explored their different views on what was at stake in the participants' everyday life. They described their perspectives on the interview in categories including codes and selected citations from the interview to consolidate the category.
(4) Theorizing everyday life as bereaved by suicide: scrutinizing the conduct of everyday life in interview transcripts, notes, and categories for each participant asking central theoretical questions such as: How did the loss disrupt the conduct of everyday life? What were their primary concerns after the bereavement? How did they pursue their concerns in various social interactions? How did social interactions influence their pursuit of concerns? What were their reasons to act as they did in relation to their concerns? How did they come to understand themselves, other people, and collective subjectivity in various action contexts?
(5) Patterns and concerns across all data material: the principal investigator wrote memos as part of an iterative analytical process between the theoretical analysis and the issue

under research (everyday life among older adults bereaved by suicide). This analytical step was designed to explore how old age influenced the conduct of everyday life when bereaved by suicide. Through theoretical interpretation of patterns in the interviews, we developed an overarching central theme that provided an abstract understanding of the new life condition as an older adult bereaved by suicide. The central theme was the standpoint, which reasoned the conduct of everyday life seen from the older adults' perspective. We identified the most important concerns pursued in their everyday life while adjusting to late-life living in the context of a loss to suicide. There were three primary concerns that older adults bereaved by suicide simultaneously pursued in different ways in their daily struggle of adjusting to understand themselves and others in the social context of their new life condition.

(6) Challenging the emerging interpretation: the authors (LH, NB, LLB) read, re-read, and discussed the emerging interpretations and reviewed the data to examine outliers and develop thematic patterns. All authors of the paper were engaged in an ongoing written and face-to-face dialogue to discuss the preliminary findings.

(7) Writing up the findings by condensing the main issues in the central theme and how they govern the conduct of everyday life and the pursuit of concerns for older adults bereaved by suicide.

Ethics

In accordance with Danish legislation, the regional research ethics committee and the Danish Data Protection Agency (REG-082-2017) were notified about the interview study; neither institution had any reservations about the protocol. All participants gave written informed consent in accordance with the Declaration of Helsinki II. Interview responses were kept fully confidential, and all details that could potentially be used to identify individual participants were altered in the presented excerpts. Data were kept in a secured database. A responsive safety plan for the participants and interviewers ensured regular group supervision of the interviewers and professional counseling for the participants if needed.

FINDINGS

Based on the analyses of the interviews, we developed a central theme of "the broken notion of late-life living." The central theme was an abstract interpretation of the interviews as a whole, therefore, we decided to exemplify the theme in depth by including lengthy quotes from a single case to contextualize the theme. We also noted that older adults strived to adjust to their broken notion of late life in their conduct of everyday life, and three primary concerns emerged: (1) seeking meaning in the suicide, (2) keeping the memory of the deceased alive, and (3) regaining life despite the loss.

The Broken Notion of Late-Life Living

Death by suicide signified not only the loss of a loved one but also the loss of the older adults' notion of late-life living, as life would no longer be as they had imagined. The broken notion of late-life living could be losing the possibility of being grandparents if the deceased was their only offspring and childless or if they were cut off from contact with grandchildren. It could also imply the loss of an imagined life as surplus parents/grandparents because the bereavement had taken their resources or they had to take responsibility for other family members (either taking care of their condition or compensating for the deceased person). It could also be the loss of living a planned, pleasurable late life as a retired couple, either because the spouse died by suicide or because a spouse was strongly affected by grief.

One example of how the notion of broken late-life living influenced the conduct of everyday life was provided by a married couple (aged 66 and 69) who had lost their son 40 months earlier. Since their son was a child, they had worried about his mental wellbeing and had substantially supported him until his death by suicide when in his 30s. They were aware that their son was suicidal as he had made suicide attempts previous and had expressed suicidal ideations. The mother discussed the loss of what was supposed to have been a part of her and her husband's late-life living:

> *I often think of the fact that we will have no more grandchildren. We will have no more grandchildren, and our friends will continue to have grandchildren, and you feel a stab in your heart when hearing that someone has a new grandson, Otto, another Arthur, and whatever else they name them these days [. . .] It is positive that we already have two grandchildren, but we would have liked a little [name of deceased* son]. . . [. . .] And there will be no new pictures of him, because of the situation – which is fixed – that is very strange. I think about it, and I *know you do too (addresses husband) [. . .].* (Participant 12)

The conduct of everyday life reflects the actions and social self-understanding by which individuals actively organize their everyday life based on personal concerns. The parents had a shared concern for their son's wellbeing and had organized their lives to support him. They wanted to see him thrive and eventually settle down with a family of his own. However, his death had terminated their son's path through life and painfully accentuated their loss of a lifelong concern. As a result, the notion of the imagined late life with their son was broken, and this was particularly profound because the probability of substituting or rebuilding their life project was limited. They would never have a grandchild from their deceased son.

It also left them in a situation where the mother had to struggle to support both her own and her husband's continued existence. The husband had lost meaningful direction in life, as he could no longer pursue the concern as a supportive father for his son. In the following quote, the husband talks about memorable situations with their son, which reminds the wife of her loss of a content husband:

> *Father: When looking at the memorial we have on Facebook, you see [name of deceased son], and you can see those football pictures from the matches which is EXACTLY when he was happy. It was so*

> *him – it was [name of deceased son]. I like seeing the pictures where he. . . him in the football stadium (tearful voice).*
>
> *Mother: Yes, where he was happy, and you were happy.* (Participant 12, Participant 13)

From the mother's perspective, she had not only lost her son and his participation in her imagined later life, she had also lost her well-functioning, happy husband. As the conduct of everyday life is negotiated in interaction with co-participants, her husband's condition significantly impacted her daily life. Their son's suicide had replaced their shared concern for his wellbeing with a daily struggle for their own existence. It was in the wife's interest to be concerned about them both and their adjustment to their broken notion of late-life living. She revealed that she would not be able to bear to lose him as well. Furthermore, she also wanted to resume the ability to fulfill her role as a useful mother and grandmother, as illustrated in the following quote:

> *I have become fairly sensitive and sometimes I need to take in those antennas [brings her hands to her head] and think, and then sometimes I also sort of need to say to [name of deceased], "You need to leave now," because there needs to be room for the other children and grandchildren as well. There is no doubt that I am not the same person; I am certain of that.* (Participant 12)

Social self-understanding is the process through which people perceive themselves and others perceive them in different action contexts. The death by suicide changed the mother's social self-understanding; she no longer experienced herself as the same strong person. Her decreased health affected her possibilities to act as wanted toward her remaining descendants. Thus, her notion of late-life living was broken, and her altered state meant that her personal concern of motherhood was no longer natural. Indeed, it had become a struggle in her conduct of everyday life with her other children and grandchildren. Furthermore, the couple experienced that other people did not understand how important their deceased son was for them in their conduct of everyday life. As an example, a friend directly told her to move on and stop talking about her dead son. Both felt that other people perceived them as obsessed with their late son. This made the broken notion of late-life living even more profound, as their participation in everyday life while adjusting to their situation distanced them from some of the people they used to view as close relatives or friends, which shrunk their social network.

Concerns in Everyday Life

To adjust to the broken notion of late-life living, the participants pursued three concurrent concerns: (1) seeking meaning in the suicide, (2) keeping the memory of the deceased alive, and (3) regaining life despite the loss. The following sections elaborate how the participants pursued the concerns in their conduct of everyday life.

Seeking Meaning in the Suicide

Seeking meaning in the suicide involved the bereaved person trying to understand why their loved ones wanted to die. From the older adults' first-person perspective, it was crucial for their adjustment to their broken notion of late-life living to comprehend the suicide of their loved one. They pursued this concern by scrutinizing problematic events in their everyday life with the deceased, such as divorce in the family and lack of parental involvement during childhood. They reviewed their own and others' roles in the suicide death and dissected the deceased's condition, actions, and statements in the months and years before the suicide. They ruminated over signs that seemed obvious in hindsight. They searched for information about the life of the deceased through dialogue with people in close contact with them. This retrospective inquiry was often combined with seeking general knowledge about suicidal behavior or mental disorders through professionals or literature. Pursuing the meaning-seeking concern completely consumed some participants' mental activity. Still they resumed daily activities such as housekeeping, leisure activities, and volunteer work, which could lead to other people praising them for coping well. However, from their perspective, nothing was the same, regardless of seemingly returning to regular activities.

Some participants comprehended the deceased's difficulties and pain if the deceased had suffered from severe mental illness. The participants expressed this in statements such as: "He got peace and, actually, I also got peace," *(Participant 7),* "Her fear of life was greater than her fear of death," *(Participant 15)* or "Now he is a star in the sky. It is as it is meant to be." *(Participant 12).* Still they ruminated and grieved. Others kept seeking meaning to attempt to adjust to their broken notion of late-life living. For example, a woman, aged 72, whose husband unexpectedly took his life 5 years earlier:

> *I'm so sorry on behalf of my granddaughter because she. . . none of us are able to forgive him, maybe one day. . . You will feel better yourself if you are able to forgive. . . but we think he should have come to us. . . if we just had noticed that there was something wrong. But we had no problems, so I didn't think. . . we had a house and a summer house and. . . we had no problems. We were very happy together. we did not have any financial problems or anything.. . . I have visited a clairvoyant twice. . . What I wish to know is why he did it, but he doesn't really want to talk about it, the clairvoyant says. so I will go back to ask again and see if I might learn more.* (Participant 4)

This bereaved spouse was convinced it would be in her own and her granddaughter's best interest to be able to forgive the deceased. It had not been possible because they were unable to understand why he died by suicide. She pursued this concern by planning a third visit to a clairvoyant, even though her late husband had refused to answer the "Why?" question at earlier afterlife meetings. Still, she wanted him to answer, convinced that it could provide some kind of meaning that would enable her and her granddaughter to forgive, let go, and move on.

Striving to find meaning was part of coming to understand themselves as a person bereaved by suicide, as well as their own and other people's roles in the suicide, and the deceased's choice to die. Finding meaning could lead to gradually comprehending or accepting the meaninglessness of death by suicide, which could extend the older adult's scope of possibilities for repairing and settling with their broken notion of late-life living.

Keeping the Memory of the Deceased Alive

Concern about keeping the memory of the deceased alive required integrating the deceased into the participant's conduct of everyday life. It was crucial that the deceased was not taken out of history as if they had never existed, but instead continued to impact their own life and those of significant others. The participants kept their memory alive by incorporating regular memorial activities into daily living at home, such as talking to a picture of the deceased or lighting a candle. They also pursued the concern outside the home at various formal occasions; for example, by mentioning the deceased in speeches, ritual visits at the graveyard, or celebrating the deceased's birthday with relatives and friends. Others shared stories and knowledge about the deceased, ensuring that their history propagated. Doing so revealed their loss and huge sorrow, and participants often felt that others did not share or understand their concern. Instead, they felt that most people avoided talking about the deceased, told them to stop grieving, or said that the deceased had acted cowardly or indecently. Some of the participants found it unbearable to exclude their late loved one from their conduct of everyday life. Avoidance by others could make it an individual pursuit, which made it difficult to address.

One mother, aged 64, had lost her only child 23 months earlier. Her daughter had been mentally ill for years, and she was aware the daughter was suicidal. In her apartment, she had many pictures and a large painting of the daughter as daily reminders. She did not only lose her daughter; her daughter was married to a man with children from an earlier relationship, and he now denied her to have contact with them, thus she lost them as well. Except for a close friend of her daughter, she was the only one pursuing the concern of keeping the memory of her daughter alive. In the following quote, she told us about a family gathering:

> *I still really miss. . . The fact that we do not talk about her. . . To me, that is the worst part. We just had a cousin's reunion. At the reunion no one brought up her name or. . . no. Not at all. . . and that made me so sad.* (Participant 3)

As the conduct of everyday life is an ongoing negotiation with co-participants, it influences older adults' options for keeping the memory of the deceased alive when other people avoid mentioning or talking about the deceased. Most participants remained silent to avoid bothering other people with their concern. More than half opted to participate in activities provided by the two non-profit organizations who offered professional counseling and peer support to people bereaved by suicide. At those sessions, they could experience mutual understanding and support for their concerns among peers and professionals. As a man who lost his wife suddenly said: "When I'm with the non-bereaved I feel awkward taking about my wife, but among others bereaved by suicide, I'm like a fish in the water." *(Participant number 16)*. Seen from the participants' first-person perspective, it created a "them and us" that made the broken notion of late-life living even more profound. However, it was more fulfilling to share the concern with people who personally knew the deceased and thus could contribute personal knowledge and shared sorrow and memories.

Keeping the memory of the deceased alive was a way for the participants to adjust to their broken notion of late-life living; they transformed their connection to the deceased into activities dedicated to keep their loved one alive in everyday life. It was a struggle for participants to establish new memorial activities because it exacerbated their sorrow and reminded them of lost late-life possibilities. In addition, other people negatively affected their ability to keep the memory of the deceased alive, as they often were not supportive.

Regaining Life Despite the Loss

The concern of regaining life despite loss was characterized by organizing everyday life by balancing mourning and taking part in daily living (i.e., not mourning). An example of taking time to mourn was talking with people who had the ability to be present with someone who was grieving. Some lacked confidants due to illness, death, or age restrictions, which reduced possibilities to mourn. Others participated in grief groups or voluntary organizations for those bereaved by suicide. Some participants had to prioritize caretaking activities for family members who needed their attention. They felt that fulfilling their obligation for a loved one's wellbeing helped them briefly set aside their own grief. Some had relatives who strongly encouraged them to participate in familiar activities and recognized that this was helpful. Other participants organized breaks from grieving by filling their calendar. Although the activities had lost some meaning due to the participants' overshadowing grief, they also helped normalize life despite the loss. One mother who had unexpectedly lost her only son 7 months earlier threw herself into housework, even though she had severe hip pain and was waiting for surgery:

> *I have really cleaned! ALL bookcases. Every corner, the bedroom closet, the dressers. I have practically taken apart the kitchen and washed it down. I set myself the goal to stay busy, in particular when my husband was out. I said to myself: "You do this now," and then I began. . .. I do not think it is wise to sit down in a chair and think, "Poor me." You need to try to pull yourself up by the bootstraps and begin doing something [. . .]. It also helps you feel better; I believe, to kick yourself into gear and steer your thoughts to. . . something else. It has helped me. I enjoy cleaning and tidying up – but this time it was just on a larger scale. Because simply sitting and doing nothing does not help you. It really does not.* (Participant 10)

This mother attempted to regain her life despite the loss, using exaggerated housekeeping as a way to survive the intense grief and reasoned that it was a way to achieve good late-life living. Heavy cleaning had been effective during an earlier life crisis, and she overcame the struggle based on her conviction that it would help her regain life as a joyful wife, resourceful mother-in-law, and dedicated grandmother. She wanted to be useful to her loved ones. She also conducted her everyday life with breaks to mourn. Some participants revealed that it could be more troublesome to create breaks from grief if they had physical challenges; e.g., preventing them from doing household chores or participating in activities outside the home.

The participants also pursued the concern of regaining life by considering other people's expectations of them to finish grieving and move on. They continued life in a seemingly usual way, but from their perspective, they were in a grieving darkness and dealing with a new life condition that changed everything. They concealed their grief as they wanted to fit social conventions, did not want to bother other people, and felt it was not appropriate to reveal their sorrow.

It could be difficult to create breaks from grief because they lacked obligations such as returning to work or family members depending on them. Furthermore, it could be hard to implement previously successful strategies like vigorous cleaning due to age-related factors like reduced physical strength, lack of endurance, or immobilization. This concern was part of adjusting to late-life living that would never be as they had imagined, but it still seemed possible to live a substantial life despite the loss.

DISCUSSION

The main theme: "*the broken notion of late-life living*" provided the insight that the participants considered their chances of substituting or rebuilding their life goals as limited. For instance, it was regarded as too late in life to rebuild the family with a new child or to find a partner functioning as a life witness. The Socioemotional Selectivity Theory suggests that time left to live influences our perspective in life. Older people describe their future as limited and are aware that they do not have much time left to pursue their goals (Carstensen et al., 1999; Charles and Carstensen, 2010). This was supported by a study exploring older adults' (age 60–83 years) experiences of their aging in relation to concerns about everyday life. The older adults contemplated their limited time left and their imminent death, which created an experience of time pressure to archive personal hopes and desires (e.g., being alive to see offspring grow up). The awareness of restricted time left was experienced as limiting the potential fulfillment of future possibilities and made them concerned about the futures of loved ones after their death (Russo-Netzer and Littman-Ovadia, 2019). The main theme in the current study indicated that suicide death profoundly shapes the remaining future for older adults bereaved by suicide. Their original expectations and wishes for late-life were broken. They did not simply experience time pressure to achieve personal hopes and desires. In addition, they struggled to pursue new concerns in their conduct of everyday life to be able to adjust to their new life condition. Furthermore, some participants took responsibility for other family members either by taking care of them or compensating for the deceased person. Their position changed with new responsibility, as others now depended on them. The awareness of a limited future can be considered a natural part of getting older, but forced re-orientation in life and increased liability may intensify time pressure for older adults bereaved by suicide.

The changes in the bereaved older adults' late-life living can be understood as a major "biographical disruption." This concept was originally developed in relation to chronic illness, as a critical situation that disrupts individuals' structures of everyday life, taken-for-granted assumptions, and expectations and plans for the future. As a result, individuals require a biographical repair to make sense of their remaining life, restore normality and control, and find new meaning and identity (Bury, 1982; Locock and Ziébland, 2015). Owens et al. (2008) used the concept to understand the experiences of parents bereaved by suicide. They found that participants' life work as parents was profoundly disrupted by the suicide. They attempted to repair their own and their children's biographical disruption, and defend everyone's moral reputation. According to Bury (1982), the attempt to normalize in the face of disruption is a part of the repair work. This hypothesis is supported by a study of older adults (age 73–91 years) with multiple chronic conditions that limited their daily living. They learned to live with their disabling condition by accepting it as an unavoidable and normal aspect of aging (Clarke and Bennett, 2013). The participants in the present study struggled to find meaning with the suicide deaths, and they often experienced their situation as strange when in social contact with others. The importance of normalization as a part of the repair work might explain why many subjects felt the need to participate in communities with peers. Russo-Netzer and Littman-Ovadia (2019) stated that connections and the feeling of belonging to a group were secure anchors for older adults that were important for coping with late-life challenges. Bereavement by suicide seems to jeopardize older adults' social connections and feelings of belonging. It may amplify their struggle to adjust to new life conditions, making them feel that the possibilities for normalization in everyday life are limited.

Strengths and Limitations

A key strength of this study was the ability to obtain in-depth understanding of the experiences, needs, and everyday life of older adults bereaved by suicide, which is an understudied area of research. Furthermore, we succeeded in recruiting nine hard-to-reach research participants who had not attended any support groups or other NGO supports related to suicide bereavement. Moreover, it is important that all authors contributed with different expertise and perspectives, which helped validate the findings.

The peer interviewers experienced a special connection with the participants, as they related to each other based on their shared experiences. The peer interviewers believed that their presence made it easier for the participants to express themselves. However, this belief is based on the perspective of the peer interviewers and needs further research to be validated, such as linguistic analysis of the actual verbal interactions in the interviews. As in a study (Forbat and Hubbard, 2016) where previous careers of people receiving palliative services interviewed current careers, it is possible that the interviewees would change the conversation topic when the peer interviewer shared their experiences, thus decreasing the opportunities for elaboration and disclosure of the investigated topic. We prompted the peer interviewers to focus on the participants' experiences. We agreed that the project investigator, with her outsider position, had the primary responsibility for covering the themes in the interview guide. Still, the peer interviewers might have influenced the interviewees in a direction aligned with their own key issues.

The interview with participant eight and participant nine, who had lost their mother/mother in law, were outliers from the central theme. They pursued the identified concerns for a short period and then continued their everyday life as before. The suicide of an older family member did not disrupt their notion of late-life living. For the purpose of research categorization, Cerel et al. (2014) suggested a nomenclature that differentiated the bereaved by suicide on a nested continuum, from a larger population "exposed" to suicide to the smallest "suicide-bereaved long-term" group that struggles across a longer period with clinically significant responses to the loss. Thus, it might have been more relevant to differentiate among the types of suicide bereaved and not only age when recruiting participants. Alternative interpretive perspectives could have been included in trying to explain the outliers, such as coping styles, social supports, or attachment styles.

Our goal was a purposive sampling to achieve maximum variety in relation to habitat, gender, kinship, and civil status. It consisted of numerous women and parents, and we did not recruit close friends or siblings. Finally, interpreting the data set through a "conduct of everyday life" perspective allowed particular aspects of the participants' experiences to stand out, while others moved into the background. Although we believe that this perspective allowed us to study and emphasize important issues in the participants' lives, an alternative perspective might also have been fruitful in analyzing and reporting findings.

CONCLUSION

We have tried to make a contribution to an area with limited research by investigating the conduct of everyday life among bereaved older adults. Participants' bereavement process was influenced by their stage in life. Their experiences were framed by a broken notion of late-life living, where they perceived themselves as having reduced possibilities to restore their life project and limited time to re-orient their life. Furthermore, we identified age-related factors that influenced the older adults' possibilities to pursue their concerns in order to adjust to their new life condition, including retirement (reduced social interaction, lack of structure, and obligations), reduced network (e.g., loss of friends to sickness or death), and decreased physical and mental health. These factors may be important to consider when supporting older adults adjusting to their new life following bereavement due to suicide.

DATA AVAILABILITY STATEMENT

The datasets for this article are not publicly available because of patient confidentiality, participant privacy, and ethical data protection laws. Requests to access the datasets should be directed to LH, Lihy@regionsjaelland.dk.

ETHICS STATEMENT

The project was assessed by the Ethical Committee for Region Zealand in Denmark and is journalized with the journal number: J.nr. 17-000048. Participants gave written informed consent, interview responses were kept fully confidential, and all details that could potentially be used to identify individual participants were altered in the presented excerpts which is in accordance with the Declaration of Helsinki.

AUTHOR CONTRIBUTIONS

JT, EK, VT, and LH conducted the interviews. JT, EF, EK, VT, LB, NB, and LH analyzed the interviews. LH drafted the manuscript. AE, LB, and NB revised the draft critically for important intellectual content. All authors contributed to the design of the study and agreed with the final draft.

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CONCEPTUAL ANALYSIS
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Making Sense of the Unique Pain of Survivors: A Psychoeducational Approach for Suicide Bereavement

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Grief, guilt, abandonment, anger, shame, and rejection are the most common feelings experienced by suicide survivors, who differ from other bereaved individuals for the intensity of these feelings. Moreover, suicide risk and psychiatric disorders associated with suicidality are more frequent in people who have lost a loved person by suicide. Given the complexity and the consequences linked to the suicide of a loved person, it is necessary to act promptly. Among the various strategies, psychoeducation has proved effective for several mental disorders and for suicide bereavement. It is a therapeutic intervention aimed at identifying and understanding the psychological features associated with the mental pain of suicide survivors, to facilitate the management of the illness and the recognition of relationships in the social environment. We developed a psychoeducational group that took place at the Suicide Prevention Center of the Sant'Andrea Hospital in Rome. It was a homogeneous, finite-group composed of 8–12 suicide survivors and conducted by two trained psychologists supervised weekly by the Director of the Suicide Prevention Center. The intervention comprised 21 weekly sessions of 90 min. Each session concerned a determined topic and began with the presentation of the issue, continued with specific exercises, and finished with a group discussion. The main goals of the group were to provide support, normalize the reactions of the survivors, and assist them in reducing their emotional suffering and their thoughts about suicide, investigate the potential presence of suicide risk, implement prevention strategies, and integrate the loss of the loved person. The psychoeducational approach we delivered for suicide survivors allows individuals to interact with other individuals in the same situation in order to help them resume the normal course of life, placing the suicide of a loved person in a broader perspective.

Keywords: survivors, psychoeducation, groups, suicide, bereavement

INTRODUCTION

With the purpose of developing a postvention group approach for suicide survivors, a new approach was developed and used at the Suicide Prevention Center in Rome. Dedicated researchers and clinicians in the area of suicidology provided a psychoeducational approach for managing the grief after the suicide of a loved one. Grief and other psychological, physical, and behavioral responses are the most frequent emotional reactions to suicide (Shear and Shair, 2005). The grief experienced after a suicide death, including the course and the duration, is similar to the grief process after other causes of death, but suicide survivors, may experience more shock or trauma due to the sudden and violent nature of the suicide (Cerel et al., 2009; Berman, 2011; Maple et al., 2017). Suicide survivorship is generally associated with traumatic experiences. Jordan and McIntosh (2011) reported that the "trauma of losing a loved one to suicide [w]as 'catastrophic'—on a par with that of a concentration camp experience" (Jackson, 2003). While literature routinely reports that survivors experience trauma and are exposed to an excess of mental disorders, complicated grief, and suicide risk, there are, of course, people who resiliently overcome such a "traumatic event." Comprehensive accounts on postvention are available and poignantly described the phenomenology of survivors of suicide (Andriessen et al., 2019). However, scholars have focused on the impact of suicide deaths on loved ones with relatively little attention on the diathetic aspects of their mental wellness prior to such experience. It is also essential to foster protective factors among such individuals, making sense of their resources, of how they coped with past traumatic experiences, and trying to implement tactics aimed at cultivating well-being and early detection of mental disorders. Grief experiences in suicide survivors are characterized by deep feelings of guilt, rejection, abandonment, anger, and shame about the death, in addition to the fear of being partly responsible for the suicide (Jordan et al., 1993; Cerel et al., 2013). Recently, Kõlves et al. (2019), comparing those bereaved by suicide and non-suicidal violent death, found significantly higher levels of psychological suffering including rejection, stigmatization, shame, and fear of being responsible in the group of suicide survivors 2 years after their loss (Kõlves et al., 2019). Moreover, the grief experience also depends on the relationship between the suicide and the suicide survivor and on the meaning that the survivor gives to the suicidal act (Tal et al., 2017). Jordan (2001, p. 91) suggested that the psychological pain of suicide survivors, "differs in three significant ways: the thematic content of grief, the social processes surrounding the survivor, and the impact that suicide has on family systems," compared to that from other causes of death. Furthermore, the authors suggested that suicide bereavement contains prominent and intense "thematic issues," including "(1) survivors feel that they caused the death directly, through mistreatment or abandonment, (2) they blame themselves for not anticipating the suicide, and (3) they frequently present feelings of rejection, abandonment, and anger" (Barrett and Scott, 1990; Cleiren and Diekstra, 1995). Several authors have stressed the association between the difficulty in understanding the suicide and several symptoms of complicated grief in suicide survivors (Currier et al., 2006). Survivors experience higher levels of rejection, shame, stigma, and blame than other bereaved people, although they share with them complicated grief, depression, hopelessness, PTSD symptoms, anxiety, and suicidal behaviors (Saarinen et al., 1999; Bellini et al., 2018). The psychological impact of suicide for both adults and adolescents seems to depend, in addition to the possible presence of psychiatric symptoms, on other factors including kinship, gender, and features related to the relationship with the suicide person (Andriessen et al., 2016).

There is also an increase in physical illness among suicide survivors, possibly due to the adoption of self-harming lifestyles, including the use of alcohol and unprescribed drugs (Erlangsen et al., 2017; Eng et al., 2019). Given the considerable emotional suffering of suicide survivors, suicidal ideation (SI) has received considerable clinical attention, especially in recent years (Sveen and Walby, 2008; Pompili et al., 2013). Several authors have reported a strong association between complicated grief and SI, with suicide survivors having a significantly higher risk of suicide spectrum disorders compared with people bereaved by other traumatic deaths (Mitchell et al., 2004; Pitman et al., 2014). Bereavement following a suicide is difficult to understand and, often, suicide survivors have difficulties in adapting psychologically to this event, becoming more vulnerable to physical complaints as well as psychiatric symptoms and suicide risk (Ellenbogen and Gratton, 2001; Jordan, 2001; Sveen and Walby, 2008). Suicide survivors present an increased suicide risk-related both to interpersonal difficulties and disruption of attachments and to their vulnerability to psychiatric disorders (Brown, 1998).

Regarding the stigma perceived by suicide survivors, studies have demonstrated that suicide survivors can be subjected to prejudice and discrimination, factors that may make their psychological suffering and their social isolation worse (Sudak et al., 2008; Scocco et al., 2017).

Much of the psychological pain perceived by suicide survivors results from the need to understand the motivations that led to suicide (Kaslow et al., 2011). Furthermore, suicide survivors often overestimate their role in contributing to the suicide death, not considering other features involved in suicide (Robins, 1981; Jordan, 2008). Survivors often experience emotional confusion and ambiguity, resulting, at least in part, from not understanding that suicide is a choice derived from intense psychological pain of the deceased in relation to, not only to mental illness, but also to relational and personal difficulties. In both cases, these questions are a source of intense suffering for survivors, especially when suicide is conceptualized as a voluntary act (Jordan, 2008).

Given the complexity and the ambiguity of the emotional reactions, feelings, and symptoms to which suicide survivors are exposed, it is essential to implement a series of interventions aimed, not only at understanding and assessing the psychological state of survivors, but also attending to the psychological needs of people in this condition (Cerel et al., 2019). Several non-pharmacological techniques have been used as a treatment for this population, and, among these, psychoeducation seems to have good clinical efficacy. In this article, we summarize a postvention psychoeducational technique for suicide survivors, showing in detail the psychoeducational model that is used in our Suicide Prevention Center.

Psychoeducational as a Postvention Intervention for Suicide Survivors

Shneidman (1969) defined the term postvention as support for suicide survivors. Postvention includes a package of interventions with the aim of facilitating recovery after the suicide of a loved person as well as assessing and preventing psychological symptoms and distress in suicide survivors (Andriessen, 2014). The World Health Organization [WHO] (2014) recognized suicide survivors' support as an important strategy in suicide prevention programs, and postvention approaches are used in many countries. A recent study indicated that, although the number of psychological postvention approaches for people bereaved by suicide is limited, the results suggest good clinical efficacy (Andriessen et al., 2019).

Among the various postvention strategies currently available, psychoeducation has shown effectiveness in preventing relapses for several mental disorders and can be considered to be a valid option also for postvention for suicide survivors. Psychoeducation is an intervention dedicated to the recognition of relationships in the social environment, and the psychoeducational model follows research on emotion expression (EE). This type of intervention identifies some psychological factors, including empathy, hyper-involvement, and emotional hostility, recurrent in some families (Brown et al., 1962; Leff et al., 1982). In the 1980s, "psychoeducational interventions" were developed for reducing the high levels of EE in the families of psychiatric patients (Vaughn and Leff, 1976; Falloon et al., 1982).

The word "psychoeducation" was first used by Anderson et al. (1980) for describing a non-pharmacological approach that included four basics elements. These included teaching the patients about their illness, and working on problem-solving, communication, and self-assertion techniques (Anderson et al., 1980). Over time, these elements have been enriched and merged, creating the most recent models of psychoeducation (Mottaghipour and Tabatabaee, 2019). Several studies have demonstrated the effectiveness of psychoeducational family interventions as compared with standard treatments for psychiatric disorders (Miklowitz et al., 2000; Colom et al., 2009). Psychoeducational programs have demonstrated good effectiveness in reducing the impact of several psychiatric symptoms in schizophrenia, bipolar disorder, and major depressive disorder, improving pharmachological adherence and increasing the identification of symptoms of several psychiatric and psychological disorders (Gastaldon et al., 2019). Colom and Vieta (2006) introduced a group psychoeducational program for patients with bipolar disorder. The target of this psychoeducational program consisted in illness awareness, adherence to pharmacological treatment, identification of prodromal symptoms and recurrences, and lifestyle regularity. Adding psychoeducation to other forms of psychiatric treatment has the advantage of helping patients and family members to understand their creative and positive role in the treatment and enhancing their ability to deal with daily stress (Pitschel-Walz et al., 2001). Psychoeducation is an adjunctive approach that has the potential to reduce the incidence of relapse, as well as rehospitalization rates and the mental health costs involved in relapsing (Shah et al., 2014; Joas et al., 2019).

While psychoeducational interventions are used for addressing adherence problems in psychiatric patients and are used in the context of suicide prevention (Battle, 1984; Jones et al., 2018), only a few studies have investigated the effects of psychoeducation interventions for suicide survivors. Wittouck et al. (2011) examined the effects of a cognitive-behavioral therapy-based psychoeducational approach on several psychological symptoms in 83 suicide survivors. However, the results showed that there were no significant effects of the psychoeducational intervention on depressive symptoms, complicated grief, and suicide risk factors. The authors suggested that the intervention may be useful as supportive counseling for suicide survivors. To better understand the pain of suicide survivors, Battle (1984) examined 36 survivors before and after group therapy, comparing them with 13 survivors who did not participate in the group and 31 patients in psychotherapy who were not bereaved. The authors focused on the differences in feelings experienced by the patients, noting how the predominant problem of the suicide survivors who participated in the group was their sense of guilt about the loved one's death, while patients who did not participate in the group were also saddened by their loss but did not blame themselves. The authors found that the assumptions that frequently caused greater pain were: (1) those in which the survivor felt "I was passive while my beloved faced defeat and finally was beaten," and (2) those that occurred when "the surviving parents, and others who knew the victim as a child, felt that the child rejected any identification that he/she may have had with them or that their child was not close to them in the first place." More recently, Battuello and Milelli (2015), in a preliminary study of six suicide survivors who underwent group psychotherapy, found that, in the course of the therapy, patients learned to deal with their psychological pain better. Patients learned to deal with, including the grief and other psychological symptoms, learning how to begin life again after the dramatic loss from suicide.

Several mechanisms can explain the effects of psychoeducational interventions, including the group experience itself, the educational and informative sessions on symptoms and adequate treatments, some other generic features of the psychotherapeutic effect, or the combination of all three mechanisms. A group setting allows patients to verbalize experiences and emotions and acquire expertise and awareness about their symptoms and psychological suffering. The personal characteristics and clinical expertise of the group leader are important for enhancing the therapeutic effect of the group approach. A psychoeducational approach stresses a more "medical" view of psychiatric and psychological suffering, considering the biological, social, and relational aspects of each disorder. Several papers have suggested that group psychoeducation therapy promotes pharmachological adherence (Colom et al., 2003). Other relational, social, and non-pharmacological therapeutic aspects of the psychoeducational intervention are also fundamental in the effectiveness of this therapy (Motlova et al., 2017). Relational and social aspects include understanding and recognizing personal triggers and prodromal symptoms, lifestyle interventions, working on problem-solving and self-management techniques, and improving social support.

A Personalized Psychoeducational Approach for Survivors

We developed a model of group psychoeducation starting from the psychoeducational program developed by Colom and Vieta (2006) for people with bipolar disorder. Even though the psychoeducational program has been validated in bipolar disorder, bipolar disorder is a different condition from suicide survival (Miklowitz and Scott, 2009). The main objectives of our program were to provide psychological support, decrease the abnormal reactions of family members, assist suicide survivors in recognizing their feelings of confusion, guilt, or anger, focus on their suicidal risk, and implement prevention strategies (**Table 1**).

The group approach, compared to the individual approach, produces several benefits by creating an interpersonal space in which survivors tell of emotional, sensory, and mental experiences. This approach allows survivors to interact with each other following the rules of therapy and to express and share emotions, feelings, and expectations. In this framework, the group provides a personal experience, promoting the development of relationships between individuals who are in the same situation of deep psychological pain. According to Yalom and Leszcz (2005), some of the therapeutic factors involved in the effectiveness of group therapy involve the sense of awareness of experiences also lived by others, the sharing of new information, the increase of hope and altruism, and the increase in mastery of relationship techniques, imitative behavior, interpersonal learning, group cohesion, and psychological adaptation to the same traumatic experience. Before entering the group, survivors have experienced, due to the suicide death, an increase in stigma and social isolation, which, in turn, result in the development and worsening of their psychological pain, distress, and psychiatric symptoms. Through the sharing of information, the use of socializing techniques, self-disclosure, verbalization of emotions and feelings, acquiring adaptive coping mechanisms and restructuring behavioral techniques, the psychoeducational group approach creates a sense of cohesion that allows survivors to improve. Furthermore, in a group approach, the recognition by individuals who suffered the death of a loved person from the suicide of both similarities and differences helps, not only to diminish the sense of loneliness, but also to develop metacognitive skills.

Research has demonstrated that several aspects of the psychological pain experienced by suicide survivors differ from other types of traumatic losses (Jordan, 2001), including the clinical expectations of the therapist who is not used to working with suicide survivors. The competence to recognize the importance of pain (to be "present" with the pain) and to understand the psychological needs of suicide survivors is fundamental in approaching clients with suicide bereavement.

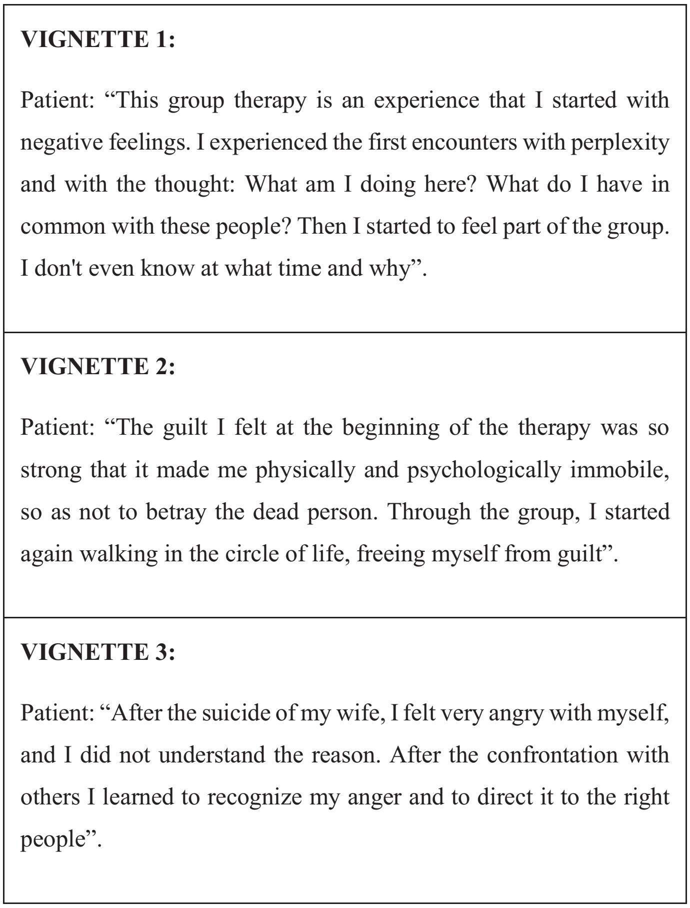
TABLE 1 | The 21 sessions of the group psychoeducation program for survivors.

1. Introduction: objectives and rules
2. Group presentation
3. Definition of suicide survivor
4. Sharing the pain caused by suicide
5. Psychological needs of survivors
6. Traumatic aftermath of suicide
7. Recurring thoughts
8. Stigma, shame, and isolation
9. Exploring unfinished issues in relationship with the deceased
10. Aiding in coping with divergent reactions among family members
11. Assessment of psychiatric symptoms
12. Understanding psychiatric symptoms
13. Risks associated with psychiatric symptoms
14. Talking about suicide
15. Assessment of suicide risk
16. Prevention of suicide risk
17. Stress-management techniques
18. Problem-solving techniques
19. Interpersonal relations and social support
20. Evaluation of the objectives
21. Final session

The objectives of our psychoeducational therapy include primarily the integration of the loss into the survivor's life. In this sense, the approach we use should be considered to be an accompaniment promoted by the therapist with the aim of allowing survivors to learn how to reinvest in life. Other features include carrying the loss, focusing on guilt and abandonment, and working on a positive therapeutic relationship to facilitate the healing process. Furthermore, psychoeducation helps suicide survivors, in particular, families, understand the nature of psychiatric distress and their role in contributing to the genesis of the psychological pain that led to suicide, allowing them to understand and internalize the death and acknowledge the devastating systemic impact of suicide on family systems.

For suicide survivors, group psychoeducation can create a deep sense of awareness of experiences lived by others, and the social cohesion of the group, acting directly and indirectly on stigma and social isolation, helps suicide survivors to verbalize information and sharing their concerns in a framework of shared hope (Center for Substance Abuse Treatment, 1999). The effects experienced by each individual in the group and by the group itself are identified during the psychoeducational experience. It is necessary that the therapists are also aware that, sometimes, the group can limit the freedom of people by imposing an adjustment to a required collective functioning both in terms of emotions and thought imposed by other members of the group (**Figure 1**).

Our psychoeducational group was a homogeneous, finite-open group (Cerel et al., 2009). All the participants were survivors of suicide and, in the therapeutic program, new members can be accepted as additional resources into the group. The participants are usually referred to the Suicide Prevention Center in Rome, and the Director of the center decides on the acceptance of the survivors, keeping in mind who can benefit



VIGNETTE 1:

Patient: “This group therapy is an experience that I started with negative feelings. I experienced the first encounters with perplexity and with the thought: What am I doing here? What do I have in common with these people? Then I started to feel part of the group. I don't even know at what time and why”.

VIGNETTE 2:

Patient: “The guilt I felt at the beginning of the therapy was so strong that it made me physically and psychologically immobile, so as not to betray the dead person. Through the group, I started again walking in the circle of life, freeing myself from guilt”.

VIGNETTE 3:

Patient: “After the suicide of my wife, I felt very angry with myself, and I did not understand the reason. After the confrontation with others I learned to recognize my anger and to direct it to the right people”.

FIGURE 1 | Examples of participants’ comments.

from a psychoeducation group therapy and also considering the composition of individuals who can benefit most from a group approach (the composition of psychoeducational group). Deciding, whether to include a person in a group, involves not only the relation between the therapist and that person but also between the other members of the group and that person. It is known that not everyone has the appropriate characteristics for joining a therapeutic group. Sometimes, the relational dynamics of a group can directly contribute to adverse outcomes for some patients, including worsening the psychological distress as a result of one’s group experience (Yalom and Leszcz, 2005).

A finite-open group offers a temporally defined experience for the group by programming its activity into a set number of educational sessions. In the first session of the psychoeducational therapy group, the therapeutic objectives of the group, and the roles of the therapist are clearly stated for the participants. The therapists in our psychoeducational program were two psychologists who work in the Suicide Prevention Center and who have dealt with suicide prevention for many years. The therapists lead the group, established its structure, and received weekly supervision from the Director of the Suicide Prevention Center. The two therapists in our program had to ensure that the psychological suffering of the survivors will be identified by the group, explored and understood by the group, and recognized as the object of group responsibility. The psychoeducational approach was composed of 21 sessions of 90 min, delivered weekly by the two therapists. The number of survivors ranged between 10 and 12 participants. Several areas were taken into account, including psychological suffering, emotional reaction to bereavement, guilt, stigma, any psychiatric symptoms such as depression, post-traumatic anxiety symptoms, possible risk of suicide, lifestyle regularity, interpersonal context, and social support. The topics of the sessions are summarized in **Table 1**. Each session begins with a 30-min talk in which the therapist presents the topic of the day, followed a period in which patients discuss the topic and share their experiences, resulting in a group discussion on feelings, emotion, and psychological distress.

The first session is an introductory session in which therapists introduce themselves and, together with the survivors, define the rules of therapy and the main objectives of the procedure. Sessions 2–9 are focused on evaluating and understand the mental state and the suffering experienced by the survivors (see **Table 2**). Therapists inform survivors about their condition and the emotional impact caused by the suicide of a loved

TABLE 2 | Investigating the relationship between the suicide and the survivors (sessions 1–9). Main points.

Description of the relationship with the suicide, the degree of relationship, as well as the type of bond.
Dwell on the time that has elapsed since the suicide and on the events that have occurred during this period of time.
Investigate how many people are aware of the suicide and whether there are unrevealed events.
Promote the telling of what happened (who found the body, the method used).
Accept the spontaneous intuitions of the survivors regarding what happened.
Explore the day of the suicide (if the survivor had noticed something significant, if the suicide had tried to ask for help).
Have the group verbalize the emotional impact of the story that they have just heard.

one, working on feelings such as anger and fear, behaviors, and stigma. Session 10 focuses on the different reactions to suicide in the family and on the impact of suicide on family relationships. Sessions 11–13 are mainly focused on the assessment of information about several psychiatric symptoms that can develop after a suicide, including depressive symptoms, anxiety, and post-traumatic symptoms. The topic of sessions 14–16 is on suicide risk. The therapists assess and inform the survivors of the possibility of their own suicidal risk.

Psychoeducational action is conveyed through relationships and the mediation of emotional-affective and body language, which fosters the emergence of images present within time and appropriate space in which they can be expressed and welcomed. The methodological approach supports non-verbal rehabilitation actions, working on the development of processes of personal re-working and self-awareness. As Shneidman proposed, the matrix of suicide lies in mental pain (psychache), a synthesis of painful emotions from which the person cannot escape. Suicide becomes, as Shneidman points out, not a movement toward death, but a movement away from the mental pain. In these sessions, therapists are able to focus on the assessment of psychological pain and suicide risk. The use of bodily experiences, inspired by the body-analytical model involving bioenergetic exercises, as an integral part of the psychoeducational group, enables participants to experience a particular form of learning and, in addition, provides a first level stimulus, activates processes that allow them to become aware of intrapsychic and relational dimensions, and facilitates the acquisition of new ways of thinking, feeling, and relating. Contact with the body represents a chance to give life to thoughts and give words to behavioral events. The involvement of the body allows putting the patient in contact with their own mental pain in order to recognize it, instead of denying it. The group offers a space for discussion of self-injurious behaviors and attempted suicide. This allows each individual to understand how their actions and impulses are perceived by others. Consideration of the perceptions of others enables each individual to gain an understanding that is more complex and realistic, including their effects on others and their own role in tackling current problems.

In sessions 17–19, the therapists address the important role of social support from family and friends by teaching general psychosocial skills using the relationships between the members of the group. In these sessions, skills training on how to effectively communicate with other people and understand social connections is offered to the group.

The psychoeducational program ends with sessions dedicated to outcome measures in different categories, including self-reports of distress, psychiatric symptoms, suicidal risk, and functioning and role appraisal. Furthermore, the survivors are assessed on how well they achieved the goals outlined by the therapist at the beginning of the group.

CONCLUSION

Given the special thematic aspects of suicide bereavement, the unique pain of suicide survivors and the stigma that many survivors perceive in their social networks, the psychoeducational group approach we developed for them offers the opportunity to interact with other suicide survivors to resume the normal course of life and place the suicide of the significant other in a broader perspective. Therapists had to deal both with grief and monitoring such risk as well as proper assessment of psychiatric disorders. The psychoeducational program we propose for suicide survivors needs to be tested with different groups in different centers.

Psychoeducation educates survivors about the nature of suicide and the psychological pain associated with suicide, and endeavors to make sense of the suicide with the help of techniques including oral presentations, reading materials, and physical exercises. Finally, several sessions are focused—on social and family problems, often present in suicide survivors, helping them cope with their family and the social network. Limitations of the program include the need that participants should be cooperative with the therapists, the duration of the program which may last several months, and the need to have two trained therapists in the field of suicide. In managing our psychoeducational approach, considerable difficulty was found in those suicide survivors, who reacted to the suicide with positive emotions. In discussing the suicide of a difficult colleague, Dover (1994) noted that he felt happy after the individual died by suicide. In his discussion of this case, Lester (2005) noted that positive emotions might sometimes be present in the survivors of suicides, but survivors may feel that there is a stigma attached to revealing these positive emotions. For example, the wife and children of an alcoholic, who physically abused his family, may feel relief if the man dies by suicide. However, since the typical emotions expressed by survivors are grief and self-blame for not recognizing the suicide's distress, the wife and children may feel that they would be judged harshly if they expressed their true feelings.

Suicidal individuals are not always easy to live with, and counselors helping survivors should bear in mind that relief and other positive emotions may be present as the primary emotion (Turchi et al., 2019). The counselor's task in these situations is to make sure that the survivors do not feel guilt over such emotions. Lester (1995) also noted that the emotions present in those whose significant other choose assisted suicide might differ from the typical survivor, and counselors must be ready to assist those involved, both the suicide and the significant others, in the time preceding the suicide and afterward.

AUTHOR CONTRIBUTIONS

IB, DE, and DL drafted the manuscript. ER and SS collected the data and summarized results. MP designed the study. All authors contributed in drafting the final version of the manuscript.

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ORIGINAL RESEARCH
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When Emergency Patients Die by Suicide: The Experience of Prehospital Health Professionals

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The suicide of a patient can be a disturbing experience for health professionals. According to literature, a patient suicide is a professional hazard in the path of prehospital emergency professionals. In the emergency context, several factors pointed out in literature as predictors of increased emotional impact and more severe traumatic reactions are present. However, the impact of patient suicide on prehospital emergency professionals is still an understudied subject. The aim of this study was to better understand the impact and emotional reactions of prehospital emergency professionals facing a patient suicide, using a qualitative approach. Semi-structured interviews were conducted with 19 prehospital professionals. Fourteen narratives about a patient suicide experience were obtained. Three main categories emerged from the process of content analyses: (1) emotional impact and related factors; (2) perceptions of impact; (3) emergency context and professional growing. Death by suicide in the prehospital emergency context had a considerable emotional impact on these professionals. Several participants described intrusive thoughts and images as a consequence of attending to the death scene. Regarding the perception of impact, there seemed to exist a variation between the levels of *exposed to* and *affected by* suicide. There are specific features of the prehospital emergency context that emerged in the narratives of participants as factors which increased the patient suicide impact, namely attending the death scene, encountering the family or other survivors, and managing the feeling of responsibility for not arriving in time of the rescue. The narratives of prehospital professionals also indicated some negative effects on their professional practice, such as doubts about their competence, training, and limits to liability. The death of a patient by suicide in the prehospital emergency context can be a difficult experience, marked with an intense emotional impact. Nevertheless, it can have some positive effects, such as professional growth and increased awareness for the phenomenon. Specific training appears to be fundamental to promote professional growth and to overcome the negative emotional impact.

Keywords: patient suicide, impact, prehospital emergency professionals, emotional reaction, narratives

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INTRODUCTION

A significant number of prehospital emergency professionals is likely to have experienced a suicide case in their practice. Indeed, the suicide of a patient is a professional hazard in the emergency context (Gaffney et al., 2009). A persons' suicide is a very emotional issue and it is expected to have emotional effects on others. The exposure to death by suicide may cause psychological, physical, and social suffering even if the deceased is unknown (Andriessen and Krysinska, 2012; Cerel et al., 2014). Despite its relatively frequent nature and the specific context of the emergency help, which generally implies a brief contact and a limited relational closeness, a patient suicide impact should not be undervalued.

The impact of a patient suicide has been studied in different groups of health and mental health professionals, including psychiatrists (e.g., Chemtob et al., 1988a; Courtenay and Stephens, 2001; Henry et al., 2004; Ruskin et al., 2004; Rothes et al., 2013b; Castelli Dransart et al., 2014), psychologists (e.g., Gorkin, 1985; Chemtob et al., 1988b; Kleespies et al., 1993), physicians (e.g., Halligan and Corcoran, 2001; Kendall and Wiles, 2010; Rothes et al., 2013a), nurses (e.g., Akeshi et al., 2003; Takahashi et al., 2011; Castelli Dransart et al., 2014), and social workers (e.g., Jacobson et al., 2004; Castelli Dransart et al., 2014). However, to the best of the authors' knowledge, only four studies (Gaffney et al., 2009; Nilsson et al., 2017; Vedana et al., 2017; Nelson et al., 2020) approached the theme of suicide impact in prehospital emergency context. These studies revealed important data, but the subject remains understudied. The delivery of prehospital care varies greatly between countries (e.g., Fairhurst, 2005), limiting transferability of results to dissimilar settings. Gaffney et al.'s (2009) study used a multidisciplinary sample, including emergency medical technicians. The authors found that emergency technicians, along with psychiatrists, were the groups with the highest incidence of patient suicide and highlighted the need for further research to better understand the specificities of the context related to this experience (Gaffney et al., 2009). Nilsson et al. (2017) conducted a qualitative study about the support provided by prehospital emergency professionals to the survivors. This study showed specificities of the prehospital emergency context, such as the feelings of inadequacy and uncertainty about the professional responsibility over the situation (Nilsson et al., 2017). Prehospital emergency professionals are usually the first health professionals that survivors contact with and even though they are strangers to each other, that temporary crisis may lead to an experience of shared closeness. According to the author, emergency professionals tend to range between an ethical conflict and compassionate reactions toward the survivors (Nilsson et al., 2017). The study of Nilsson et al. (2017) was focused on support and responsibility of prehospital professionals toward survivors, not addressing the emotional impact of patient suicide *per se*. The study about the experience of nurses in assisting people with suicidal behavior in prehospital context conducted by Vedana et al. (2017) reinforces that this assistance is a demanding and even disturbing experience in the emergency work. Although Vedana et al.'s (2017) study also includes the experience and impact of death by suicide, it is not always clear when it is referring to suicides or suicide attempts. A very recent study (Nelson et al., 2020) highlighted that ambulance staff presented long-term and emotionally impacting memories of suicide cases and often had difficulties to deal with the persons bereaved by suicide at the emergency setting, reporting uncertainty, anxiety, and lack of training. Nelson's study used a small sample of paramedics and technicians and was conducted in the scope of a prehospital emergency setting based on the Anglo-Saxon model, centered essentially on the activity of paramedics, "of taking the patient to the hospital" (Dick, 2003; Al-Shaqsi, 2010). Thus, this limits transferability of results to contexts that adopt the Franco-German model of "taking the hospital to the patient," as is widely implemented in Europe (e.g., Al-Shaqsi, 2010).

There is a general agreement in the relevant literature that a patients' suicide can be a disturbing experience for health professionals (e.g., Rothes et al., 2013a,b, 2017; Séguin et al., 2014; Castelli Dransart et al., 2017) and even trigger traumatic reactions (Chemtob et al., 1988a,b, Cryan et al., 1995; Gaffney et al., 2009; Castelli Dransart et al., 2014). Despite the fact that losing a patient to suicide generates stress and emotional suffering among health professionals, these emotions rarely present clinical levels of significance (Séguin et al., 2014). Furthermore, this event could be an opportunity for professional growth and to increase skills to manage suicidal patients (Rothes et al., 2013a,b).

Specific factors have been identified as predictors of an increased emotional impact and more severe traumatic reactions (Castelli Dransart et al., 2014, 2017). These factors are related with the characteristics of the context of prehospital emergency work, such as the attendance at the death scene (Gutin et al., 2011; Cerel et al., 2014) and the feeling of responsibility (Castelli Dransart et al., 2017), namely for saving life. In general, health professionals guide their practices and decision-making based on the moral and ethical principle that one should always try to save a person's life, and the extent of this responsibility depends on the context of intervention (Mishara and Weisstub, 2005). Indeed, prehospital emergency professionals work to assure an effective and rapid health caregiving to the victims (Instituto Nacional de Emergência Médica, 2019). In this context, the professionals' main obligations are to provide emergency care at the setting of the occurrence, to provide an assisted and safe transportation of the patient into the hospital, and to provide adequate information to guarantee the coordination between all care systems involved (Instituto Nacional de Emergência Médica, 2019). The National Institute of Medical Emergency (INEM) follows the denominated Franco-German model of emergency care delivery, which is based on the "stay and stabilize" philosophy (e.g., Al-Shaqsi, 2010). At the INEM, around 80% of human resources are frontline professionals: 356 physicians, 266 nurses, and 756 prehospital emergency technicians, who are available for direct contact with all the incoming emergency calls (Instituto Nacional de Emergência Médica, 2018). In Portugal, in the year 2018, a total of 1,319,443 emergency activations were registered, of which 32,251 were directly related to psychiatric or suicidal problems (Instituto Nacional de Estatística, 2018).

Despite its evident importance, there is a paucity of literature about how prehospital professionals emotionally deal with patient suicide focusing on their experiences. To improve postvention support in this context, there is a need to better understand the experiences of the prehospital emergency professionals when a patient dies by suicide.

As key to suicide research and prevention activities in recent decades, the importance of postvention and those with lived experience was acknowledged (O'Connor and Portzky, 2018), in which it may be relevant to include the experience of health professionals. Therefore, the aims of this study were to understand the impact and emotional reactions of prehospital emergency professionals facing a patient suicide and to explore the existence of specificities related to the prehospital emergency context.

MATERIALS AND METHODS

The present study is part of a larger qualitative investigation that aimed to explore the conceptions, practices, and experiences of prehospital emergency professionals toward suicidal patients. The data used in the present study focused on the theme of professionals' experiences, narrated by the participant during the interview. At that moment, professionals were invited to recall and report an impactful suicide attempt attendance with as much detail as possible, recollecting the whole process of care, their attitudes, feelings, and difficulties. Most of the professionals described cases of death by suicide indicating the interest of this study's focus on patient suicide impact on prehospital emergency professionals.

Sampling Process and Participants

The participants of this study were prehospital emergency professionals from the INEM, specifically professionals who work at the front line – physicians, nurses, and prehospital emergency technicians.

A combined methodology was used in the sampling process: (1) convenience, (2) snowball, and (3) emergent subgroup. (1) Convenience sampling started with few information-rich participants from each catchment region, who were easily accessible to the researchers and (2) snowball sampling, asking each participant for contacts of others who could also provide their perspectives, creating a chain of participants. (3) Furthermore, during fieldwork researchers realized that a significant number of participants described cases of death by suicide rather than suicide attempt, as was asked and while others described both situations. That is, patient suicide impact in the prehospital emergency context emerged as a critical issue and this emergent subgroup of prehospital professionals who described patient suicide situations became an information-rich sample providing a specific insight into the understudied phenomenon of patient suicide impact on prehospital professionals. Thereby, during data collection, the pertinence of studying patient suicide impact in prehospital emergency professionals arose. Furthermore, it was planned in advance to pursue the three following criteria: (a) homogeneity, (b) heterogeneity, and (c) saturation. (a) Homogeneous sampling would be applied regarding the specific experience of suicidal cases (participants must have experience with suicidal patients in the prehospital emergency context) and (b) heterogeneous sampling would be followed regarding professional group (physicians, nurses, emergency technicians), years of experience, and also region of the country. Two different catchment regions were selected based on their different characteristics. One was a large urban center that also covers suburban areas with high density, located in the North of the country, and the other one was a region with less density, including rural areas and located in the Center of the country. (c) Another planned criterion for sampling was the saturation or redundancy of collected information, that is, the strategy was to stop the chain of recruitment of participants when no new information was forthcoming from the new interviews. Based on methodological recommendations (Guest et al., 2006), it was estimated that about 12 interviews would be necessary to reach saturation.

From the 19 professionals composing the global investigation, 14 described cases of death by suicide as the most impactful experience in this specific practice area. Among these participants were seven women and seven men. Regarding their occupation, there were four physicians, eight nurses, and two prehospital technicians. Participants' ages ranged between 34 and 55 years (M = 41.6; SD = 5.8). Years of professional experience in the health sector varied from 8 to 33 years (M = 17.1; SD = 7.4) and the years of experience at INEM varied from 4 to 19 years (M = 10.6; SD = 5.7).

Data Collection

Data were collected by means of a semi-structured interview organized into three main themes: conceptions about people who attempt suicide, prehospital practices used in cases of suicide attempt, and professionals' experiences in this area. The topics of the interview were based on conclusions of previous researches (Rees et al., 2014, 2015, 2017). Moreover, a small questionnaire was used to collect socio-demographic and professional data, including information about training on suicide prevention. The data present in this study were followed by the next guiding question: "I would like you to think about the suicide attempts you attended in this service so far. Among them, can you select one that has particularly affected you or that has been more significant for you? Furthermore, I would like to ask you to describe the situation and your own experience, in as much detail as possible."

Participants were personally contacted and invited to voluntarily participate in the study. All of them signed an informed consent approving the audio recording of the interview and the use of data for research purposes guaranteeing confidentiality of their personal information. Most interviews were conducted in the participants' workplace and lasted approximately 35 min (range: 15–60 min).

Data Analysis

All the interviews were fully transcribed, and data were submitted to content analyses following the methodological recommendations of Bardin (1977) and in a more systematic and detailed way, following the thematic analysis as formulated by Braun and Clarke (2006, 2013). Inductive thematic analysis was used to generate an analysis from the data (from the bottom up) (Braun and Clarke, 2006, 2013). To analyze the data, no *a priori* coding categories were identified, and themes were allowed to emerge from the data. However, and as exposed by qualitative authors (e.g., Braun and Clarke, 2013), despite categories not emerging from theory, the analysis was also shaped by the standpoint of researchers and their disciplinary knowledge. Based on Braun and Clarke (2006, 2013), the researchers conducted the systematic analysis through a six-step process: (1) First, the researchers became familiar with the data by reading each transcript twice – one first reading in a fluid way and in a second reading, during which the initial ideas for coding were written in the margins of files. (2) In the second step, the initial codes were generated by two researchers (the two first authors), who systematically coded each unit of meaning across the entire data set and collated data relevant to each code. To identify aspects of the data that relate to research objectives, researchers did a complete coding across the entire dataset. To code, a manual hard-copy process was used and both kinds of codes were used: semantic and latent. That is, mainly codes were used that relate the semantic content of the data (data-derived or semantic codes) but also researchers-derived or latent codes. Researchers who coded the transcribed interviews worked through each interview in full, before proceeding to the next. (3) The third phase entailed sorting the codes into potential themes. In these second and third phases, the two researchers – first and second author – worked together to reach consensus. According to guidelines for qualitative research (e.g., Elliott et al., 1999), two researchers were used as analysts (first and second authors) and two researchers (third and fourth author) for a verification step. (4) In the fourth phase, themes were reviewed and refined, checking whether the data cohered together meaningfully within each theme. (5) In the fifth phase, final themes were defined and (re)named. (6) In the sixth phase, the report was written, and excerpts from participants' interviews were selected to illustrate each theme. In these fifth and sixth phases, the third and fourth authors reviewed data to confirm and expand findings (Hill, 2012).

ETHICAL CONSIDERATIONS

The study protocol was approved by the Ethics Committee of the Faculty of Psychology and Educational Sciences of University of Porto (Ref^{a}: 2019/02-1).

Anonymity and confidentiality of the participants was guaranteed throughout the study, according to the Portuguese law of data protection.

RESULTS

Content analysis resulted in 3 main categories and 15 subcategories conveying the prehospital professionals' patient suicide experience. Findings are summarized in **Figure 1**.

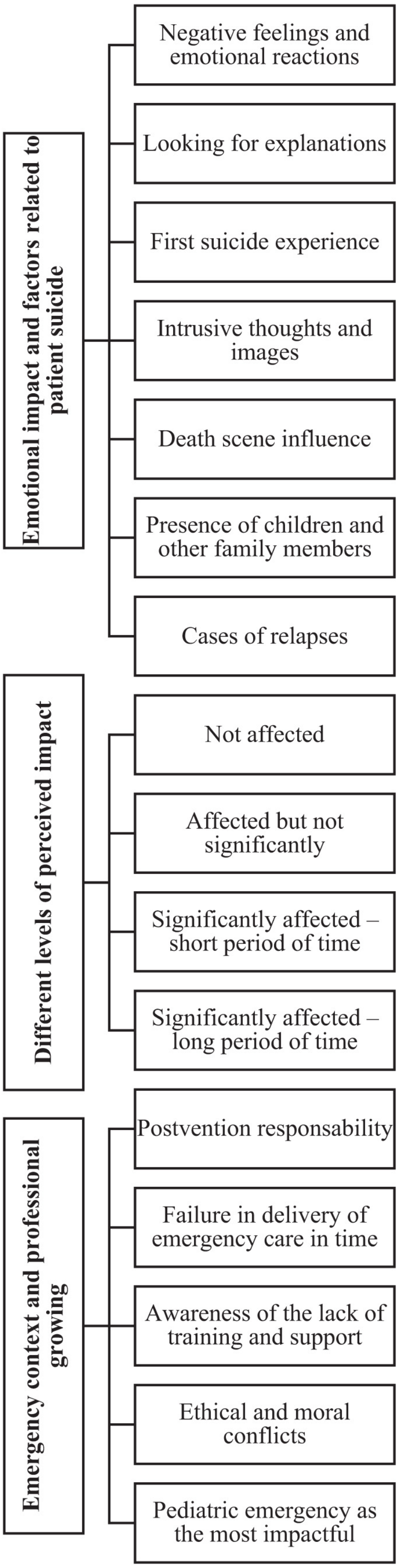

FIGURE 1 | Summary of categories from the prehospital professionals' interviews content analysis.

Emotional Impact and Factors Related to Patient Suicide Impact

Negative Feelings and Emotional Reactions

Prehospital professionals reported a set of feelings and emotional reactions revealing that a death by suicide in the emergency context is likely to have a considerable emotional impact on the health professionals. Overall, it was difficult for these professionals to identify a specific emotion felt toward a suicide situation. Instead, professionals reported mixed feelings as anger at the deceased, guilt for not arriving on time, feeling sorry for the families, incomprehension, horror in shocking situations and, in few cases, empathy.

"And the fact that I knew that the last time I arrived on time... and this time I didn't... it's complicated, it's complicated to digest..." (Participant 10).

"That context had a particular impact on me, perhaps because it wasn't difficult for me to relate to that man." (Participant 6).

Looking for Explanations

The emergency professionals often revealed an attempt to understand why the person died by suicide:

> *"Probably because of some family problem, maybe a divorce, he isolated himself in that hotel room. (...) I think in that moment he felt cornered and ended up killing himself."* (Participant 6).

> *"He lived alone, and his wife had just died. I think it was all this anguish that lead him to suicide."* (Participant 10).

First Suicide Experience

The first suicide attendance experience seems to have a particular impact on the prehospital professionals, emerging as the most impactful case for some of them:

> *"The one that affected me the most was perhaps the first hanging, because I'd never seen one before."* (Participant 1).

> *"I had just started my work in the emergency service. I think it was my first suicide* [attendance], *at least the first I can recall, and it was a far-fetched situation."* (Participant 2).

Intrusive Thoughts and Images

Different participants described intrusive thoughts and images as consequence of attendance to the death scene, revealing that a patient suicide may trigger stress and traumatic reactions.

"Despite my job not giving me nightmares, until today I could still evoke the clothes he was wearing, the way he was hanging, describe everything upside down..." (Participant 4).

"This is the situation I remember the most and I think it will stay in my mind for many years." (Participant 5).

"It was the situation in which I had more flashes in my head. That is to say, I went to sleep, I woke up and that would still come to my mind. It was terrifying." (Participant 13).

Death Scene Influence

The prehospital emergency health professionals described the death scene as an aspect that impacted and affected them. Some of them reported symptoms of stress and traumatic reactions, such as intrusive thoughts and images, feelings of shock and horror, and sporadic insomnia related to the suicide context and its characteristics.

In this study, the death scenario appears as a factor related to a greater impact in different situations including beautiful scenarios in which the shock comes from the contrast between the fatality and the beauty of the outdoor space:

> *"The view was so beautiful, and it was a very sunny day. It was a place where no one expected something bad could happen. I remember arriving to the scene and thinking to myself 'How could someone commit suicide here?"* (Participant 2).

Horror situation, mainly if the body was deformed or mutilated:

> *"I arrived at the scene and found a 36-year-old young lady floating in 5 liters of blood in bed. She was found like this by her 17-year-old son. This was a Dantesque scenario."* (Participant 5).

> *"It was terrifying, a terror, a complete beheading... During months, it kept coming back to my mind all the time."* (Participant 13).

And situations in which the scenario reveals the anticipation and detailed planning of everything:

> *"What struck me was the plan he had put together before he did that (...) That table was impressive, everything in detail, that felt-tip pen... Whoever got there would know exactly what to do."* (Participant 13).

For some participants, having contact with specific details was very impactful:

> *"In this case, it was the detail. Everything was so tidy, the dogs were missing, the gun which wasn't his but from his notary friend. The detail of the registers, the bills yet to be paid and instructions on how the family should proceed to pay them off. Also, the letters all set to be sent to the family members, with the posting money aside."* (Participant 7).

> *"At first, I thought it was only one more suicide, but then what had the greatest impact on me was a farewell letter he had with him. Later, in the emergency room, we were able to read it and his words really affected me."* (Participant 14).

In this last case, reading the farewell letter may also have meant an emotional approach to the deceased.

Presence of Children and Other Family Members

The presence of children or other vulnerable relatives in the emergency situation was described as a factor of increasing stress and difficulties.

> *"The difficulty in that situation was not with the patient itself, who was already dead, but with the wife and the children standing there, looking at us with so many expectations about our work."* (Participant 11).

> *"That situation affected me. We couldn't do anything to the victim because she was already death at our arrival. But that little girl, probably around eleven years old, she was clearly disturbed. In the first moment, she didn't even want to talk to us..."* (Participant 12).

Regarding the presence of children or other survivors in the suicide scene, some prehospital emergency professionals describe an emotional alienation as coping strategy and a mechanism of self-protection.

> *"At some point, we create compensation mechanisms. Mechanisms that lead us to isolate ourselves, to push us a little away from some things. At some point, I think that's what we do. (. . .) I tell myself 'I have to block this, this is not mine.' Even to protect ourselves."* (Participant 7).

> *". . . then I must go away. It is work. I get there, I take care of it and I go away."* (Participant 4).

Cases of Relapses

When the patients were previously attended by the professional, the death by suicide seems to have had a greater disturbing effect and was described associated to feelings of guilt and frustration. Specifically, they reported guilty because the first attempt "*I arrived on time. . . and this one I didn't arrive in time*" (Participant 10).

Different Levels of Perceived Impact

The professionals' narratives revealed the existence of different levels of effects of being exposed to the patient's death by suicide:

Not Affected

> *"I clearly admit that I see a suicide attempt as a situation of normal pathology. It does not cause me any inconvenience or any. . . How can I say. . . any additional emotional impact."* (Participant 12).

Affected but Not Significantly

> *"There was a situation that affected me. A grandfather was accused of abusing his granddaughter. So, he wrote a letter saying that he had never done anything to the girl and that he was tired of being accused by everyone. But if it was true or not, we'll never know."* (Participant 3).

> *"The impact has to do with the way you perceive what you see when you get there. In my case I don't recall any situation that had greater repercussions nor that kept me thinking about it much longer."* (Participant 1).

Significantly Affected – Short Period of Time

> *"I went to sleep, I woke up and that would still come to my mind, or during my daily routine. It was terrifying, a terror, a complete beheading. . . During months, it kept coming back to my mind."* (Participant 13).

Significantly Affected – Long Period of Time

> *"That is the situation that I remember the most and I think I'll remember it for years (. . .) She was lying in a pool of blood, her skin was thin and pallid like paper."* (Participant 5).

Some professionals identified themselves personally with the case, revealing an emotional entanglement with the situation and perhaps a countertransference mechanism, contributing to a great emotional impact and typical grief reactions.

> *"It's hard to deal with. It's because. . . my husband's grandfather also committed suicide. . . these are always situations that mark us because they remind us of a lot of old things."* (Participant 10).

Emergency Context and Professional Growing

Postvention Responsibility

Prehospital emergency professional's revealed specific concerns regarding family, and especially toward children and adolescents. This is one of the reasons that trigger psychologists' presence to be requested at the death scene.

When faced the survivors, some prehospital professionals revealed a high sensibility beyond their sense of responsibility:

> *"No matter how short the time we have in there is, the few words we say to the family can be very important and impact them forever, in a positive or negative way. . . In this traumatic moment, we are very important for those people."* (Participant 11).

Other reported that their responsibility is to activate the professional assistance of a psychologist at the death scene and that they should only focus on the tasks they were trained to do and quickly get out of there.

Failure in Delivery of Emergency Care in Time

Suicide cases placed prehospital emergency professionals in the face of incapacity, challenging their competence and mission to save patients, keep them alive, and take them safely to the hospital. For some participants, the suicide was interpreted as a failure to rescue, namely a delayed emergency help – "*we did not arrive in time*."

Awareness of the Lack of Training and Support

Faced with the difficult challenge of dealing with family members or other survivors, many prehospital professionals realized the insufficient education and training they have. These professionals stated that it would be useful to receive postvention training to promote professional growth in this area.

> *"I have no training in giving bad news, I have no training in dealing with a suicide attempt, I don't have it."* (Participant 2).

> *"No one teaches us in college how to give bad news. We learn it from experience and those who have interest go and search for it. . ."* (Participant 7).

> *"I openly assume I am not fully trained or able to talk with the patient or the family. That is the hardest part. . . There should be more training, there should be more support."* (Participant 4).

The professionals' narratives also indicated some effects on professional practice, including self-doubt and questioning of the limits of responsibility, awareness about the lack of training on suicide prevention and the need to use emotional strategies of self-protection.

> "*That's the hardest part. . . There should be more training, there should be more support [. . .] He was about twenty years, it was by hanging, we have to inform the parents, it was horrible, it was very complicated."* (Participant 4).

The lack or the insufficient formal help system in these cases, regarding survivors and professionals, also arose from the narratives of prehospital emergency professionals.

Ethical and Moral Conflicts

Some narratives revealed that situations of suicide give rise to ethical and moral conflicts. Suicide in the context of prehospital emergency seems to put professionals in a confrontation between restricting their work to the basic goal of saving lives, focusing on issues of physical stabilization, and feelings of ethical responsibility and moral sensibility toward survivors. There is also a conflict between the sensibility and willingness to protect survivors and the need to protect themselves, thus facing the limits of their moral responsibility and their professional limitations.

Pediatric Emergency as the Most Impactful

Different prehospital professionals explained that the most impactful emergencies were pediatric situations rather than suicidal behaviors:

> *"In my opinion, there are more traumatic situations than suicide attempts. I think it may depend on the circumstances. For example, if children were involved in the situation, even just as bystanders, it would gain another dimension."* (Participant 2).
>
> *"Now I am thick-skinned. Whatever comes, it doesn't interfere that much with me anymore. But, if they are children, it still upsets me a lot."* (Participant 13).

DISCUSSION

In the authors' best knowledge, this is the first available study to investigate specific distressing experiences about a patient suicide in the prehospital emergency context, covering nurses, physicians, and prehospital emergency technicians. Thus, it brings important findings to postvention, particularly regarding the impact on prehospital health professionals. The emerged categories show similar impact characteristics to those found in previous studies with other professional groups (e.g., Rothes et al., 2013a,b; Castelli Dransart et al., 2014), as well as highlight some specificities of the emergency context, which may increase emotional impact and traumatic reactions. The present study adds data to the few previous studies, which approached the experience of suicide cases in prehospital emergency context (Gaffney et al., 2009; Nilsson et al., 2017; Vedana et al., 2017; Nelson et al., 2020).

The fact that death by suicide is one among many causes of death or trauma to which emergency professionals can be exposed to may explain that patient suicide impact on emergency professionals has been less studied than in other professional groups.

The narratives of the participants in this study add further evidence that a patient suicide can be a disturbing experience for the health professionals involved, demanding adequate postvention measures to re-establish the well-being of the professional. To date, this was already expectable when considering psychologists, psychiatrists, GPs, nurses, and social workers (e.g., Castelli Dransart et al., 2014, 2017; Séguin et al., 2014), but the present study adds original empirical data that reinforce the importance of not neglecting the effects of suicide on the prehospital emergency team, which in turn can be fundamental to rescue people at risk and even influence the future therapeutic process. The provided care by prehospital emergency professionals is fundamental because it can influence future decisions of help-seeking (Royal College of Psychiatry [RCP], 2010). In this study, prehospital professionals reveal personal resources to functionally cope with the suicide case, as found in previous studies (e.g., Pieters et al., 2003; Rothes et al., 2013b); however, it is not negligible that there are descriptions of increased difficulties in the aftermath of the event, such as stress reactions and insomnias, which may indicate being in need of help.

In this study, prehospital professionals looked for possible reasons that led to suicide and reported them in their interviews, revealing the need for reintegration of the suicide experience as a loss that needs to be taken into account. This search for answers is a normative process of adaptation after suicide (e.g., Postuvan, 2017) and it occurred even when prehospital professionals did not know the deceased. This process is part of the human nature and entails a social role in the stability and assurance of social values (Palgi and Abramovitch, 1984).

Among the experiences described in this study, professionals pointed several reasons for their choice of the traumatic suicide event. Often the experience chosen as the one which caused more concern and anguish was the first time a professional saw a suicide in the emergency context. Thus, the results of this study somehow reinforce the findings of previous studies, which showed that having less experience may increase the emotional impact of the death by suicide of a patient (Chemtob et al., 1988a; Wurst et al., 2010). However, there is no consensus in literature regarding the influence of years of experience on the impact of a patient suicide, as different studies achieved different results. Findings from Chemtob et al. (1988a,b) studies showed a decreasing impact with the increasing of age and years of practice among psychiatrists, whereas in a similar survey with psychologists there were no significant differences. Gulfi et al. (2010) found that young professionals have a tendency to make greater changes in their practice than older colleagues but found no differences regarding the intensity of emotional impact. Other two studies concluded that the intensity of reactions and distress in the aftermath of a patient suicide was independent from age and years of experience (Hendin et al., 2000; Hendin et al., 2004).

As also found in previous studies with different professional groups (e.g., Chemtob et al., 1988a,b; Cryan et al., 1995; Gaffney et al., 2009), some prehospital professionals reported that the most impactful patient suicide triggered traumatic symptoms, such as intrusive thoughts and images. Furthermore, these findings support the conclusion that the greatest impact is more likely to occur when several risk factors are involved and associated to the lack of support and training (Castelli Dransart et al., 2017). Indeed, different predictors of stress and traumatic impact defined in literature were described by those participants who had stress reactions in the aftermath of the death by suicide of an emergency patient, namely, a shocking death scenario (Gutin et al., 2011), the lack of training and support (Castelli Dransart et al., 2017), and a closeness with the patient (Cerel et al., 2014, 2017), even if it is a subjective closeness, through identification or countertransference mechanisms (e.g., "*It was a person of my age*"). Nelson et al. (2020) also found this mechanism of identification as a potential risk factor for a greater distress. In agreement with findings of the influence of both the emotional closeness and the exposure to a higher number of suicides as potential factors that increase negative consequences (Van Orden et al., 2010; Cerel et al., 2017), in this study the rescue to relapses seems to have had a greater disturbing effect. This situation of the suicidal behavior's repetition emerged associated to a specific category of the emergency work context – the feeling of responsibility for not arriving in time. The responsibility for the care was identified in previous studies as a predictor of an increased emotional impact (Castelli Dransart et al., 2017).

This study reinforces the conclusion that the death scene may affect the emotional impact but adds that not only a horror scenario or a mutilated body may be predictors of increased negative impact, as identified in previous studies (e.g., Gutin et al., 2011; Nilsson et al., 2017). The reactions and negative feelings may also be more intense if there is a contrast between the tragic event and the context or if the professionals had contact with specific details, such as a suicidal farewell letter. This in turn may increase the perceived closeness with the deceased acting as moderator of the impact, as already pointed out in the literature (Cerel et al., 2014, 2017; Castelli Dransart et al., 2017).

Prehospital professionals revealed feelings of responsibility toward the survivors, concerns about family needs and protection from the intense situation, especially when children are involved. They also reported doubts, feelings of uncertainty and incapacity and lack of skills to deal with the survivors, which sometimes led to contact the psychological emergency staff. These feelings and doubts regarding the care of survivors are in line with the outcomes of Nilsson et al. (2017) that studied the experiences of facing the family of a deceased by suicide in the prehospital emergency context. These findings are also in accordance with Nelson et al.'s (2020) study, which concluded that having to deal with the intense emotional reactions of bereaved individuals is a difficulty for the paramedics. The loss of a patient by suicide and the coping processes of the prehospital emergency professionals of this study varied from professionals whose exposure to suicide did not appear to affect them (although it may be a process of denial as a defense mechanism) to professionals whose narratives included normal grief reactions, even though they did not last long. Adopting the categories of terminology proposed by Cerel et al. (2014), this study found that the perception of impact apparently varies between the levels of exposed to affected by suicide; the levels of bereaved were not found. These results are consistent with those found by Séguin et al. (2014). The authors reviewed 37 studies about the impact of a patient suicide and concluded that for the majority of health professionals the loss of a patient by suicide may often trigger grief reactions, although they are not part of a grieving process, namely because professionals recovered fast. Moreover, the findings of this study showed that the death by suicide may have a constructive consequence on the prehospital emergency professionals, increasing the awareness of the importance of training and support in this field. Several participants pointed out the lack of preparation and training as a difficulty. The interviews created an opportunity for professionals to reflect and increase their awareness about the suicide phenomenon. Previous studies had already highlighted the potential constructive effect that patient suicide may have in the professional growing (e.g., Rothes et al., 2013b), especially if proper training and support is provided. Thus, the present study underlines that providing more training on suicide prevention for those working in prehospital emergency context is fundamental. This specific education should include the anticipation and preparation for patient suicide. Moreover, the training aimed at prehospital professionals should approach specific features of the emergency context, mainly those that participants of this study highlighted as risk factors for increased negative impact and stress reactions: cases of relapses, death scenario, presence of children and other survivors, details' knowledge and emotional closeness, and not to arrive on time.

Future research on suicidal behaviors in prehospital emergency context should explore the relationship between the professionals' conceptions toward suicide and patient suicide impact and study the effects of socio-professional variables, including training and years of experience in prehospital emergency care. Given the wide range of time intervals between the case chosen to be described as the most impactful and the moment of the interview (among the professionals who referred this aspect), it is advisable to systematize and analyze this variable in future studies. Future research should investigate the experience of psychologists who have experienced patient suicide in the specific prehospital emergency context.

Limitations

The study only covers two regions of the country. Besides the fact that suicide presents different characteristics depending on the area of the country, social and cultural variability inter regions may have influenced the way prehospital emergency professionals deal with the patient suicide experience. Another limitation is that interviews were conducted within the context of the professionals' work and in some cases, it had to be interrupted and later restarted, losing some depth and fluidity.

CONCLUSION

In general, a suicide case in prehospital context seems to be an impactful experience for the professionals, triggering traumatic and stress reactions for some. Further research on contextual variables and about the relation between perceived impact and coping strategies can provide useful clues to be integrated in formal training in suicide and eventual postvention measures aimed at prehospital emergency professionals.

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available on request to the corresponding author.

ETHICS STATEMENT

The study protocol was approved by the Ethics Committee of the Faculty of Psychology and Educational Sciences of University of Porto. The participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

IR contributed to the conception of the research and study design, participated in the data collection, analyzed and interpreted the data, planned and wrote the draft of the manuscript in full, and wrote and rewrote large sections. IN contributed to the conception of the research and study design, collected most of the data and transcribed the data, analyzed and interpreted the data, and wrote parts of the manuscript. AC contributed to the conception of the research and study design, participated in the collection data and transcription, contributed in the data analysis (as reviewer), contributed in the discussion and interpretation of data and in references search, and provided some critical clues. MH contributed to the conception of the research and study design, contributed in data analysis (as reviewer), questioned and discussed the outcomes and interpretation of the data, and supervised the work in all stages. All authors contributed to the article and approved the submitted version.

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The Experience of Adults Bereaved by the Suicide of a Close Elderly Relative: A Qualitative Pilot Study

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Suicide in older persons is a serious issue in many countries. The act of intentionally causing one's own death is often associated with lack of social support, thwarted belongingness, or chronic interpersonal difficulties. Therefore, suicide has a significant interpersonal dimension that can influence those left behind. However, studies that have investigated the impact of older adults' suicide on their family are scarce. The objective of this pilot study was to assess the feasibility of a qualitative research on the psychosocial experience of adults bereaved by the suicide of an elderly relative. This research could recruit three participants (daughter, grand-son, and grand-niece) who had lost to suicide a close family member aged between 75 and 90. The analysis of the content of the semi-structured interviews revealed seven main themes: (1) finding an explanation to the suicide, (2) give meaning to the loss, (3) the emotional processes of mourning, (4) the repercussions of the suicide on the individual and the family, (5) looking for support, (6) the taboo and secrecy of suicide, and (7) perceptions of aging and the end of life. To explain the suicide of their loved one, the bereaved mentioned various factors related to aging, such as loss of autonomy, illness, and fear of placement. Although the older relative was perceived to be approaching death because of his/her age, the suicide was still unexpected and shocking and led to various emotions (shock, anger, and guilt) and to family conflicts. Suicide remains a taboo subject, but the newly legalized medical assistance in dying is seen as a potential solution to suffering in old age. Further investigation is clearly needed on this topic and this pilot study indicates that the main difficulties will lie in the choice of selection criteria for participants and in the recruitment process.

Keywords: suicide, grief, bereavement, older adults, family, close relatives

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INTRODUCTION

Suicide is a public health problem among older adults (Richard-Devantoy et al., 2013; World Health Organization, 2014). According to the World Health Organization (2020), the percentage of the world's population over the age of 60 will double from 2000 to 2050, from around 11 to 22%. Although the suicide rate for people aged 65 years and older has fallen in the province of Québec (Canada) since the 1980s, the total number of deaths by suicide has actually risen by 40% due to the growing number of individuals in this age group (Association québécoise de prévention du suicide, 2014). In 2017, the suicide rate for older adults was 11.3; however, it was five times higher for men (20.6) than women (3.7; Levesque et al., 2020).

Suicide is a serious issue that takes place in a context of interpersonal relationships between the person who died by suicide, family members, and close acquaintances. Any research concerning suicide in the older age group would be incomplete without accounting for the perspective of the bereaved (Andriessen and Krysinska, 2012). Accordingly, the issue of late-life suicide must be addressed in order to prevent the negative repercussions on family and friends. Previously, it has been estimated that for each completed suicide, between 6 and 10 persons were profoundly affected by the death (Cerel et al., 2008). New data, from a random-digit dial survey (*N* = 1736, where veterans were deliberately oversampled), lead to an estimate of 135 adults exposed per suicide death (Cerel et al., 2019). In addition, because suicide by an older person remains a taboo subject, and because it is considered normal for older people to die, the bereaved find it more difficult to acknowledge their grief (Figueiredo et al., 2012). Furthermore, suicide in older adults may be viewed as a rational act when the person is suffering from a chronic debilitating disease, as well as a means of controlling the timing of one's death while escaping the prospect of burdening others. For these reasons, many may view suicide in old age as an "acceptable" solution to a predicament (Cerel et al., 2008). Yet, few studies have investigated the impact of the suicide of an older person on their close adult relatives (Cerel et al., 2008). It is possible that these bereaved adults would have specific experiences and needs that differ from those of other bereaved individuals (Harwood et al., 2002).

To address this issue, it is useful to adopt a theoretical approach based on suicide bereavement and postvention (Andriessen et al., 2017). The literature on suicide has shown that this type of death seems to expose the bereaved to a complex grieving process and that postvention (intervention support for the bereaved) could be an important strategy for suicide prevention since survivors of suicide loss seem to have a higher risk of suicidal behavior (Andriessen, 2009). Bereavement after a suicide comprises various prominent and intense thematic issues (Jordan, 2008). After the shock that usually accompanies the event, survivors of the loss must cope with mixed feelings, unanswered questions, family relational disturbance, and social stigma. In addition, they frequently report feelings of guilt, shame, and social isolation, not to mention negative consequences for their social, physical, and mental well-being (Jordan, 2008; Tal Young et al., 2012; Pitman et al., 2014). Suicide has an undeniable psychosocial impact on the survivors.

Nevertheless, whereas the literature is abundant on individuals who have lost a close relative or friend to suicide, the survivors, as well as the deceased, are usually aged under 65. Few studies have involved adults whose older relative intentionally ended their life (Kjølseth et al., 2009). Among the existing research, Harwood et al. (2002) showed that relatives (children, spouses, and sibling) and friends of older adults who died by suicide experienced more stigma, shame, and sense of rejection than relatives of older adults who died from natural causes. One qualitative study, done in Brazil by Figueiredo et al. (2012), showed that family members of older people who died by suicide reported social stigma and prejudice, social isolation, feelings of guilt, rage, and anguish, and for some, irreverence. They tried to distance themselves from the location of the suicide (the home) since it had become a threatening environment for them. Survivors also mentioned that they had not believed that their older relative would end their life even when the latter explicitly said they would.

With the scarcity of studies on the topic, it remains unclear whether adults who faced the suicide of an older relative suffer similar or different experiences and consequences, as those reported in studies with other groups of bereaved individuals, and if they have a need for particular support. It seems necessary to fill this gap in the literature. However, it also appears relevant to include an internal pilot in the design of our main study in order to see if adjustments are necessary to the methodology since it might be difficult to recruit participants due to the stigma and feelings of shame associated with suicide (Cerel et al., 2008; Janghorban et al., 2014). Moreover, since the aim of the main study is to make an insightful analysis of the experience of the bereaved, it is necessary to verify the suitability of the instrument to increase confidence in the trustworthiness of the data that may be obtained (Malmqvist et al., 2019). In addition, the pilot study could provide a ground for self-assessment of the main researcher's preparation and capacity to practice a qualitative inquiry, for improving skills in conducting an in-depth interview and seizing opportunities for probing emerging topics during the interview process; all of which would enhance the credibility of the research (Nunes et al., 2010; Padgett, 2016). In fact, a well-planned and thoroughly conducted internal pilot study would ensure higher research quality when a depth of understanding is sought (Malmqvist et al., 2019). Thus, the objective was to have a preliminary overview of the psychosocial experience of adults bereaved by the suicide of an elderly relative and to assess the feasibility of a qualitative research on this topic in order to improve the efficiency and quality of the forthcoming main study.

METHODS

Study Design

Given the lack of studies on individuals bereaved by the suicide of an older family member (Cerel et al., 2008; Figueiredo et al., 2012), a qualitative approach was deemed appropriate to examine the psychosocial experience of the survivors following this event (Hjelmeland and Knizek, 2010). Therefore, we used a semi-structured interview to question the participants about their experience at the time of the loss. All potential participants that were contacted for the study received information about the suicide prevention center of their region, which offers services to the bereaved, or about the psychological clinic of the university, in case they needed it.

A number of selection criteria were established to ensure that potential participants were not overly vulnerable. First, to be included in the study, they had to be older than 18 years.

Second, they had to have lost to suicide a parent or a grandparent aged 65 years and older between 2 and 20 years ago. The 2-year minimum was expected to give participants sufficient time since the death to step back from the event and to be able to reflect on their experience, while the 20-year maximum was chosen according to the number of years since the suicide, observed by local prevention centers in members of support groups for survivors. Third, they could neither present a diagnosis of depression or other mental health disorders nor should they report suicidal ideation, as verified by the PHQ-9, described below.

Ethical Consideration

This research was approved by the Human Research Ethics Board of the University of Québec in Trois-Rivières[1] and different strategies were planned to minimize risks to participants considering that the area of suicide-bereavement is highly sensitive and people who have been impacted are extremely vulnerable. The major risk associated with this study refers to the reactivation of painful memories and the discomfort caused by certain questions. Although some bereaved people may find the interview difficult and even upsetting, it should be noted that a few studies have concluded that participants usually assess this type of interview positively and find it useful (Cooper, 1999; Dyregrov et al., 2011; Andriessen et al., 2018). A safety plan has also been formulated to protect participants. The interviewer paid special attention to signs of complicated grief, excessive stress, or suicidal ideations during the meeting and asked about their current emotional state at the end of the interview. After the interview, they were referred to psychosocial resources who could support them in their mourning, such as the psychological clinic of the university, and were given the 24-h contact number of the Centre for Suicide Prevention.

Procedure

Participants were recruited through advertisements posted in public areas of the university and in various coffee shops around the city of Trois-Rivières. The local university has over 15,800 students or employees aged between 20 and 65 years. The advertisements were also posted on social networking websites (e.g., Facebook) and widely published online by suicide prevention centers. People who showed interest in the study were scheduled for an initial telephone interview. The purpose of this interview was to explain the research objective, the potential benefits and risks of participating, and the duration and nature of their participation. It also led to the verification of the inclusion and exclusion criteria. It should be noted that four other participants contacted the research coordinator, but they were excluded because their relative was between 50 and 65 years old. They were referred to another study investigating the experience of people bereaved after the suicide of a "babyboomer".

The French translation of the Patient Health Questionnaire (PHQ-9) was used to screen for depression and suicidal ideations (Kroenke et al., 2001). It contains nine questions and takes about 5 min to complete. It has 77% sensitivity and 85% specificity (Institut national d'excellence en santé et en services sociaux, 2015). Participants who scored higher than 4 (indicating at least minimal depression) or who reported suicidal ideations on item 9 would be excluded from the study and referred to a mental health resource, as desired. No potential participant was excluded. Consequently, a date was set for a semi-structured face-to-face individual interview. The interviews took place at the Interdisciplinary Laboratory for Research in Gerontology (LIREG) at the University of Quebec in Trois-Rivières with the principal investigator (GMD) and the participant only. The principal investigator of this study is currently completing a doctorate degree (PhD) in clinical psychology. She also took a 45-h university course on qualitative research, in addition to various suicide prevention training.

Prior to being interviewed, the participants signed a voluntary informed consent form. No participant received any monetary compensation for participating in the study. The interview covered various topics with 13 questions intended to incite participants to recount their experience and express their thoughts and emotions concerning the suicide of their older relative (see **Appendix 1**). It was developed by the principal investigator on the basis of existing research on people bereaved by suicide. When they expressed intense emotions, the researcher showed empathy and slowed the pace of the interview to allow them the time needed to communicate. Field notes were taken by the researcher throughout the interview in order to identify the main ideas and to further question the participant on his/her experience. The interviews lasted from 43 to 105 min (see **Table 1**). Each participant was assigned a numerical code to ensure anonymity.

Participants

Participants were recruited from the general population over a 15-month period. Initially, we intended to recruit children and grandchildren only, but since it was difficult to find adults who were willing to share their experience, we also accepted a participant who had lost her grandaunt with whom she was emotionally close. The sample of the current study includes three adults who lost a close relative whose age at the time

TABLE 1 | Demographic characteristics of the interviewees and the deceased.

Interviewee	Gender	Age	Deceased's relationship to the interviewee	Deceased's age at suicide	Time since the suicide (years)	Length of interview (minutes)
A	Male	20–25	Grandfather	80–85	3	50
B	Female	30–35	Great aunt	75–80	15	44
C	Female	60–65	Father	85–90	2	105

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of the suicide varied from 75 to 90 years. We had planned to recruit at least 12 participants, as recommended by certain studies (e.g., Isaacs, 2014) on qualitative research methodology, but we could only recruit three. The bereaved participants consisted of a man between 20 and 25 years of age, as well as two women aged between 30–35 and 60–65, respectively. These age ranges are used to ensure anonymity considering the small sample. The time since the suicide ranged between 2 and 15 years. **Table 1** presents some information on the nature of the relationship between the bereaved and the deceased and their demographic characteristics. Interviews were held from June to November 2019.

Data Analysis

An inductive method was chosen for the data analysis as current research on adults bereaved by the suicide of an older person remains scarce (Thomas, 2006). This conventional method has the advantage of producing reliable knowledge through in-depth examination of a limited number of cases (Miles et al., 2013). First, the interviews were audio-recorded and fully transcribed. The verbatims were not returned to the participants for comments or corrections. Then, the first author performed a thematic analysis of the interviews' content following a step-by-step guide suggested by Braun and Clarke (2006). During the analysis, the investigator attempted to preserve the original meaning by making a full and accurate representation of the participants' statements, including pauses and tone. Repeated and immersive readings of the verbatim transcriptions led to the identification of recurring themes, which were coded by the first author using the qualitative software NVivo 12, as it facilitated preliminary thoughts to emerge across cases and develop linkages between categories and initial themes (Bengtsson, 2016). Therefore, analysis first began with assigning broad codes to the data, followed by building a second cycle of codes on the initial broad codes, and grouping them into meaningful categories or themes (Kalpokaite and Radivojevic, 2019). The themes were then discussed and refined with another researcher (SL) to establish interjudge agreement. The aim was to ensure that the categories accurately represented the participants' experiences. Thus, based on multiple discussions, authors reached a high degree of consensus.

RESULTS

The analysis of the content of the semi-structured interviews revealed seven main themes: (1) finding an explanation to the suicide, (2) give meaning to the loss, (3) the emotional processes of mourning, (4) the repercussions of the suicide on the individual and the family, (5) looking for support, (6) the taboo and secrecy of suicide, and (7) perceptions of aging and the end of life.

Theme 1: Finding an Explanation to the Suicide

Results indicated that the bereaved relatives tried to understand and justify the suicide by seeking various explanations for the act, all of which were associated with aging, physical illness, cognitive decline, and fear of placement in a nursing home. All three participants recounted that, prior to the suicide, their relative suffered from physical or neurological conditions. Furthermore, two of them had been diagnosed with Alzheimer's disease a few months before they ended their life. Participant A specified that his grandfather had often voiced his fears about Alzheimer's disease. *He had seen what Alzheimer's was like, because there was a nursing home that he visited a lot. He knew about Alzheimer's, and he was, sort of … not vain, but proud. He did not want to go through the Alzheimer stages, the decline. He knew everything that would happen, and it was out of the question for him to take that route* (Interviewee A, grandfather).

In addition, some participants believed that the way their relative learned about the diagnosis of Alzheimer disease was problematic and contributed to the exacerbation of the shock of the news.

It was the start of Alzheimer's. But what happened for the drugs (is that), the pharmacist and the nurse did not say it was for Alzheimer's, and that it was really for memory problems. What really shocked him was when they called him for a renewal, and they said, "then for your Alzheimer's drugs." He did, "What? I do not have Alzheimer's." He was downright … As if it was a plot against him and everyone wanted to hide that it was Alzheimer's, so it was a shock for him […] It's sure there might have been something that should have been done. As much from professionals, as much as perhaps from us too. At the time, we did not know (Interviewee A, grandfather).

Persistent physical pain, often listed among predisposing factors for suicide in older adults, also constitutes a common explanation mentioned by the participants (Harwood et al., 2006). *So, the next afternoon, a doctor came because he had gotten to a point that … He wasn't eating, he was confused. In the end, he had sinusitis. […] It seemed like that marked the beginning of the end … (Interviewer: This was what trigged it, you think?). Yes. Then antibiotics … And from then on, his questions, they never stopped. We saw that … even in those days, and for the rest of his life, he was always in some kind of pain* (Interviewee C, father).

Transfer to a nursing home is a crucial moment in the life of an elderly person. However, the adaptation to this transition largely depends on the meaning attributed to this event. Two of the participants described the inability of their loved one to accept a placement in a long-term care facility, whether it was decided or a possibility.

I think he hid his symptoms well. I think that he knew more about the stage he had reached in his illness than he let on. Or more accurately, being proud, he did not want to show it. "Oh no, I'm still able to live at home." … He knew that if he said: "Hold on, there's a lot of things going on in my head," … He knew that he was going to be placed (Interviewee A, grandfather).

At the same time, we were very aware, well, … or rather we were sort of aware at the time, that she was sick. As for her, she had always told my father, "Me, I'll never end up in a nursing home or a hospital, or whatever … If I get sick, I'm going to die in my own home" (Interviewee B, grandaunt).

Although illness was the main reason mentioned to explain their relative's suicide, participants also stated various losses (e.g., driving license, freedom) or the development of conditions, like dependency, that had major consequences on their relative's quality of life and dignity. Everything that had given value to their lives had been lost. Losing a driver's license can have serious consequences since its possession is intimately linked with older people's identity and feelings of independence, agency, self-worth, and autonomy (Whitehead et al., 2006). Their older relative's increasing feelings of powerlessness emerged through the descriptions of these disappointments and losses.

So, she would say: "Nobody's going to wipe me, that's for sure." And in the same way, "Nobody's going to take care of me" (Interviewee B, grandaunt).

It was the Alzheimer's that led to the suicide, it's clear. Because he was still … he was still active. Another thing that happened, also, was the loss of his driving license, not long before. Because that's what comes with it. He was very autonomous, my grandfather. He loved going out for a drive. He loved having his freedom, doing his things, going grocery shopping, and his little routine. […] So, it's clear that this made him feel more isolated, you understand (Interviewee A, grandfather).

In addition to the awareness of the deficits, the threat of placement, and the refusal to mourn the loss of one's previous abilities, the feeling of being trapped was an element that seems important in the participants' perception of the suicide. *I think that he was deteriorating and that he did not see any way out* (Interviewee C, father).

According to the participants, these older adults wanted to maintain control over their lives and solve their problems in their own way.

The driving license, the fact that there was a place in a nursing home waiting for him, all that. That's clear … Then, the fact that he had not already been told that he had Alzheimer's. All that, the melting pot. I think that, in hindsight, me, I'd say, … He wanted to take care of it in his own way, before he lost his autonomy completely and became dependent. I think that it's clear that he would not have wanted that! He would not want to be a burden. That would be out of the question (Interviewee A, grandfather).

Because sometimes we tell ourselves, yes, there's always a way to make things better, and to ask for help, but sometimes, you may be fed up. So, it depends on the situation. For her, I think that she could have (ask for help), but at the same time, if that was always her mindset, "Me, I'll never die in a hospital, and I do not need to be taken care of," well, … she had decided that she wasn't going into a hospital, and she wasn't going to be taken care of (Interviewee B, grandaunt).

Finally, some participants attributed the suicide to attitudes or behaviors believed to be held by the older generation. For example, participant B describes a lack of flexibility or a low level of "openness to experience" that characterize certain personality traits associated with suicide among seniors (Duberstein, 1995). The lack of openness to new experience is characterized by short-term concrete life goals, behavior that is not conducive to change, the absence or few interests, and a limited range of emotions.

People aging as a couple live for their couple and there is nothing else. But at the same time, these people did not know what volunteering was. These people have known: we work and when we stop working… Well back in time, they would die when they stopped working. Today they do not die, but they do not know what to do. They were not brought up to that either and they were not brought up to talk about what they were going through (Interviewee B, grandaunt).

Theme 2: Give Meaning to the Loss

After looking for explanations for the suicide (see first theme), participants questioned their own visions of life and some took concrete action in order to reconstruct their views and get through the mourning process. For example, participant A described how the event had pushed him to study gerontology so he could increase his knowledge about mental illness and make sense of this loss in his life. He also found a job with older adults thereafter in order to get involved with this population and help them.

I'm the only one in my family who said I'm going into gerontology. I want to understand more about what happened. So, with these courses, I have a better understanding of mental illness. It's hard to understand something when you do not have the knowledge, you do not know the theories about it. It has helped me a lot in personal terms too […] I'll tell you, that helped me get through my mourning […] I sort of experienced another vision of life. You could say that I was looking for something: a meaning. It made me question things. It brought out a lot of things that I had inside me. You know, philosophize about life and all that. Become more aware of what life is (Interviewee A, grandfather).

The suicide also disturbed their convictions about the deceased. To make sense of the loss, the participants clung to diagnoses given by professionals. *Very narcissistic, so one could also imagine that feeling himself decline, for someone who's … that must be very hard to live with, even for someone who is not narcissistic. So, one could imagine that … (Interviewer: This put additional stress). You would know better than me. But that's my feeling. For me, that's how I understand it. That's how I made sense of it all* (Interviewee C, father).

All the participants were unanimous in their belief that understanding the suicide and their relative's perspective on life helped them to make sense of it. Meaning reconstruction or the ability to change one's view of a situation had a positive influence on their mourning process and on accepting the loss.

For me, that's how I overcame it, for sure. I wanted to understand. Knowledge about what really drove it [the suicide], and what had really made it happen. By working with older people, too, by witnessing their reality, by seeing other situations (Interviewee A, grandfather).

Me, I was less emotional, because I found that I could understand her reasoning. Put it this way: me, I do not want to die, or be sick, or suffer needlessly. So, I understand what she did (Interviewee B, grandaunt).

Minor Theme: Desire to Help

Finding something positive in a negative experience helps to derive meaning from a loss and buffer against the psychological damage of such events (Sutin et al., 2010). Helping others is a way to turn a negative situation into something positive. Altruism seemed to be the central motivation among the bereaved to participate in a study on this topic. Indeed, they hoped that with their contribution they would help prevent suicide and help advance research and services for survivors (Dyregrov et al., 2011). It might also be a way to give meaning to their loss.

Well it's interesting [this study]. I liked it. I think it allowed to take a step back. We took it that way at the time, but there what we would like today? And then, yes finally, you realize that I would have liked to know her more (Interviewee B, grandaunt).

It's good that we talk about it, it's good that there are studies like that that are being done, I find it great, that's why I signed up. When I saw it [the poster], I said to myself, I'm going to participate. I said to myself, I'm going to give a hand (Interviewee A, grandfather).

Theme 3: The Emotional Processes of Mourning

The emotions experienced by the participants were very intense at the beginning of the mourning process. On the day of the suicide, all the participants reported shock when they heard the news as well as great sadness. Although they might have expected their relative to die eventually, as a result of their condition and their advanced age, the suicide was experienced as a brutal and unexpected event. *We were not expecting it … yes, he was sick, but it had not yet gotten to the point that death was imminent or obvious. It was more brutal (Interviewer: You thought there was more time?). Yes […] Because never in my life would I have said that my grandfather was going to get Alzheimer's, and that he was going to commit suicide, that's for sure. Never, never, never, would the thought have occurred to me* (Interviewee A, grandfather).

All the participants said that they had forgotten some of what happened on the day of the suicide. Participants A and C, who had gone to the scene as soon as they received the news, described feelings of intense shock that seemed to plunge them into a black hole. *For the rest of the day, after the shock had settled, we talked, but to be honest, I do not remember what we said at all. The shock was a little too much* (Interviewee A, grandfather). *That evening, the coroner came, but my mind was a blank. I do not know if anyone was with my mother when I got in touch with her (Interviewer: You do not remember?). A total black hole* (Interviewee C, father).

Two of the participants reported anger against the deceased. One of them associated this anger with her frustration at not being informed about the suffering of her relative, and therefore not having the opportunity to help her. However, this anger appeared to be attenuated by her awareness of the difficulty of passing judgment on other people's lives. *Just tell us that you are suffering. At least we can try, if only to sympathize, help with the chores. I do not know. I tell myself, we lived far from each other, but I mean … maybe there was something we could have done all the same, but we did not know, because people do not tell us … Me, I say, you cannot blame someone … they have their reasons for doing it. It was too much for her, you do not know what's going on in her mind, you cannot judge her* (Interviewee B, grandaunt). Another participant also expressed anger, particularly since she was very involved in caregiving for her older parent and had spent a lot of time meeting his needs. She associated her resentment with her perception of suicide as a selfish gesture (or lack of consideration for others) and to the tangible consequences for the people left behind. *He had no business doing that, leaving my mother all alone, she who took care of him for his whole life. And who left it all up to me. He left it all up to me […] I think that it's selfish. I think that he realized that he was deteriorating, and he did not want to deal with the problems* (Interviewee C, father).

The participants also said they felt guilty, but this feeling was moderated by whether or not they felt they had done everything in their power at the time. For instance, participant A expressed remorse that he had not been there enough for his grandfather. However, he said that his mother felt even more guilty because she blamed herself for having missed the signs of suicide. In contrast, participant C refused to feel guilty because she believed that she had given everything she could to her father when he was alive and, therefore, had nothing to regret. *Guilty, no. I think that I gave him everything that I could. And even if I had understood what he might have intended, he acted the next day* (Interviewee C, father).

In association with the guilt, we noted regrets and the need to formulate diverse scenarios that might have led to a different outcome. These hypothetical scenarios began with: "If I could…" or "I should have …" or "If the situation had been…" *[My mom] was saying: "I could have, I should have been there, or if I had been there, if I had seen the rope, if I had realized," … Thinking over everything that was said, going over all their conversations* (Interviewee A, grandfather). In participant C's case, geographic distance led her to create a scenario in which she would have lived close by and might have noticed some signs of suicidal ideation. *I mean, we did not know what condition she was in. She would have been nearby, I would have seen her every week. I would have seen it eventually, I do not know, that she had lost weight, or that she was exhausted, or that she seemed in pain* (Interviewee B, grandaunt).

Theme 4: Repercussions of the Suicide on the Individual and the Family

Suicide affects the personal lives of those left behind. Mourning after a suicide can become a profoundly isolating experience, one that may have a significant and quite deleterious impact on the survivor's relationships with family and friends (Jordan, 2008). In addition to the sorrow that is common after all losses, two suicide survivors showed high levels of distress in several domains of their functioning. *I had the impression that I vegetated for months. […] I was very, very rattled by the whole thing. […] I never felt like going to my Tai Chi class. I did not feel like it. And I could not concentrate. There were even times when I had trouble reading. […] I stopped eating. I've gained back two pounds, but I lost 20 after my father died. My appetite is not very good. […] I was assessed* *by a psychiatrist, who told me that it was impossible for me to go back to work* (Interviewee C, father).

They clearly stated that their priority was to take care of their own needs. *So, the way I was functioning, I'll tell you, for the … first 3 or 4 months, it was clear, it (my own well-being) took precedence. My priority was more … to take care of myself* (Interviewee A, grandfather). Another had to take care of her mother, who had Alzheimer's disease, which influenced her grieving process. *I asked myself the other day, … I said to myself, and if Mom had not been there, how would I have gotten through it? It would have been totally different, if you do not have someone to look after 24/7* (Interviewee C, father).

Two participants described the consequences of the suicide on family relationships. At first, there seemed to be some closeness and support. However, for one of the participants, conflicts surrounding the deceased's inheritance raised tensions, particularly with the extended family. These conflicts over money considerably altered the relationships between family members.

For the first year, it brought [the family] together. We were really close. As soon as the inheritance of the house came up, then the squabbles erupted. And it went on and on. So now we do not speak anymore. Me, I still say hello, and all that. We had some family dinners where we were really close, and now that's all finished (Interviewee A, grandfather). For the other participant, family tensions arose after trying to manage the multiple responsibilities associated with the suicide of their father and the needs of their mother who suffer from Alzheimer's disease.

Well, it brought us together because we really had to work together, my brother and me. But I could not do it anymore. I could not stand it anymore. I told myself, after it's all over, I'll never speak to him again. Everything was really messed up (Interviewee C, father).

Theme 5: Looking for Support

Looking for support was the main coping strategy used by the participants. They all mentioned having received family, marital, or friends' support. In fact, whether it was the day of the suicide of their close relative or in the short term, they were accompanied by those around them.

[Interviewer: What helped you deal with this (your grandfather's suicide)?] The family. At the beginning, we were still quite united. We had family meetings, regularly. Several times, especially the first week, we saw each other all the time. What I think was good anyway (Interviewee A, grandfather).

On the other hand, we understand from the participants' discourse that family's and friends' help was not always enough and that it is important to receive support from professional or community resources that specialize in services for those bereaved by suicide.

I think it's good to consult with someone who is neutral. Because it is good to have family, friends, or other support, but people cannot be completely objective. While an outside person will help mourn the way the person needs to do it […] When I look at families where people do not speak, well if you need help, and someone has committed suicide and you should not talk too much about what you feel, well what do you do with your pain? Where are you going? So, someone neutral, that's good […] If you do not have it [support], you have to go get it (Interviewee B, grandaunt).

Even though participants presented a positive perception of the various services they received (social worker, support for Alzheimer caregivers, bereavement counseling center), it appeared however that the bereaved had to do their own research in order to find an organization likely to support them. These specialized services did not come to them automatically.

But I had to pull myself together so quickly. And then afterwards, I organized myself to get help, I managed to get help from the Alzheimer's association. At the last minute […] I had started to consult; I had done research I think in December to get help. Because the therapist I had consulted for years, she had retired a few months earlier. And I discovered the Bereavement counseling center. And when I called the line, when I said it was suicide, I was told there was someone specializing in violent deaths who will call me back (Interviewee C, father). *First step to know: that there are resources, second step, to use them. But still, it's difficult* (Interviewee A, grandfather).

Theme 6: The Taboo and Secrecy of Suicide

In general, all participants agreed that suicide is still a taboo subject and that it is an uncomfortable topic for family members and for people in their community. Participant A felt that there is a significant difference between suicide and other types of death: *I think people do not know how to deal with this. It's not like a death … you know, cancer, or whatever. It's a suicide. It's like a taboo* (Interviewee A, grandfather). In fact, the feeling of shame associated with the suicide of a family member is mentioned in the literature as the most common feeling among families, due to the stigma and social prejudice associated with the act. In this sense, it is not surprising that participants' testimonies revealed that the suicide was surrounded by silence and secrecy.

What was hard, too, was the fact that it was a suicide. The fact that we know each other. It's a community, so it's even smaller, and it was a great burden. […] It's like you are uncomfortable with everybody. You know that the person knows what happened. You're not sure how to act with them. You know that it's really uncomfortable. And everybody else, I think they do not know how to deal with it either […] (Interviewee A, grandfather).

We do not talk about … and my mother's family does not talk about it much. I actually have two families that, … where things are not said. People can think their thoughts, and people would like to have better ties, but we do not talk to each other. So, if someone has suicidal thoughts tomorrow morning, I think that nobody will know about it (Interviewee B, grandaunt).

The emotionally charged nature of the topic made it difficult to divulge the suicide to others, especially those that are perceived as fragile or vulnerable and believed to be in need of protection (Cerel et al., 2008).

In the elevator, I decided that I would not tell my mother the truth. With her Alzheimer's and everything, she would feel guilty. I knew it. I knew her. Emotionally, it's hard to manage (Interviewee C, father).

Theme 7: Perceptions of Aging and the End of Life

Following the suicide of their close older relative, the bereaved participants thought about their own aging. Because they attributed the suicide to age-related loss of faculties, two of the participants expressed fears about ending up alone and useless, losing their autonomy and cognitive abilities, and above all, being placed in a nursing home. Thus, their negative perceptions of aging, which were connected, among others, with the experiences they had gone through with their older relative, seemed to heighten the participants' fears about getting old.

I would still like to make some kind of contribution, and not to die alone. With dignity. First, being physically and rationally sound, because you can be one or the other, and it's no more fun being one more than the other. And yes, if it's possible, with autonomy. Even if you are not autonomous in every respect, but you are at home, if you have a little help, but you still feel involved. People have to feel useful (Interviewee B, grandaunt). *Me, I do not want to lose my faculties. You see people, it's really … at the end, I was at the end of my rope. With two parents, my mother with Alzheimer's, my father, he was at the beginning … I think that I'm at greater risk than most people. I'm going to write it in my advance directives. I want to make it clear to my daughters* (Interviewee C, father).

Medical assistance in dying (MAiD) was recently legalized in Canada. In the participants' mind, MAiD offered them an option to avoid problems associated with aging even if this law is accessible only for terminally ill patients. All the participants viewed this as an acceptable way to end a life of unbearable suffering. They felt that the death of their relative would have been less tragic if they had had access to this solution and that the mandatory discussions involved in the MAiD procedure could have resulted at best in a change of mind for their relative.

I'm glad that we have it now (MAiD), because you can have a degenerative disease, where you know that you are going to die without dignity or forgotten. I mean, you yourself forget things, so do you really want to live like that? Do we have to live like that? Me, I think not (Interviewee B, grandaunt).

Because if the person judges that it's not a good quality of life, like my grandfather said. But instead of doing it the way he did (by suicide), he would have had to get it approved, and people would have had to know about it, talk about it, maybe even get him to change his mind, make him see that he still had some years to live. I think that it (MAiD) would have helped (Interviewee A, grandfather).

However, participant B had some knowledge about the extent of the administrative procedures attached to the request for MAiD, and she felt that her grandaunt would certainly not be eligible for this life-ending procedure. *I do not know how open she would have been to that, or to fight for that, knowing her. I do not know if she would have been … because it can be long, you know. […] So, I tell myself, would she have fought to demand it? … Take the tests, find out what she had, why she had it. I do not know if she would have done that* (Interviewee B, grandaunt).

DISCUSSION

The aim of this pilot study was to assess the feasibility of a qualitative research on the psychosocial experience of adults who were bereaved by the suicide of an older person in order to improve the quality and efficiency of the main study. The pilot data presented here are promising and suggest that further investigation is needed on this topic but that some modifications are necessary to improve the methodology (In, 2017), especially on selection criteria and recruitment strategies. As for the semi-structured interview, it covered all pertinent topics and will be suitable for use in the main study. Furthermore, with each interview the main researcher, a doctoral student in psychology, could improve her skills in conducting a qualitative interview, but it was still difficult to seize opportunities for probing emerging topics during the interview process. For example, some participants mentioned seeing their loved one at the scene of the suicide and it would have been relevant to question more about the impact that this had on their grieving process. This will be done in the main study.

Three selection criteria were chosen to ensure that potential participants were not overly vulnerable: age (18 years and over), no depression or suicidal ideation, and bereaved by suicide between 2 and 20 years ago. However, this choice led to a very heterogeneous sample, with only one of the three participants being a first degree relative. We would recommend selecting participants according to the nature of their relationship to the deceased, recruiting separately participants who lost a parent, a grand-parent, or another close elderly relative to suicide. It could also be pertinent to reduce the timespan since the suicide to less than 10 years, but to keep the minimum to 2 years, even if the former would exclude some potential participants. One of the limitations of a retrospective study like ours refers to the fact that participants do not necessarily remember events, that occured a long time ago, in the same way and with equal precision, especially in the case of a traumatic event (Brewin, 2011). Screening for depression and suicidal ideation should be maintained, but participants do not have to be automatically excluded since repercussions on mental health are often consequences of the suicide of a close family member (Figueiredo et al., 2012). By excluding these participants, the portrait of the survivors' psychosocial experience would be incomplete. However, with a good safety plan, the interview could provide support to participants who do not use mental health services and give them the opportunity to share their experience (Andriessen et al., 2018).

Recruitment difficulties of this pilot study show the challenges that the main research will face to ensure sufficient numbers of respondents. Only three persons accepted to be interviewed; therefore, it was impossible to get enough data to reach saturation, which refers to the point in data collection where new participants do not provide any additional insights (Saunders et al., 2018), and ensure that we have a precise portrait of the psychosocial experience of adults who lost an elderly relative to suicide. Advertisements in public spaces or online by suicide prevention centers were not effective. It could be more appropriate to use individual or professional contacts, referred as the snowball technique, to increase confidence and trust of potential participants and to overcome recruitment problems. In addition, we would suggest reaching out to support groups for those bereaved by suicide even if those participants might present special socio-demographic or motivational characteristics. It may also be relevant to ask the coroner office to send a letter of invitation to participate in the research study to families bereaved by suicide. However, despite the recruitment difficulties, it is important to note that all the participants assessed their experience in the study positively, which corroborates the value of the interviews for those bereaved by suicide (Cooper, 1999; Dyregrov et al., 2011; Andriessen et al., 2018). Thus, this observation supports the feasibility of the study on this aspect. Furthermore, it is important to note that the main study will take place during the COVID-19 pandemic. Thus, the interviews will now be online. We can therefore believe that more people will be able to participate, considering that we will target all regions of the province of Quebec rather than just one. In addition, individuals may be more inclined to participate in the study considering the increase in social isolation associated with the current pandemic (Gunnell et al., 2020).

Qualitative studies of older adults who ended their life are rare as are those that investigate the impact of this event on close family members. Therefore, the preliminary results of this qualitative study fill some gap in the literature on survivors of older adults' suicide which tended to focus mainly on the spouse (McIntosh, 1993; Clark and Goldney, 2000). The present study explored the effects of the suicide of an older person on other members of the family, in this case, a daughter, a grandson, and a great niece. Interestingly, there were some similarities in the participants' reports, even if their profiles and the nature of their relationship to the deceased differed in each case. The following discussion will highlight some possible biases that can occur in order to avoid them in the main study.

Results indicated that participants tried to explain and understand the cause of the suicide of their relatives. The search for explanation is a common reaction in all bereaved individuals whether the death is caused by suicide or through natural causes (Harwood et al., 2002). In our study, all participants attributed the suicide to problems associated with aging and that their older relative could not engage anymore in activities that were meaningful to them. As a matter of fact, physical illness, pain, cognitive decline, and fear of placement, as well as poor quality of life, are known risk factors for suicide in older persons (Harwood et al., 2006; Draper et al., 2010; Rurup et al., 2011; Duberstein and Heisel, 2014; Conejero et al., 2018). The various losses faced by the older adults removed opportunities to play key roles in the life of their community or family (whether as caregivers, volunteers, and grandparents) and increased thwarted belongingness, which is a risk factor for suicide (Van Orden et al., 2010). It should be noted that all the participants recruited in this pilot study indicated that their elderly relative suffered from a physical or cognitive decline, even though older adults can intentionally end their life without having a precise reason to do so (Rurup et al., 2011; Van Wijngaarden et al., 2016). Do participants perceive ill-health as an acceptable and understandable reason for the suicide of their loved one and, consequently, are more willing to take part in the research? This result highlights even more the relevance of the coroner's suicide list as a recruitment strategy to contact various types of survivors to optimize the diversity of the sample.

The participants also felt that suicide was a way for the deceased to regain control over their lives when a disease was threatening their autonomy and quality of life (Rurup et al., 2011). This need for control was also observed in a psychological autopsy study that examined the characteristics of older suicides (Kjølseth et al., 2009). The lack of openness to experience (Duberstein, 1995), the difficulty reengaging in new goals when significant obstacles occur (O'Connor et al., 2009), as well as the feeling of being trapped in an unwanted situation, were also mentioned by participants as personal characteristics of their older relative who died by suicide. The latter supports the psychological theory of suicide of O'Connor and Nock (2014), which considers that feelings of entrapment could be a contributor to suicidal behavior.

It should be noted that two of the older adults had been diagnosed with Alzheimer's disease. This is not surprising since recent studies indicated that older adults with mild cognitive change and early phase dementia are at increased risk of suicidal behavior, often in the context of comorbid depression (Draper et al., 2010; Conejero et al., 2018). The common belief that dementia is associated with a lack of competence and planning probably increases the shock of the relatives who did not expect their relative to be able to end their life. The main study should expect that part of the sample will have experienced the suicide of an older relative who suffered from cognitive decline and that depressive reactions and suicidal behaviors can be regarded as likely outcomes after the announcement of the dementia diagnosis (Draper et al., 2010).

Seeking reasons for the suicide and reconsidering or restructuring their basic belief system and their world-view appear to help the survivors make some sense of the death (Neimeyer and Sands, 2017). Actually, for many bereaved individuals, suicide is an inexplicable death and they feel the need to understand the motivations and the frame of mind of the deceased (Jordan, 2008). On the other hand, this event also challenged their perception of the world, as a sensible and meaningful place. Suicide can be understood as shattering the assumptive world of the survivor, as destroying the foundational beliefs about their perception of life. As Neimeyer and Harris (2016, p. 165) explain: "a central process of grieving is the attempt to reaffirm or reconstruct a world of meaning that has been challenged by loss". Participants were clearly changed by the suicide and needed to reconstruct their beliefs about life after it was shattered by the event. Accordingly, some seem to have experienced posttraumatic growth, which refers to positive transformations concerning self-perception, interpersonal relationships, and philosophy of life (Genest et al., 2017). In fact, posttraumatic growth often leads to helping others in a selfless and meaningful way, as evidenced by one of the participants entering the field of gerontology to assist distressed older adults and the fact that all participants wanted to be involved in this study in order to improve knowledge on suicide bereavement. In addition, the nature of the psychiatric disorder of the deceased and its role in contributing to the suicide can be invaluable to survivors. This knowledge can help survivors put their beliefs about their responsibility and the preventability of the suicide into a realistic perspective (Jordan, 2008).

Castelli Dransart (2017) also found that the search for meaning was an important theme in the interviews of 50 survivors, most of them aged below 40 years. Her participants reported four post-suicide challenges: dealing with the impact of the suicide, searching for meaning, clarifying responsibility, and finding a personal style of reaction and coping. These themes validate the results of present study and support the notion that certain ways of reacting to the suicide of a family member are universal, regardless of the deceased's age.

Furthermore, results indicated that the suicide was a brutal and unexpected event (Figueiredo et al., 2012), even if the participants could have expected the possible death of their loved one due to their health condition. This finding corroborates the results of a qualitative study by Jones (2018) with nine adults bereaved by the suicide of a parent aged 50–65 years. Thus, it appears that the suddenness of the event and the shock at the manner of death contributed to the surreal feelings associated with the suicide, independently of the deceased person's age. Although the loss of an older relative might be predictable, the manner of death is not.

Participants also expressed anger, especially those who were involved in caregiving and who had spent significant amounts of time seeing to their older relative's needs. This result is in line with results from Figueiredo et al. (2012), who showed that anger is one of the most common reactions to the suicide of an older relative. The mourners usually considered the suicide as a display of contempt, or as an ungrateful response for the care that was given.

Beyond the impacts on their personal and practical lives, participants also described the consequences for their family. These included tensions between family members and conflicts surrounding the deceased's inheritance. This concurs with the results by Figueiredo et al. (2012), who noted that instead of joining together in mutual support, family members tend to distance themselves from each other following a suicide, and even more so when financial disputes arise. However, one of the problems inherent to family research on suicide survivors is that the quality of the previous relationships within the family is rarely assessed, making it difficult to comment on the specific implications of the death for family relationships and communications in the aftermath of the suicide (Cerel et al., 2008). Thus, it might be relevant to question the participants during the semi-structured interview not only on the impact of suicide on their family, but also on relationships and family dynamics before the suicide of their older relative.

We also noted that although all the participants agree that it is important to receive support from specialized professionals, they said it was a challenge to find and contact them. Despite the lack of controlled empirical study, clinical experience has highlighted a number of interventions or programs that may be of help to suicide survivors. Thus, despite the various existing resources in postvention (Andriessen and Krysinska, 2012), the study points out to the importance of offering these services systematically on a continuous basis. Indeed, numerous challenges remain with regards to program and policy development, research and clinical practice, to ensure effective care for those bereaved by suicide (Andriessen and Krysinska, 2012).

As in other studies (Harwood et al., 2002; McMenamy et al., 2008; Figueiredo et al., 2012; Jones, 2018), participants expressed guilt and regrets following the suicide of their relative. However, one participant reported no such feelings, considering that she gave a lot of time to her parents. It seems that feelings of self-blame may emerge when grieving survivors continue to ask themselves "Why?" and "What if?" (Capuzzi, 2004). Suicide also had repercussions on the mental health of the participants as observed in several studies on the impact of close family members who intentionally ended their life (Jordan, 2008; Tal Young et al., 2012; Pitman et al., 2014).

In addition, the participants stressed the fact that suicide by an older person is a taboo and secret topic, corroborating the stigma displayed toward suicide and the survivors (Cerel et al., 2008; Sudak et al., 2008). In the case of suicide by an older person, some hypotheses have been proposed to explain this. For instance, the passive and fragile image of older people appears to be inconsistent with the act of suicide, which is viewed as both active and violent. In addition, most religions prohibit suicide. Furthermore, there is little media coverage on suicides by older people (Éthier et al., 2014), as most reported suicides are enacted by younger people. This stems from a social belief that younger people are at greater risk for suicide, which distracts the public from other age groups. Consequently, the general population has little awareness of the fact that other age groups die by suicide, including older persons.

Furthermore, it is possible that the taboo and secrecy surrounding the suicide, in addition to the guilt and regrets felt by the participants, contributed to the recruitment difficulties. Shame may make it exceptionally difficult for family members to speak about the topic of suicide (Cerel et al., 2008). Moreover, even when survivors are not actually avoided by others, they may incorrectly expect to be judged harshly by others. Together, these difficulties may create a cycle of misunderstanding and avoidance with regard to participating in a research on suicide bereavement. Therefore, recruitment difficulties might partly lie in the experience of stigma or shame. Nonetheless, benefits of research participation, reported by traumatized populations, include reducing stigma, normalizing trauma-related reactions, and ensuring safe disclosure of trauma-related information (Newman and Kaloupek, 2004). Publicity about the research should address these beliefs for potential participants and increase their confidence in the compassionate attitude of the researchers as well as the possible benefits of their participation.

One unique component of this study was that participants were asked to reflect about how the recently legalized MAiD would influence the way they see aging and the suicide of their relative. Fear of aging was strong, partly because of the experience they went through with their older relative. However, MAiD seemed to offer them an alternative to dependency and cognitive decline should they eventually consider their lives to be no longer worth living (Van Wijngaarden et al., 2016). The participants' interest in MAiD could indicate a tendency to consider this practice as a socially acceptable alternative to suicide (Mishara and Weisstub, 2018) and would endorse the position that death is a rational solution to the problems of old age (Yuryev et al., 2010). Therefore, in the context of MAiD, it would be pertinent to add some questions to the interview of the main study about participants' perception of the help and support that was offered by health care providers to their older relative. What was done to relieve the older adult's distress, alleviate the suffering, and prevent the suicide? Did they feel that, for the care providers, the life of an older person was deemed worth saving? These perceptions could influence the risk of suicide in survivors when they will face their own difficulties associated with the aging process.

Future studies could also investigate the consequences of suicide on the survivors. For example, evidence suggests that suicide survivors may be at greater risk than other bereaved individuals for a variety of psychological problems, including posttraumatic stress disorder (PTSD) and suicidal behavior (Mitchell et al., 2004; Jordan, 2008; Pompili et al., 2008). It would be useful to add questions on these topics to the semi-structured interview. Furthermore, as proposed by Levi-Belz and Lev-Ari (2018), it is important to examine the personal factors that may help suicide survivors deal with, and recover from, their devastating loss. In fact, their results indicated that securely attached individuals scored highest on posttraumatic growth compared with other attachment styles. Hence, it would be informative to add some questions to address the participants' attachment style in order to corroborate (or not) Levi-Belz's and Lev-Ari's (2018) observation.

CONCLUSION

This pilot study investigated the experience of three adults who were bereaved by the suicide of an elderly relative they felt emotionally close to. It showed that like other people bereaved by suicide, those who lost an older family member experienced this event as a shock that significantly perturbed their life. The main difference was related to the fact that the latter found explanations to the suicide in the difficulties associated with the aging process, such as physical and neurocognitive disorders, as well as dependency to others. This perspective seemed to increase participants' fear of growing old and the need to find a solution to avoid it, such as the recently legalized medical assistance in dying. In conclusion, this pilot study indicates that it is possible to investigate this topic with some modifications to the selection criteria and recruitment strategies for the main study.

DATA AVAILABILITY STATEMENT

Datasets are available on request to the corresponding author.

ETHICS STATEMENT

The study was reviewed and approved by the Human Research Ethics Board of the University of Québec in Trois-Rivières. The participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

GM-D and SL contributed substantially to all research phases, including study conception and design and data analysis and interpretation. GM-D, SL, and CV-Q contributed to data interpretation, manuscript writing and final approval, and critical revision. All authors contributed to the article and approved the submitted version.

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Conflict of Interest: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

APPENDIX 1: SEMI-STRUCTURED INTERVIEW

Today, we'd like you to talk about your relative and how his/her suicide affected you and the people close to you.

1. Tell me about your relative. What kind of person was he/she? How would you describe your relationship with him/her?
2. Tell me about the day that your relative died by suicide. How did it happen? How did you learn about it?
3. Tell me how you reacted to the loss of your relative to suicide. How did you feel about the act and the reasons why he/she did it?
4. How have you been coping with this?
5. How has your relative's suicide influenced your life? (your relationships, the way you look at life, and the way you think about your close relative)
6. Have you managed to find hope, comfort, or acceptance since the suicide of your relative?
7. How has the suicide of your relative made you feel? How has it affected the way you function now?
8. Tell me about your family. How did they react to the suicide of your relative? Has this brought you closer to them or created more distance?
9. Has the suicide of your relative changed your relationships with other people in your life, such as friends or colleagues? If yes, in what way?
10. Have there been any other suicides by older people in your family? (If yes, repeat the previous questions for this family member)
11. What suggestions would you give to other people who might be in the same situation?
12. There's been a lot of talk in the media about medically assisted dying. How does this affect the way you view the suicide of your relative?
13. How do you view old age? How do you feel about growing old yourself?

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SYSTEMATIC REVIEW
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Notification of Unexpected, Violent and Traumatic Death: A Systematic Review

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Background: The way the death of a person is communicated can have a profound impact on the bereavement process. The words and expressions that are used to give the tragic news, the characteristics of who communicates it, the physical setting in which the notification is given, the means used (e.g., in person, via phone call, etc.) are just some of the factors that can influence the way survivors face one of the most difficult moments in their lives.

Aim: To review the literature on the topic of death notification to verify the state of the art related to this important procedure.

Methods: A systematic review was conducted with PRISMA criteria on English-written materials produced from 1966 to 2019.

Results: Out of the initial 3,166 titles considered, 60 articles were extracted for this review. A content analysis has revealed four main areas of interest: (1) protocols and guidelines; (2) emotional reactions of recipients and notifiers; (3) professional figures involved in the notification process; and, (4) types of death.

Discussion: The communication of death represents a complex and stressful experience not only for those who receive it but also for those who give it. Alongside the acquisition of a necessary technique and execution methods, the process should involve the selection of notifiers based on personality characteristics and communication styles.

Conclusion: Indications for the need of better training and protocols sensitive to different circumstances emerge. Adequate preparation can positively influence the quality of communication and the effects it produces, both on recipients and notifiers. In vocational training, more space should be devoted to this demanding task.

Keywords: death notification, notifiers, recipients, emotional reaction, training, traumatic death, breaking bad news, receiving communication of death

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INTRODUCTION

One of the crucial aspects related to the experience of death is the way in which an individual is informed of the loss of a loved one. People who die from sudden and violent causes (such as road accidents, murder, overdose, suicide, accidents at work, natural disasters, terrorist acts, etc.) often have partner, family and friends to whom the events that have led to death must be communicated (Adamowski et al., 1993; Stewart, 1999; Marco and Wetzel, 2012). But "death notification" is a significant moment that could change the life of survivors (those who suffer the loss) forever (Stewart, 1999). The words and expressions that are used to give the tragic news, the characteristics of who communicates it (doctor, policeman, nurse), the physical setting in which the notification is given (home, hospital, patrol car, offices of the police, etc.), the means used (in person, via phone calls, telegram, mail, or instant messaging) are just some of the factors that can influence the way survivors face one of the most difficult moments in their lives (Wheeler, 1994; Stewart, 1999). These circumstances represent painful memories related to the loss that will never be forgotten, and constitute a real break in the narrative story of the person, who will have to reconstruct new meanings around the loss and oneself (Stewart, 1999; Janzen et al., 2003-2004). In fact, most people remember—even after many years—every derelated to this painful communication. It would therefore be desirable that the notification of death could take place under the most appropriate conditions (Smith-Cumberland, 1994, 2007), as it potentially influences the path of elaboration of the mourning of the people involved. In this regard, it has been seen that people who cannot find any kind of meaning in their traumatic experience are more likely to develop persistent psychological distress, psychosomatic disorders, post-traumatic stress disorder (PTSD), and complicated bereavement (Horowitz et al., 1997; Murphy et al., 2002; Neimeyer et al., 2002; Armour, 2003).

De Leo Fund is a non-governmental organization (NGO) that deals with providing psychological support to people who have experienced an unexpected and violent loss (e.g., suicide, road accident, natural disaster, etc.). The people who turn to the NGO often report—together with the description of the experiences related to the loss—the details relating to the moment in which they were told of the death. The peculiarities of that sad notification frequently appear of remarkable importance in the narratives of clients of De Leo Fund, seemingly able to influence their bereavement process. In staff members of the NGO, this has promoted an interest in examining dynamics and variables that occur in the death notification process, by starting with a review of the existing literature on the subject. The main purpose of this study was, therefore, to examine the state of the art of the literature on this topic, with particular attention to critical issues and good practices that should be taken into account in the communication of a traumatic death, in order to eventually provide competent training to operators and improve the notification task.

Among the many issues to clarify are, for example, the identification of the figures most commonly involved in the notification process (e.g., who is responsible for communicating the death? To whom is a death communicated?), and the management of emotional reactions that may involve both the notifier and the target person (recipient) during the notification process, as well as the possible psychopathological consequences associated with the death notification experience. A further question concerns the general recognition in the literature of this area of research, and the current state of the art regarding existing protocols, guidelines, and practical recommendations. Ultimately, the research question from which our systematic review started was to investigate whether there are more adequate strategies or behaviors than others to be considered when it is required to make a death communication to survivors who they have lost a loved one for traumatic, unexpected, and violent death (i.e., an external cause of death: accident, suicide, homicide) and to understand if this process could have consequences on the physical and emotional level of those who are required to communicate and who those who receive the news.

METHODS

The compilation of this review followed PRISMA criteria. All the selected studies were examined, while no selection criteria were placed with respect to outcome and design of the individual studies.

There was no review protocol. Articles published in English language from 1966 to 2019 concerning the subject of death notification were selected. All articles that appeared without abstracts, or in the form of editorials or articles in periodicals, book chapters, book reviews or book chapters, dissertations and comments were excluded from the search.

The review of the literature focused on the notification of death in cases of unexpected, traumatic, and violent death. This refers to external causes of death only (i.e., accidents, suicides, and homicides). In light of this, we included only the studies investigating:

A. The characteristics of effective communication of traumatic death (conceptual articles reporting guidelines, protocols, and good practices);
B. Specific aspects of the death report, or seeking to improve the death notification process (e.g., articles assessing the effectiveness of new protocols; communication skills of the notifier, non-verbal language, gestures; needs of training on death notification of specific professional figures (for example, policemen);
C. Possible correlation between death notification and development of psychopathology (i.e., how the level of support perceived during the death notification process could correlate with psychopathological disorders);
D. Risk factors of the person to whom the notification is made; these have to be taken into account at the time of reporting death (e.g., how to communicate the death of a loved one to a drug abuser or a psychotic person);
E. Implications for the notifier (e.g., possible acute stress disorder for those who provide first aid; reactions of medical doctors/psychologists/other health professionals facing the news of the death of a patient);
F. Immediate and/or long-term reactions of those who receive the notification of a traumatic death.

Defining the pertinent criteria was functional in differentiating the collected material and dividing it into more specific areas of investigation. Articles specifically investigating non-traumatic and non-violent death notification were excluded from this research. Deaths associated to palliative care were also excluded from the investigation. Exclusion also concerned:

G. Articles investigating perinatal death and infant death syndrome (SIDS);

H. Articles in which the death notification focused only on cases of cancer, cardiovascular and neurological diseases (these are not external causes of death).

Articles were identified through the following databases: Ebsco PsycINFO, Ebsco CINAHL, Scopus, Web of Science, MEDLINE PubMed, using as keywords: "death notification," "death communication," "notification of death," "communication of death," notification and "traumatic death," communication and "traumatic death," notification and "sudden death," communication and "udden death."

Researchers (JZ, AVG, SB, SD) carried out independently the bibliographic search for each keyword, as well as the subsequent elimination of duplicates. Each researcher (JZ, AVG, SB, SD) carried out searches in all databases. In checking for duplicates between the different search engines, the citations with slightly different title and the same abstract, the citations with the same title and abstract but different year of publication, and the citations with the same title and abstract but different title of the magazine were eliminated.

Once the final number of citations was obtained, three independent components of the research team (JZ, AVG, SB) carried out inclusion assessment in a standardized open mode. Disagreements between researchers were resolved by consensus methods. During the screening phase, it was not considered necessary to examine the full text of all articles. A fourth researcher (SD) complemented the reviewing process, while the senior author (DDL) oversaw the entire review process. **Figure 1** shows the process of documents identification according to the PRISMA flowchart.

The assessment of risk of bias was performed at the study level. The main risk of bias in the inclusion criteria was related to the decision, implemented before conducting the content analysis, to include studies in which the type of death was not specified and studies that evaluated the overall death notification in relation to traumatic deaths and other types of death. In addition, studies with different size and methodology were also considered, resulting in a strong heterogeneity of the results. The risk of bias associated with the choice of the English language concerned the possibility that this language is associated with studies that are published faster and cited more often.

Figure 1 shows the process of identifying documents according to the PRISMA flowchart.

RESULTS

A total of 60 studies were included in our review. The analysis of study contents evidenced a remarkable degree of similarity, with most studies being of narrative type and conceptual content (i.e., most studies aimed at providing a global picture of the many aspects involved in the notification process). Despite the overlapping, we identified four dimensions as representative of the main aspects emerging from the studies. With the term "dimensions," we want to indicate the main themes that emerged from the content analysis phase, i.e., summaries of information relating to a particular topic or domain of data with shared meanings. In particular, the identification of dimensions followed a reflexive, deductive thematic analysis phase. Once the data collection was complete, four researchers of the team (JZ, AVG, SD, SB) performed individually the analysis phases, during which they took notes on their initial impressions of each article. In a second moment, the contents of interest (i.e., those in line with the research question) were assigned labels (a few words or a short sentence), which had the purpose of clearly evoking the relevant characteristics of the papers, in order to be able to encode them. Then, researchers—with full agreement between them—defined a list of themes, which ended in four dimensions that guided the subsequent research phases. The dimensions identified are: (1) protocols and guidelines (number of studies = 51); (2) emotional reactions of the recipients and those who communicate the news, and/or pathologies that can influence the bereavement process ($n = 46$); (3) professional figures who perform the notification and recipients of the bad news ($n = 59$); (4) type of death to be communicated ($n = 56$) (See **Table 1**).

As anticipated, the total number of studies from each area exceeds the total number of studies selected due to the overlap of multiple thematic areas within the same study.

Death notification in relation to the first identified dimension concerns the state of the art regarding theories and practical training implemented in communicating death. Here, heterogeneity of collected data and difficulty in distinguishing protocols and guidelines from training programs and simulation exercises should be underlined.

The second area/dimension concerns the role of the emotions of those who communicate and receive the notification of death, and the risk factors/circumstances that can influence the bereavement process (psychopathologies, disabilities, people at risk, etc.).

Nurses, doctors, paramedics, social workers, psychologists, and policemen are placed in the third group of studies as main actors involved in the notification process. Characteristics of the population receiving the notification are also reported in this area.

In relation to the type of death, some studies have addressed the issue of death notification in relation to traumatic deaths, while others have also dealt with natural deaths, or have not specified the type of death or have treated sudden and unexpected death without specifying their cause.

Overall, the evaluation of the 60 studies included in our review revealed the presence of a vast heterogeneity between methodologies and research designs. The typology of the studies appeared distributed as follows (**Table 2**): conceptual/narrative studies ($n = 24$), surveys ($n = 9$), cross-sectional surveys ($n = 2$), reviews ($n = 3$), qualitative studies ($n = 8$), pre-post design studies ($n = 7$), validation studies ($n = 4$), prospective observational ($n = 2$), mixed-method design study (qualitative/quantitative) ($n = 1$). The prevalence of conceptual/narrative studies within our review and the scarcity of quantitative studies did not permit to aggregate data and provide numbers resulting from contamination. It was not possible to trace the risk of bias of each individual study and carry out an assessment of the outcome and results of each individual work.

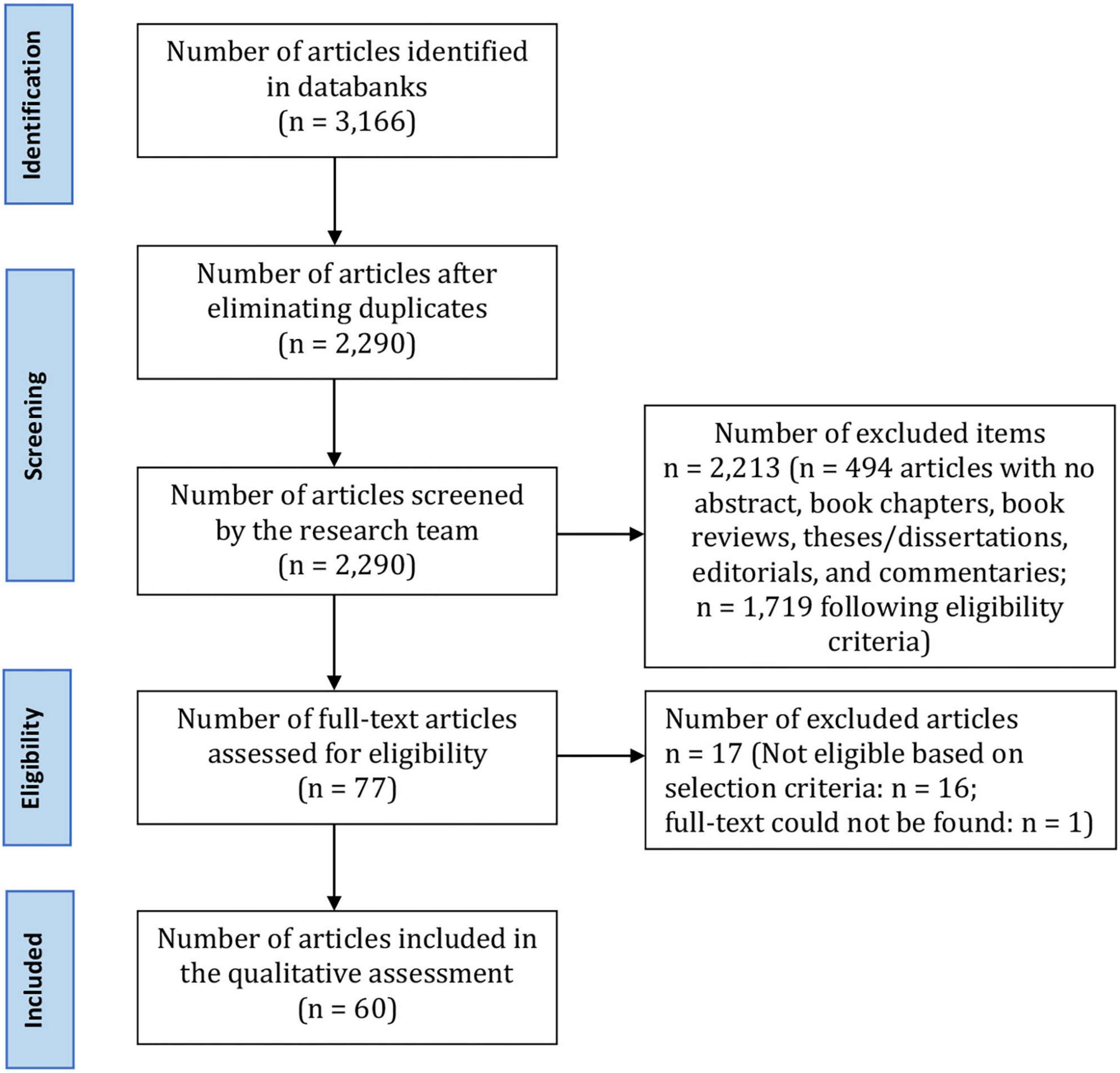

FIGURE 1 | Decision tree for studies selection based on PRISMA criteria.

From our review of the literature we tried to obtain a picture of the state of art of a topic we consider of importance, such as the problem of death communication in the event of an unexpected, traumatic, and violent death.

First Dimension: Protocols and Guidelines

In relation to the first dimension, a total of 51 studies concerning death notification have highlighted the current state of the art regarding intervention plans, guidelines, strategies and protocols to make an adequate communication (see **Table 2**). In this dimension, a total of 20 studies focused on the description of general protocols and general guidelines that can be used during the death notification process (**Table 2**).

A total of 7 studies focused on the description of training programs for emergency department health workers aimed at improving the communication skills of the professionals involved in the role of notifier (**Table 2**). Only one study highlighted the usefulness of a specific training on death education in critical emergency situations, called the *"Emergency Death Education and Crisis Training"* (EDECT) program. It is a theoretical-experiential training that proposes role-playing and group activities, aimed at modifying the attitudes with respect to the theme of death and most common behaviors of emergency

TABLE 1 | Dimensions identified through the reviewing process.

1. Protocols, guidelines, educational programs, communication strategies and techniques, role-playing: $n = 51$
General protocols/guidelines: $n = 20$
Training programs/exercises/guidelines for emergency department: $n = 7$
Specific protocols (e.g., GRIEV_ING, SPIKES, ABCDE, Dryer, "In Person, In Time," DNR): $n = 13$
Role play/simulations: $n = 4$
Police officer procedures: $n = 2$
Privacy management processes in the notification process: $n = 1$
Telephone communication about death: $n = 1$
Practical recommendations for schools and school professionals: $n = 1$
Bibliotherapy for children: $n = 1$
Strategies/techniques for communicating death in hospices and nursing homes: $n = 1$
2. Emotional reactions of notifiers and recipients and pathologies/circumstances that can influence the mourning process: $n = 46$
Emotional reactions of both the communicator and the recipient: $n = 19$
Emotional reactions of those who communicate: $n = 12$
Emotional reactions of recipients: $n = 15$
3. Professional figures involved in the notification process: $n = 59$
Doctors: $n = 7$
Healthcare workers: $n = 18$
General/unspecified category: $n = 6$
Multidisciplinary team (medical and nursing staff, psychologists, priests/chaplains. social workers, etc.): $n = 15$
Law enforcement: $n = 3$
Students: $n = 2$
Trainees: $n = 3$
Nurses: $n = 3$
School workers: $n = 1$
Disability service personnel: $n = 1$
4. Type of death that should be notified: $n = 56$
Traumatic death (e.g., road accident, homicide, overdose, suicide): $n = 9$
Unexpected and sudden death: $n = 20$
Type of death not specified: $n = 10$
Miscellaneous types of death (traumatic, unexpected/sudden, due to illness, natural): $n = 17$

Components of identified dimensions.

doctors who must carry out death communication. The program also includes specific medical education hours on the notification process (CME) (Smith-Cumberland and Feldman, 2006).

A total of 13 studies have investigated some specific protocols that can be used as a reference during a death notification (**Table 2**). One of the most used is the GRIEV_ING protocol (Hobgood et al., 2009, 2013; Shoenberger et al., 2013; Reed et al., 2015; Carmack and DeGroot, 2016; Karam et al., 2017; Shakeri et al., 2017). In this regard, the importance of an educational intervention, based on simulation, is highlighted for the acquisition of the skills necessary to face a death notification. In the United States, one of the most popular protocols is the so-called "*Six-Step Protocol*" for the delivery of bad news (SPIKES: acronym for the words Setting, Perception, Invitation, Knowledge and Empathy). It is a protocol aimed primarily at doctors who provide information on unfavorable prognoses, but can also be used to inform the family of the death of a patient (Scott, 2013; Shomoossi et al., 2013; Williams-Reade et al., 2018). One study described the ABCDE notification strategies that propose accurate intervention plans for healthcare professionals who are required to make a death notification (Shomoossi et al., 2013). A study examined a further protocol, developed by Dyer (2001), in which the more general guidelines for the notification of death are expanded, adding rules relating to telephone communication and the timing appropriate for meeting with the person to whom the death news should be referred (Sobczak, 2013). A study focuses on the communication protocol *"In Person, In Time,"* which provides useful information to effectively reduce the stress level of the notifier at the time of communication (Sobczak, 2013). An article focused on a learning program, called the DNR approach (Brand and Mahlke, 2017): it is an educational program useful to facilitate learning, based on practical experiences within peer groups, to strengthen notification skills. Four studies have highlighted the usefulness of role-playing and immersive simulation experiences of the notification process (Schmidt et al., 1992; Douglas et al., 2012; Shaw et al., 2012; Galbraith et al., 2014). Two studies have shown notification procedures for law enforcement, in particular police officers, often involved in traumatic death experiences, such as traffic accidents, suicides and homicides (Spencer et al., 1987; Brand and Mahlke, 2017).

A study highlighted the importance of protecting privacy in the information provided to partner/family/friends during the notification of the death of a loved one (Basinger et al., 2016). Another study presented strategies on how to make an adequate death notification commencing by a phone call (Ombres et al., 2017). Whenever possible, phone calls should not be the only way to communicate the traumatic death of someone: direct contact with survivors should always be encouraged.

An article described practical recommendations for notification of death to students in case of a loss within the school environment (Servaty-Seib et al., 2003).

Another study highlighted the potential of bibliotherapy as a tool to facilitate the communication about death to children who need to face the loss of a loved one (Arruda-Colli et al., 2017). A study described some techniques and strategies for communicating the death of a resident in nursing homes and hospice-type structures (Rivolta et al., 2014).

Second Dimension: Emotional Reactions of Notifiers and Recipients and Circumstances or Pathologies That Can Influence the Bereavement Process

A total of 46 studies (**Table 2**) have investigated death notification in relation to the main emotional experiences that accompany a death notification process, taking into account both the experience of the notifier and those who receive the news. A total of 19 studies (**Table 2**) described the notification process,

TABLE 2 | Characteristics of studies included in the systematic review.

Author (year)	Country	Target population	Sample (*n*)	Study design	Dimensions/themes			
					Protocols and guidelines	**Emotional reactions and pathologies**	**Type of professionals**	**Types of death**
Dubin and Sarnoff (1986)	Pennsylvania (USA)	Doctors and health personnel of emergency dept.s	NA	Conceptual/ narrative	Protocols/ General guidelines	Emotional reactions of recipients	Health professionals	Sudden and unexpected death
Parrish et al. (1987)	Florida (USA)	Family members of patients who died in Emergency Department	66	Survey	NA	Emotional reactions of recipients	Health professionals	Sudden and unexpected death
Spencer et al. (1987)	California (USA)	Homicide detectives of Los Angeles Police Department	50 Ss filled in a questionnaire. 21 made also a telephone interview	Cross-sectional survey	Police officer procedures	Emotional reactions of notifiers and recipients	Law enforcement personnel	Sudden and unexpected death
Haglund et al. (1990)	Washington DC (USA)	Law enforcement, medical examiner and coroner officers	NA	Conceptual/ narrative	NA	Emotional reactions of notifiers and recipients	Multidisciplinary Team (law enforcement, medical examiner and coroner offices)	Miscellaneous
Schmidt et al. (1992)	Oregon (USA)	Residents of Oregon Health Sciences University	NA	Conceptual/ narrative	Role games/Simulations	NA	Health professionals	NA
Adamowski et al. (1993)	Canada	2 groups of survivors in Ottawa General Hospital.	66	Survey	Protocols/ General guidelines	Emotional reactions of notifiers and recipients	Multidisciplinary Team (doctors, nurses, psychologists, chaplains, social workers, etc.)	Miscellaneous
Swisher et al. (1993)	Pennsylvania (USA)	45 resident and 20 physicians in emergency dept.s at the Medical College of Pennsylvania	65	Survey	Protocols/General guidelines	Emotional reactions of notifiers	Health professionals	Sudden and unexpected death
Marrow (1996)	UK	Emergency dept.s personnel	NA	Conceptual/ narrative	Protocols/ General guidelines	Emotional reactions of notifiers and recipients	Health professionals	Sudden and unexpected death
Moroni Leash (1996)	California (USA)	Medical professionals, University students in death and dying classes and family members of newly admitted intensive care unit patients.	200 medical professionals, 100 University students, 100 family members.	Conceptual/narrative	Specific Protocols (e.g., SPIKES, ABCDE, "In Person, In Time," DNR, etc.)	NA	Health professionals	Miscellaneous
Viswanathan (1996)	New York (USA)	Physicians in the departments of medicine, surgery, family practice, and psychiatry at the State University of New York Health Science Center at Brooklyn	155	Survey	NA	Emotional reactions of notifiers	Doctors	Sudden and unexpected death
Von Bloch (1996)	Texas (USA)	Health care professionals	NA	Conceptual/ narrative	Protocols/ General guidelines	Emotional reactions of notifiers and recipients	Health professionals	Sudden and unexpected death

(Continued)

TABLE 2 | Continued

Author (year)	Country	Target population	Sample (*n*)	Study design	Dimensions/themes			
					Protocols and guidelines	**Emotional reactions and pathologies**	**Type of professionals**	**Types of death**
Ahrens and Hart (1997)	Illinois (USA)	General emergency physicians	122	Survey	Training programs for emergency department health workers (EDECT e CME)	Emotional reactions of notifiers	Doctors	Sudden and unexpected death
Olsen et al. (1998)	Chicago (USA)	Emergency dept.s personnel	NA	Conceptual/ narrative	Protocols/ General guidelines	Emotional reactions of notifiers and recipients	Multidisciplinary Team (doctors, nurses, psychologists, chaplains, social workers, etc.)	Sudden and unexpected death
Smith et al. (1999)	Maryland (USA)	Emergency physicians, paramedics and other emergency personnel	NA	Conceptual/narrative	Training programs for emergency department health workers (EDECT e CME)	Emotional reactions of notifiers	Health professionals	Sudden and unexpected death
Stewart (1999)	Florida (USA)	Those involved in notifying a road accident-related death	NA	Conceptual/narrative	Protocols/General guidelines	Emotional reactions of notifiers and recipients	Multidisciplinary Team (doctors, nurses, psychologists, chaplains, social workers, etc.)	Traumatic death
Stewart et al. (2000)	Florida (USA)	Participants from 14 different professions potentially involved in notifying death	240	Survey	NA	Emotional reactions of notifiers and recipients	Multidisciplinary Team (doctors, nurses, psychologists, priests/ chaplains, social workers, etc.)	Miscellaneous
Kaul (2001)	Michigan (USA)	Emergency physicians, paramedics and other emergency personnel	NA	Conceptual/narrative	Specific Protocols (e.g., SPIKES, ABCDE, "In Person, In Time," etc.)	Emotional reactions of recipients	Multidisciplinary Team (doctors, nurses, psychologists, chaplains, social workers, etc.)	Miscellaneous
Stewart et al. (2001)	Florida (USA)	Death notifiers (law enforcement officers, emergency medical technicians, victim advocates, coroners, etc.) in 7 cities of USA.	245	Survey	Protocols/ General guidelines	NA	Multidisciplinary Team (doctors, nurses, psychologists, priests/ chaplains, social workers, etc.)	Miscellaneous
Benenson and Pollack (2003)	England	Emergency medicine residents	70	Prospective observational	Training programs for emergency department health workers (EDECT e CME)	Emotional reactions of notifiers	Doctors	Sudden and unexpected death
Janzen et al. (2003-2004)	Canada	Parents who had experienced the sudden death of a child in Ontario	20	Qualitative study	Protocols/General guidelines	Emotional reactions of notifiers and recipients	Multidisciplinary Team (doctors, nurses, psychologists, priests/ chaplains, social workers, etc.)	Miscellaneous
Servaty-Seib et al. (2003)	Indiana (USA)	School communities	NA	Conceptual/ narrative	Practical recommendations for schools and school professionals	Emotional reactions of recipients	School workers	Miscellaneous

(Continued)

TABLE 2 | Continued

Author (year)	Country	Target population	Sample (*n*)	Study design	Dimensions/themes			
					Protocols and guidelines	**Emotional reactions and pathologies**	**Type of professionals**	**Types of death**
Hart and DeBernardo (2004)	Baltimore (USA)	Law enforcement personnel	NA	Conceptual/ narrative	Protocols/ General guidelines	Emotional reactions of notifiers and recipients	Law enforcement personnel	Miscellaneous
Levetown (2004)	Texas (USA)	Emergency care personnel	NA	Conceptual/ narrative	Training programs for emergency department health workers (EDECT e CME)	Emotional reactions of recipients	General category/ unspecified	Miscellaneous
Deffner and Bell (2005)	Arizona (USA)	Nurses in state of Arizona	190	Survey	NA	Emotional reactions of notifiers	Nurses	Unspecified type of death
Goodrum (2005)	North Carolina (USA)	Bereaved of murdered loved ones	32	Qualitative study	NA	Emotional reactions of recipients	General category/ unspecified	Traumatic death
Hobgood et al. (2005)	North Carolina (USA)	Residents in emergency medicine	20	Pre-post study	Training programs for emergency department health workers (EDECT e CME);	Emotional reactions of notifiers	Trainees	Sudden and unexpected death
Smith-Cumberland and Feldman (2005)	Maryland, Pennsylvania and Utah (USA)	Emergency medical technicians from 14 states.	136	Survey	Protocols/General guidelines	Emotional reactions of notifiers	Doctors	Unspecified type of death
Eberwein (2006)	Maryland (USA)	Mental health professionals	NA	Conceptual/ narrative	Protocols/ General Guidelines	Emotional reactions of recipients	Health professionals	Traumatic death
Quest et al. (2006)	Georgia (USA)	Undergraduate medical students on their fourth-year.	37	Prospective observational	NA	NA	Students	Sudden and unexpected death
Smith-Cumberland and Feldman (2006)	Wisconsin (USA)	Emergency medical professionals	83	Pre-post study	Training programs for emergency department health workers (EDECT e CME)	NA	Health professionals	NA
Scott (2007)	England	Emergency medical professionals and police officers	NA	Conceptual/narrative	Protocols/ General guidelines	Emotional reactions of notifiers and recipients	Multidisciplinary Team (doctors, nurses, psychologists, chaplains, social workers, etc.)	Traumatic death
Miller (2008)	Florida (USA)	Professionals potentially involved in notifying death	NA	Conceptual/narrative	Protocols/General guidelines	NA	General category/unspecified	Traumatic death
Mitchell (2008)	Maryland (USA)	Professionals potentially involved in notifying death	NA	Conceptual/narrative	Protocols/General guidelines	Emotional reactions of recipients	General category/ unspecified	NA
Hobgood et al. (2009)	North Carolina (USA)	Fourth-year medical students at the University of North Carolina	138	Pre-post study	Specific Protocols (e.g., GRIEV_ING, SPIKES, ABCDE, "In Person, In Time," DNR, etc.)	NA	Students	Unspecified type of death
Parris (2011)	UK	Emergency medical professionals	NA	Conceptual/narrative	Protocols/General guidelines	Emotional reactions of recipients	Health professionals	NA
Douglas et al. (2012)	Canada	Paramedics in urban and rural areas of Ontario	28	Qualitative study	Role games/simulations	Emotional reactions of notifiers and recipients	Health professionals	Miscellaneous

(Continued)

TABLE 2 | Continued

Author (year)	Country	Target population	Sample (*n*)	Study design	Dimensions/themes			
					Protocols and guidelines	**Emotional reactions and pathologies**	**Type of professionals**	**Types of death**
Marco and Wetzel (2012)	Ohio (USA)	Patients who were involved in a fatal motor vehicle crash between 2005 and 2009.	21	Cross-sectional survey study	Protocols /General Guidelines	Emotional reactions of recipients	General category/unspecified	Traumatic death
Roe (2012)	Michigan (USA)	Emergency medical professionals	NA	Conceptual/narrative	Protocols/General guidelines	NA	Multidisciplinary Team (doctors, nurses, psychologists, chaplains, social workers, etc.)	Sudden and unexpected death
Shaw et al. (2012)	Australia	Doctors employed in Sydney metropolitan hospitals.	31	Mixed-method design (quantitative/ qualitative)	Role playing/simulations	NA	Doctors	Sudden and unexpected death
Douglas et al. (2013)	Canada	Paramedics in urban and rural areas of Ontario	28	Qualitative study	NA	Emotional reactions of notifiers	Health Professionals	Miscellaneous
Hobgood et al. (2013)	North Carolina (USA)	Emergency medical service personnel	30	Pre-post design	Specific Protocols (e.g., GRIEV_ING, SPIKES, ABCDE, "In Person, In Time," DNR, etc.)	NA	Health Professionals	Unspecified type of death
Scott (2013)	England	Emergency medical professionals	NA	Conceptual/narrative	Training programs for emergency department health workers (EDECT e CME)	NA	Health Professionals	Sudden and unexpected death
Shoenberger et al. (2013)	South California (USA)	Physicians of emergency departments	NA	Review article	Specific Protocols (e.g., GRIEV_ING, SPIKES, ABCDE, "In Person, In Time," etc.)	Emotional reactions of notifiers and recipients	Doctors	Miscellaneous
Shomoossi et al. (2013)	Iran	Nurses working in hospitals in Sabzevar, in Iran.	97	Development and validation of a scale	Specific Protocols (e.g., SPIKES, ABCDE, "In Person, In Time," etc.)	Emotional reactions of notifiers and recipients	Nurses	Miscellaneous
Sobczak (2013)	Poland	Doctors involved in death notification	NA	Conceptual/ narrative	Specific Protocols (e.g., SPIKES, ABCDE, "In Person, In Time," etc.)	NA	Doctors	Unspecified type of death
Galbraith et al. (2014)	Midwestern (USA)	Senior-level nursing and social work students	32	Development of a valid simulation model	Role games/simulations	Emotional reactions of notifiers and recipients	Multidisciplinary Team (doctors, nurses, psychologists, social workers, etc.)	Sudden and unexpected death
Rivolta et al. (2014)	Torino (Italia)	Health care nurses of two nursing homes and two hospices	55	Qualitative study	Strategies for communicating death in hospices and nursing homes	NA	Nurses	Unspecified type of death
Baumann and Stark (2015)	New Jersey (USA)	Forensic death investigators and other death notifiers	NA	Conceptual/narrative	Protocols/ General guidelines	Emotional reactions of recipients	Multidisciplinary Team (doctors, nurses, psychologists, chaplains, social workers, etc.)	Traumatic death

(Continued)

TABLE 2 | Continued

Author (year)	Country	Target population	Sample (*n*)	Study design	Dimensions/themes			
					Protocols and guidelines	**Emotional reactions and pathologies**	**Type of professionals**	**Types of death**
Reed et al. (2015)	Ohio (USA)	First-year pediatric and internal medicine residents	44	Pre-post design	Specific Protocols (e.g., GRIEV_ING, SPIKES, ABCDE, "In Person, In Time," etc.)	Emotional reactions of notifiers and recipients	Trainees	Unspecified type of death
Basinger et al. (2016)	Midwestern (USA)	College students who had lost a parent or a sibling.	21	Qualitative study	Privacy management processes in the notification of death (CPM)	Emotional reactions of recipients	NA	Miscellaneous
Carmack and DeGroot (2016)	Virginia (USA)	Lay people recruited via social media, and other means	302 in study 1; 319 in study 2)	Development and validation of a new scale	Specific Protocols (e.g., CADS, GRIEV_ING, SPIKES, ABCDE, "In Person, In Time," etc.)	Emotional reactions of notifiers	Multidisciplinary Team (doctors, psychologists, etc.)	Unspecified type of death
Peters et al. (2016)	New South Wales (Australia)	Individuals bereaved by suicide	10	Qualitative study	NA	Emotional reactions of recipients	Multidisciplinary Team (doctors, nurses, psychologists, chaplains, social workers, etc.)	Traumatic death
Veilleux and Bilsky (2016)	Arkansas (USA)	Therapists and residents after a patient death (e.g., suicide)	NA	Conceptual /narrative	Protocols/General guidelines	Emotional reactions of notifiers	Multidisciplinary Team (doctors, nurses, psychologists, chaplains, social workers, etc.)	Traumatic death
Arruda-Colli et al. (2017)	Maryland (USA)	Storybooks about dying, death and bereavement in English, French or Spanish, published 1995-2015	210	Review article	Bibliotherapy for children	Emotional reactions of recipients	General category/ unspecified	Miscellaneous
Brand and Mahlke (2017)	Germany	German police officers	NA	Conceptual/ narrative	Specific Protocols (e.g., SPIKES, ABCDE, "In Person, In Time," DNR, etc.); Police officer procedures	Emotional reactions of recipients	Law enforcement personnel	Sudden and unexpected death
Karam et al. (2017)	Lebanon	Residents of PGY3 and PGY4 Lebanese anesthesiology	16	Pre-post training	Specific Protocols (e.g., GRIEV_ING, SPIKES, ABCDE, "In Person, In Time," DNR, etc.)	Emotional reactions of notifiers	Trainees	Miscellaneous
Ombres et al. (2017)	Maryland (USA)	Internal medicine residents	67	Review article	Telephone communication about death	Emotional reactions of notifiers and recipients	Health professionals	Sudden and unexpected death
Shakeri et al. (2017)	Chicago (USA)	American University - 4 years emergency medicine training program	40	Validation study	Specific Protocols (e.g., GRIEV_ING, SPIKES, ABCDE, "In Person, In Time," DNR, etc.)	NA	Health professionals	Unspecified type of death
Tuffrey-Wijne and Rose (2017)	UK	Social care staff that worked in residences for intellectually disable people	20	Qualitative study	NA	Emotional reactions of notifiers and recipients	Disability service personnel	Unspecified type of death
Williams-Reade et al. (2018)	California (USA)	Pediatric surgery residents	15	Pre-post study	Specific Protocols (e.g., SPIKES, ABCDE, "In Person, In Time," etc.)	Emotional reactions of notifiers and recipients	Health professionals	Sudden and unexpected death

taking into account both perspectives. From the notifier's point of view, the notification process is mostly judged as difficult and stressful (Adamowski et al., 1993; Stewart et al., 2000; Janzen et al., 2003-2004; Hart and DeBernardo, 2004; Douglas et al., 2012; Williams-Reade et al., 2018). The reactions most commonly described by the notifier are: anxiety, guilt, sadness, identification with the target, discomfort, avoidance, anguish, frustration, isolation, insomnia, lowering of mood, recurrent nightmares, feelings of helplessness, substance abuse, marital conflict, PTSD, chronic stress response syndrome, and professional burnout (Spencer et al., 1987; Veilleux and Bilsky, 2016; Tuffrey-Wijne and Rose, 2017). In general, professionals involved in communicating the death of a person highlighted a lack of sufficient preparation for carrying out the task and the need to acquire more skills for managing the emotional reactions of those who receive the bad news and own emotions (Olsen et al., 1998; Douglas et al., 2013). Considering the target's perspective, the notification task is more commonly associated with reactions such as: emotional trauma, pain, despair, anger, crying, screaming, sadness, aggression, depression, emotional distress, strengthening of significant relationship ties, perception of stigma, social isolation, avoidance of relationships, distress, sense of emptiness, increased heart rate, fainting, cardiac arrest, and nausea (Haglund et al., 1990; Adamowski et al., 1993; Janzen et al., 2003-2004; Hart and DeBernardo, 2004; Scott, 2007; Galbraith et al., 2014; Basinger et al., 2016).

Twelve studies dealt in particular with the notifier's emotional experience and a total of 15 studies (**Table 2**) examined the experience of recipients. With regards to the notification experience from the side of the notifier, some detailed information is provided regarding the long-term effects of stress and discomfort perceived during the process, as well as some of the most common psychopathological risk factors (Stewart, 1999; Hobgood et al., 2013). Finally, the studies that highlight the main reactions of those who receive a death notification underline the devastating impact that this experience, if not adequate, could have in the lives of recipients, as well as the significant influence of this experience on the bereavement process and on the onset of psychopathology and possible increase in suicidal risk. Sudden and violent deaths can trigger acute psychological responses; they can increase the risk of developing complicated bereavement, in addition to the onset of physical and psychological symptoms. In turn, these could lead to an increase in suicidal risk and general mortality (Kaul, 2001; Mitchell, 2008; Parris, 2011; Baumann and Stark, 2015; Peters et al., 2016; Brand and Mahlke, 2017; Ombres et al., 2017).

Third Dimension: Professional Figures Involved in the Notification Process

Nearly all studies ($n = 59$) dealt with this aspect (**Table 2**). The review revealed significant diversity among operators involved in the death notification process. The professional category most involved in the role of notifier is that of healthcare workers (evidenced in 18 studies). In six studies, professional role of the notifier is unspecified. In others, several professional figures are seen as working synergistically—in communicating the death of a person—within a multidisciplinary team ($n = 15$). Among these are: medical and nursing staff, religious officers and priests, psychologists, social workers, etc.) (**Table 2**). A total of seven studies highlighted the role of doctors in the death notification task. Three studies focused on the role of law enforcement officers. Three articles focused on the figure of nurses; another study on that of school operator. Students are also the target of two studies as well as studies on trainees ($n = 3$). Finally, one article considered staff working in services for people with disabilities (see **Table 2** for specific references).

Fourth Dimension: Type of Death to Be Notified

When it comes to death notification, it is fundamental to dwell on the peculiar characteristics of each type of death to examine the components that may influence the different loss experiences. A death from natural causes has a very different impact on partner/family/friends than a death from sudden and violent causes. A total of 56 studies focused on providing information about the different types of death. Nine studies focused on traumatic death experiences (such as traffic accidents, suicides, murders, overdoses) (**Table 2**). Other studies have examined deaths both from sudden and unexpected causes ($n = 20$); in some studies the theme of death has been studied without specifying its type ($n = 10$); finally, a number of studies ($n = 17$) have considered a miscellaneous ensemble of deaths (traumatic, unexpected and sudden, by disease, natural) (**Table 2**).

DISCUSSION

In recognition of the importance of the notification process, protocols, and recommendations have been developed to help professionals and rescuers called to perform death notifications (Hall, 1982; Parrish et al., 1987; Collins, 1989; Wells, 1993; Williams and Frangesch, 1995; Byers, 1996; Ptacek and Eberhardt, 1996; Von Bloch, 1996; Spungen, 1998; Boss, 1999, 2002; Stewart, 1999; Benenson and Pollack, 2003; Miller, 2003a,b, 2004; Eberwein, 2006; Nardi and Keefe-Cooperman, 2006). It is important, in fact, that notifiers (doctors and other health workers, psychologists, priests, members of law enforcement, and the school community) do not underestimate the impact that they could have during the first meeting with the partner/family/friends of the deceased. Professionals who do not develop an awareness of how their attitudes can influence the notification process are likely to cause more stress in recipients, often in an unintended way, and to live the moment of communication with greater anxiety.

Ideally, the notifier should be well-informed about the details of the death, have enough time to support the survivors of the deceased, and be able to respond to the physical and emotional reactions exhibited by them (denial, anger, aggression, withdrawal, isolation, tears, pain, guilt, fear, etc.) (Wright, 1996). It is also important to consider the psychophysical characteristics of the individuals who are going to be informed, and evaluate the secondary health risks that may arise following the notification of death. In some cases, it may be useful to evaluate suicide risk or to take individual risk factors into account. For example, it often happens that people with intellectual disabilities are over-protected and often not informed of the death of a loved one (Tuffrey-Wijne and Rose, 2017).

What emerges from the literature is that not much information is available on how to deal with sudden death, and that there is still a shortage of educational material in this area for emergency professionals (Smith et al., 1999). In addition, standardized protocol for making death notifications by phone in different contexts appear to be lacking (Ombres et al., 2017). The professional figures mainly called to deal with the notification processes often do not receive adequate training to learn how to provide painful communications in the most appropriate way. This causes the notification process to be perceived as a particularly difficult and stressful event for notifiers, as well as for those who are required to receive the bad news. It is known, in fact, that this task emotionally involves not only the family members and other survivors of the deceased but also the professionals who are called to communicate death (Meunier et al., 2013). Moreover, communicating death to a close person or family member without an adequate strategic plan can contribute to aggravating the pain of loss (Mitchell, 2008; Ombres et al., 2017). Improving the notifiers' skills and competences, along with understanding the possible reactions of those who receive a death report, can increase the chances that the death notification process may result as sensitive, empathetic, respectful, and compassionate.

The importance of an intervention that aims to facilitate the bereavement process from a traumatic loss has been discussed in the literature by taking into consideration the contribution of different professional groups, including the clergy (Frantz et al., 1996; Weaver et al., 1996), health workers (Gyulay, 1989) and law enforcement (Clark, 1981). A multidisciplinary team engaged in the notification process can be made up of doctors, nurses, psychologists, social workers, policemen, priests and, in general, sensitive, professional and caring staff who act through a cooperative and coordinated approach (Walters and Tupin, 1991; Adamowski et al., 1993; Anderson, 1993). It is essential, in fact, that each team member is aware of their role and the complexity of the notification process, in order to promote and ensure effective support for survivors (Young et al., 2012; Groos and Shakesperare-Finch, 2013).

In this regard, the need for a deeper understanding of the problems that people face when losing a loved one has been well-highlighted, as well as the need for professionals to be better trained in the difficult task of death notification (Gyulay, 1989; Kalkofin, 1989; Neidig and Dalgas-Pelish, 1991; Weaver, 1993; Parry, 1994; Weaver et al., 1996). There is evidence that most staff have a desire to improve their notification skills for managing crisis situations, especially in emergency settings (Olsen et al., 1998).

Studies outlining protocols and guidelines have highlighted some aspects to be especially promoted in the notification process: simplicity, brevity, practicality, proximity, immediacy, and expectation of a reasonable result (Aguilera, 1998; Mitchell, 2004). Some studies have supported the preventive importance of a skilled and sensitive death notification, through a set of fundamental tasks and events, deemed salient regardless of who makes the notification and the setting in which it is carried out. To perform a "proper" death notification, the various components include: (a) correct identification of both the deceased person and the partner/family/friends to be notified; (b) a first contact (preferably not by telephone) with the survivors and an invitation to a meeting at their home or hospital; (c) to provide all the details about the accident and the medical procedures implemented (if any). It has been seen that both the physical setting in which information is given and the speed with which it is exposed can significantly influence the survivors' ability to assimilate all the details of communication; (d) to provide the news of death. In this regard, it is important to use clear and direct language and avoid the use of euphemisms, especially in dealing with children; (e) to respond to survivors' reactions by offering immediate emotional support; (f) to give the opportunity to view the body after the notification; (g) to offer short and long-term assistance through follow-up following the notification process, which guarantees survivors that they may obtain further information on death circumstances (this is particularly important for those types of losses that involve a high risk of developing PTSD) (Dubin and Sarnoff, 1986; Spencer et al., 1987; Cooke, 1993; Tye, 1993; Stewart, 1999; Stone et al., 1999; Kaul, 2001; Stewart et al., 2001; Li et al., 2002).

Several studies that examined the impact on recipients for the notification received revealed significantly worse results if death, and in particular the causes of death, were communicated by telephone. The limits of this approach—which should only be used in cases where survivors are really far away (Stewart, 1999)—have been repeatedly stressed. Nevertheless, telephone notification is still a widely used communication method, in particular by law enforcement officers when they are required to report deaths resulting from road accidents, homicides and/or suicides (Spencer et al., 1987; Stewart, 1999; Miller, 2008). In the particular case of deaths resulting from a murder, it would be appropriate to inform the deceased's partner or family members of the possibility that the media can contact them. It would be also useful to provide them with suggestions on how to manage various aspects, including those related to the protection of privacy (Clark, 2011; Baumann and Stark, 2015).

At least one study has tried to identify practices related to death notification deemed less useful by survivors (Eberwein, 2006). From what emerged, notifiers should avoid providing unsolicited advice or encouragement for a rapid recovery. During notification, they should not endorse any specific emotional attitude or attempt to identify with the survivor's experience. Instead, positive notification approaches would include: authentic expressions of closeness and concern on the part of the notifier, and the opportunity to let survivors venting their feelings while counting on the presence of another person during the notification process. Another aspect considered as important is the type of language to be used (clear, simple, and direct) and the tone of voice (which should express confidence). These are details, in fact, that a survivor could potentially remember throughout his/her life and therefore deserve special attention. On the other hand, people who are experiencing a loss first of all need respect, a fundamental prerequisite for an adequate notification of death (Eberwein, 2006).

The review also revealed that it would be important being able to predict possible emotional responses of survivors, in order to carefully select notifiers, keeping in mind the personality of each operator and their communicative and expressive styles (Adamowski et al., 1993). It has been seen, for example, that a person with high anxiety levels, with fear of death and strong apprehension related to communication, could feel strongly unable to manage a notification process and be predisposed to avoiding issues related to death (Daly and McCroskey, 1984). Indeed, it must be considered that the notification process is a highly stressful task for notifiers, both physically and emotionally (Hart and DeBernardo, 2004). On the other hand, it has been seen that staff anxiety could be reduced with a better understanding of the responses experienced by survivors at the time of notification (Finlay and Dallimore, 1991), such as denial, withdrawal, anger, sadness, isolation, and self-reported auto- or hetero guilt feelings (in the case of deaths by suicide and murder) (Wright, 1996; Constantino et al., 2002).

To date, there are still few studies describing initiatives with training programs that provide practical recommendations on who should carry out a death notification and how and when this should take place. Educational programs have been proposed to improve communication skills (Nordstrom et al., 2011), as well as the integration of death notification protocols within University courses of those students potentially involved in emergency situations (Baghcheghi et al., 2011). The GRIEV_ING Death Notification Program is among the most popular protocols; through the enhancement of specific immersive experiences, simulations and roleplaying, it aims to improve the communication skills necessary to face a death notification task within different contexts (Benenson and Pollack, 2003; Karam et al., 2017). The GRIEV_ING educational intervention is considered useful in improving the notifier's self-efficacy and the general sense of trust within the notification process. Focused on promoting the development of empathic communication, the intervention prepares notifiers to competently address emotionally charged topics, frequently associated with increased stress (Hobgood et al., 2005).

In addition to improved ability to notify, some studies have demonstrated the usefulness of these programs also in improving the self-esteem of the personnel involved in the demanding task of death notification, limiting work stress and burnout (Karam et al., 2017).

Limitations of the Study

Our review has several limitations. First, there was no review protocol. Second, only studies written in English were taken into consideration. Third, the between-study heterogeneity was high with regards to study design, quality of study, types of death, and targets, making quite difficult to create standardized categorizations for all articles. In addition, thematic overlaps were frequent, with the majority of studies reporting general indications on all important areas of the topic, sometimes in a succinct manner, some others in a quite extended one. These limits, together with the difficulty—on some occasions—in distinguishing between guidelines and training programs, created difficulties in the interpretation of results; for example, it was not easy to derive specific indications for specific circumstances. Furthermore, the scarcity of quantitative study doesn't allow identifying the advantages of certain types of intervention compared to others.

CONCLUSIONS

The review of the literature and the content analysis underlined the complexity of the death notification process. Numerous variables affect its impact: circumstances of death; quality of communication (verbal or non-verbal); characteristics of the context in which the notification is carried out; presence or absence of sources of support for survivors, personality characteristics of notifier and recipient; etc.

The complexities of this sensitive area reinforce the view that more research is needed, and training gaps exist within the professional paths of the figures potentially involved in this difficult task (Smith et al., 1999; Smith-Cumberland and Feldman, 2005).

Notification skills could be improved through specific educational programs, which can direct eventual notifiers toward the acquisition of communication abilities useful for the management of emergency situations. Some of the training courses and protocols that already exist, in fact, can constitute a resource for improving one's sense of self-efficacy and general confidence in dealing with emotionally charged topics and highly stressful situations (Parrish et al., 1987; Sykes, 1989; Iserson, 1999). The painful experience of having to know that a loved one unexpectedly died can be somewhat contained and alleviated by the use of structured and multidisciplinary approaches by notifiers, as a result of staff education campaigns (Adamowski et al., 1993). Raising awareness on the consequences of a bad notification process and its long-term impact appears as particularly important. Future work could focus on aspects that are still not very well-profiled, such as the definition of notification procedures taking into account situational differences, and professional and personal characteristics of the figures most frequently involved in the task.

AUTHOR CONTRIBUTIONS

DDL has conceived the work, coordinated the study, and written the final manuscript. AS and CA have contributed to the early stages of the research with literature searches and summary reports. JZ provided literature search and scrutiny and several paper drafts. AVG and SD have contributed to searches and to draft parts of this review. SB made the literature search and screening of papers. All authors contributed to the article and approved the submitted version.

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SUPPLEMENTARY MATERIAL

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