Navigating Grief: Exploring the Factors Affecting Trauma and Depression in Suicide Bereaved Individuals

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Article

Navigating Grief: Exploring the Factors Affecting Trauma and Depression in Suicide Bereaved Individuals

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Abstract: Research on suicide bereavement has increased over the decades, however, previous studies have rarely taken into account factors such as relationship, demographics, body discovery, and suicide method on trauma and depression severity. The present study examined relationship to deceased, suicide method, body discovery, age, and gender in terms of depression and PTSD symptoms utilising retrospective data from the suicide bereavement service 'The Tomorrow Project' of the third sector service Harmless. A total of 431 bereaved clients completed IES-R and PHQ-9 self-report measures on intake and were analysed against the predictive variables. Contrary to hypotheses, results showed no statistical significance in terms of relationship, suicide method, body discovery, or age. Significant gender differences were detected with women showing higher depression and PTSD symptoms than men (p = <.001) with a slightly larger effect size in terms of PTSD symptoms ($F(1,421) = 18.35$, p = <.001; partial η^2 = .042). Results are discussed in the terms of the need for further investigation into gender differences in suicide bereavement and the need to include gender as a risk factor for severe trauma in clinical screening after a suicide has been experienced.

Keywords: suicide; bereavement; suicide bereavement; depression; trauma; PTSD

Introduction

The death of someone close is always a profound and distressing event, however there is evidence to suggest that losing someone to suicide is particularly impactful on survivors (e.g. Farberow, 1992; Farberow et al., 1992). Scholars posit that bereavement following suicide is characterised by distinct experiences not commonly seen after other forms of death, such as the search for meaning in suicide, feelings of stigma, and a sense of being misunderstood and unfairly blamed by others (Harvey, 2014; Jordan, 2001). Suicide bereavement is associated with various physical and mental health detriments (Maple et al., 2017; Pitman et al., 2014). Numerous studies have documented adverse grief experiences in individuals bereaved by suicide, including high levels of distress, trauma symptoms, and feelings of abandonment, rejection, guilt, shame, and anger (Cerel et al., 2008; Jordan et al., 1993, 2008; Robins, 1981; Sveen & Walby, 2008). Additionally, suicide bereavement has been associated with increased risk of suicidal thoughts and behaviours (Crosby & Sacks, 2002; Jordan, 2001; Krysinska, 2003; Latham & Prigerson, 2004; McIntosh, 2003; Pompili et al., 2006; Szanto et al., 1997). These negative outcomes have been observed in both adults and adolescents (Andriessen et al, 2016; Jordan, 2001; Mann et al., 2005; McIntosh, 2003), with less is currently known about suicide bereavement in young people (Cerel & Aldrich, 2011).

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It has also been found that suicide survivors may often experience complicated grief (CG), characterised as prolonged, acute grief which does not lessen with time (Young et al., 2012). CG can have negative impacts on survivors' day to day functioning, including their performance at work and in social settings (Lannen et al., 2008; Melhem et al., 2007; Monk et al., 2006; Prigerson et al., 1997). Furthermore, CG is associated with poor mental health outcomes, such as higher rates of co-occurring psychiatric conditions such as posttraumatic stress disorder (PTSD) and depression (Golden & Dalgleish, 2010; Newson et al., 2011; Shear et al., 2011; Simon et al., 2007) as well as an increased risk of suicidal behaviours (Dell'osso et al., 2011; Latham & Prigerson, 2004; Mitchell et al., 2004; Prigerson et al., 1999; Szanto et al., 1997; Szanto et al., 2006).

Evidently, suicide bereavement is linked to a range of adverse effects on individual wellbeing. However, the negative effects of suicide bereavement may vary depending on certain factors. Grad (2005) suggests that factors at individual, family, and societal levels may influence one's bereavement experience. These factors encompass the role and position of the deceased in one's family structure, the method of suicide employed by the deceased, the manner in which the bereaved discover the deceased's body, and the age and gender of the bereaved individual.

Relationship to Deceased

Suicide bereavement is a complex and challenging experience that can have significant impacts on the mental health and well-being of survivors. It has been well-documented in the literature that individuals who are closely related to the deceased, such as immediate family members, may be at a higher risk of experiencing negative mental health outcomes following a suicide. This includes symptoms of depression, post-traumatic stress disorder (PTSD), and even an increased risk of suicide themselves (Dyregrov et al., 2003; deGroot et al., 2006; Jordan, 2001; Mitchell et al., 2004; Mościcki, 1995; Nakajima et al., 2012). Several studies have noted the detrimental effects of suicide bereavement on family members, with Dyregrov et al. (2003) and deGroot et al. (2006) highlighting the increased prevalence of complicated grief among close relatives of suicide victims. Additionally, research by Jordan (2001), Mitchell et al. (2004), Mościcki (1995), and Nakajima et al. (2012) has drawn attention to the higher rates of depression and PTSD symptoms in individuals who are closely related to the deceased. These findings underscore the importance of considering the relationship to the deceased when examining the impact of suicide bereavement.

However, the relationship between the survivor and the deceased is not the sole determining factor in the bereavement process. Pitman et al. (2016a) have reported conflicting evidence, suggesting that the relationship to the deceased may not have a significant impact on the grieving process. Furthermore, Begley and Quayle (2007) have identified additional factors that may influence the bereavement experience, such as the age and gender of the survivor. This highlights the need for further research to better understand the complexities of suicide bereavement and the various factors that may contribute to negative mental health outcomes.

When it comes to children who have lost a parent to suicide, the impact can be particularly profound. Brent et al. (2009) and Cerel et al. (1999) have found that suicide bereaved children are at a greater risk of developing symptoms of depression, anxiety, aggression, withdrawal, and PTSD. However, there is conflicting evidence regarding the specific effects of suicide bereavement on children. Some studies, such as those by Brown et al. (2007), Pfeffer et al. (1997, 2000), suggest that the cause of death of a parent may have differential effects on survivors. Moreover, the circumstances surrounding the death of a parent may also play a role in the grieving process. Cerel et al. (2000) and Shepherd & Barraclough (1976) have noted that families with minor children may experience chronic stressors prior to the suicide of a parent, which could potentially impact the mental health outcomes of the children following the loss. Additionally, Brent et al. (2009) found that children whose parents died in accidents exhibited higher levels of depression, anxiety, and complicated grief compared to children bereaved by suicide. This challenges the notion that suicide bereavement is inherently more burdensome than other causes of parent death.

In the realm of bereavement following suicide, the experiences of parents and partners who have lost a loved one to suicide are of particular interest due to the unique challenges they face in

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coping with the loss. Research has consistently shown that parents who have lost a child to suicide are at a heightened risk of experiencing complicated grief (CG) (Murphy et al., 1999; Murphy et al., 2003a). The emotions that suicide bereaved parents may grapple with include feelings of guilt, responsibility, distress, and anger towards the deceased, as well as a sense of shame regarding these emotions (Lindqvist et al., 2008; Maple et al., 2010; Murphy et al., 2003b; Range et al., 1985; Reynolds & Cimbolic, 1988). Moreover, suicide bereaved parents have been found to experience more intense negative outcomes compared to other bereaved individuals, with studies indicating higher levels of guilt, shame, and shock among parents compared to spouses and children bereaved by suicide (Reed & Greenwald, 1991). Furthermore, suicide bereaved parents may struggle more than parents who have lost a child to a natural cause of death in making sense of the tragedy (Keesee et al., 2008; Lindqvist et al., 2008; Murphy et al., 2003). The societal stigma and negative judgements that suicide bereaved parents may face add an additional layer of complexity to their grieving process (Range et al., 1985; Reynolds & Cimbolic, 1988). However, individual factors such as the age of the deceased child and the parents' familial circumstances have been found to influence the intensity of grief experienced by suicide bereaved parents (Schneider et al., 2011; Lindqvist et al., 2008).

In the case of partners who have lost a loved one to suicide, research indicates that they too are at an increased risk of experiencing distress, depression, anxiety, and suicidal thoughts compared to partners bereaved by other causes of death (Agerbo, 2003, 2005; Brent et al., 2009; Clark & Goldney, 2000; Erlangsen et al., 2017; Kreitman, 1988). This heightened vulnerability is reflected in their higher utilisation of mental healthcare services (Erlangsen et al., 2017). Additionally, suicide bereaved partners may grapple with feelings of rejection or abandonment (deGroot et al., 2006).

The experiences of bereavement and support needs of ex-partners who have lost a partner to suicide are under-researched, but initial findings suggest that they may experience complicated grief to a similar extent as other survivors more closely related to the deceased (Pitman et al., 2016a, b). Despite the limited evidence available, studies have shown that ex-partners may not exhibit significantly different levels of depression and other psychopathological measures compared to ex-partners bereaved by accidental death (Barrett & Scott, 1990; Cerel et al., 2000). However, there is some indication that non-relatives, such as ex-partners, may be less likely to identify as 'suicide survivors' compared to closer relatives, potentially due to feelings of undeserving grief or support (Cerel et al., 2013).

Suicide bereavement is a highly complex and devastating experience that can have long-lasting impacts on individuals who have lost a loved one to suicide. While much research has focused on the experiences of parents, children, and spouses, the impact of a sibling's suicide on survivors is an area that has received less attention in literature. However, existing research suggests that individuals who have lost a sibling to suicide often experience feelings of grief, abandonment, anxiety, and may exhibit symptoms of PTSD (Dyregrov & Dyregrov, 2005; Tal Young et al., 2012). Studies have also shown that suicide bereaved siblings are at an increased risk of depression, particularly if they have a history of psychiatric disorders (Brent et al., 1992, 1993; Dyregrov & Dyregrov, 2005). Additionally, research has found that suicide bereaved twins are at a higher risk of suicide themselves, with this risk being higher in women and potentially increasing over time (Pompili et al., 2006; Rostila et al., 2012, 2013). These findings highlight the importance of understanding the unique challenges and vulnerabilities faced by individuals who have lost a sibling to suicide. Additionally, research suggests that younger siblings may be more negatively affected by the suicide of a sibling, indicating a potential relationship between age and psychological functioning in this population. It is crucial for mental health professionals to consider the age of the sibling when providing support and intervention following a suicide loss. While most evidence points to sibling suicide having a predominantly negative impact on survivors, Begley and Quayle (2007) propose that surviving siblings may also find their relationships strengthened by the shared experience of losing a sibling to suicide. This highlights the complexity of grief and the potential for growth and resilience in the face of tragedy.

In addition to siblings, friends of suicide victims also experience significant challenges following a loss. Research has shown that friends of suicide victims may be at an increased risk of developing

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PTSD, suicidal behaviour, and suicide attempts (Brent et al., 1995; Diekstra, 1989; Erlangsen et al., 2017; Tidemalm et al., 2011; Pitman et al., 2016a). Pitman and colleagues (2016a) emphasize that the risk of suicide attempt following bereavement is not limited to blood relatives, but also extends to non-relatives including friends. This highlights the need for support and intervention for all individuals affected by a friend's suicide. Despite the challenges faced by friends of suicide victims, research indicates that they may receive less support and experience stigma, blame, and avoidance from family and social networks following a loss (Pitman et al., 2018). This lack of support can exacerbate the grieving process and increase the risk of mental health issues for friends of suicide victims.

Overall, the research on suicide bereavement highlights the need for increased attention and support for individuals who have lost a sibling or friend to suicide. Mental health professionals should be aware of the unique challenges faced by these individuals and tailor interventions to address their specific needs. Future research should also focus on second-degree relatives and non-relatives to gain a deeper understanding of their experiences and support needs following a suicide loss.

Suicide Method

The impact of suicide method on the bereaved is a topic that has not been extensively researched in the field of psychology. Callahan (2010) conducted a study on this subject and found that there was no significant association between suicide method and grief severity. However, anecdotal reports suggest that suicide by more "violent" means, such as firearms, may be correlated with more distress and complicated grief (Hauser, 1987). The study by Callahan (2010) provides important insights into the relationship between suicide method and grief severity in the bereaved. However, it is essential to note that this research is limited by the fact that it only included a small sample size and did not consider other factors that could potentially influence the results. In order to better understand the impact of suicide method on the bereaved, further research with larger, more diverse samples is needed.

Additionally, the lack of consensus in the literature regarding the relationship between suicide method and psychiatric distress in the bereaved highlights the need for more studies on this topic. While Callahan (2010) found no significant associations between suicide method and grief severity, other researchers have suggested that the method of suicide may play a role in the psychological outcomes for the bereaved. For example, Hauser (1987) reported that suicide by firearms was associated with higher levels of distress and complicated grief. The discrepancies in the findings of existing studies may be due to methodological differences, sample characteristics, and other variables that were not taken into account. It is important for future research to address these limitations and conduct more rigorous investigations into the impact of suicide method on the bereaved. This will help to better understand the factors that contribute to the psychological outcomes for individuals who have lost a loved one to suicide.

In summary, the impact of suicide method on the bereaved is a complex and understudied area in the field of psychology. While Callahan (2010) found no significant associations between suicide method and grief severity, anecdotal reports and other studies suggest that there may be a relationship between the method of suicide and psychological outcomes for the bereaved. Further research with larger, more diverse samples is needed to better understand these relationships and to provide more comprehensive support for individuals who have experienced the loss of a loved one to suicide.

Discovering the Body

Discovering the body of a loved one after a suicide is a traumatic experience that can have lasting effects on the mental health and well-being of the bereaved individual. Research has shown that individuals who witness the suicide or find the body after death are at an increased risk of developing post-traumatic stress disorder (PTSD), experiencing flashbacks, nightmares, and heightened levels of distress (Callahan, 2010; Tal Young et al, 2012; De Leo et al, 2013). This experience is often the most

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significant predictor of distress after a suicide, surpassing other factors such as the relationship to the deceased, the method of suicide, age, and gender (Callahan, 2010).

Fielden (2003) has described the term "throwness" to capture the chaos and immediate disruption that discovering a loved one's body after suicide can bring to a person's life. The sudden and violent nature of suicide can intensify trauma and lead to more severe grief reactions (Jordan, 2008, 2010; Kristensen et al, 2012). In contrast to other types of sudden and potentially violent deaths, such as road traffic accidents or homicides, where law enforcement or passers-by are often the ones to discover the body, suicide bereaved individuals are more likely to come face to face with the aftermath of the death (Reed & Greenwald, 1991; Wrobleski, 1991).

Sherba et al's (2019) study on the impact of suicide on social workers and counselors found that witnessing a client's suicide attempt or discovering the body was the most distressing experience reported by participants, with a high proportion also at risk of experiencing compassion fatigue. Notably, rumination, the persistent and distressing thoughts related to the suicide, is a common experience among suicide bereaved individuals and can be further intensified if they witnessed the death or found the body (Jordan, 2008).

Studies have consistently linked the act of witnessing a suicide or discovering the body to the development of PTSD symptoms following sudden loss (Brent et al., 1992; Hull et al., 2002; Melham et al., 2008). These symptoms may include intrusive images of the suicide, impaired cognitive function, and heightened emotional distress (Tal Young et al, 2012). Interestingly, Spillane et al (2018) found that intrusive images were also reported by those who were informed of the death via a third party, suggesting that the trauma of suicide bereavement extends beyond those who directly witnessed the event.

However, not all studies have found a clear link between body discovery and adverse psychological outcomes. Omerov et al (2017) reported that bereaved parents who lost a child to suicide did not have a higher risk of nightmares, intrusive memories or thoughts, anxiety, or depression, regardless of whether they witnessed or discovered the body. In a qualitative study by Spillane et al (2018), a participant even reported feeling a sense of calm when discovering the body, which provided them with an opportunity to say goodbye to the deceased. Wilson & Marshall (2010) found no significant relationship between the need for professional help and the act of discovering the body after a suicide, highlighting the complexity and variability in individual responses to such traumatic experiences. It is clear that while body discovery can have a profound impact on bereaved individuals, the extent of this impact may vary depending on a range of factors.

Age

The impact of age on the grieving process has been a topic of interest in the bereavement literature, with various studies highlighting the differences in emotional responses among different age groups. Older adults are often thought to have better emotional control and experience less distress following the loss of a loved one, particularly a spouse (Charles & Carstensen, 2007; Liechtenstein et al, 1996). However, when faced with sudden and unexpected deaths, such as suicide, older adults may experience higher levels of PTSD and depression (O'Connor, 2010a; Onrust & Cuijpers, 2006; Zisook et al, 1998). In a study conducted by O'Connor (2010b), it was found that older adults exhibited higher levels of PTSD symptoms in the months following bereavement compared to depression symptoms. This challenges the notion that older adults are better equipped to deal with loss and highlights the importance of considering the specific circumstances of the death in understanding the impact on the bereaved individual. Furthermore, studies on bereavement in old age are rare, as it is often seen as a normative life event (O'Connor, 2010b).

Contrary to the idea that older adults are more resilient in the face of loss, research by Hicks Patrick & Henrie (2016) suggests that emerging adults may actually experience less grief than middle-aged and older adults. This challenges the assumption that age directly correlates with the intensity of grief experienced. Similarly, Doveling (2017) points out that adolescents and young adults often turn to social media for support and connection following a loss, highlighting the influence of generational differences in coping mechanisms.

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Adolescents, in particular, are at risk for developing mental health conditions such as anxiety, depression, and PTSD following the loss of a loved one (Brent, 1993). Leopold & Lechner (2015) found that young children who lost a parent in adolescence experienced a significant decline in life satisfaction compared to older children. Additionally, adolescents who lose a parent may struggle to relate to their peers and find it challenging to seek comfort and support from friends.

Despite the prevalence of research on age and bereavement, there is a lack of literature specifically focusing on the age of the bereaved in the context of suicide. Many studies tend to emphasise the relationship between the deceased and the bereaved, as well as the age of the deceased, as factors influencing the grieving process (Middleton et al, 1998; Schneider et al, 2011). Understanding the role of age in the bereavement process, particularly in middle-aged adults, is crucial for providing targeted support and interventions for those who have lost a loved one to suicide.

Gender

Gender differences in the experiences of suicide bereaved partners have been a topic of interest in the field of bereavement research. However, findings in this area have been inconsistent, with some studies reporting that bereaved men have poorer mental health outcomes than bereaved women, while others have found the opposite. Callahan (2000) compared non-bereaved and bereaved men to non-bereaved and bereaved women and found that bereaved men had poorer mental health outcomes. In contrast, Murphy et al. (1999) found that bereaved women had poorer mental health outcomes using a similar methodology.

One factor that may contribute to inconsistencies in findings is the gender bias present in research on suicide bereavement. Many studies in this area have relied heavily on female participants, as it can be challenging to recruit men for research (Grad et al., 2017; McGoldrick, 2004; Stroebe et al., 2008). This gender bias may skew the results and limit our understanding of how gender influences bereavement outcomes. In clinical settings, women are more likely to seek help after a loss, while men may be at greater risk of suicide following their partner's suicide (Agerbo, 2005). Interestingly, McNiel et al. (1988) found that women whose husbands died by suicide experienced more guilt than women whose husbands died in accidents. Additionally, women who have experienced the suicide of a sibling are at higher risk of suicide themselves (Rostila et al., 2012, 2013). Women also tend to have higher grief scores than men after the suicide of a loved one and are more likely to engage in help-seeking behaviors such as therapy and support groups (Reed, 1993; Baum, 2004; McGoldrick, 2007).

Men, on the other hand, may cope with grief differently than women. Research suggests that men may "avoid" grief through silence, anger, and addiction, and may find other ways to cope, such as focusing on work or hobbies (Aho et al., 2006; Cacciatore et al., 2013). Daggett (2002) has suggested that cultural conditioning and biopsychosocial factors influence gender-specific grieving patterns. Men may also underreport their true feelings in both research and clinical practice, as they feel pressure to "man up" and be strong in the face of loss (Aho et al., 2006; Creighton et al., 2013). Men may also delay expressing their grief, as external demands such as funeral arrangements, work responsibilities, and family obligations take precedence (Cacciatore et al., 2013). Logan et al. (2024) found in a systematic review that suicide-bereaved men are at risk of developing mental health problems such as depression and PTSD, as well as experiencing interpersonal and social dysfunction. These challenges may be exacerbated by societal expectations of masculinity and the pressure to conform to gender norms.

Hypotheses

The specific hypotheses tested by this study were that the following variables would have a significant effect on both PTSD and depression scores; (1) relationship to deceased - with the strongest effect seen in parents who have lost their children, (2) discovery of the body - with the strongest effects seen in PTSD scores, (3) the age of the bereaved, (4) gender. It was also predicted that (5) suicide method would **not** have a statistically significant effect on PTSD and depression scores.

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Methodology

Context and Setting

The Tomorrow Project operates a specialized bereavement service within Harmless, an East Midlands-based Centre of Excellence for self-harm and suicide prevention. This integration allows for a comprehensive approach to suicide prevention, addressing both the immediate crisis and the long-term impact on bereaved individuals.

Referral and Initial Contact

The Tomorrow Project primarily receives referrals directly from law enforcement agencies upon notification of a suicide or suspected suicide. This immediate referral system ensures rapid response, with initial contact often occurring within three days of the bereavement.

Clinical Assessment and Intervention

Upon first contact, bereaved individuals undergo a thorough clinical assessment to evaluate their psychological state and needs. This assessment forms the basis for the subsequent targeted bereavement intervention. The intervention typically consists of an average of 12 sessions over 3 months, providing ongoing support and therapeutic care.

Materials

The IES-R and PHQ-9 score are used within the bereavement pathway service at Harmless/Tomorrow Project. Scores are taken from clients on intake and throughout their journey. The IES-R is a reliable and validated psychometric test that measures the impact of stressful and traumatic life events (Weiss, 2007). The IES-R has clients recall a single traumatic event (in this case the suicide of someone close to them) before rating 22 statements via a likert scale from 0-4, where 0 is “not at all”, and 4 is “extremely”. Statements include “I had dreams about it” and “I was jumpy and easily startled”. The scoring range of the IES-R is 0-88. Any score over 4 is considered a clinical concern for PTSD and scores over 33 represent the best cut off for a probable PTSD diagnosis.

The PHQ-9 measures severity of depression and has been validated for use in Primary Care within the NHS mental health services (Kroeknke et al, 2001; Cameron et al, 2008). The PHQ-9 scores each of the DSM-IV criteria for depression including “little interest or pleasure in doing things” via a likert scale from 0 (not at all) to 3 (nearly every day). Although the PHQ-9 is not a screen tool for depression, it can be used to make a tentative diagnosis in at-risk populations (de Man-Van Ginkel et al, 2012; Haddad et al, 2013). Scores between 10-14 indicate “moderate” depression, scores of 15-19 indicate “moderately severe” depression, and scores between 20-27 indicate “severe” depression. Both the IES-R and the PHQ-9 were used due to the reliability and validity of the tests, as well as the plethora of literature suggesting those who are suicide bereaved are at a high risk of PTSD and depression (Tal Young et al, 2012; Wagner et al, 2021; Grafiadeli et al, 2022).

Participants

In this study, existing data from Harmless’ Tomorrow Project Suicide Bereavement Service client records from December 2019 to March 2024 across Nottinghamshire, Derbyshire, and Leicestershire were utilised. The participants in the study consisted of clients who had undergone a PHQ-9 and IES-R test upon intake, with a total of 431 individuals included in the analysis. The age range of the participants varied from 11 to 77 years old, with an average age of 34 years. The gender distribution of the participants was predominantly female, with 73.6% of clients identifying as such, while 26.4% identified as male. Additionally, only one client identified as a different gender expression.

The majority of participants in this study were of White British ethnicity, non-religious, and identified as straight or heterosexual. These demographic characteristics provide a snapshot of the client population served by the Suicide Bereavement Service during the specified timeframe.

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The majority of participants in the current study sample experienced their intervention within the first 3 months of their loss to suicide. In order to examine the mental health and psychological distress levels of the clients, the PHQ-9 and IES-R tests were administered upon intake. These tests allowed for the assessment of depressive symptoms and levels of post-traumatic stress, providing valuable information for understanding the mental health needs of the participants.

Data Analysis

Data was analysed in SPSS using a one-way MANOVA for each category. MANOVA tests the null hypothesis that the means for each group are equal and can determine whether there are any differences between independent groups on more than one continuous dependent variable. Psychometric scores from The Patient Health Questionnaire (PHQ-9) and the Impact of Events Scale - Revised (IES-R) were taken from the Bereavement database and were analysed against relationship to deceased, method of suicide, body discovery, and various demographics including age and gender.

Results

Relationship to Deceased

A majority (31.9%) of clients referred to the service who received psychometric assessment were bereaved parents dealing with the loss of their child, followed by loss of spouse/partner (20.2%), loss of a parent (18.3%), loss of a sibling (12.8%), loss of a friend (12.5%), and loss of an ex-partner/spouse (4.4%). Witnesses/first responders were omitted from data analysis due to the small sample size, "other family" such as cousins or grandparents were also omitted from analysis. There was no statistically significant difference in trauma and depression scores due to the relationship of the client to the deceased, $F(10,848) = 1.74$, $p = .068$; Wilk's $\Lambda = .96$, partial $\eta^2 = .02$. See Table 1 for a breakdown of mean and standard deviation values for IES-R and table 2 for PHQ-9.

Table 1. Relationship to Deceased vs IES-R Score.

Deceased Relative	Mean	Standard Deviation	N
Deceased Parent	44.19	17.55	79
Deceased Child	48.81	18.23	137
Deceased Spouse/Partner	49.79	17.52	87
Deceased Friend	47.15	18.56	54
Deceased Sibling	49.13	16.28	55
Deceased Ex	49.42	22.47	19
Total	48.02	17.97	431

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Table 2. Relationship to Deceased vs PHQ-9 Score.

Deceased Relative	Mean	Standard Deviation	N
Deceased Parent	12.23	6.24	79
Deceased Child	15.63	6.66	137
Deceased Spouse/Partner	15.31	6.53	87
Deceased Friend	14.67	6.18	54
Deceased Sibling	14.95	5.44	55
Deceased Ex	15.21	6.69	19
Total	14.71	6.44	431

Suicide Method

In terms of suicide method, there were eight distinct groups; drowning, fall from height, hanging, rail, poisoning (via drugs), poisoning (via Co2), suffocation/strangulation, and injury with a sharp object. Other groups included firearms, lying in front of a moving object, poisoning (other chemicals), self-immolation, and "unknown". However, due to small sample sizes and missing data, the latter groups were omitted from analysis. This left 263 clients for analysis. A majority of clients experienced bereavement due to suicide by hanging (62.5%) followed by poisoning via drugs (16.6%), railways (5.3%), suffocation/strangulation (4%), drowning (3.4%), falling from a height (3.2%), injury with a sharp object (2.9%), and poisoning via Co2 (2.1%). There was no statistically significant difference in trauma or depression scores based on the method of suicide, $F(14,742) = .98$, $p = .47$; Wilk's $\Lambda = .96$, partial $\eta^2 = .02$. For full breakdowns of mean and standard deviations, see Tables 3 and 4.

Table 3. Suicide Method vs IES-R.

Method	Mean	Standard Deviation	N
Drowning	43.46	21.61	13
Fall from height	41.42	13.21	12
Hanging	47.82	18.13	237
Rail	51.1	19.97	20
Poisoning (Drugs)	48.14	17.08	63
Poisoning (Co2)	58.88	13.08	8

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Suffocation/Strangulation	49.27	21.99	15
Sharp object	55.55	18.93	11
Total	48.21	18.17	379

Table 4. Suicide Method vs PHQ-9.

Method	Mean	Standard Deviation	N
Drowning	11.23	6.35	13
Fall from height	12.75	5.66	12
Hanging	14.2	6.41	237
Rail	14.4	7.17	20
Poisoning (Drugs)	15.29	6.69	63
Poisoning (Co2)	16.13	2.95	8
Suffocation/Strangulation	15.47	8.44	15
Sharp object	16.55	7.45	11
Total	14.40	6.55	379

Discovering the Body

Due to missing data (as this statistic is not one Harmless/The Tomorrow Project have always collected) there was a significantly smaller sample size (n = 163). Over half (66.3%) of clients who had this data recorded did not discover the body, whereas 33.7% of clients did. There was no statistically significant difference in trauma and depression scores based on the client discovering the body of the deceased, $F(2,160) = .39$, $p = .68$; Wilk's $\Lambda = .995$, partial $\eta^2 = .005$.

Table 5. Body Discovery vs IES-R.

Discovered Body	Mean	Standard Deviation	N
Yes	44.51	14.97	55
No	46.2	19.27	108

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Total	45.6	17.9	163

Table 6. Body Discovery vs PHQ-9.

Discovered Body	Mean	Standard Deviation	N
Yes	14.51	6.26	55
No	14.46	7.17	108
Total	14.48	6.86	163

Demographics

Age

Regarding demographics, there was a lack of data and small sample sizes for clients who were under the age of 11, therefore these were omitted from data analysis. The sample size for this analysis was n = 369. A majority of clients (26%) were in the 41-50 age bracket, followed by 31-40 (19.2%), 21-30 (17.9%), 51-60 (14.4%), 11-20 (11.9%), and 60+ (10.6%). Again, there was no statistically significant difference in trauma and depression scores based on age groups, $F(10,726) = .765$, $p = .663$; Wilk's $\Lambda = .979$, partial $\eta^2 = .010$.

Table 7. Age Bracket vs IES-R.

Age Bracket	Mean	Standard Deviation	N
11-20	46.07	16.39	44
21-30	48.09	18.75	66
31-40	50.54	17.27	71
41-50	47.38	19.42	96
51-60	49.85	18.51	53
60+	42.92	17.38	39
Total	47.84	18.22	369

Table 8. Age Bracket vs PHQ-9.

Age Bracket	Mean	Standard Deviation	N

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11-20	13.39	5.37	44
21-30	15.12	6.59	66
31-40	15.31	5.84	71
41-50	14.95	6.89	96
51-60	15.32	6.91	53
60+	13.18	6.37	39
Total	14.64	6.43	369

Gender

Nearly three quarters (72.1%) of clients identified as female, 27.9% identified as male, and only 1 client identified as any other gender expression, therefore they were removed from analysis. The sample size for this analysis was n = 307. There was a statistically significant difference in trauma and depression symptoms based on the gender of the bereaved, $F(2,420) = 11.22$, $p = <.001$; Wilk's $\Lambda = .95$, partial $\eta^2 = .05$. For full breakdowns of means and standard deviations please see tables 9 and 10 below. In terms of the PHQ-9, gender had a significant difference in the scores, $F(1,421) = 19.21$, $p = <.001$; partial $\eta^2 = .044$. The same effects are found in the IES-R scores, albeit at a slightly larger effect size, $F(1,421) = 18.35$, $p = <.001$; partial $\eta^2 = .042$.

Table 9. Gender vs IES-R.

Gender	Mean	Standard Deviation	N
Male	42.22	18.69	118
Female	50.38	17.12	305
Total	48.1	17.93	423

Table 10. Gender vs PHQ-9.

Gender	Mean	Standard Deviation	N
Male	12.47	6.41	118
Female	15.45	6.23	305

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Total	14.62	6.42		423

Discussion

The results of this study suggest that the experience of losing a loved one to suicide is inherently traumatic, resulting in heightened PTSD and depression symptoms for the bereaved. The findings indicate that regardless of the relationship to the deceased, the method of suicide, the circumstances of body discovery, or the demographic characteristics of the client, individuals who have lost someone to suicide are likely to experience significant psychological distress.

The average IES-R score within the sample was found to be 48, well above the threshold for a probable diagnosis of PTSD. This suggests that the impact of suicide bereavement on individuals' mental health is substantial, with scores high enough to potentially compromise immune system functioning. Additionally, the average depression score of 14.7 falls between the categories of "moderate" and "moderately severe" on the PHQ-9 scale, further indicating the significant emotional toll of suicide loss.

Interestingly, the study found that gender was the only demographic variable that had a statistically significant impact on trauma and depression scores. Women were found to be more likely to develop severe PTSD and depression symptoms compared to men. This suggests that there may be gender differences in the ways in which individuals process and cope with the trauma of losing a loved one to suicide.

Contrary to expectations, the study did not find significant variations in psychometric scores based on the relationship to the deceased, the method of suicide, or the circumstances of body discovery. This challenges previous research that has suggested these factors may play a role in determining the severity of mental health outcomes for suicide bereaved individuals. Instead, the results suggest that the act of suicide itself is a significant factor in determining the level of psychological distress experienced by those left behind.

Overall, this study provides valuable insights into the psychological impact of suicide bereavement and highlights the need for targeted support and intervention services for individuals who have lost someone to suicide. By understanding the factors that contribute to PTSD and depression symptoms in this population, mental health professionals can better tailor their approaches to meet the specific needs of suicide bereaved clients. Further research is needed to explore the nuanced complexities of suicide bereavement and to develop effective interventions that promote healing and resilience in the face of such a devastating loss.

Relationship with the Deceased

The relationship between the bereaved individual and the deceased is a crucial factor in understanding the impact of loss on mental health outcomes such as PTSD and depression. While previous literature has provided conflicting results on this topic, the present study aimed to contribute to this body of research by examining the relationship between the individual and the deceased.

Some studies have suggested that individuals who have a close relationship with the deceased, such as a family member, may be more at risk for developing depression, PTSD, and suicidal ideation (Dyregrov et al., 2003; deGroot et al., 2006; Heikkinen et al., 1993; Jordan, 2001; Mitchell et al., 2004; Mosciciki, 1995; Nakajima et al., 2012). However, other studies have indicated that the quality or closeness of the relationship may hold more significance than the formal relationship itself (Reed and Greenwald, 1991). For example, the level of attachment to the deceased was found to be more strongly correlated with grief outcomes than the type of relationship (Reed and Greenwald, 1991). In the case of suicide bereavement, it was expected that parents who have lost a child to suicide would experience more negative outcomes compared to other bereaved individuals, such as feelings of shame, guilt, and shock (Reed & Greenwald, 1991). However, protective factors such as the age of the deceased child and the presence of other surviving children can mediate these negative effects (Lindqvist et al, 2008; Schneider et al, 2011). Similarly, friends of suicide victims were expected to

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have lower PTSD and depression scores compared to first-degree relatives, as they may need less support and experience less complicated grief (Mitchell et al, 2004; Wilson & Marshall, 2010). However, it is important to note that friends of suicide victims may also be at an increased risk of developing PTSD (Brent et al., 1995).

The present study utilised retrospective data from a third-sector service, which may have implications for the results compared to previous studies that have used recruited participants or healthcare data. By examining the relationship between the bereaved individual and the deceased and its impact on mental health outcomes, this study adds to the growing body of research on grief and bereavement. Further research is needed to fully understand the complex relationship between the bereaved individual and the deceased and its implications for mental health outcomes.

Suicide Method

The method in which an individual chooses to end their life is a topic that has long intrigued researchers. Many studies have focused on whether the suicide method has any influence on the severity of PTSD and depression among the bereaved. However, the findings have been inconsistent and often inconclusive. This study aimed to contribute to the existing literature by exploring the potential impact of suicide method on the mental health outcomes of the bereaved.

Contrary to expectations, the results of this study revealed that the method of suicide had no significant effect on the severity of PTSD and depression. This finding is in line with previous research conducted by Callahan (2010), who also found that suicide method did not correlate with the severity of grief among the bereaved. Interestingly, hanging emerged as the most common method of suicide within the sample, which is consistent with data from the World Health Organisation (WHO, 2014) mortality database. Previous studies have also highlighted hanging as the predominant method of suicide in many countries, particularly among men (Ajdadid-Gross et al, 2008).

It is worth noting that poisoning (via drugs), commonly referred to as “overdose”, was the second most prevalent method of suicide in the sample. Again, this finding aligns with data from the WHO database. Despite these findings, it is crucial to acknowledge the scarcity of research on the impact of suicide method on the mental health outcomes of the bereaved. The results from this study suggest that the method in which an individual takes their own life may not play a significant role in determining the level of trauma and depressive symptoms experienced by the bereaved.

Discovering the Body

The discovery of a loved one's body after suicide is a traumatic event that can have lasting effects on the mental health of the bereaved. Despite the widely held belief that finding the body would exacerbate symptoms of PTSD and depression, the findings of this study do not support this hypothesis. This is in contrast to previous research which has suggested that discovering the body of a loved one may intensify trauma severity.

Callahan (2010), DeLeo et al (2014), Jordan (2008, 2020), Kristensen et al (2012), and Rando (2015) have all reported that finding the body of a loved one can lead to increased PTSD and depression scores. Fielden (2003) noted that individuals who discovered a loved one's body after suicide experienced a sense of terror and internal chaos. The DSM-IV also specifies witnessing a death as one of the criteria for a PTSD diagnosis (APA, 1994). However, the results of the present study are consistent with Omerov et al (2017), who found that suicide-bereaved parents who had discovered their child's body did not experience higher rates of nightmares, intrusive memories, avoidance of thoughts or places, anxiety, or depression. Spillane et al (2018) also found that intrusive images of the deceased and how they died were not limited to those who discovered the body but were also experienced by those who learned of the death through a third party.

While Jordan (2008) suggested that discovering the body can intensify trauma symptoms, it is important to consider that many suicide-bereaved individuals will exhibit severe symptoms even if they did not witness the death or find the body. Furthermore, research on the effects of discovering

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the body after suicide is limited, and there is no consensus on whether this event has any effect on trauma or mental health in suicide bereavement.

Age

Age is an important demographic factor to consider when studying the impact of suicide bereavement on individuals. In the study conducted by Middleton et al (1998), it was found that there was no significant difference in PTSD and depression scores based on age group. However, the majority of clients in their study fell within the 41-50 age category. This finding is consistent with the lack of literature regarding the age of the bereaved in suicide-focused research. Most papers tend to focus on the relationships to the deceased rather than the demographics of the bereaved.

In contrast, studies on bereavement in general have shown that older adults may have better emotional control than younger individuals. Charles & Carstensen (2007) found that older adults report better control over their emotional states compared to younger people. Liechtenstein et al (1996) also reported that older adults have less negative reactivity and perceive less distress when faced with the loss of a spouse. These findings suggest that age may play a role in how individuals cope with the loss of a loved one. However, the study by Hicks Patrick & Henrie (2016) found no significant effects for age in terms of grief after the loss of a loved one. Similarly, Jacobs et al (1986) also found no significant effects for age in their study on suicide bereavement. These conflicting findings suggest that the impact of age on the bereavement process may vary depending on the individual and the specific circumstances of the loss.

It is important to note that while some studies have found no significant effects for age, there may still be specific age-related difficulties to suicide bereavement that have not been fully explored in the existing literature. Future research should continue to investigate the role of age in the bereavement process to better understand how different age groups cope with the loss of a loved one to suicide.

Gender

In recent years, there has been a growing body of research exploring the relationship between gender and mental health outcomes in bereavement. The present study adds to this literature by investigating the impact of gender on trauma and depression severity in individuals who have experienced the suicide of a loved one. The findings reveal that gender plays a significant role in shaping the psychological response to bereavement, with women exhibiting higher levels of trauma and depression symptoms compared to men.

One possible explanation for this gender difference is the way in which men and women express and cope with their emotions. Previous research has suggested that women are more likely to openly express their emotions and seek support from others, while men may be more inclined to suppress their feelings or seek distraction through work or other activities. (Aho et al, 2006; Cacciatore et al, 2013; McGoldrick, 2007; Reed 1993). This pattern of emotional expression and coping strategies may contribute to the higher levels of distress observed in women compared to men in the present study. Furthermore, societal norms and gender stereotypes may also play a role in shaping the psychological response to bereavement. Research has shown that men may face pressure to conform to traditional notions of masculinity, which can lead to the avoidance of emotions and vulnerability (Aho et al, 2006; Creighton et al, 2013). This fear of appearing 'un-masculine' may drive men to use psychological defences to distance themselves from their emotional struggles, ultimately impacting their mental health outcomes in bereavement (Kierski & Blazina, 2010).

On the other hand, women may be more socialised to seek help and support when experiencing distress, leading to higher rates of engagement with therapeutic interventions such as therapy and support groups (Baum, 2004). The present study found that a majority of individuals accessing support services for suicide bereavement were female, suggesting that women may be more inclined to seek out professional help in coping with their grief.

The findings of this study indicate that women who have been bereaved by suicide have higher levels of PTSD and depression symptoms compared to men. This raises important questions about

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the underlying factors that may contribute to these differences. One potential explanation could be the social and cultural expectations that are placed on women to be more emotionally expressive and nurturing (Aho et al, 2006; Baum, 2004). Women may also be more likely to internalize their emotions and experiences, leading to higher levels of psychological distress following a traumatic event such as suicide bereavement.

Another possible explanation for the gender differences in symptom scores could be related to the dynamics of the relationship between the bereaved individual and the deceased. Research has shown that women tend to have closer and more intimate relationships with their loved ones (Hook et al, 2003; Peplau & Gordon, 2014), which may increase their vulnerability to experiencing greater levels of grief and distress following a suicide. Additionally, women may also have different coping strategies and support networks compared to men, which could impact their ability to effectively process and manage their emotions.

Limitations

The present study explored a comprehensive list of possible variables that may affect PTSD and depression scores in the suicide bereaved. However, larger studies with a more diverse range of participants may be needed. A majority of clients in the study were cisgender, White British, heterosexual, and non-religious, therefore, one could argue that these results do not adequately represent the UK third sector services as a whole and the research findings cannot be generalised. Another important point to note is that some methods of suicide were ruled out of analysis due to small sample sizes. As stated in the results, both suicide via firearms an self-immolation were not included in the data analysis, however, these methods may have a bearing on trauma and depression scores, and previous research has shown more "voilent" methods of suicide have a serious impact on the mental health of the bereaved (Hauser, 1987). Relationships with the deceased such as cousin, uncle, grandparent etc, were also not analysed due to small sample sizes along with first responders, passers-by, and/or witnesses.

Implications for Clinical Practice

Clinicians play a critical role in supporting individuals who have been bereaved by suicide, especially in light of the gender differences in mental health outcomes that have been identified in recent research. It is essential that clinicians are equipped with the knowledge and skills necessary to provide effective interventions for this vulnerable population.

One key recommendation for clinical interventions is to ensure that routine and vigilant screening for the development of posttraumatic stress disorder (PTSD), complex grief, depression, and suicidality forms an integral element of the work with those bereaved by suicide. Individuals who have experienced the loss of a loved one to suicide may be at increased risk for developing these mental health issues, and early identification is crucial for effective intervention and support.

In light of the gender differences in mental health outcomes following suicide bereavement, clinicians should pay particular attention to the specific needs of female clients. Women who have been bereaved by suicide may be at higher risk for experiencing psychological distress and may face unique challenges in coping with the stigma and shame that can surround suicide. Therefore, it is important for clinicians to tailor their interventions to address the specific needs and experiences of female clients in order to provide appropriate support and care.

In addition, clinicians should consider incorporating gender-sensitive approaches into their interventions with individuals bereaved by suicide. This may involve creating a safe and non-judgmental space for clients to express their emotions, providing psychoeducation on grief and trauma, and facilitating access to support groups or individual counseling services that address the unique needs of women who have experienced suicide loss.

Furthermore, clinicians should work collaboratively with other stakeholders, such as policymakers and service providers, to ensure that the support services and resources available to individuals bereaved by suicide are inclusive of gender differences in mental health outcomes. By taking a holistic and gender-sensitive approach to clinical interventions, clinicians can better support

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individuals who have been impacted by suicide loss and help them on their journey towards healing and recovery.

Implications for Future Research

Future research in this area must seek to further explore and understand the gender differences in symptom scores among individuals bereaved by suicide. One avenue for exploration could be conducting qualitative studies to gain a deeper understanding of the experiences and perspectives of women and men who have been bereaved by suicide. These studies could provide valuable insights into the unique challenges and coping mechanisms that individuals of different genders may employ in response to suicide bereavement.

The majority of participants in the current study sample experienced their intervention within the first 3 months of their loss to suicide, a factor that must be considered when interpreting results. While the study examines longitudinal intervention data, the relatively short intervention period compared to the life long complexities of bereavement may limit the scope of findings. To fully understand the long-term impact of the intervention, further follow-up assessments are necessary. Therefore, clinical inferences should be drawn within the context of the specified timeframe and not extrapolated beyond it. Additionally, future research should also aim to include more diverse samples in terms of ethnicity, religion, and sexuality to ensure that findings are generalizable to a broader population. By capturing the experiences of individuals from various cultural and social backgrounds, researchers can gain a more comprehensive understanding of the complexities of suicide bereavement and how gender may intersect with other identity markers to influence mental health outcomes.

Moreover, replication studies that investigate the relationship between gender, suicide method, and body discovery are also needed to corroborate and expand upon the findings of this study. Recruiting participants to research studies rather than relying solely on retrospective data analysis may also provide researchers with a more nuanced and in-depth understanding of the experiences of individuals bereaved by suicide.

Conclusion

Suicide is a global public health crisis, with millions of people taking their own lives each year. The impact of suicide is not limited to the individual who dies by suicide, but also extends to their loved ones who are left behind to make sense of the tragedy and navigate their grief and loss. Understanding the experiences of those bereaved by suicide is crucial in order to provide effective support and interventions for this vulnerable population.

The findings of this study suggest that losing a loved one to suicide can have profound and lasting effects on the mental health and well-being of the bereaved, regardless of their relationship to the deceased, the method of suicide, or the circumstances of the discovery of the body. It is clear that suicide bereavement is a unique form of trauma that can trigger symptoms of post-traumatic stress disorder (PTSD) and depression in those left behind.

One of the most striking findings of this study is the significant gender difference in PTSD and depression symptoms among those bereaved by suicide, with women reporting higher levels of distress compared to men. This gender disparity in mental health outcomes is consistent with previous research on suicide bereavement, which has consistently found that women are at higher risk for developing psychological difficulties following the loss of a loved one to suicide. The reasons for this gender difference are not entirely understood, but it is likely that societal and cultural factors play a role in shaping women's experiences of grief and trauma. Women are often socialized to be more emotionally expressive and to seek out social support, which may render them more vulnerable to the intense emotions and psychological distress that can accompany suicide bereavement. Additionally, women may face unique challenges in coping with the stigma and shame that can surround suicide, which may further contribute to their heightened risk for developing PTSD and depression.

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These findings have important implications for policymakers, mental health practitioners, and service providers who work with individuals bereaved by suicide. It is essential that these stakeholders recognize the gender differences in mental health outcomes following suicide bereavement and tailor their interventions and support services accordingly. This may involve providing targeted support for women who are at increased risk for developing PTSD and depression, as well as integrating gender-sensitive approaches into existing frameworks for supporting the suicide bereaved.

In conclusion, the findings of this study highlight the need for a more nuanced understanding of the experiences of those bereaved by suicide, particularly in relation to gender differences in mental health outcomes. By acknowledging and addressing these differences, policymakers and mental health practitioners can better support and care for individuals who have been impacted by suicide loss. Further research is needed to explore the underlying mechanisms behind the gender differences in mental health outcomes following suicide bereavement, but in the meantime, it is crucial that we take steps to ensure that women who are bereaved by suicide receive the support and care that they need to heal and recover from their loss.

Conflicts of Interest: The authors declare no conflicts of interest.

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