Research Study

What is the narrative of the suicide-bereaved?

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Abstract

Suicide deaths have continued to rise (World Health Organization, 2023), and of particular note is the damage each death inflicts on the people surrounding them. One of the ways to understand the complexities around suicide and prevention is to speak to those left behind, to understand their experience and how they navigated and made sense of their loss. This research takes this approach by conducting a qualitative study of suicide bereavement. Eight suicide-bereaved participants took part in unstructured interviews. A narrative analysis of their stories was conducted to gain a greater understanding of suicide and suicide bereavement. The research was exploratory in nature, and the research question was: "What is the narrative of the suicide-bereaved and how does it shift through time?" The findings show initially the presence of chaos and disorientation, followed by survival and reorganisation, and then moving towards support and living with the duality of not having all the answers. Future research could benefit by incorporating a wider range of cultures and genders, alongside looking at the different relationships within the loss. A major theme of note was the participants' desire for change in how mental health is cared for, with many of them moving into advocacy work.

Keywords: suicide bereavement, suicide grief journey, suicide, suicide prevention

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Introduction

The World Health Organization (2023) lists suicide as the world's number one cause of premature death that is preventable, and for every person who dies by suicide at least twenty people will be impacted by their death. Over 700,000 people die worldwide yearly by suicide, and those are simply the ones reported. Due to legality and stigma, it is estimated that suicides are underreported in many countries. Suicide is classified as a public health problem on a global scale, making more research in understanding it imperative.

The theory that exists to explain why suicides happen is limited, and suicide research is primarily quantitative. The interpersonal theory of suicide by Van Orden *et al.* (2010) speaks of the damage that is caused worldwide by suicides, as well as the lack of theory that has been developed. The main grounds of the interpersonal theory of suicide are thwarted belongingness, and this theme is

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also noted by Motillon-Toudic *et al.* (2022), who conducted a literature review on social isolation and suicides. Additionally, during the coronavirus in 2019 and the later lockdowns 2020, the isolation was noted to increase suicidal behaviour, especially among vulnerable groups (Sher, 2020; Ciotti *et al.*, 2020). Sabbath (1969) highlighted the fear of burdensomeness on one's family as being a component in studying suicidal behaviour. Filiberti *et al.* (2001) also noted this when researching terminally ill cancer patients who died by suicide. Schneidman's (1998) theory listed internal and external pressure, psychological pain, and poor mental health as contributing factors. Other theoretical perspectives range from suicide being influenced by chemical factors, to having a social component, and there is a level of crossover among these theories (Chu *et al.*, 2010; Joiner *et al.*, 2010). The World Health Organization (1998) addressed the overlap between the study and prevention of suicide being both sociological and psychological, which can present challenges when approaching prevention as it is a large area for inquiry.

When one looks at the risk factors that are associated with suicide, not only is mental health and social isolation noted but also the branches that go between the personal and the social. For example, Van Orden *et al.* (2010) discussed the literature around suicide risk factors, the most researched risks identified being previous attempts of suicide, physical and mental illness, isolation, conflict among family, and being unemployed. Additional risk factors identified, although not as well studied, were hopelessness, sleep issues, incarceration, military combat, childhood trauma, and homelessness. Thus, what was highlighted was the presence of a mix of issues that can come from external or environmental factors but also personal ones. Veterans are highly at risk, as noted by Anestis and Bryan (2013) in their study of suicides among the United States (US) military veterans. They hypothesised that the higher numbers of suicides could in part be due to access to and training with firearms; the factors could therefore be environmental and situational. Personal factors were also considered, as the high rates of psychological pain many US veterans experience in the form of post-traumatic stress disorder (PTSD) is a prominent factor. Pompili *et al.* (2013) conducted a literature review about PTSD and suicide rates and the connection was significant, with those with a history of PTSD having died more frequently from suicide. Furthermore, Nichter *et al.* (2021) shared that suicide is one of the leading causes of death in US veterans, having risen by 30% in the last decade. Additionally, the suicide crisis among US veterans is seen as such an epidemic that the US Veterans Affairs (2022) launched a suicide prevention campaign titled "Mission Daybreak" (2023), with 20 million dollars in prize money for suicide prevention strategies.

PTSD can come from various forms of trauma, one of them being childhood trauma. Zatti *et al.* (2017), in a meta-analysis on childhood trauma and suicide, found that those with childhood trauma were more likely to have suicide attempts, especially if physical abuse had been involved. Barbosa *et al.* (2014) found similar connections between childhood trauma and suicide attempts when studying youth. Additionally, the study showed women have higher attempt rates than men. This is different from what Ruch *et al.* (2019) state on youth suicides: males die by suicide more often; however, rates of female deaths by suicide have risen too. Struszczyk *et al.* (2019) and

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Madrigal de León *et al.* (2019) noted the crossover between mental health challenges, substance abuse, and suicides in youth, as did Pompili *et al.* (2012) and Milner *et al.* (2017), who also addressed the lack of qualitative research when it comes to suicide. Specifically mentioned is the need for a greater understanding of suicides among male-dominated industries where substance abuse can be an issue. Thematic analysis was conducted on 34 cases of suicide in this field, and some of the themes identified were mental health challenges, relationship breakdowns, struggles with employment, custody battles, substance abuse, workplace injury, and legal and financial issues. Many of the themes identified were interconnected, and it was also noted how workplace colleagues were often seen as support, making shifts in employment detrimental. This shows how community support and social structures can play huge roles in suicide prevention. Murphy *et al.* (2018) also noted a community aspect around suicide.

Focus groups were used by Perceval *et al.* (2018) to research farmer suicides in Australia, the main themes found being social factors and stigma towards groups of people, as well as relationship issues. The study showed the social factors that can contribute to suicide, and the need for suicide to be seen as more than simply an issue within a person but an illness of society and communities.

New Zealand has one of the highest rates of youth suicide according to Stubbing and Gibson (2019). Their research showcased themes of constant pressure and inescapable problems, as well as mental health challenges. When they researched suicide ideation among females with major depressive disorder (MDD) in Pakistan, Qamar *et al.* (2021) noted that 60% of all suicides worldwide happen in Asia. The main themes identified were psychosocial factors and challenges accessing support for MDD.

Rasmussen *et al.* (2014) approached suicide research by analysing ten men who died by suicide to gain insight into their state of being. They interviewed informants who had been close to the men who died. The themes identified were developmental struggles in gaining independence, anger, and a low tolerance for feelings of shame.

Chávez-Hernández *et al.* (2009) conducted analysis on suicide notes, focusing on the cultural differences between the US and Mexico. Their findings show that although there are differences in culture, there were very few differences in the notes, and this was also found in Canada, Australia, Germany, the United Kingdom, Russia, and Hungary. This demonstrates that the suicidal mind is the same no matter the culture or country, and that psychological pain is always at the forefront.

Leenaars *et al.* (2014) in Lithuania also studied suicide notes and found a theme of traumatisation, possibly in relation to genocide. This is seen among indigenous people, who are at the highest risk of suicide worldwide (Leenaars, 2006). Lazarides *et al.* (2019) also studied suicide notes, specifically in South Africa, their findings showing themes of psychological pain, hopelessness, self-blame, and pressure. Research of suicide notes can offer valuable insights; however, this is only limited to people who leave notes. Cerel *et al.* (2015) shared a six-year study that found that

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only 18% of people who die by suicide leave notes. Additionally, Callanan and Davis (2009), in a ten-year study, spoke of 32% out of a sample of 621 people who left notes. However, they also considered the challenges with these calculations as not all notes were accessible, and some were written in means that were less likely to be documented.

When looking at risks connected to suicide, there is confusion around what is a suicide attempt and what is self-harm, as prior suicide attempts are seen as being a high indicator of death by suicide, while self-harm is not (Van Orden *et al.*, 2010). Silverman *et al.* (2007) address how self-harm can be connected to suicide ideation at times, but that it can also be unrelated. Additionally, the World Health Organization (1998) stipulated that thoughts of suicide can be unrelated to any acts to end one's life, and many who think of suicide may never act on it. Observing suicide risk among different groups of people, the high risk that is present for those who are suicide-bereaved is apparent. Pitman *et al.* (2017) connected this partly to the stigma that is present with suicide loss. Jordan and McIntosh (2011) estimated that for every suicide 14 people are deeply impacted by the death. Also noted is that survivors of suicide loss experience more stigma and less social support than other grievers.

Ross *et al.* (2018) conducted a longitudinal study with suicide-bereaved parents, and their findings showed themes at the 6-month mark such as searching for answers, meaning-making, and coping strategies. At the 12-month mark, they observed a greater sense of meaning and post-traumatic growth. Smith *et al.* (2011) also noted post-traumatic growth in suicide-bereaved, but due to social and societal constructs, this is often not discussed. However, normalising the resilience that can come from trauma can be beneficial and help to instil hope.

Spillane *et al.* (2019) addressed the need for greater care for suicide-bereaved, as well as for respect for their unique voices. According to Pitman *et al.* (2018), suicide loss is the most stigmatising of sudden deaths, leading to higher risks of mental health issues for those suicide-bereaved. Brent *et al.* (2009) also noted the impacts on mental health for suicide-bereaved, as well as themes of social awkwardness and self-stigmatising narratives. Sheehan *et al.* (2018) looked at the stigma connected with suicide, specifically how stigma impacts suicide-bereaved families. Another aspect of suicide loss stigma was explored by Vandecreek and Mottram (2009): they looked at the narratives of suicide-bereaved and how their spirituality was impacted, as well as the role of their religious community.

Conversing with suicide-bereaved about their experience could add to understanding their grief process. In line with this, Silvén Hagström (2019) used a narrative approach when researching youth whose parents died by suicide and found that a narrative approach was supportive and allowed for more meaning-making. Miklin *et al.* (2019) also highlighted the need for meaning-making when a suicide happens and the importance of supporting the bereaved with that process. Goulah-Pabst (2023) employed a narrative approach when interviewing 14 suicide-bereaved, looking specifically at the stigma and threats to social bonds due to the loss. Furthermore, they found that suicide loss support groups were considered an important step in reducing the sense of

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stigma and isolation. Tal Young *et al.* (2012) noted the stigma and trauma that the suicide-bereaved experience, as did Sanford *et al.* (2016), who shared that those bereaved have described it as PTSD. Bellini *et al.* (2018) looked at PTSD and intrusive thoughts in the bereaved, as well as higher risks of suicidality.

Struszczyk *et al.* (2019) conducted a scoping review of suicide prevention strategies implemented specifically for men. They found more specific strategies for prevention among males were needed, with a focus on more qualitative research, especially with middle-aged men who can have the highest rates of suicide. Bergmans *et al.* (2017) used qualitative analysis to study females with recurrent suicide attempts and noted the vast complexities in working with suicidal patients. Also seen was the harm that could be done if clinicians were judgmental or shaming of the patient's states. O'Connor and Nock (2014) added to this by addressing how most people struggling with suicidal thoughts do not receive treatment, and how there is a desperate need for research on interventions.

To grow our knowledge around suicide prevention, more research in the area is needed. Berta *et al.* (2022) discussed that a greater understanding of psychopathology and mental health is necessary, specifically around suicide where there seems to be a gap in research. Bennett *et al.* (2023) addressed how quantitative research dominates the subject of suicidology and how more qualitative research is needed. One of the possible reasons for less research on suicide than on other issues is the ethical challenges when researching suicide, as even among research ethics committees suicide can be a difficult topic (Barnard *et al.*, 2021). Prinstein (2008) also addressed the lack of research on suicide, some of which is acknowledged as being partly due to the ethical considerations, as those who suicide cannot participate in studies; those who are suicidal cannot easily participate due to the same ethical concerns. Therefore, finding a window to gain greater understanding and support around suicide is vital.

This study aims to gain greater insights into suicide, to open more prevention strategies, and to reduce the stigma around suicide by interviewing suicide-bereaved. The rationale behind this is that much can be gained in understanding suicides by speaking to those closely impacted by them. The bereaved are a group of people who have experience in this area out of a very real need for understanding, meaning-making, and survival. This study hopes to shine a light on the vast knowledge that can be obtained by interviewing suicide-bereaved, and to encourage other researchers to do the same.

This study has a similar approach to the one Macdonald *et al.* (2022) took when exploring the narratives of Australian suicide-bereaved. However, this study has a wider participant sample, including men and women, partners and family members of people who suicided. Additionally, most participants will have taken part in a suicide loss support group. Groos and Shakespeare-Finch (2013) found that suicide loss support groups could help participants shift their narrative, support meaning-making, and offer a sense of universality. Goulah-Pabst (2023) also saw support groups as beneficial.

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Thus, this research study proposes the question: "What is the narrative of the suicide-bereaved and how does it shift over time?"

Objectives

1: To gain greater insights into suicide and suicide prevention by hearing the narratives of the bereaved.
2: To understand the suicide-bereaved experience and narrative and how time shifts the grief process and meaning-making for the bereaved.
3: To reduce stigma around suicide by opening conversations about suicide and encouraging further research.

Methodology

This study used qualitative methods in the form of a narrative analysis and took an inductive approach, setting no preconceived assumptions but rather using an exploratory lens and focusing on the personal narrative of the suicide-bereaved and their grief process. Hjelmeland and Knizek (2010) expressed the need for more qualitative research to help understand the phenomenon of suicide. Osafo (2021) addressed the complex societal contexts that impact views of suicide among cultures, and how this requires a high level of care, making qualitative study a valid choice. The rationale for a qualitative approach was due to the gentleness needed with the topic of suicide. Qualitative methods allow for detailed insights, while still supporting the participants. Sandford *et al.* (2023) used a qualitative approach in studying suicide. The same methodology was chosen by Latakiene and Skruibis (2015) and Ratnarajah *et al.* (2014). Narrative analysis offers space for the bereaved to share their story which can be supportive, as Mastrocinque *et al.* (2020) observed in their study of homicide and suicide-bereaved. Bosticco and Thompson (2005) also highlighted the restorative power of stories for those grieving, as did Silvén Hagström (2017). The researcher had experience with suicide loss, which Smith *et al.* (2011) noted as beneficial when researching suicide-bereaved, as their personal experiences around suicide were seen as comforting by participants and allowed for greater ease of conversing.

Methods for Data Collection

Eight unstructured interviews were conducted. The choice of unstructured interviews was motivated by a wish for all participants to share their stories with only slight direction from the researcher, resulting in the focus being on their story. Interviews were conducted online through video conferencing. The audio of the interviews was recorded for later transcription and analysis. Once transcribed, the data was analysed using narrative analysis. This required many detailed rounds of reviewing the data and organising the participants' stories into timelines of their grief process, as well as rounds of connecting the similarities and differences within each story.

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Participants

The participants were eight individuals who had someone close to them die by suicide. The original desired participant number was six. However, more participants volunteered to take part in the study, so the sample was extended to include two more. Pietkiewicz and Smith (2014) shared how the richness of data desired in qualitative studies requires smaller sample sizes. For example, in a qualitative study exploring suicide attempts, Latakiene and Skruibis (2015) had only three participants, while Richardson *et al.* (2021), in a similar qualitative study, had only twelve participants. Furthermore, National University (2020) recommends six to ten participants on average for narrative analyses. All participants of this study were located in British Columbia, Canada, with five having a cultural background as Canadians, and three having cultural backgrounds from Colombia, Argentina, and England. The participant ages ranged from 30 to 79, with the average being in their mid-40s. The time since their loss ranged from within the first year to three years after, with the average being in their second year. There were seven females and one male. Three participants were grieving siblings, four were grieving adult or young adult children, and one a romantic partner. There were no restrictions to the relationship to the bereaved in this study and it was open to any type of suicide loss.

Procedure

Sampling was non-probabilistic in the form of purposive sampling, which is most common when conducting narrative analysis (National University, 2020). Participant recruitment was with support from the BC Bereavement Helpline (2023) and Crisis Centre BC (2013) in using their database of participants who had reached out about their suicide loss support group. Potential participants were informed of the study through an email poster. They were provided with information prior to taking part in the interview. Participant consent forms were requested to be completed, and participants were given the option to ask questions. The interviews were conducted over a four-week period, were unstructured, and 60 to 90 minutes long, depending on each participant and the amount they shared. Additional time was allocated at the end of the interview for extra support if needed. The interviews were conducted online via video call. The participants were asked some prompts during the interview, such as to share more, questions regarding their grief process, and some demographic questions for sampling clarity. Participants were made aware of the option to take breaks if needed, as well as that of declining to answer question prompts. The interview was recorded, and confidentiality was ensured for the participants through the use of pseudonyms for themselves, as well as for their person who suicided. All participants were made aware of their right to withdraw. One week after the interview, email follow-ups were conducted to check in with the participants' well-being. Additional support was available for participants, and these resources were provided in the information debriefing form which was shared directly after the interview. Once all interviews and follow-ups were conducted, transcription of the interviews took place, followed by the narrative analysis.

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Ethics

The British Psychological Society's *Code of Human Research Ethics* standards were met (Oates *et al.*, 2021). Due to the sensitivity of the topic and the vulnerability of the participants, the ethical reviews were thorough. Additionally, ethical considerations for the researcher were put in place in the form of proper support from supervisors and rest between interviews and analysis.

Reflexive statement

This study was conducted by an inside researcher, meaning I, as the researcher, have experienced suicide bereavement. My loss, at the time of writing this, occurred 15 years ago, and I have worked in the field of suicide loss for 10 years both as a support group leader and an individual counsellor supporting suicide-bereaved people. I feel the personal background I have in this area supported me in navigating a very heavy and highly sensitive area with grace. Due to the stigma surrounding suicide, entering this territory without personal experience could be challenging. However, being suicide-bereaved myself allowed for an openness when participants were sharing their stories. Although I have this personal experience, none of their losses were the same as my loss, and I feel I remained neutral and objective throughout the interview process and the data analysis. This research has allowed for a greater understanding of the narrative of the suicide-bereaved both in my own story and in being witness to that of others. I can track my own process of destruction and rebuilding, as well as that of going into advocacy work, similar to what was noted by many of the participants.

Findings

The narratives of the bereaved are broken into three parts: beginning, middle, and end of their stories. This latter part does not mean that their stories have come to an end, but it simply tracks how the story has been organised thus far. The nested narratives within their stories are divided into those same three groups, along with the themes that were found between all eight participants. These themes are shared with participants' quotes to demonstrate the narratives.

Chaos and disorientation

In the beginning, the participants experienced chaotic, mixed feelings described as shock and disbelief, with a mix of anger, guilt, grief, regret, going through all the "what ifs", shame, disconnection, and, for some, suicidal thoughts.

Sandy described it by saying: *"It was a complete shock. We had no idea that suicide was anything we needed to be concerned about."* She continued: *"It was awful. Those first few weeks and months were just completely horrendous and awful. You really do feel like you are going insane and that you will never, ever, ever be able to function again."*

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Kerry said: *"I would say 3 days after, I was, I was totally distraught, I mean, just out of my mind."* Jean also commented: *"It was like the worst of the worst; it was just too bad. But I also felt, I also felt so much guilt for like not being there."*

Beth described it by saying: *"At the very beginning of it, it just felt like this raw nerve that you couldn't control. It was just uncontrollable crying."* The stigma connected to suicide was noted for many of them and is part of that initial chaos and disorientation, as it impacted how they navigated the outside world. Many of them spoke of isolating themselves from others to try and cope, how trying to connect to those close to them required sharing the story, and how even trying to process talking about it with others was complex.

Samantha said: " *We isolated a lot. I think I can recognise that I also have internalised a fair bit of shame and stigma around it."* Owen said: *"With other people, there's always like stigma and people just don't wanna say the wrong thing."* Part of the disorientation at this first stage was the feeling of being challenged by their previous beliefs of life and their own identity.

Gail spoke of it in how she was behaving: *"I just started trashing my place. I've never done that in my life."* Similarly, Beth spoke about how she always considered herself very strong and capable, but this experience challenged that. Beth said: *"I had a lot of trouble. Like I said, I consider myself a professional who's very well put together and I couldn't even navigate through the health care system.*"

Survival and reorganisation

Following the period of disorientation, participants described how, to survive, they had to reorganise how they navigated the world and even the sense they had of life. This stage involved opening to reorganisation. As Owen said: *"I just wanted to know what my purpose was, like, I was feeling purposeless or trying to give like meaning to, to life or whatever."*

Part of the reorganisation was going into "researcher mode" to try to understand suicide. This included both researching suicide and educating themselves around it. Sandy noted: *"I was just like a detective for weeks and months, I just delved into every single thing I could find."* Beth said: " *We didn't really know a whole lot until we started connecting with his friends and stuff later."*

An aspect of this research and the reorganisation phase was their reckoning with their perceptions of those that suicide. For example, Samantha spoke about this by sharing how the perception of a regular or high-functioning person dying by suicide is not understood: *"Everybody was shocked, the people that I was turning to, and it just was atypical in a lot of ways. And so, I think that that kind of story needs to be heard more because, especially with the university crowd, you have high achieving kids who've never had to ask for help before."* Jean also addressed this when describing her experience in the suicide loss support group: *"I was really hoping that as they share their stories this pattern would emerge of the type of people that*

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suicide. But then everybody started sharing and it was all over the place. And it left me with this feeling, it was a bit unsettling, like, oh my god! It could be anyone. And it gets you thinking that anyone under a certain set of circumstances could make that decision."

The desire for something to change in the world regarding how suicide and mental health are handled was noted as a focus for reorganisation and something concrete to move towards. This was seen in how Samantha spoke about her daughter before she died: *"I think she probably internalised some of the social stigma just around mental health in general and asking for meds, and our medical system unfortunately confirmed those stigmas for her."*

Samantha also spoke about her desire to support how students are cared for when it comes to their mental health: "*If I ever do put myself into suicide prevention space, it'll be in that specific community."* Francis addressed it with the hope for a better world in which this isn't happening: "*I hope suicide will be lost, it will be something like 'oh, back in the day.' But I don't know. Unfortunately, it still keeps happening."*

Living with duality

Across all participants there was a sense of accommodation to the loss, which involved living with duality. This meant that they had to live with the trauma and the pain, and accept it as a part of life, whilst seeing how their person was flawed but also beautiful.

This place was viewed as being very existential. It was a place they were moving towards with their life, a place of being aware of the lack of control one has but also choosing to live. Jean said: *"It's hard to live in a world that can feel very scary at times and there's so much out of your control, but you also have to be open for the great things that happen in life."* Samantha said: *"It's not linear and it's not a direct correlation, but like that whole idea of acceptance is really hard for me. I try to think about it as more like integrating the reality of it rather than accepting it."* Sandy said: *"I think for me it's just really trying to be open minded to everything and to the beauty in the world, even when it's incredibly sad, that it's beautiful."*

Some participants spoke of feeling the role of duality more clearly than others. For example, Jean said: *"If you can accept that those two, dark and light, good and bad, beauty and horror, exist right, and learn to make space for pain, it gets a lot easier in a way."*

On route to this duality phase, all participants reached out for help and support, either through support groups, individual counselling, online forums, or community resources. Kerry said: *"I made the decision that I need to help myself. I need to help myself and I need to decide myself that I want to still be in the game of living."*

Additionally, the desire to be around others who knew what it was like, and to be with that community, was spoken of. For example, Owen said: *"The support group was great because it was, you know, peers who were going through something similar, who knew that this is not just your regular grief."*

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They also spoke about how they have had to learn to care for themselves and their mental health better. Francis said: *"I'm just more patient and more intentional with my boundaries because before I would just kind of give, give, give to everyone."* Gail said: *"You're doing things for them or for whoever or whatever, but I realise I have to now put some effort into forgiving myself."*

The flip side of getting support was a desire to give back to others. This was a way of supporting their own meaning-making and being a part of changing the way mental health is understood. Beth said: *"It opened my eyes up to the world, even in the way that I interact with people who are in distress. For me it was entirely, it was life altering. It made me want to be a better person."* Sandy said: *"His love, there's a lot I've taken up, a lot of the things he loved. I loved them already and it was a reminder to get back into it, or it's a spur to be more of it."* Francis said: *"So I got back to reading because before I was so busy. So, I've done a lot of things in his memory and been intentional about it."*

Some went more deeply into advocacy. Kerry took a suicide loss facilitator training: *"To make a difference, or trying to feel like my life has more meaning, or that I can do something to help others. So, I did take the course as a participant and then I took it as a facilitator."*

Owen said about joining a suicide prevention committee: *"I felt like I wanted like to give back, or to try to help people going through a similar process. Just helping them to get through it, or like learn to live with it. So, I joined the committee."* Beth shared about changing careers: *"I'm now working for a nonprofit society. And, again, it kind of goes back into like it made me reevaluate a lot of things about my life and want to do stuff more for people that are in need."*

While some were more focused on their well-being and their families rather than societal change and connecting with the grief and prevention community, Francis shared: "*We gotta live full lives because when we get to heaven, or whatever the on yonder place that we go to, we have like 10 million stories to tell him."*

It should be noted that the way each of them made sense of it at times looked different, but the deeper layers of it were highly similar. It was more about the way in which each person was applying and expressing it that seemed unique, as well as the way they were remembering their person and making meaning and sense out of something that felt meaningless.

Discussion

The main themes identified in this study were described as chaos and disorientation, survival and reorganisation, and living with duality. Within each theme, there were sub-themes present. The chaos and disorientation theme included feelings of shock, disbelief, anger, guilt, grief, shame, regret, traumatisation, disconnection, and suicidal thoughts.

Those that have someone close to them die by suicide can be at greater risk of dying the same way, and this was mentioned as a fear by 50% of the participants. This is in line with what Pitman

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et al. (2017) noted for suicide-bereaved, as did Bellini *et al.* (2018) and Brent *et al.* (2009). Although stigma was felt, most of the participants mentioned feeling well supported by their friends and family initially. However, over time there was the fear of burdensomeness and wearing their support systems out. Levi-Belz and Ben-Yaish (2022), Van Orden *et al.* (2010), Filiberti *et al.* (2001), and Sabbath (1969) also addressed the fear of burdensomeness that suicide loss survivors experience and noted that it can be a high-risk factor leading to suicide.

Furthermore, even though there was a sense of support, one does not know if that support may have been greater in the event of a different sort of death, especially when it comes to community support and being in a small town or small work environment—this was specifically mentioned as being hard when it came to the stigma surrounding their loss. Barnard *et al.* (2021) and Prinstein (2008) also recognised the stigma and the need for more open conversations around suicide. This was something mentioned by participants, as most of them shared how it felt valuable to be interviewed since it was an opportunity to speak openly about their experience. Some even mentioned that even among their families it was not easy to openly speak about suicide and their loss.

This supports what Goulah-Pabst (2023) researched about social bonds being impacted by suicide loss. Even though some support was seen, community and systems support were different. Some had supportive employers who were understanding, but then found the support systems challenging to navigate, which Jordan and McIntosh (2011) also found in studying survivors of suicide loss. They also noted how there is less social support and more stigma than in other losses.

Two of the participants who were really struggling with their mental health and despair noted that getting support either from a doctor or a suicide loss competent mental health professional was hard. This in turn made them think about the person they lost to suicide and the help they would have been given even if they had tried to seek support. One participant discussed how that happened when their person reached out for support and how, unfortunately, they were shamed and treated as less-than. O'Connor and Nock (2014) echoed this in saying there is a need for more resources for those who openly say they are suicidal. Additionally, Bergmans *et al.* (2017) also addressed the stigma around mental health, saying that those who are suicidal must be treated with compassion and that shaming or stigmatising behaviour can be highly damaging.

The shock and trauma were never spoken of directly as PTSD by the participants, nor were there formal diagnoses. However, they identified the feelings that Paris (2016) correlated to PTSD, such as intrusive thoughts, avoidance, detachment, numbness, and hyperarousal. Tal Young *et al.* (2012), Sanford *et al.* (2016), and Bellini *et al.* (2018) all similarly identified these same trauma responses among the suicide-bereaved.

The survival and reorganisation theme was noted as being a time when many participants went into "researcher mode", trying to understand suicide and make sense of their world. They also looked at suicide in line with trying to understand risks and what led their person to that place,

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which involved addressing their perceptions around those that suicide. When the participants were going into this mode of searching for answers, of note by all eight of them was how much mental and emotional distress they felt their person was in. Schneidman (1998) and Stubbing and Gibson (2019) also noted mental distress and how it is seen in those that suicide.

One of the risks participants spoke of was childhood trauma—60% of them felt it was a contributing factor, while the other 40% did not see it as being present. Childhood trauma and PTSD are noted as risks of suicide by Anestis and Bryan (2013), as well as Pompili *et al.* (2013), Zatti *et al.* (2017), and Barbosa *et al.* (2014). Another risk factor 25% of the participants noted was the isolating they felt their people were doing, with the COVID-19 pandemic having played a role in this as well (Ciotti *et al.*, 2020). Motillon-Toudic *et al.* (2022) similarly addressed the risk of suicide by those who isolate, as did Van Orden *et al.* (2010) and Sher (2020).

Youth and student suicides were present, with 50% of the participants' deceased people having been 27 and under, and 25% of them having been current students. The participants felt there was a lot of pressure their people put on themselves, and they felt it was mostly self-imposed pressure, as many of them were spoken of as having had very high standards for themselves but low self-worth. Stubbing and Gibson (2019), when researching youth suicides, also noted themes of self-pressure. Ruch *et al.* (2019) and Struszczyk *et al.* (2019) additionally looked at the factor of age in suicide. Challenges handling strong emotions such as anger, fear, and shame were experienced by 36% of the participants' people, and alcohol and substance misuse by 50%. Rasmussen *et al.* (2014) also connected a low tolerance to feelings of shame and anger to people that commit suicide. Madrigal de León *et al.* (2019) and Pompili *et al.* (2012) equally saw substance misuse and suicides as being connected.

Mental health and gender were spoken of by 60% of the participants, who felt aspects of gender were a factor. Specifically, they talked of how they felt it could be stigmatising for men to ask for help or express their emotions, and possible for them to have the pressure to be perceived as tough by male peers. Qamar *et al.* (2021) spoke of mental health and gender among those that suicide, as did Struszczyk *et al.* (2019) and Milner *et al.* (2017). Other themes that have not yet been mentioned that participants identified as risk factors were relationship breakdowns, family conflict, lack of employment, the economy, the environmental crisis, workplace stressors, and lack of adequate sleep; this is similar to research by Milner *et al.* (2017) who also noted relationship breakdowns as being a risk, as well as unemployment and workplace stressors. Van Orden *et al.* (2010) addressed the risk of unemployment, as well as conflict among families. What is less researched and of interest to note is the environment factor, which was brought forward by 25% of the participants who said the state of our world and the harm that is being done to the environment weighed heavily on their people's minds. 50% of the participants noted prior suicide attempts by their people, with 75% of them having mentioned feeling suicidal prior to their death. The World Health Organisation (1998) also spoke of the risk factor of prior suicide attempts.

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Participants spoke of suicide notes as a means of gaining some information and understanding of where their dead loved ones were at; however, less than 25% of them left notes. One note was found that had been written possibly far ahead of time, and one participant felt the lack of a note was an indicator of how distressed their person must have been. Another participant felt the presence of a note was showing how determined their person was. Callanan and Davis (2009), Chávez-Hernández *et al.* (2009), Leenaars *et al.* (2014), Cerel *et al.* (2015), and Lazarides *et al.* (2019) all studied suicide notes in different ways, with similar mixed findings as notes were not consistently left.

The living with duality theme was seen as a place where participants were moving forward with their lives, while holding the duality of the pain and horrors of the world but also the beauties of it. All the participants reached out for support and help in different ways to care for their mental health, knowing the seriousness of their pain, and that this was not something they could get through on their own. Suicide loss support groups were discussed as being helpful, although some found groups hard to find and get into, and some mentioned not knowing how helpful they were until after the fact. Goulah-Pabst (2023) and Groos and Shakespeare-Finch (2013) discussed the value of suicide loss support groups. Another form of support was seen in individual counselling, which was very helpful for some but not so much for others.

Help was also found in community loss events and online suicide loss forums. Pitman *et al.* (2018) and Sheehan *et al.* (2018) also concluded the importance and need for suicide loss survivors to gain support. The desire for community was something many of the participants moved towards, specifically to be around others who had experienced suicide loss. Additionally, the stigma within society and the Canadian culture was noted as being difficult, especially the politeness. They spoke of how difficult it was to be around other people, as they felt people would not understand or they would have to defend their person that died. Murphy *et al.* (2018) and Perceval *et al.* (2018) also spoke of the desire for community support for the bereaved.

Community in the form of religious spaces was mentioned by one participant as being helpful. However, some participants mentioned the harm they felt their religious upbringing had on them in connection with stigma around suicide. Others wondered if having faith and just believing in something bigger than themselves would have made it all easier to make sense of. Although none of the participants spoke of moving towards religion, many of them addressed needing to understand their lives and their purpose. Vandecreek and Mottram (2009) also discussed how faith can be impacted while going through suicide loss.

When looking at the duality phase, it can be seen how meaning-making was different for each participant and how complex it was to live with that unanswered question and the duality of life. An important thing to note is not so much that some clear sense of life was achieved but that living with the unknown became more tolerable over time. Ross *et al.* (2018), Silvén Hagström (2019), and Miklin *et al.* (2019) spoke of how meaning-making for suicide-bereaved is imperative. Although it is a process they must go through, the actual steps can look different for each person.

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There were changes that all participants made in their lives in different ways: changes in careers, life direction, and what felt important. Post-traumatic growth is not the language that was used by participants; however, it seems accurate to describe it as such. Ross *et al.* (2018) and Smith *et al.* (2011) mentioned post-traumatic growth and how suicide-bereaved must grow to survive, and how that narrative can be hopeful for other bereaved. Although the participants were all able to access help, many of them mentioned how it was neither easy to find nor readily accessible. This was discussed by some, so much so that they chose to become involved within their communities to help make the support better for others who may be going through similar situations. This desire for advocacy work and being a part of changing the way suicide is perceived and understood was seen in seven out of the eight participants in this study, but is something that has not been noted much in other research.

From the participants in this study, there was a willingness and a desire to participate in research. This was seen in the amount of people that reached out, and of the ones that did participate many of them spoke about how taking part in the research study felt like a way they could do something with their pain and help with aiding the understanding of suicides. Furthermore, 80% of the participants were actively involved in prevention and education or giving back to the community in connection to mental health. Berta *et al.* (2022), Bennett *et al.* (2023), and Hjelmeland and Knizek (2010) noted the need for more qualitative research when it comes to suicide loss. Spillane *et al.* (2019) addressed the need to hear the suicide-bereaved voices and the insights they can offer. Macdonald *et al.* (2022) similarly concluded that suicide-bereaved have highly valuable insights and that they can be a resource for researchers.

Recommendations

An awareness of when the bereaved need support and how much stability is needed in the beginning is valuable for clinicians working with the bereaved. Knowing that a period of disorientation is to be expected, can help those going through suicide loss understand their journey, and know that it will take time to gain reorientation. For the mental health system, to provide greater care for those who are suicidal is of paramount importance. Corporations being more understanding of mental health and grief, as well as continued resources for the suicide loss community, would also be beneficial. Continued stigma reduction is necessary, as well as looking into reducing stigma around male emotions and their mental health. More research on suicide loss survivors moving into advocacy would also be valuable, as would understanding the correlation between suicides and the environmental climate of the world (Fountoulakis *et al.*, 2016; Williams *et al.*, 2015).

Limitations

A limitation to the study is the greater proportion of female participants compared to that of males, resulting in there not being a balanced share of genders in the participants providing the narratives analysed: having a balanced sample of genders could have shown different results.

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Furthermore, the participants were mostly siblings and parents of the people who suicided; thus, their grief and processes to cope may vary when compared to those of suicide-bereaved that had other types of relationships to people who committed suicide. Future research could consider different cultural backgrounds, as most participants in this study were Canadian. Although there is stigma towards suicide in North America, it is less stigmatised than in parts of the world where suicide is still considered a crime. In Canada, it has been decriminalised since 1972 (Kellner, 2006). In conducting online interviews, there is also a restriction on how accessible the study was to those with technological limitations; thus, further research could consider other interview mediums.

Conclusion

This research study aimed to answer the question of what the narrative of the suicide-bereaved is, and how it shifts over time. The findings show many shifts that take place, and that the narrative consists of the process of being completely broken down and having to rebuild oneself again. This reconstruction is seen not only in the griever's sense of self but also in their relationship with the world and those close to them. Time is very relevant in that it shifts the process and allows for reconstruction to take place; without that time the ability to gain perspective and space from the pain would not exist. Continuing to open dialogue around suicide is valuable: this was mentioned by the participants, and many of them were eager to share things that helped them cope and wanted these resources to be known by other grievers. Other strategies and techniques to cope were mentioned, including how pets were a huge source of comfort to some of the participants. Nature walks, individual counselling, grief forums, community events, and connecting with fellow grievers were also discussed as useful resources throughout their grief journey.

One of the things seen through this research was the sense that the suicide grief journey moves backwards compared to grieving a non-suicide death. For example, with a less stigmatised death, there is a natural process of viewing the dead person in a positive light. Seeing the person this way can help validate why one feels such deep despair with their death. However, due to the nature of suicide, and the person who dies contributing to their own death, seeing them in a positive light can be far more challenging for those grieving. The internalised stigma around suicide, alongside societal stigma, can add an incredibly painful dynamic for the griever. The process of seeing someone who has died as human and equally flawed as everyone else (neither worse nor better) is something that happens naturally over time with less traumatic grief; with a suicide, the deceased person's goodness can feel lost to the trauma of their death, and the griever must work through the hardest parts first, at the beginning of their grief journey. In this way, the bereaved must first come to terms with their person being flawed and human, and then, over time, connect more to their positive side. Understanding the very different grief journey with a suicide loss can help other suicide-bereaved understand why their loss seems so different to navigate than other kinds of deaths. Additionally, the role stigma plays in the equation is vast, and therefore opening conversations about suicide is imperative if one is to challenge this stigma.

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What is the narrative of the suicide-bereaved?

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