Portfolio One: Major Research Project

Support Needs of Self-Defined Family Members Bereaved by Suicide

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Abstract

Background: In 2024, over 7,000 individuals died by suicide across the UK, and it was estimated that over 945,000 individuals were impacted by suicide in some way. Individuals bereaved by suicide are more likely to experience suicidal thoughts and attempt suicide themselves than those bereaved by other means. Well-designed suicide bereavement support could act as a form of 'prevention support' if it is accessible to and accessed by those who need it, though research suggests they do not tend to access support services.

Method: This mixed-methods study aimed to identify the support needs of self-defined family members bereaved by suicide in the UK. Forty-six participants completed an online questionnaire, sharing their experiences of support following their bereavement. Descriptive statistics and conceptual content analysis were utilised to analyse the findings.

Findings: Five themes, each representing different support needs, are presented: 1) the conditions shaping access to support, 2) early interactions, 3) suicide-specific support, 4) peer support as a space for shared understanding and connections, and 5) preferences for the format and timing of the support.

Conclusions: The findings of this study can be utilised to offer a clearer framework for services seeking to improve their support for people bereaved by suicide; for example, individuals being proactively offered supportive 'check-ins' on significant dates could be seamlessly built into existing NHS digital systems. Limitations, such as a gender disparity in responses (Females: 91%; Males: 9%), led to recommendations for future research to have more of a specific focus on suicide bereavement support for males in the UK.

Keywords: suicide, bereavement, support, self-defined family, UK

Chapter One: Introduction

1.1 Chapter Introduction

This research is situated within the field of suicide bereavement support in the United Kingdom (UK). Suicide is defined as death as the result of self-injurious behaviour with the explicit intent to die (Silverman et al., 2007). This chapter introduces the research by situating the researcher's positionality, acknowledging how personal and professional perspectives shape the approach to this research. It then traces the history of suicide within the UK, providing context for how understandings of suicide have evolved. This leads to an overview of current suicide prevalence rates, highlighting its scale and implications for public health. Building on this, the chapter explores recent national policies and frameworks that have sought to address suicide bereavement support. Finally, the chapter concludes by presenting the rationale for undertaking a systematic scoping literature review, which forms the focus of the second chapter.

1.1.1 A Note on Language

The terminology used to describe suicide can influence how it is understood and discussed. Although awareness of the impact of language has developed, the phrase "commit suicide" is still commonly used, yet it carries connotations of criminality and may reinforce stigma (Nielsen et al., 2016; Padmanathan et al., 2019). This will be critiqued further in the latter parts of this chapter. Furthermore, High (2024) identified that self-defined family members bereaved by suicide often found it difficult to share their experiences because of this stigmatisation. *Self-defined family members* are those individuals who may feel, or behave like family members, though may not be related by blood (Places, 2024). In recognition of these concerns, this research aims to avoid stigmatising terminology and

instead uses phrases such as “suicide,” “die by suicide,” or “bereaved by suicide.” This choice is intended to support more open and compassionate dialogue throughout the research.

1.2 Personal and Theoretical Positioning

1.2.1 Positionality

Positionality involves the researcher’s deliberate reflection on how their contextual backgrounds may influence the research process. This includes acknowledging how personal perspectives can shape the formulation of research questions, interactions with participants, and interpretation of the findings (Bourke, 2014). Understanding the positionality of the researcher can provide a foundation for reflexivity to help explore and examine how the position may shape any interpretations or decisions made throughout the research process (Sibbald et al., 2025). In mixed methods research, maintaining reflexivity is particularly important, as it enhances transparency in methodological choices and the integration of qualitative and quantitative data (Plano Clark, 2016).

I grew up in a white, middle-class family as the youngest of a large family, in the Hertfordshire countryside. From a young age, I was exposed to the inner workings of the National Health Service (NHS), which gave me a unique perspective on both its strengths and its systemic challenges. I witnessed the dedication of healthcare professionals working within an underfunded system, and I saw firsthand how access to support could vary dramatically depending on something as arbitrary as a postcode. These early experiences made me acutely aware of the privileges my family had, privileges that were often hard-won through persistence and advocacy. I was fortunate to receive support that many others had to fight for alone. This awareness stayed with me as I entered the NHS professionally, where I saw these inconsistencies not only persist but expand. The injustice of unequal access left me unsettled and motivated to understand and address these disparities more deeply.

I ‘got through’ childhood with a sense of hope and support, but I often wonder what might have happened if that support had not been available in the way that it was. That question continues to shape how I approach my work, both as a clinician and as a researcher.

Throughout this thesis, I will include personal reflections to offer transparency around my biases and decision-making; these are presented in the final appendix (Appendix N). My aim in this thesis is to remain reflexive and open about how my perspective influenced the research process.

1.2.2 Theoretical Perspective

To ensure clear philosophical reasoning, it is important to state the ontological and epistemological foundations underpinning this research. Ontology refers to assumptions about the nature of reality, whether social phenomena exist independently of human perception or are shaped by it (Guba & Lincoln, 1994). For example, it questions whether things like grief, support systems, or social norms exist on their own or are created through how people experience and interpret them. This research was informed by a critical realist ontological perspective, which assumes that real structures and mechanisms, such as institutional responses, access to services, or societal stigma, shape the experience of suicide bereavement, even if they are not directly observable (Zachariadis et al., 2013). For example, the ability of an individual bereaved by suicide to access timely support may be influenced by systemic factors like funding models or healthcare policy, which operate beneath the surface of personal experience.

Epistemology is a branch of philosophy that examines the nature of human knowledge, seeking to understand the foundations of our beliefs and how we acquire what we know (Sol & Heng, 2022). This research adopted a social constructionist epistemology,

recognising that the experience of suicide bereavement is deeply personal and shaped by social interactions and cultural contexts (Neimeyer et al., 2014).

Combining a social constructionist epistemology with a critical realist ontology can create some tension, as one (social constructionism) explains knowledge as socially created, and the other (critical realism) assumes that structures may exist beyond our own interpretation (Bogna et al., 2020). However, this philosophical stance supported the use of mixed methods by allowing the research to explore both the measurable patterns of support provision and the nuanced, subjective experiences of those affected by suicide bereavement.

1.3 History of Suicide in the UK

To understand the current landscape of suicide and suicide bereavement in the UK, it is important to be aware of the historical, legal, and cultural foundations upon which existing attitudes and support systems have been built.

During the medieval and early modern periods in the UK, suicide was deemed to be a transgression against God and a criminal offence (MacDonald & Murphy, 1990). In the Christian Church, suicide was believed to be a sin, a direct wrongdoing to God's sovereignty over life and death (MacDonald & Murphy, 1990). Consequently, individuals who died by suicide were denied a burial in church graveyards and instead were often buried in places and circumstances which were underscored with symbolic acts of shame, such as at a crossroads and driving a stake through the body to prevent the soul from returning (MacDonald & Murphy, 1990; Murray, 1998).

The UK legal structure mirrored these religious beliefs. Under English common law, suicide was described as a felony; *'felo de se'*, translated as a 'felon against oneself' (Houston, 2010). Subsequently, this allowed the Crown to seize the deceased's property,

reinforcing the shame and stigma associated with suicide by punishing the family (MacDonald & Murphy, 1990; Seabourne & Seabourne, 2000). This punitive system was enforced by coroners, who the Crown appointed to determine the cause of unexpected deaths and whether any were *felo de se* (Hunnisett, 1961). The combined influence of religion and legal authority shaped a strong message that portrayed suicide as both morally wrong and socially unacceptable. This narrative contributed to a lasting stigma that continues to affect how suicide is viewed in society today (Lehmann et al., 2021).

Though not published during his lifetime due to controversies, Scottish philosopher Hume wrote an essay, *Of Suicide*, which helped to start challenging the narrative of suicide from sin and crime towards reason, autonomy and personal choice (Hume, 1783; Lecaldano, 2014). Nonetheless, for much of the seventeenth and eighteenth centuries, the legal and social views of suicide remained unchanged, with suicide still being criminalised (MacDonald, 1989).

The start of the nineteenth century in the UK witnessed suicide expand from being a criminal and religious wrongdoing, to a moral and social disappointment too. Gates (1988) reflected on the public outrage over the death of Viscount Castlereagh in 1822, who, despite dying by suicide, was buried in Westminster Abbey. Writers of this period often described a widespread cultural fascination with death in Victorian Britain, with particular attention given to the deaths of women, especially those involving suicide (Jalland, 1996, p. 319; Brown, 2004). These Victorian narratives often framed female suicide as a symbol of emotional vulnerability and social deviance, using it as a moral lesson to reinforce expectations of feminine restraint and domestic conformity (Higonnet, 1985).

The legal system during this period became more punitive, criminalising the attempt of suicide through the *Offences Against the Person Act 1861*, adding to the stigma and,

ultimately further discouraging any help-seeking for suicidal thoughts (Offences Against the Person Act 1861, 1861); Thomas & Gunnell, 2010).

During the early to mid-twentieth century, interpretations of suicide in the UK began to shift from viewing it as a moral transgression to understanding it as a symptom of mental illness. This evolving perspective was reflected in the formation of the Samaritans in 1953 by Reverend Chad Varah, who aimed to provide emotional support to individuals experiencing crisis (Day, 1974). The charity's compassionate approach marked a significant parting from earlier punitive attitudes and laid the foundation for modern suicide prevention efforts. A key legal milestone followed with the passing of the *Suicide Act 1961*, which decriminalised suicide in England and Wales, recognising that those who attempt to take their own lives require care rather than punishment. Notably, suicide had never been a criminal offence in Scotland, and Northern Ireland adopted similar reforms in 1966 (Suicide Act 1961, 1961; Thomas & Gunnell, 2010).

The late twentieth century marked a shift in how suicide and mental health were understood in the UK. During this period, suicide began to be reframed as a public health concern (Pirkis et al., 2024). This was influenced by changes in psychiatric care, most notably in the cessation of institutions, which saw the closure of large psychiatric hospitals and a transition towards community-based mental health services. These reforms were driven by growing recognition that institutional care often did not support recovery and that individuals were better supported in their communities (Craig & McCarthy, 2022).

In more recent years, thanks to the hard work of people with lived experience, bereaved families and mental health organisations, the public attitudes towards suicide have become slightly more understanding and open (Wyllie et al., 2025). Campaigns such as the *National Suicide Prevention Alliance's (NSPA) Our Language Matters* in 2024 demonstrated

that the words we use can either reinforce stigma or help create a more supportive environment (NSPA, 2025). This further reinforces the importance and gravity of using sensitively appropriate language in suicide bereavement research. However, even with these changes, stigma continues to affect how suicide is discussed, with many people feeling uncomfortable sharing their suicidal thoughts and seeking support (Rüsch et al., 2014; Wyllie et al., 2025).

It is important to critique that much of the body of literature which forms the narrative of the historical context of suicide in the UK is *necessarily* dated, such as Hume (1783), Hunnisett (1961), Gates (1988), Murray (1998), and Seabourne & Seabourne (2000). Whilst the legislative and societal shifts occurred several years ago, and therefore offer essential historical grounding, the heavy reliance on these older pieces of literature also shows a clear lack of more recent suicide-related research. More recent literature does not tend to explicitly consider the historical context and how this shapes attitudes, perceptions, and support-seeking behaviour (Greiner et al., 2024).

However, given that legal frameworks have evolved, the decline in religious condemnation, and public perceptions have gradually altered, it is necessary to examine the prevalence of suicide within the UK and identify if it may vary across different populations.

1.4 Prevalence

Reporting the suicide rates for the UK is inherently complex, shaped by both statistical limitations and historical context. In the UK, suicide data is typically published based on the date of registration rather than the actual date of death, which can lead to confusion and misinterpretation (Office for National Statistics [ONS], 2025). This delay between occurrence and registration distorts annual figures and complicates reporting (Turnbull et al., 2024). Furthermore, although suicide was decriminalised in 1961, coroners

continued applying the stricter criminal standard (*"beyond all reasonable doubt")* of proof for many years, and only recent shifts to a civil standard ("*on the balance of probabilities")* have begun to improve the accuracy of suicide registration statistics (ONS, 2020). Prior to this, stigma and legal consequences for the affected family often led to underreporting or misclassification of suicides (Tøllefsen, Hem, & Ekeberg, 2012).

Whilst data collection is now more robust, the combination of registration delays, shifting definitions, and historical stigma continues to make suicide statistics difficult to interpret accurately (ONS, 2025). Nonetheless, while these limitations must be acknowledged, understanding the prevalence of suicide in the UK remains crucial for identifying more at-risk groups, shaping effective prevention strategies, and allocating mental health resources where they are most needed.

Over the last twenty years, suicide rates within each UK nation have shown relative consistency when considered in the context of their own previous trends (Dougall et al., 2017; Gascoigne et al., 2025). As such, the following section will present the most recently available prevalence data.

In England, the suicide rate decreased by less than one per cent between 2023 and 2024, and increased in Wales by approximately 12% (ONS, 2025). In Scotland, there was a decrease of 11% in suicide rates over these years (NRS, 2025). In Northern Ireland, the suicide rates increased by 30% between 2023 and 2024 (NISRA, 2025a; 2025b). Across all four countries, males consistently had a higher prevalence of dying by suicide than females (ONS, 2025; NRS, 2025; NISRA, 2025b). This was evident even where there was a decrease in rates, for example, in Scotland, whilst there was a decrease in male suicides by 12%, the mortality rate was still 2.9 times as high for males than it was for females (NRS, 2025).

Table 1 presents the suicide prevalence data across the UK reported in 2023 and 2024 per country.

Table 1

Suicide Prevalence Data across the UK

Country	Year	Suicide Deaths Registered per 100,000 people
England	2023	11.2
	2024	11.1
Wales	2023	14.0
	2024	15.7
Scotland	2023	14.4
	2024	12.7
Northern Ireland	2023	13.3
	2024	17.4

Note. The 'Suicide Deaths Registered per 100,000 people' column represents the average age-standardised suicide rate per 100,000 people, aged 10 years and over.

Sources: ONS (2025), National Records of Scotland [NRS] (2025), Northern Ireland Statistics and Research Agency [NISRA] (2025a), NISRA (2025b).

As England and Wales share a unified registration and statistical system, managed by the Office for National Statistics, the following reported data combines figures from both countries (ONS, 2025).

In 2024, the highest suicide rate among men in England and Wales was observed in those aged 50 to 54, at 27.5 deaths per 100,000 people, a shift from 2023, when the 45 to 49 age group had the highest rate. Amongst women, the most affected group also changed: in 2024, women aged 45 to 49 had the highest rate at 7.9 per 100,000, replacing the 50 to 54 age group, which led in the previous year with a rate of 9.2 (ONS, 2025).In Scotland, those aged 25-64 years old (age groups 25-44 and 45-64) were the highest at risk for dying by suicide in 2024 (NRS, 2025). In 2024, the highest number of suicide deaths among men in Northern Ireland occurred in the 25–29 age group, while among women the peak was in the 40–44 age group (NISRA, 2025b). Suicide remains the leading cause of death for males under 50 across the whole of the UK, which in part has led to the recent formation of the *Men's Health Strategy* in 2025 (Department of Health and Social Care, 2025). This strategy aims to improve men's physical and mental health by focusing on prevention, early diagnosis, reduced inequalities, and better access to supportive, community-based care (Department of Health and Social Care, 2025).

In 2024, the North East of England recorded the highest suicide rate, with 15.1 deaths per 100,000 people, while London had the lowest at 8.3, the lowest amongst all English regions (ONS, 2025). Comparing figures from 2023 to 2024, suicide rates rose in four out of nine regions. The most notable increase occurred in Yorkshire and The Humber, where the rate climbed from 12.2 to 13.7 per 100,000. Conversely, the East of England experienced the largest decline, dropping from 10.9 to 9.6 per 100,000 (ONS, 2025). The NRS (2025) noted that annual suicide figures vary considerably in Scotland, particularly in smaller Health Board and Council areas. To reduce the impact of these fluctuations and provide more stable estimates, the NRS reports suicide data using five-year moving averages rather than single-year figures. Based on this reporting framework, the suicide mortality rate was higher than the Scottish five-year average (14.0 per 100,000) in two health board areas: NHS Tayside

(17.7 per 100,000) and NHS Highland (16.7 per 100,000) (NRS, 2025). The rate of probable suicide mortality in NHS Lothian was below the five-year national average, recorded at 11.5 deaths per 100,000 individuals. In 2024, the Northern Trust and Southern Trust recorded the highest levels of suicide deaths in Northern Ireland; by contrast, the Western Trust reported the lowest levels (NISRA, 2025b).

For every person who dies by suicide, there is a ripple effect of those affected both directly and indirectly (Maple et al., 2016). In 2024, over 7,000 people died by suicide across the UK, and it has been estimated that for every person who dies by suicide, 135 people are impacted in some way (Samaritans, 2024; Cerel et al., 2018). This means that in that one year, approximately 945,000 people were impacted by suicide in the UK. More recent research suggests that this figure could be substantially higher when accounting for the influence and reach of social media (Bell & Westoby, 2023).

1.5 Postvention and Policies

1.5.1 Exposure to Suicide

Individuals bereaved by suicide often experience a uniquely intense and complex emotional journey. Unlike some other forms of loss, suicide bereavement is frequently marked by guilt, self-blame, anger, and feelings of abandonment (Jordan & McIntosh, 2011; Andriessen et al., 2019; Alves Anet et al., 2026). Many of those bereaved by suicide report persistent questions about what they could have done to prevent the death, or where/with whom to place blame, which can lead to intrusive thoughts and prolonged psychological distress (Gibbons, 2024). Furthermore, research suggests that individuals bereaved by suicide often feel stigmatised, judged or misunderstood by others, which can result in social withdrawal and a sense of marginalised grief, where their loss is not fully acknowledged by society (Feigelman et al., 2009; Pitman et al., 2016). Marek and Oexle (2024) highlighted

that the sense of isolation experienced by those bereaved by suicide can be intensified by societal unease around the topic of suicide, which further results in a lack of open dialogue and few opportunities for grief to be expressed.

Research indicates that individuals bereaved by suicide have an increased risk of developing certain mental health conditions, such as depression, anxiety, and post-traumatic stress disorder (Pitman et al., 2014; Grafiadeli et al., 2021). They are also, potentially, more likely to experience complicated grief, a prolonged form of mourning, compared to those grieving from other types of loss, such as sudden deaths or accidents (Young et al., 2012; Wilson et al., 2020; Tal et al., 2016). Moreover, individuals bereaved by suicide are also more likely to experience suicidal thoughts and attempt suicide themselves than those bereaved by other means (Cerel et al., 2016; Pitman et al., 2016). In a study conducted by McDonnell et al. (2022), the experiences of suicide bereavement were surveyed of more than 7000 individuals, and over a third of these reported suicidal ideations, and 8% disclosed having attempted suicide as a direct consequence of their loss. Furthermore, the majority did not access available support services, often perceiving them as inadequate or unsuitable for their needs. Thus, recent research indicates that well-designed suicide bereavement support, often referred to as ‘postvention support’ could act as a form of ‘prevention support’ if it is accessible to and accessed by those who need it (Kaşıkara et al., 2026; Stubbe, 2023).

Given the complexity of these experiences, it is essential to understand how UK policies might respond to the support needs of those affected by suicide bereavement and inform service provision and development.

1.5.2 UK Policies

There are a range of national policies and frameworks within the UK which have been developed to guide the provision of support for individuals bereaved by suicide. The funding

of £1.08 million by the Department of Health and Social Care in 2019, dedicated to the development of pilot programmes across ten regions of England to support those bereaved by suicide, reflected the growing need for support (Department of Health and Social Care, 2019). Alongside government initiatives, several charities and organisations have produced standards to strengthen practice. A few of these include: Support After Suicide Partnership (2025), National Institute for Health and Care Excellence (2019), Department of Health and Social Care (2023) and British Standards Institution (2025). These policies are outlined in Table 2. Due to the known increased risk of suicidal ideation following suicide bereavement, The Suicide Prevention Strategy for England (2023) has also been included in this table.

Table 2

Key Suicide Bereavement Support Policies in the UK

Policy/ Framework	Year	Organisation	Areas of Focus	Key Features
Suicide Prevention Strategy for England (2023 to 2028)	2023	Department of Health and Social Care	National suicide prevention and bereavement support	A cross-sector plan aimed at reducing suicide rates by supporting at risk-groups.
The Compelling Case for Suicide Bereavement Support - Support After Suicide Partnership (SASP)	2025	SASP	Advocacy for support	Highlights the impact of suicide (emotionally and economically) and promotes actions for services and commissioners.
BS 30480 Suicide and the workplace	2025	British Standards Institution (BSI)	Organisational responses	Offers guidance for workplaces and organisations on prevention, intervention and support for people affected by suicide in the workplace.
National Institute for Health and Care Excellence (NICE) Suicide Prevention Quality Standard (QS189)	2019	NICE	Clinical and public health standards	Quality statement 5 states that people bereaved by suicide should be offered tailored support for their needs.

It is important to note the ‘newness’ of some of these policies, and that whilst the emergence of these policies demonstrates progress, their novelty highlights the lack of long-standing infrastructure for suicide bereavement support within the UK. This raises questions about the consistency of provision, the readiness of services to meet diverse needs, and the extent to which these frameworks will translate into sustainable practice across communities (National Suicide Prevention Alliance & SASP, 2025). Additionally, without clear evidence of reductions in suicide rates or measurable improvements in support outcomes in the UK, it remains uncertain whether these strategies are achieving meaningful impact or whether they risk becoming symbolic commitments rather than drivers of substantive change.

1.6 Scoping Literature Review Rationale

As described, the persistently high prevalence of suicide across all regions of the UK and the fact that national rates have not shown sustained decreases, despite efforts, there remain many people impacted by the ripple effects of suicide. Therefore, there is a need to understand more about what suicide bereavement support exists. Although new policy frameworks, including those introduced in 2025, signal progress in recognising suicide bereavement support as a public health priority, there is currently no comprehensive review of the literature examining what forms of support exist and how they are delivered. Such a review could provide a broad understanding of the current landscape of suicide bereavement support in the UK. It would allow for mapping of what forms of support are available, identifying to whom these services are offered, and clarifying which organisations or sectors are offering them. Additionally, a focus on levels of engagement and disengagement would highlight whether individuals remained engaged in the support. This review could also serve as a baseline for future comparison, enabling assessment of whether the introduction of new policies leads to meaningful changes in practice and outcomes.

Whilst a previous literature review has examined suicide bereavement support in an international context, including studies that did not exclude the UK, this review did not identify any specific support provision within the UK itself (Coquelin et al., 2025). This absence highlights a significant gap in the evidence base and reinforces the need for a focused, systematic scoping literature review to establish what forms of support currently exist.

A scoping literature review allows for a broad mapping of what support exists in the UK, which can then aid the construction of the proceeding research, rather than assessing the effectiveness of support, for which a systematic literature review might have been more appropriate (Mak & Thomas, 2022; Khalil et al., 2025; Powell & Koelemay, 2022).

Chapter Two: Scoping Literature Review

2.1 Overview and Aims

The following chapter presents the scoping literature review conducted to address the gap in the existing body of research, as no comprehensive synthesis on this topic currently exists, solely within the UK context. It aims to answer the primary research question: *What support is available for individuals bereaved by suicide in the UK?* Given the breadth of this topic, sub-questions were developed to structure and aid the analysis of this review. The sub-questions were constructed through discussions with the research team to ensure they addressed the issues raised in Chapter One, whilst also identifying gaps for further exploration through research.

The sub-questions included: 1) *In what formats is support provided?* 2) *Is data on participant drop-out rates publicly available or systematically reported?* 3) *How soon after the bereavement is support being offered?* 4) *Is the theory behind the support being offered shared in the research?* 5) *Does the support offered vary depending on age?*

This chapter will describe the methodological approach employed to address this research question and sub-questions, present the findings from a narrative synthesis of the relevant UK-based literature, and critically examine the clinical implications (Popay et al., 2006). It will also explain how these findings shaped the focus and direction of the subsequent empirical study.

2.2 Methodology

2.2.1 Question Configuration

To develop the primary research question for this scoping literature review, the PICo framework was utilised. This tool, comprising of Population, Phenomena of Interest, and

Context (PICo), is particularly effective for structuring questions in qualitative research that seeks to explore human experiences (Stern et al., 2014). Table 3 provides the PICo breakdown applied to this research question.

Table 3

PICo Question Development

PICo Element	Question Configuration
Population (P)	Individuals bereaved by suicide
Phenomena of Interest (I)	Forms of formal and/or informal support (e.g., psychological, social, peer-led, professional interventions)
Context (Co)	United Kingdom

2.2.2 Scoping

Preliminary scoping searches were carried out using databases such as Google Scholar, Scopus and PROSPERO to determine whether a systematic literature review on this topic had already been conducted, and to identify potentially relevant studies for inclusion. At this stage, the intention was to undertake a systematic literature review; however, the initial searches revealed a significant lack of UK-based research addressing suicide bereavement support in sufficient depth to build an empirical research study upon. Given this limited evidence base, a scoping review was deemed more appropriate to explore the breadth of existing literature due to the more flexible and inclusive examination of available evidence, making it particularly suitable for an under-researched area (Munn et al., 2018).

2.2.3 Search Strategy

The Sample Phenomenon of Interest Design Evaluation Research (SPIDER; Cooke et al., 2012) is a tool which can be utilised when developing a search strategy, ultimately facilitating the identification of relevant studies. This tool was employed to develop the search strategy in this scoping literature review (Table 4).

Table 4

SPIDER Tool

S: Sample	PI: Phenomenon of Interest	D: Design	E: Evaluation	R: Research Type
People bereaved by suicide in the UK	Support systems for suicide bereavement	Interviews	Experiences	Qualitative
		Surveys	Evaluations	Quantitative
		Peer-review journals	Stories	Mixed methods
		Grey Literature: policy-based research on suicide bereavement support in the UK	Narratives	

Concepts and search terms were developed utilising this SPIDER tool. The researcher screened search terms drawn from existing suicide bereavement literature. These terms were expanded using a thesaurus to capture broader and related concepts and subsequently discussed and refined in collaboration with the wider research team. Boolean connectives 'AND'/'OR', quotation marks and asterisk were used as truncation symbols to aid the yielding of relevant articles. These are illustrated in Table 5.

Table 5

Concepts and Search Terms

Concepts	**Search Terms**
Concepts One: Suicide	'suicide' OR 'Self-inflicted death' OR 'ended their life' OR 'Intentional self-harm resulting in death' OR 'took their own life' OR 'chose to die'
	AND
Concept Two: Bereavement	bereave* OR mourn*
	AND
Concept Three: Support	'postvention' OR 'support' OR 'intervention' OR 'pathway*' OR 'peer support' OR 'NHS' OR 'counsel*' OR 'therap*' OR 'care' OR 'treatment' OR 'rehabilitation' OR 'healing'

Inclusion and Exclusion criteria were utilised to help determine which studies were relevant to answer the research question and sub-questions of this scoping literature review. These criteria were discussed amongst the research team and applied to the search terms. Please see the criteria outlined in Table 6.

Table 6

Inclusion and Exclusion Criteria

Criteria	Justification
Inclusion	
Research/studies conducted within the UK.	This review only focused on support offered in the UK.
Interventions, groups, support, or services supporting those bereaved by suicide.	Required to answer the research question.
Peer-reviewed journal articles, grey literature (for example, articles published by services).	Both types of literature was included in this review to ensure a broad coverage of academic and practice-based evidence, aligning with the exploratory aims of a scoping review.
Qualitative, quantitative or mixed-method studies.	All methodological approaches were included to ensure a comprehensive coverage of the research field.
Studies published in English.	Only literature published in the English Language was accessible to the lead researcher.

Support for all ages.	This allows for a broader understanding of suicide bereavement support across life stages.
Exclusion	
Literature reviews and meta-analysis.	These were excluded as they do not present original primary research data.

Searches were conducted across a wide range of databases, including: PubMed, Scopus, Medline, CINAHL, Psychology and Behavioral Sciences Collection, APA PsycArticles, Ethos (grey literature), and Government websites (grey literature). These databases were selected to support a comprehensive and methodologically sound search strategy, each offering strengths across distinct disciplinary domains, including clinical medicine, health sciences, nursing, psychology, and the broader social sciences (Bramer et al., 2017).

Grey literature refers to research and informational resources that are disseminated outside conventional academic publishing frameworks, such as through institutions, government agencies, or professional organisations (Mahood et al., 2014). Databases encompassing grey literature were incorporated into the search strategy of this scoping literature review to enhance the breadth and depth of evidence captured, recognising that grey literature may contribute to a more balanced and comprehensive understanding of the topic (Paez, 2017).

2.2.4 Search Process

The initial searches from the databases yielded 4746 results, which were all imported to Covidence Systematic Review Software (Covidence, 2023). The researcher selected this software as it streamlined the review process and supported collaborations by enabling

tracking between multiple reviewers (Cleo et al., 2019; Affengruber et al., 2024). A total of 2440 duplicates were identified, and thus 2306 studies progressed to the first of two phases of screening. In this first phase, the researcher and a colleague (heron referred to as the 'second reviewer') reviewed the titles and abstracts of the studies against the inclusion/exclusion criteria (outlined in Table 6). At this stage, 38 studies progressed to the second phase of screening, whereby the full texts were read and assessed for eligibility by the researcher and the second reviewer. Nine articles were deemed appropriate to be included in this review. The reference lists of included studies were also screened to identify any additional relevant articles, though this yielded no further results.

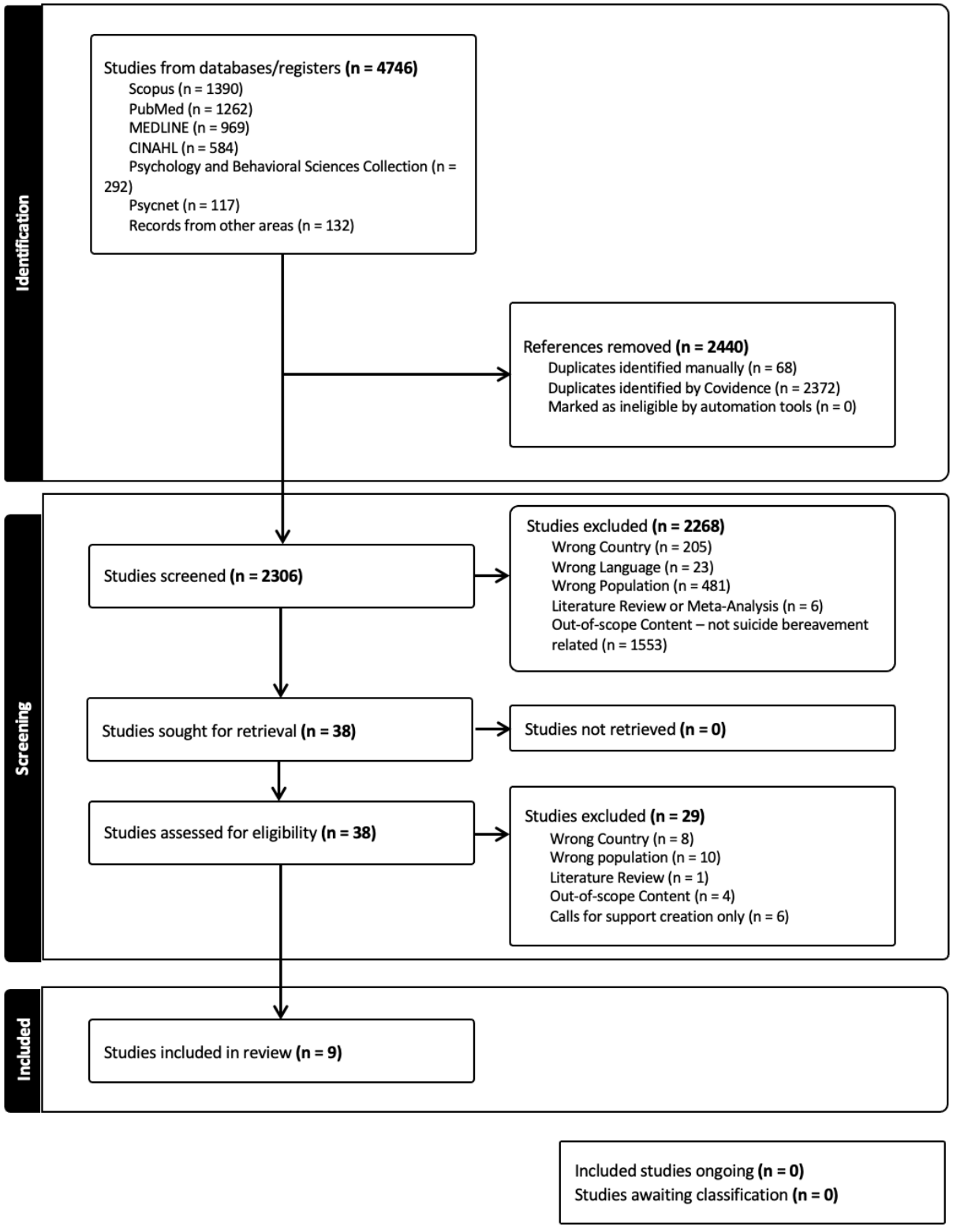
A summary of this process is illustrated in Figure 1 in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow-chart (Page et al., 2021). The PRISMA framework was selected to ensure transparent reporting and methodological consistency throughout the search process (Sarkis-Onofre et al., 2021). The PRISMA Extension for Scoping Reviews (PRISMA-ScR) checklist was also utilised to ensure transparent, comprehensive, and methodologically rigorous reporting throughout this review (Tricco et al., 2018) (presented in Appendix A). Searches were initially conducted in August 2025 and were repeated in November 2025 to ascertain if any new articles had been published during this time; no new articles were identified.

All studies were screened independently by two reviewers (one of whom was the lead researcher) to increase transparency, increase objectivity and reduce personal bias in the selection of articles (Waffenschmidt et al., 2019). Inter-rater reliability, the agreeableness, between the reviewers, was calculated using Cohen's kappa statistic (Cohen, 1960; McHugh, 2012). During the first phase of screening, there were 71 conflicts between the researcher and the second reviewer, and 10 conflicts in the second phase. The conflicts were mostly due to

misinterpretations, for example, of the content in the abstracts, and due to human error (clicking the wrong option on Covidence), and were resolved via discussions between the reviewers. Where there was no consensus, the researcher would have made the final decision; though this safeguard was not utilised, as ultimately all decisions were agreed upon unanimously. The initial 71 conflicts resulted in a Cohen's kappa score of 0.53, indicating a moderate agreement between the researcher and the second reviewer. The conflicts in the second phase resulted in a Cohen's kappa score of 0.41, also indicating a moderate agreement.

Figure 1

PRISMA Flow Chart



2.2.5 Data Summary

The researcher reviewed the nine qualifying studies, identifying the type of support in the study, the aim of the study, a summary of the findings, the strengths and limitations, and the clinical implications/recommendations, and compiled their main findings into a summary table (Table 7).

Table 7

Summary of Studies

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
Evaluation of a Resource for People Bereaved by Suicide (Hawton et al., 2012)	Self-help booklet titled *Help is at Hand*. Offers information, emotional guidance on grief, practical advice and resources for further support.	To evaluate the use and impact of *Help is at Hand*, a hardcopy and online booklet produced as part of England's suicide-prevention strategy.	Most participants found the booklet helpful, particularly its tone, layout, and relevance to their experiences. Main issue was individuals accessing it in a timely manner.	Strengths: Mixed-methods approach using questionnaires, interviews and a focus group. The study included both individuals bereaved by suicide as well as professionals, allowing for a broader understanding of how the resource is used and perceived.	Ensure more timely distribution of the resource. Raise more awareness of it so that more professionals are aware of it to share with individuals. Participants recommended that contact details for

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
				The resource was actively distributed as part of the national suicide prevention strategy, making the finding directly applicable to practice. Limitations: There were a low number of respondents to the questionnaire, and these all came from the same geographical area thus there may be limited generalisability. The study was conducted approximately 14 years ago,	sources of support should be on a removable page in the booklet. The resource could be used to help train professionals supporting individuals. The resource was originally distributed to individuals bereaved by any traumatic death; the study recommends that the resource is

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
				and as suicide bereavement support and national policies have developed since its publications, it leads to considerations surrounding the contemporary relevance if its findings.	more specifically distributed to just those bereaved by suicide.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
GPs' experiences of dealing with parents bereaved by suicide: a qualitative study (Foggin et al., 2016)	Informal, relational support from GPs to families/parents bereaved by suicide.	To explore the experiences of GPs dealing with parents bereaved by suicide.	GPs felt as though they did not have enough training or guidance to adequately support individuals bereaved by suicide. Some GPs reported a feeling of obligation/duty of care to support a family following a suicide bereavement, though were hesitant to reach out fearing they might worsen the distress.	Strengths: The first study to explore GPs experiences in this area. Some of the findings are consistent with that identified in previous research (e.g. GPs acknowledging it is their responsibility to support families following a bereavement by suicide). Limitations: The sample of GPs may have been biased – those	Suicide bereavement training for GPs - Suggestions for greater support and training for GPs supporting those bereaved by suicide including evidence-based-theory driven. Emotional support for GPs - Better systems should also be in place to offer support directly to GPs due to their higher risk of mental health problems (due to poor

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
				with an interest in this topic area, and those with (on average) 22 years of experience, thus potentially limiting the generalisability of the findings.	recruitment and often working in isolation). Improved referral pathways - Streamlining and coordinating suicide bereavement services available could help with identification and referrals for GPs to support patients.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
Support received after bereavement by suicide and other sudden deaths: a cross-sectional UK study of 3432 young bereaved adults (Pitman et al., 2017)	Formal support (as defined by Pitman et al., 2017) from: health services, social services, private therapy, voluntary sector, police officers. Funeral directors, coroners' officers, school/college/ work	To test the hypothesis that people bereaved by suicide are less likely to receive formal or informal support than people bereaved by other causes of sudden death.	Those bereaved by suicide were significantly less likely to receive informal support from friends and family than those who were bereaved by other causes. Those bereaved by suicide were more likely to report stigma and shame, potentially explaining why there was reduced support-seeking. Those bereaved by suicide were more likely to experience delays in	Strengths: The study enabled a direct comparison in support for those bereaved by suicide, and those bereaved by sudden natural/unnatural deaths. The findings remained consistent under different analytical conditions, and the carefully defined sample helped clarify how broadly the results could be applied. Limitations:	Improve early access to support - the researchers recommend ensuring timely access to both formal and informal support services. Address stigma and shame – public education and stigma-reducing efforts to encourage help-seeking and community support is recommended.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
	counselling services. Informal support (as defined by Pitman et al., 2017) from: friends and family, spiritual/religious advisors. Other support (as defined by Pitman et al., 2017) from: self-help		accessing any form of support (both formal and informal). Those bereaved by suicide were more likely to report unmet needs for emotional and practical support. Those bereaved by suicide were more likely to access specialist suicide-specific support. Those bereaved by suicide had higher rates of depression, post-traumatic	The study utilised a cross-sectional design thus limiting the ability to determine a causality between bereavement type and outcomes. Possible self-selection bias as participants were recruited only through UK higher education institutions, meaning the sample may not represent all young adults (e.g. those not in education or from a different socioeconomic background).	Specific support for suicide bereavement - the support offered to those bereaved by suicide should be tailored specifically to the needs of those bereaved by suicide.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
	resources, 'other'.		stress and suicidal ideation.	Potential recall bias as the data was self-reported, participants may have misremembered or misinterpreted the support they received (though the researchers excluded participants who bereavement was before age 10 years old in attempt to minimise this bias).	

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
Support Needs and Experiences of People Bereaved by Suicide: Qualitative Findings from a Cross-Sectional British Study of Bereaved Young Adults (Pitman et al., 2018)	Formal support as defined by Pitman et al., 2018) from: professionals, healthcare practitioners, therapists or counsellors in statutory, voluntary or private sector. Informal support as defined by Pitman et al., 2018) from:	To explore the nature of young adults' experiences of support after bereavement by suicide and their views on valued and unhelpful aspects.	Many participants described feeling judged or avoided by others, which impacted their access to informal support. Unlike other types of bereavement, suicide loss is marked by others' avoidance and unease, which can deepen isolation and hinder access to help. Barriers to formal support were reported such as long-wait times. Peer support, including that offered by extended	Strengths: The findings from this study align with previous research showing that those bereaved by suicide often face stigma, social discomfort and reduced informal support. This was the largest UK study of its kind, and it supports the national suicide prevention strategy. The researchers directly invited participants allowing them to clearly define their sample (and the	Proactive outreach – support needs to be offered more proactively rather than waiting for help-seeking, and to be offered early and repeated offers. Future research – a survey focusing solely on support experiences might yield richer data. Also focusing on other groups, such as ethnic minorities, older adults, and

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
	friends and family, religious/spiritual advisor. Other support (as defined by Pitman et al., 2018) from: self-help resources.		social networks (e.g. neighbours or colleagues) was greatly valued by some. Some preferred silence about the loss to avoid being treated differently or intrusively, but most agreed that others' social awkwardness made grief more isolating and hindered meaningful informal support Professional support was reported to feel validating,	limits of its generalisability). Limitations: Possible selection bias as participants were recruited only through UK higher education institutions, meaning the sample may not represent all young adults (e.g. those not in education or from a different socioeconomic background).	those in lower socio-economic groups. Training - for healthcare professionals, GPs, police etc, to support the emotional impact.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			Knowing that professional support was available, even if not taken up, was reassuring to some. 25% of respondents received no support, and provided reasons including low expectations of potential benefits, fear of asking for support, and negative experiences of trying to access it.	Possible response and recall bias may have occurred due to the population sample. The researchers acknowledged that there may have been two leading questions, assuming negative experiences, which may skew the respondents. Some of the responses were brief or incomplete, which limited the known context, potentially due to response fatigue.	

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
'It's like getting a group hug and you can cry there and be yourself and they understand'. Family members' experiences of using a suicide bereavement peer support group (Ali & Lucock, 2020)	Peer support group (SOBS)	This study explored the experiences of family members who attended a suicide bereavement peer support group.	The group was described as a safe space where those bereaved by suicide could express their emotions freely and feel understood by others with a similar experience. The group provided a sense of belonging and reduced isolation and help to normalise their grief. Being in a non-judgement environment was also described as being beneficial.	Strengths: This study adds to only a small body of research on suicide bereavement peer support groups. It helps to capture the lived experience of bereaved families, offering insight into what they found helpful or unhelpful. This study has practical relevance as the findings can help inform service development and delivery of peer support.	Trained facilitators - having a trained facilitator was reported as beneficial for maintaining structure and emotional safety in the group. Peer support - to be included in future service provision Future research - the researchers recommended further research to explore the impact of peer

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			Participants appreciated the structure of the group, including its consistency. Some noted the importance of having a trained facilitator at regular meetings.	Limitations: There was a small sample size and thus limits the generalisability of the findings. Adding to this, the sample lacked demographic diversity, also potentially impacting the generalisability. All participants were from one peer support group, so findings may not reflect experiences in other peer support groups. Possible self-selection bias, as participants volunteered	support and to evaluate its effectiveness across more diverse populations.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
				their participation, they may have had more positive experiences or stronger views.	

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
Experiences of support from primary care and perceived needs of parents bereaved by suicide: a qualitative study (Wainwright et al., 2020)	Primary care support	To explore the perspectives, experiences, and support needs of parents bereaved by suicide.	Parents/participants described uncertainty about where to seek support and identified barriers to support such as stigma and lack of awareness. GPs were generally seen as approachable and a potential source of support and information after the suicide bereavement. Parents often had to seek out information themselves, and some found their GP lacked	Strengths: This study provides insight into the experience of parents bereaved by suicide. Participants were recruited via multiple approaches, which supported the researchers to include participants with a range of experiences. The interviewing researcher had personal experience of suicide bereavement, which helped build rapport with participants. To increase transparency, this was	Referral to specialist services - the NHS's 24-hour helpline aimed to offer timely post-bereavement support. GPs should be equipped to direct bereaved individuals to such services, helping reduce stigma and adverse outcomes. GPs may struggle to assess the reliability of third-sector services, especially given their short-term funding. Regular updates and

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			knowledge about suicide bereavement resources or where to refer them. While some parents described positive experiences, others felt desperate and unsupported due to limited guidance from their GP. Parents/participants appreciated when their GP initiated contact after the suicide, as it encouraged them to seek support they might not otherwise access.	disclosed to participants prior to their agreement in the study. Two team members regularly reviewed transcripts to monitor the process. Many of the findings from this study are consistent with that identified in other research, such as the importance of GP support, even though at times they felt the GPs were uncertain in how to respond. Limitations:	links with trusted local services are recommended. Accessible information - Practices should offer literature on national resources like *Help is at Hand* and suicide bereavement groups, which parents found especially helpful for reducing isolation and normalising grief. Training for GPs - the GPs are often the first

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			They suggested home visits could be especially helpful, noting that barriers like triage systems, emotional distress in waiting rooms, and short appointment times made in-practice consultations difficult. Parents described feelings of shame and stigma surrounding suicide bereavement, which made them fearful of others' reactions and hesitant to	Potential bias from the interviewing researchers due to their personal experience. Parents had been bereaved for two to 10 years, which may have influenced their reflections on support received.	point of contact for families, and while they are seen as approachable, many lack confidence and clarity in how to respond. Standardised training and awareness are recommended.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			talk about the death, even with professionals. They valued support that was non-judgmental, expressing relief when they felt accepted and understood. Support groups were seen as helpful, especially for reducing isolation, normalising grief, and offering hope through shared experiences with others bereaved by suicide.		

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
Sharing is Caring: A Realist Evaluation of a Social Support Group for Individuals Who Have Been Bereaved by Suicide (Adshead & Runacres, 2022)	Social support group	To understand the experiences of individuals attending a suicide bereavement social support group, and to explore the perceived impact of this on wellbeing.	The support group helped foster relationships and enabled participants develop greater self-compassion and independence. Attending the group created a shared experience that gave participants access to a supportive community, which they viewed as equally valuable to formal mental health services. It offered emotional relief, dependable peer relationships, and helped	Strengths: Realist framework - this allowed the researchers to focus on participants' subjective experiences rather than the factual accuracy of events. Limitations: Generalisability - all participants were recruited from the same support group in the Northwest of England, so findings may not apply to other groups	The research suggests that the findings of this study can be used to inform policy and service design with the aim of the support group being tailored for individuals bereaved by suicide, The researcher recommends further research in this area being conducted, in varied populations to improve the

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			foster acceptance of their grief. Men often suppressed their emotions to appear strong, hoping their feelings would fade without help. Support groups helped challenge this by offering a safe space to share and feel relief among others who understood. Seeking external support (from the group) helped participants maintain healthier relationships with their loved ones by	with different characteristics. Demographic data - was not collected, which could affect how experiences are understood. Analysis - the researcher developed *Context. Development, Outcome* (CMO), which relied on their interpretation, therefore different researchers analysing the same data might produce different results and findings.	generalisability of the findings.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			relieving emotional pressure. Although some were initially hesitant to join, the need to manage difficult emotions and unexpected 'emotional outbursts' motivated attendance. The group offered emotional relief, connection, and a sense of routine and stability. Lack of adequate support led participants to seek external outlets to manage emotions and reduce		

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			isolation. By combining support group attendance with physical, creative, and spiritual activities, they found routine, social connection, and improved self-esteem and self-acceptance.		

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
Understanding impact and factors that improve postvention service delivery: findings from a study of a community-based suicide bereavement support service in England (Bell et al., 2024)	Community-based support	To explore and evaluate a community-based suicide bereavement service.	Multi-agency collaboration with real-time suicide surveillance (RTSS) enabled timely identification and outreach to bereaved individuals through coordinated efforts across health, police, and community services. Persistent, proactive contact helped engage those who might not otherwise seek support. Volunteer-led support provided empathy and	Strengths: This study was the first of its kind in the UK to look an innovative service model which integrates proactive outreach, multi-agency collaboration, and lived experience support. The findings align with previous research recommending a public health approach to postvention that emphasises multi-agency collaboration and timely, tailored support.	Public Health Alignment - The researchers recommend a public health approach to postvention that emphasises multi-agency collaboration and timely, tailored support. Core Components for Future Services: the researchers recommend integrating Real-Time Suicide Surveillance (RTSS) and persistent

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			emotional safety through lived experience. Continuous, open-ended support allowed individuals to access help as long as needed. Between May 2020 and April 2022, the service received 537 referrals, with a general upward trend over time. Police RTSS was the most common referral source, followed by self-referrals.	It provides evidence-based justification for adopting four innovative components in community-based suicide bereavement services. Limitations: The study's sample focused on volunteers and service users, which may have introduced bias and led to overly positive findings due to non-random participant recruitment. The two-year duration was not sufficient to evaluate the long-term impact or	proactive contact from the outset.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			Referrals spanned from under 18 to over 65. 326 females were referred, 211 males and one (non-binary). Most referrals were for immediate family members of the deceased, but over time there was an increase in referrals for professionals, colleagues, and witnesses to the death.	sustainability of the service, with some implementation challenges potentially emerging over time.	

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
'You Just Wear a Mask': An Interpretative Phenomenological Analysis Study to Explore the Impacts of Bereavement by Suicide Among Peer Support Group Members (Whitebrook & Churchyard, 2025)	Peer support group	This study aimed to assess the ramifications of bereavement by suicide within a cohort of peer-support group members.	Five themes and 20 sub-themes were identified: *"Never going to live a normal life"* - Life unravelling - Priority shifts - Family fractures - Disempowerment *"You just wear a mask"* - Forever changed - Loss of joy - Isolation - Pretense *"I'm conflicted"*	Strengths: Shared lived experience amongst peer group members fostered openness and a willingness to disclose, with many describing the process as cathartic. The researcher's background as a SoBS volunteer helped build trust and rapport with participants. Efforts were made to reduce bias, such as conducting interviews away from	Future research – should include participants from a more diverse background, including those from ethnic minorities, males and participants from other peer support groups.

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			- Desire to Know the unknowable - Logic vs. Emotion - Frustration vs. Understanding - Breaking the Silence Vs. Perpetuating the Taboo *"I Just Want Change"* - Loss of Trust in the Healthcare System - Trauma Exacerbation - Lack of Support/ Signposting	regular SoBS activities and encouraging honest feedback. Limitations: Participants who volunteer with SoBS may hold different perspectives than those outside the organization.	

Title, Author(s), and Publication Date	Type of Support	Aim of Study	Summary of Findings	Strengths and Limitations	Clinical Implications / Recommendations
			- Insufficient Investment *"Everyone in the Room Understood"* - Sense of Belonging - Understanding and Acceptance - Giving Back - Gaps		

2.2.6 Summary of Studies

Type of support and aims of studies. Two studies in this review explored the role of GPs in primary care, supporting families after a suicide bereavement (Foggin et al., 2016; Wainwright et al., 2020). Foggin et al. (2016) explored this from the perspective of GPs themselves, while Wainwright et al. (2020) focused on the experiences of bereaved families, specifically the parents' experiences. Both aimed to understand the nature of GP involvement, including their approaches, responses, experiences, and the type of support offered. Peer and social support groups were the focus of two of the studies, with aims centred on capturing participants' experiences and evaluating the perceived impact of group support (Ali & Lucock, 2020; Adshead & Runacres, 2022). Formal and informal support systems were mapped in Pitman et al. (2017, 2018); the former explored whether those bereaved by suicide receive less support than those bereaved by other sudden deaths, while the latter explored young adults' views on helpful and unhelpful support following suicide bereavement. These studies defined 'formal support' as services provided by professionals such as healthcare practitioners, therapists, police officers, funeral directors, and coroners' officers; 'informal support' included support from friends, family, and religious or spiritual advisors; and 'other support' referred to self-help resources. One study focused on a community-based suicide bereavement service that operated through real-time suicide surveillance (systems that collect and share information about suspected suicides as close to the time of the event as possible) and multi-agency collaboration (Bell et al., 2024). They aimed to explore how this coordinated approach supported individuals bereaved by suicide in the community. Hawton et al. (2012) evaluated the use and impact of a self-help booklet developed as part of England's suicide prevention strategy. Finally, Whitebrook et al. (2025) aimed to gain an understanding of suicide bereavement within a cohort of peer-support group members.

Summary of Findings. Four studies specifically highlighted that people bereaved by suicide often face stigma, feelings of shame, and emotional discomfort (Pitman et al., 2017; Pitman et al., 2018; Wainwright et al., 2020; Whitebrook & Churchyard, 2025). These experiences frequently created barriers to seeking help and limited their access to support. Isolation emerged as a common experience across four of the studies, with participants sharing their value for specific environments, such as support groups, where they felt accepted and could share openly without fear of judgment (Ali & Lucock, 2020; Adshead & Runacres, 2022; Pitman et al., 2018; Whitebrook & Churchyard, 2025). Concerns around timely access to support were presented across three of the studies, with delays in receiving help often intensifying emotional distress (Hawton et al., 2012; Pitman et al., 2017; Bell et al., 2024). Furthermore, Bell et al. (2024) highlighted how early intervention through coordinated outreach and real-time suicide surveillance can enhance engagement and ensure individuals receive support when they feel they need it most. Foggin et al. (2016) and Wainwright et al. (2020) both explored how GPs engage with families following a suicide bereavement, revealing varied experiences. Some GPs expressed a sense of responsibility to offer support, while others felt uncertain or worried that reaching out might unintentionally increase distress (Foggin et al., 2016). Families valued proactive contact from their GP, yet also highlighted a lack of GPs' awareness around appropriate resources and referral options (Wainwright et al., 2020).

Additional findings are explored in section 2.3, to answer the research questions of this review.

Strengths and Limitations. Researchers from three of the studies shared strong alignments with UK national suicide prevention efforts, increasing their relevance to practical service delivery (Hawton et al., 2012; Pitman et al., 2018; Bell et al., 2024). Hawton et al.

(2012) evaluated a resource that was actively distributed as part of the national strategy, while Pitman et al. (2018) conducted the largest UK study of its kind, directly supporting national policy goals. Bell et al. (2024) evaluated a community-based model that incorporated proactive outreach and multi-agency collaboration, reflecting public health recommendations for postvention support. All nine studies reported challenges with generalisability due to sample characteristics or recruitment methods (Hawton et al., 2012; Foggin et al., 2016; Pitman et al., 2017; Pitman et al., 2018; Ali & Lucock, 2020; Wainwright et al., 2020; Adshead & Runacres, 2022; Bell et al., 2024; Whitebrook & Churchyard, 2025). Four of the studies relied on a small or demographically narrow sample, such as recruiting from a single support group or organisation (Ali & Lucock, 2020; Adshead & Runacres, 2022; Bell et al., 2024; Whitebrook & Churchyard, 2025). One study had a low questionnaire response rate, and from just one geographic area, which limited the generalisability of the findings (Hawton et al., 2012). Both studies by Pitman et al. (2017; 2019) focused solely on students in UK higher education, excluding other young adults, again potentially narrowing the applicability of the findings to other ages and those of a different socioeconomic background. The sample of participants used in Foggin et al. (2016) were GPs with a particular interest in suicide bereavement, and had an average of 22 years of experience, thus again, potentially limiting the generalisability of the findings. Finally, the researchers in Wainwright et al. (2020) acknowledged that the participants (the parents) had been bereaved for two to 10 years, and that this factor may have influenced participants' reflections on the support they received, consequently having potential issues of generalisability of these findings due to possible recall bias.

Clinical Implications or Recommendations. All the studies either recommended further research to address gaps in understanding and improve generalisability, or offered suggestions for enhancing the support available to those bereaved by suicide (Hawton et al.,

2012; Foggin et al., 2016; Pitman et al., 2017; Pitman et al., 2018; Ali & Lucock, 2020; Wainwright et al., 2020; Adshead & Runacres, 2022; Bell et al., 2024; Whitebrook & Churchyard, 2025). Four of these studies explicitly recommended improvements (or changes) to training for professionals who support individuals bereaved by suicide (Hawton et al., 2012; Foggin et al., 2016; Wainwright et al., 2020; Pitman et al., 2018). Hawton et al. (2012) recommended that the resource could be utilised to help train professionals supporting those bereaved by suicide. Two studies recommended the need for more training for GPs to support those bereaved by suicide more confidently and with clearer guidance in relation to any onward signposting/referrals (Foggin et al., 2016; Wainwright et al., 2020). Finally, training was also recommended for a wider range of professionals, including police and healthcare workers, to help them support the emotional impact of suicide bereavement (Pitman et al., 2018).

2.2.7 Quality Appraisal

Whilst systematic literature reviews often employ quality appraisal tools to exclude studies deemed methodologically poor quality, they are less commonly utilised in scoping literature reviews (Gough et al., 2017; Levac et al., 2010). Nonetheless, incorporating a quality appraisal tool can enrich the depth of a scoping review by supporting the identification of potential methodological limitations in the studies for consideration, rather than being used as an exclusionary tool (Tricco et al., 2016). Many appraisal tools are tailored to a single study design (such as qualitative) and lack cross-design validation (Souto et al., 2015). The Mixed Methods Appraisal Tool (MMAT) was selected as it was specifically designed to assess the quality of studies for literature reviews incorporating studies spanning across multiple methodological designs, including quantitative, qualitative and mixed-method designs (Hong et al., 2018). The development and instructions of the MMAT encourage

researchers to provide a qualitative understanding of the study's methodological strengths and limitations, rather than reducing it to a single metric (Hong et al., 2018).

The MMAT begins with two screening questions to determine whether the identified study qualifies as an empirical study. These questions are: One) *Are there clear research questions?* Two) *Do the collected data allow the research questions to be addressed?* If the researcher answers '*Yes*' to both questions for the study, the study progresses through to full appraisal, whereby the researcher answers '*Yes*', '*No*' or '*Can't Tell*' to the five corresponding criteria. In the case of mixed methods studies, this process is extended to include three distinct sets of criteria, for example, qualitative, quantitative, and mixed methods questions, resulting in a total of 15 items that must be evaluated to ensure each component is rigorously assessed.

All nine studies were appraised using the MMAT. These included six qualitative studies, one quantitative descriptive study, and two mixed methods studies. All studies successfully met the two initial MMAT screening criteria.

The six qualitative studies included Foggin et al. (2016), Pitman et al. (2018), Ali and Lucock (2020), Wainwright et al. (2020), Adshead and Runacres (2022), and Whitebrook and Churchyard (2025). Five of these studies met all five of the MMAT criteria for qualitative research, demonstrating strong methodological coherence (Foggin et al., 2016; Ali & Lucock., 2020; Wainwright et al., 2020; Adshead & Runacres., 2022; Whitebrook & Churchyard., 2025). These criteria included the appropriateness of the qualitative approach, adequacy of data collection methods, derivation of findings from the data, validation of interpretations, and coherence across data sources, collection, analysis, and interpretation. However, Pitman et al. (2018) received a '*Can't Tell'* rating for the second criterion (*Are the*

qualitative data collection methods adequate to address the research question?), as the researchers of the study did not explicitly provide this information.

The single quantitative descriptive study, conducted by Pitman et al. (2017), met three of the five MMAT criteria for quantitative research. It utilised a relevant sampling strategy, appropriate measurement tools, and suitable statistical analysis. However, it received '*Can't Tell'* ratings for sample representativeness and risk of nonresponse bias, as the researchers did not explicitly report on how representative the sample was or whether nonresponse bias had been addressed.

The two mixed methods studies, Hawton et al. (2012) and Bell et al. (2024), were assessed across three MMAT domains: qualitative, quantitative descriptive, and mixed methods. Both studies met all five qualitative criteria. In the quantitative domain, both studies met at least three of the five criteria, but received '*Can't Tell'* ratings for sample representativeness and nonresponse bias due to insufficient reporting. In the mixed-methods study type, both studies provided a clear rationale for using mixed methods and demonstrated effective synthesis of findings. However, neither of the studies explicitly addresses divergences between qualitative and quantitative results, resulting in additional '*Can't Tell'* ratings.

The researcher of this scoping literature review acknowledged that the MMAT is designed to assess methodological quality exclusively and does not incorporate ethical considerations within its core criteria (Hong et al., 2018). However, ethical appraisal is recommended as an integral process to ensure comprehensive evaluation of research integrity (Booth et al., 2016). Other validated appraisal tools, such as the Critical Appraisal Skills Programme (CASP), explicitly include ethics-related questions, including informed consent, confidentiality, and ethical approval (CASP, 2024). Following consultation with the wider

research team, the researcher decided to incorporate the CASP ethical question *('Have ethical issues been taken into consideration?'*) and one of the ethical suggestions relating to informed consent into the scoping literature review to ensure that ethical considerations were assessed alongside methodological rigour.

All the studies included in the scoping literature review received formal ethical approval from their respective institutional ethics committees, suggestive of a consistent commitment to research governance and participant protection. In eight of the nine studies, researchers explicitly reported obtaining informed consent from participants, either in-person or online, ensuring that participants were aware of the study's purpose and their rights before taking part. One study, Ali & Lucock (2020), confirmed ethical approval but did not clearly state whether informed consent was obtained, and thus, the absence of a direct reference in the published article means this aspect remained unclear. Consequently, this was rated as *'Can't Tell*'.

Overall, all the studies included in this scoping literature review were of good quality. The researcher did not '*weight'* any of the studies whilst synthesising the data, and as such, each study contributed equally to the findings.

Table 8 provides a summary of the MMAT and ethical considerations for the studies in this SLR.

Table 8

Quality Appraisal Summary

Categories	Methodological quality criteria	Hawton et al., 2012	Foggin et al., 2016	Pitman et al., 2017	Pitman et al., 2018	Ali & Lucock, 2020	Wainwright et al., 2020	Adshead & Runacres, 2022	Bell et al., 2024	Whitebrook & Churchyard, 2025
Screening questions	Are there clear research questions?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Do the collected data allow to address the research questions?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Qualitative	Is the qualitative approach appropriate to answer the research question?	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes

Categories	Methodological quality criteria	Hawton et al., 2012	Foggin et al., 2016	Pitman et al., 2017	Pitman et al., 2018	Ali & Lucock, 2020	Wainwright et al., 2020	Adshead & Runacres, 2022	Bell et al., 2024	Whitebrook & Churchyard, 2025
	Are the qualitative data collection methods adequate to address the research question?	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes
	Are the findings adequately derived from the data?	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes
	Is the interpretation of results sufficiently substantiated by data?	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes
	Is there coherence between qualitative	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes

Categories	Methodological quality criteria	Hawton et al., 2012	Foggin et al., 2016	Pitman et al., 2017	Pitman et al., 2018	Ali & Lucock, 2020	Wainwright et al., 2020	Adshead & Runacres, 2022	Bell et al., 2024	Whitebrook & Churchyard, 2025
	data sources, collection, analysis and interpretation?									
Quantitative descriptive	Is the sampling strategy relevant to address the research question?	Yes	-	Yes	-	-	-	-	Yes	-
	Is the sample representative of the target population?	Can't tell	-	Can't tell	-	-	-	-	Can't tell	-
	Are the measurements appropriate?	Yes	-	Yes	-	-	-	-	Yes	-

Categories	Methodological quality criteria	Hawton et al., 2012	Foggin et al., 2016	Pitman et al., 2017	Pitman et al., 2018	Ali & Lucock, 2020	Wainwright et al., 2020	Adshead & Runacres, 2022	Bell et al., 2024	Whitebrook & Churchyard, 2025
	Is the risk of nonresponse bias low?	Can't tell	-	Can't tell	-	-	-	-	Can't tell	-
	Is the statistical analysis appropriate to answer the research question?	Yes	-	Yes	-	-	-	-	Yes	-
Mixed Methods	Is there an adequate rationale for using a mixed methods design to address the research question?	Yes	-	-	-	-	-	-	Yes	-

Categories	Methodological quality criteria	Hawton et al., 2012	Foggin et al., 2016	Pitman et al., 2017	Pitman et al., 2018	Ali & Lucock, 2020	Wainwright et al., 2020	Adshead & Runacres, 2022	Bell et al., 2024	Whitebrook & Churchyard, 2025
	Are the different components of the study effectively integrated to answer the research question?	Yes	-	-	-	-	-	-	Yes	-
	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes	-	-	-	-	-	-	Yes	-
	Are divergences and inconsistencies	Can't tell	-	-	-	-	-	-	Can't tell	-

Categories	Methodological quality criteria	Hawton et al., 2012	Foggin et al., 2016	Pitman et al., 2017	Pitman et al., 2018	Ali & Lucock, 2020	Wainwright et al., 2020	Adshead & Runacres, 2022	Bell et al., 2024	Whitebrook & Churchyard, 2025
	between quantitative and qualitative results adequately addressed?									
	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Yes	-	-	-	-	-	-	Yes	-
Ethics	Have ethical issues been taken into consideration?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Categories	Methodological quality criteria	Hawton et al., 2012	Foggin et al., 2016	Pitman et al., 2017	Pitman et al., 2018	Ali & Lucock, 2020	Wainwright et al., 2020	Adshead & Runacres, 2022	Bell et al., 2024	Whitebrook & Churchyard, 2025
	Was informed consent obtained from participants?	Yes	Yes	Yes	Yes	Can't Tell	Yes	Yes	Yes	Yes

2.2.8 Synthesis Strategy

Multiple synthesis methodologies were considered when conducting this review, including thematic analysis, framework synthesis, and narrative synthesis. Thematic analysis could have supported the identification of common experiences and highlighted patterns within the qualitative data, and framework synthesis could have helped understand how the findings mapped onto existing frameworks (Braun & Clarke, 2006; Brunton et al., 2020), Due to the inclusion of qualitative, quantitative, and mixed-methods studies in this scoping literature review, it was important that the synthesis methodology would be capable of integrating diverse forms of evidence whilst maintaining methodological sensitivity (Munn et al., 2018). Therefore, narrative synthesis was selected for this review due to its ability to bring together findings from a variety of studies and present them in a clear and structured way (Popay et al., 2006).

As described by Popay et al. (2006), narrative synthesis involves the researcher familiarising themselves with the studies, organising findings thematically or by research question, and integrating insights to address broader review aims. This synthesis approach aligned with the overarching aim of this review and was deemed most appropriate for answering the primary research question (*What support is available for individuals bereaved by suicide in the UK?*). The synthesis process involved structured engagement with the nine included studies, in which each sub-research question was addressed individually by the researcher before integrating the findings to respond to the final overarching question.

2.3 Findings

2.3.1 Narrative Synthesis of Findings

In what formats is support provided? Five of the studies described support that was offered face-to-face, such as support groups or in-person GP consultations (Foggin et al., 2016; Ali & Lucock, 2020; Wainwright et al., 2020; Adshead & Runacres, 2022; Whitebrook & Churchyard, 2025). One study described a self-help support booklet that could be accessed both online and in hard copy (Hawton et al., 2012). Three studies, whilst describing support experiences, did not explicitly state whether the interactions were face-to-face, remote, or hybrid (Pitman et al., 2017; Pitman et al., 2018; Bell et al., 2024).

Is data on participant drop-out rates available or systematically reported? None of the studies included in this review reported the drop-out rates from the discussed suicide bereavement support.

How soon after the bereavement is support being offered? Most of the studies described when those bereaved by suicide accessed or engaged with support, though they did not explicitly state when the support was offered. Only one study, Bell et al. (2024), stated that support is proactively offered soon after the bereavement via real-time surveillance, though a specific timeframe was not provided, and the researchers did not state a specific duration for support, but encouraged ongoing, *"open-ended access."* The eight remaining studies did not state when the support was offered, but instead loosely described when the support was accessed, such as at different stages of post-bereavement (Hawton et al., 2012; Foggin et al., 2016; Pitman et al., 2017; Pitman et al., 2018; Ali & Lucock, 2020; Wainwright et al., 2020; Adshead & Runacres, 2022; Whitebrook & Churchyard, 2025).

Is the theory behind the support being offered shared in the research? While several studies describe aspects of emotional safety, empathy, or accessibility of the support (e.g., Ali & Lucock, 2020; Whitebrook & Churchyard, 2025), none of the reviewed literature explicitly outlined a psychological or theoretical framework underpinning the support being offered (Hawton et al., 2012; Foggin et al., 2016; Pitman et al., 2017; Pitman et al., 2018; Wainwright et al., 2020; Adshead & Runacres, 2022; Bell et al., 2024).

Does the support offered vary depending on age? Bell et al. (2024) reported receiving referrals for individuals ranging in age from under 18 to over 65; however, the study did not indicate that the support provided was adapted based on age. Hawton et al. (2012) did not specify the intended age group for the *Help is at Hand* booklet, although all study respondents were adults. The remaining seven studies focused exclusively on adults or young adults aged 18 and over (Ali & Lucock, 2020; Adshead & Runacres, 2022; Foggin et al., 2016; Pitman et al., 2017, Pitman et al., 2018; Wainwright et al., 2020; Whitebrook & Churchyard, 2025).

What support is available for individuals bereaved by suicide in the UK? The nine studies included in this review described a range of support options available to individuals bereaved by suicide in the UK. GPs were identified as a source of support within primary care, whereby they could offer follow-up contact, signposting to specialised services (yet limited literature was retrieved about these services), and general emotional support (Foggin et al., 2016; Wainwright et al., 2020). Peer and social support groups were also evidenced, offering spaces for connections to be developed over shared experience (Ali & Lucock, 2020; Adshead & Runacres, 2022). Ali and Lucock (2020) specifically presented a volunteer-led peer support group, which was organised by Survivors of Bereavement by Suicide (SOBS). A community-based postvention model was presented by Bell et al. (2024),

which involved real-time suicide surveillance, multi-agency coordination, and proactive outreach to those affected. Formal and informal support systems were described in Pitman et al. (2017, 2018), with formal support including professionals such as healthcare workers, police, and coroners, and informal support encompassing family, friends, and faith leaders. Finally, Hawton et al. (2012) described a self-help booklet offering practical guidance, emotional advice, and information on navigating the more 'official' procedures following a suicide.

2.4 Discussion

2.4.1 Summary of Findings

This scoping literature review aimed to identify what support is available for individuals bereaved by suicide in the UK. Nine studies were included in this review and were analysed using narrative synthesis.

Overall, the review identified a range of formal (e.g. offered by professionals) and informal (e.g. friends and family), direct (such as peer-support groups and GP support) and indirect (handbooks) support. It also reflected research highlighted in Chapter One, that individuals bereaved by suicide face specific challenges such as stigma and feelings of shame, and that these experiences also act as barriers to seeking support. Receiving and accessing support in a timely manner was also emphasised as a concern within some of the studies.

Whilst the review aimed to gain an understanding of the drop-out rates of the suicide bereavement support, none of the studies reported on this. The absence of this information highlights a significant gap within the current literature. It leaves questions surrounding whether this data was ever collected, but not reported, or if this data was published in third-

sector service reports that might have been held within the grey literature. This could be an area of focus for future research.

2.4.2 Sources of Funding and Conflicts of Interest of Studies

Declaring sources of funding in research and potential conflicts of interest helps ensure transparency and can assist in understanding whether external, systemic priorities may have influenced the interpretations of findings (COPE Council, 2025).

This scoping literature review received no external funding and was carried out as part of the requirements of the degree of Doctor in Clinical Psychology.

The Hawton et al. (2012) study clearly stated that it was supported by a Department of Health grant, with additional support provided through various National Institute for Health Research (NIHR) awards and institutional contributions. One author was supported through an NIHR Senior Investigator award, another through an NIHR Programme Grant for Applied Research, and another through the NIHR Research Design Service for the East Midlands. Additional institutional support was provided by the University of Nottingham and by the East Midlands Development Centre, NHS East Midlands. The authors shared that the views expressed are those of the authors and do not necessarily reflect those of the NHS, NIHR, or Department of Health. One author was employed by the Department of Health, and two authors contributed to the development of *Help is at Hand* for the Department of Health; all other authors reported no conflicts of interest.

The Foggin et al. (2016) study stated that it was an independent research study funded by the NIHR under the Research for Patient Benefit Programme. They shared that the views expressed are those of the authors and not necessarily the views of NICE. Two authors have been personally bereaved by suicide, and one author has held roles on NICE guideline

development groups related to self-harm, depression, and suicide prevention, as well as assisting on a national advisory group. All other authors reported no competing interests.

The Pitman et al. (2017) study was not commissioned and received ethics approval from the University College London (UCL) Research Ethics Committee. They did not report any conflicts of interest.

The Pitman et al. (2018) study was funded by the Medical Research Council through a Population Health Scientist Fellowship, which also covered open-access publication costs, and additional support was provided through a Guarantors of Brain Fellowship for qualitative analysis. Support was also received from an NIHR Biomedical Research Centre and an NIHR Collaboration for Leadership in Applied Health Research and Care. The article stated that the funding bodies had no role in the study design, data collection, analysis, interpretation, manuscript preparation, or the decision to publish. One author recently co-produced a public guide on supporting people bereaved by suicide in collaboration with voluntary sector organisations. All other authors reported no conflicts of interest.

In the Ali and Lucock (2020) study, the authors shared that the research was undertaken as part of a PhD at the University of Huddersfield, and had some support from SOBS, along with guidance from the doctoral supervisory team, and support from a regional NHS Foundation Trust. Any specific external funding for this research was not explicitly stated in the article.

The Wainwright et al. (2020) study was funded by the NIHR through the Research for Patient Benefit Programme. Two of the authors had been personally bereaved by suicide, and two researchers sat on the Suicide Prevention Advisory Group at the Department of Health in England, whilst another author provided expert testimony for suicide prevention guidelines at NICE. All other authors reported no conflicts of interest.

Adshead and Runacres (2022) did not explicitly state any sources of funding for the research but did declare that there were no conflicts of interest.

The Bell et al. (2024) study was supported by the NHS Humber and North Yorkshire Integrated Care Board and the Humber and North Yorkshire Health and Care Partnership; no specific funding beyond the organisational support described was specified. All three researchers hold positions at the University of Hull. No conflicts of interest were reported.

Finally, the Whitebrook and Churchyard (2025) study reported no conflicts of interest, and no details surrounding funding were specified in the article.

2.4.3 Strengths and Limitations

Strengths. This review represented a novel contribution to the literature by focusing specifically on the support available to individuals in the UK who have been bereaved by suicide. While previous reviews have explored available support more broadly across international or multi-regional contexts, such approaches often overlooked more informal or less structured forms of assistance in the UK, such as support provided by GPs (Coquelin et al., 2025). Furthermore, as the NHS, within the UK, offers a free at the point of access service for physical and mental healthcare (Khan, 2023), the findings from other contexts, which may rely more heavily on support funded by insurance, may have limited applicability to the UK (without further resourcing identified). By narrowing the geographical scope, this review offered a more detailed understanding of the current landscape of support within the UK, and highlighted the pathways individuals are choosing or being directed toward in their search for support.

A further strength of this review is the involvement of two reviewers throughout the screening process. This dual-review approach enhanced the methodological rigour by

ensuring that decisions regarding study inclusion were not made in isolation, thereby reducing the potential for individual bias or subjective interpretation (Stoll et al., 2019). Discrepancies between reviewers were discussed and resolved collaboratively, which contributed to a more balanced and transparent selection of studies. This process also strengthened the reliability of the findings by promoting consistency and accountability in the application of inclusion and exclusion criteria.

Limitations. One potential limitation of this review is that, although grey literature was included in the search strategy, none of the identified articles met the inclusion or exclusion criteria for selection. This raised the possibility that other forms of support available in the UK may exist but were not captured in this review. Whilst the researcher considered changing the search terms to cater better for grey literature (for example by excluding the use of Boolean connectives), this was at the detriment of the results retrieved on the more academic databases (such as PubMed), and thus, following consultation with the research team, it was agreed to keep the search terms as originally constructed. Future research could address this gap by conducting a dedicated review of grey literature, with search terms and eligibility criteria specifically tailored to identify community, charity or third sector-based support services.

Another potential limitation of this review is that two of the sub-research questions could not be fully addressed due to gaps in the literature. Specifically, none of the included studies reported participant dropout rates, limiting insight into engagement and retention within the support being offered. This may be because the point at which support formally ends may be unclear, making it difficult to determine whether an individual has completed the intervention/the support or simply disengaged. Additionally, all studies focused

exclusively on adults, at least aged 18 and over, making it difficult to determine whether, or how, support is adapted for younger individuals.

2.4.4 Critical Appraisal

The CASP checklist for systematic reviews was deemed appropriate as a quality appraisal tool for this scoping literature review (Critical Appraisal Skills Programme, 2023). The CASP was completed by the researcher and then reviewed by a member of the research team. This review can be seen in Table 9.

As is outlined below, this scoping literature review demonstrated a high level of methodological quality – answering *'yes'* to nine of the ten criteria. One of the ten criteria asks whether all relevant studies were included, though the researcher deems that it is not possible to be completely certain, as some research may be held on databases which were excluded due to paywalls, studies not clearly indexed, or the aforementioned challenges of searching on grey literature databases.

Table 9

CASP Checklist of this Scoping Literature Review

Checklist question	Yes	No	Can't tell
Did the review address a clearly focused question?	✓		
Did the authors look for the right type of papers?	✓		
Do you think all the important, relevant studies were included?			✓
Did the review's authors do enough to assess the quality of the included studies?	✓		
If the results of the review have been combined, was it reasonable to do so?	✓		
What are the overall results of the review?	✓		
How precise are the results?	✓		
Can the results be applied to the local population?	✓		
Were all important outcomes considered?	✓		
Are the benefits worth the harms and costs?	✓		

2.5 Conclusion

This scoping literature review aimed to scope the types of support available to individuals in the UK who have experienced bereavement due to suicide. The review encompassed nine studies published between 2012 and 2025, revealing a range of support types. These included self-help resources, peer-led and social support groups, GP involvement within primary care, and community-based services. The findings also highlighted several barriers to accessing support, particularly timely access, as well as the stigma surrounding suicide bereavement, which discouraged some individuals from seeking support or disclosing their needs. Notably, none of the reviewed studies explicitly referenced the psychological theories or conceptual frameworks underpinning the development of the support interventions. Furthermore, the extent of participant engagement remains unclear, as dropout rates were insufficiently reported across the literature.

2.6 Rationale for the Current Study

High (2024) focused their research on '*Exploring the Narratives of Self-defined Family Members who have Experienced Suicide Bereavement'* and identified that '*services within the UK need to ensure that they have a clear understanding of what specific support survivors need*.' While 2025 saw the introduction of several new policies, as previously mentioned, and standards aimed at strengthening suicide bereavement support in the UK, these, though well-intentioned, highlight the ongoing need for research into what forms of support individuals bereaved by suicide are most likely to engage with.

All the articles included in this scoping literature review focused on adult support, and the current study will build upon this foundation by continuing to explore support for adults bereaved by suicide. By undertaking this research now, the study will aim to capture the

service provisions experienced prior to the introduction of new (2025) policies, providing a valuable baseline against which future developments can be assessed. Previous research, including studies by McCarron et al. (2019) and Hickmann et al. (2022), highlighted the critical role of patient engagement in shaping their care and support, signifying that their involvement is instrumental in fostering participation. This underscores the importance of incorporating the perspectives of those affected by suicide bereavement into discussions about the types of support to be offered. Furthermore, as Heath et al. (2019) reported, identifying what support a population group may find helpful should not be misinterpreted as an assumption that they will necessarily engage with that support; as such, this will also be explored.

Based on this rationale, this study aimed to respond to High's (2024) research by better understanding what support self-defined family members who have experienced suicide bereavement feel would be beneficial, and to ascertain if they would engage in this support if offered to them. As such, the research question was:

What support do self-defined family members bereaved by suicide want, and would engage in?

Chapter Three: Methodology

3.1 Chapter Overview

This chapter outlines the methodological framework underpinning this research study, explaining the research design, mixed-methods approach, consultation processes, ethical considerations, participant recruitment strategy, and the development of the questionnaire. As explained in Chapter One, this research was conducted from a social constructionist epistemological perspective and a critical realist ontological underpinning (Neimeyer et al., 2014; Zachariadis et al., 2013). This is important as they underscore and guide how the researcher constructed the study and understood the participants' experiences. The data presented in this research is therefore interpreted with a focus on how the meaning of participants' experiences of suicide bereavement support is created, and the broader structures (such as access to services or societal stigma) that may influence participants' experiences of support provisions.

3.2 Design

Questions exploring participants' experiences of support following their bereavement were asked via a questionnaire, hosted on the Qualtrics platform (accessed either directly via a link or via scanning a QR code on the recruitment poster). Open-ended questions generated qualitative data, and closed-ended questions produced quantitative data; further details of these can be read in section 3.6 (Data Collection). The use of both qualitative and quantitative data classified this study as a mixed-methods design (Almeida, 2018). Whilst interviews with participants were considered, an online questionnaire was selected as the method to collect data as research suggests that people are more forthcoming about sensitive or stigmatised experiences (such as suicide) when completing self-administered, anonymous questionnaires (Durant et al., 2002; Murdoch et al., 2014). This was further evidenced in

Heath et al. (2018), whereby nine out of 12 participants opted for non-visible modes of participation (such as by telephone or email) when sharing experiences of a sensitive and stigmatised topic. The researchers reported that participants believed they could be more open in these formats, and feeling better able to provide detailed responses when not face-to-face with the researcher.

3.2.1 Mixed Methodology

Mixed methodology refers to a research approach whereby the researcher intentionally integrates qualitative and quantitative methods within the same study, with the aim of gaining a more comprehensive understanding of the studied phenomenon (Taherdoost, 2022). It is based upon the notion that combining different forms of data offers insights that would be less complete than if only one method were used (Johnson et al., 2007). Whilst qualitative methods can aid in understanding more complex, dynamic experiences, and quantitative methods have the capacity to produce generalisable findings, the integration of both methods offers the benefits of both (Zhang & Creswell, 2013). During mixed-method research, the data can be 'mixed' in three main ways, often dependent on the research aim of the study (Teddlie & Tashakkori, 2009; Zhang & Creswell, 2013). The 'mixing' approaches are outlined in Table 10.

Table 10

Three Approaches to Data Mixing

Data 'Mixing' Approach	Process
Integration	Qualitative and quantitative data are concurrently collected and analysed separately before being integrated in the interpretation phase.
Connection	The findings from one set of data are used to inform the next stage of data collection, for example quantitative findings may guide the researchers qualitative sampling.
Embedding	One set of data is inserted into the other, often larger design, for example, interviews (qualitative data) being embedded in a clinical trial (quantitative data).

Note. Teddlie and Tashakkori (2009), and Zhang and Creswell (2013).

Rationale for Mixed-method Design. As this study was informed by a critical realist understanding of suicide bereavement and a social constructionist epistemological stance, a mixed-method design was considered most appropriate for this study, as it would enable the exploration of both measurable patterns in support and the nuanced, subjective accounts that show how bereavement support is experienced.

The qualitative elements of the questionnaire were to allow for a richer, more nuanced understanding of participants' experiences, while the quantitative components provided

structured, generalisable insights into patterns of support engagement (Tracy, 2024; Fadele & Rocha, 2025). With the qualitative and quantitative data collected concurrently and analysed separately, this study mixed the data via integration during the interpretation stage. This allowed the researcher to familiarise and analyse both sets of data, before then enabling the qualitative findings to enrich and extend the quantitative findings (Zhang & Creswell, 2013). Integration was deemed the most appropriate approach to answer the research question of the current study by the researcher, as it allowed both strands of the data to carry equal weight and supported the exploration of overall trends (such as types of support accessed), alongside the experiences shaping these trends (such as the participants' experience accessing the support).

3.2.2 Quantitative Methodology – Descriptive Statistics

The quantitative strand of data was analysed using IBM SPSS Statistics (Version 31), whereby descriptive statistics, which were generated from the closed-ended questionnaire items, were used to summarise preferences for support, experiences, and key participant characteristics. Descriptive statistics, whilst relatively common to report, can offer important insight by condensing large datasets into clear and interpretable summaries through measures such as the mean, mode, median, and standard deviation, enabling researchers to identify patterns that might otherwise remain obscured (Cooksey, 2020). Whilst descriptive statistics are not inherently complex to report, they can also be displayed in visual formats, such as graphs and charts, making them even more accessible for readers to interpret, thus potentially further enhancing research communication (Alabi & Bukola, 2023). Accessible information is especially important in suicide bereavement research, whereby improving the readability of findings can support more open discussions and help to challenge some of the stigma that can restrict communication amongst those bereaved by suicide (Hanschmidt et al., 2016).

3.2.3 Qualitative Methodology – Qualitative Content Analysis

An inductive conceptual content analysis, a form of qualitative content analysis, was selected as the method to analyse the qualitative strand of data in this study (Krippendorff, 2019). Whilst content analysis is used across qualitative and mixed-methods research, the terminology used to describe it in its different forms varies considerably across the disciplines, which can create ambiguity when selecting and describing a method (Hsieh & Shannon, 2005; Krippendorff, 2019; Neuendorf, 2017). One widely used framework, particularly in psychology and health research, distinguishes between conventional, directed, and summative approaches (Hsieh & Shannon, 2005). Another framework, more common in information-science research, differentiates between conceptual and relational content analysis (Krippendorff, 2019). To help clarify how this research study positions its approach within this broader landscape, an overview of the main forms of content analysis is presented in Table 11.

Table 11

Forms of Content Analysis

Approach	Description	Reason for Rejection
Conventional Content Analysis	Categories emerge inductively from the data, without pre-defined codes	This is designed for topics where very little is known and researchers build categories from scratch, but there is already some understanding of suicide bereavement support, so a fully open-ended approach was not needed.
Directed Content Analysis	Existing theories/research guides the development of pre-defined codes prior to data analysis	This analysis approach was not appropriate as it relies on pre-existing categories generated from theories and frameworks, which could restrict how participants responses of what support they want would be interpreted.

Approach	Description	Reason for Rejection
Summative Content Analysis	The researcher starts by counting words or content, and then interprets the underlying meaning.	This approach was not appropriate as it relies on counting words before exploring underlying meaning, whilst this research study focused directly on the deeper meaning behind participants' support needs rather than the frequency of specific terms.
Conceptual Content Analysis	The presence and frequency of key concepts within the data is counted.	Chosen Approach. This approach was appropriate as it involves identifying and organising reoccurring concepts, such as what support people want, whilst not losing the richness of the participants experiences.
Relational Content Analysis	Relationships between concepts are examined	This approach was not appropriate because it focuses on analysing how concepts connect to each other, whereas this research study is focused on identifying the support people want, rather than mapping relationships between multiple ideas.

Note. Hsieh and Shannon (2005), Neuendorf (2017) and Krippendorff (2019.

This research study utilised an inductive conceptual content analysis approach, which involved identifying key ideas in participants' responses (codes) and, when appropriate, noting their frequency (Elo & Kyngäs, 2008; Krippendorff, 2019). This approach aligns with Krippendorff's (2019) broader view of content analysis as a process centred on identifying and organising concepts within textual data.

Furthermore, as conceptual content analysis can be carried out either inductively (concepts are generated from participants' responses), or deductively (predetermined concepts informed by previous research), it offered the flexibility to identify support needs to be recalled directly from participants' experiences (Elo & Kyngäs, 2008). An inductive approach was appropriate for this research study as it allowed ideas and themes to be determined directly from the participants' responses to open-ended questions, rather than attempting "to fit" their experience of suicide bereavement into pre-determined categories. A deductive approach was considered; however, because this research study was not designed to test an existing theory or framework and was instead more exploratory in nature, an inductive approach was felt to be the more appropriate choice (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005).

This approach was well-suited to mixed-methods research, as the combination of systematic coding and quantification allowed the qualitative patterns to be interpreted alongside the quantitative results (Hsieh & Shannon, 2005; Krippendorff, 2019).

The inductive conceptual content analysis followed a systematic process whereby the researcher first familiarised themselves with the data, then created initial codes by working through the data line-by-line, organised these codes into concepts, and counted their frequency.

Consideration of other Analytic Approaches. Various qualitative analysis methods, such as narrative analysis, interpretive phenomenological analysis, and thematic analysis were considered as potential analytic approaches for this study; however, as this research study aimed to recruit a comparatively large number of participants and relied on questionnaire-based data, these methods were not selected due to their, in-depth, and potentially time-heavy interpretive requirements (Smith, 2016; Tuffour, 2017; Naeem et al., 2023).

Strengths and Limitations of Inductive Conceptual Content Analysis. The strengths and weaknesses of inductive conceptual content analysis were also considered before selecting this as the qualitative analysis method for this research study (with added applicability to suicide bereavement research). These are presented in Table 12.

Table 12

Strengths and Weaknesses of Inductive Conceptual Content Analysis.

Strengths	Weaknesses
Flexibility. Concepts emerge directly from the data, which is valuable in suicide bereavement support research where the experiences being shared may be very personal.	**Subjectivity.** Researcher interpretation of the data may introduce subjectivity, especially within the context of suicide bereavement where sensitive information may be shared.
Exploratory. This makes it well suited for topics which are under-researched.	**Comparability.** The inductive nature of it may raise challenges in terms of comparing the findings with existing literature.
Systematic but transparent. The method allows researchers to document and refine their coding decisions as understanding increases, which is advantageous when integrating the qualitative and quantitative strands of data together.	**Over-coding.** Breaking text down into too small of a concept can make data feel fragmented and lack context.

Light quantification. Counting concepts can help highlight any patterns, for example frequently mentioned support needs or barriers to support.	**Reliability.** Ensuring there is consistency and reliability is a challenge in qualitative content analysis.
Epistemological alignment. Interpretation of the concepts occurs within contextual and social meanings, which fits with the social constructionist stance of this research.	
Flexibility. Concepts emerge directly from the data, which is valuable in suicide bereavement support research where the experiences being shared may be very personal.	

Note. Hsieh and Shannon (2005), Elo and Kyngäs (2008), Schreier (2012), Elo et al. (2014), Bengtsson (2016), and Krippendorff (2019).

3.3 Consultation

Research suggests that involving people who have direct, personal experience of the topic being explored can strengthen the quality and relevance of research, policy and service development (O'Shea et al., 2019; Cluley et al., 2022). This lived experience, often described using terms such as "experts-by-experience," "consultants," "consumers," or "people with lived experience," brings insight that may not be considered through professional or academic knowledge alone (Krysinska et al., 2023). The literature shows that conducting research *with* those at the centre of suicide bereavement/prevention, rather than doing research *to* or *for* them, leads to a better experience for service providers and service users (National Mental Health Commission, 2019). In line with the preferences of those with lived experience contributing to the development of this research study, they will be referred to as "Experts-by-Experience" (EbEs) hereon.

Four EbEs supported this study. Two of the EbEs were recruited from the Support After Suicide Partnership (SASP). One EbE was recruited via the Suicide-Safer Project, and one EbE was recruited via the secondary supervisor, Dr Katie High. All consultations with the EbEs were conducted via email correspondence and video calls using Microsoft Teams Software. To ensure that EbEs maintained control over when and how they participated, prior to an EbE engaging or reviewing any resources/data, the lead researcher 'checked-in' with them to ask if they felt it was a 'good' day for them to view potentially sensitive information.

Table 13 presents the areas in which the EbEs offered support.

Table 13

EbE Consultation Involvement

Research Stage	Task Completed
Methodology	Reviewed content and use of language on the following documents: - Participant recruitment poster - Participant information sheet - Participant consent form - Participant questionnaire items - Participant debrief sheet - List of contactable services for participants
Data Analysis	Reviewed content categories
Discussion	Reviewed implications of recommendations for service developments Support reflection on what gaps/questions still need answering
Dissemination	Advised on formats for dissemination of the research

EbEs were not involved in the design of the study, nor in the development of the research question. Instead, these aspects were informed directly from the research (such as the scoping literature review) and discussions within the research team.

3.4 Ethical Considerations

This research study received ethical approval from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority (protocol number: 0522 2025 Jun HSET; Appendix D). This research study received its first ethical approval in February 2025 (Appendix B); however, two amendments were made following consultation with EbEs and with the research team. The first approved amendment was to add a question enquiring about the participant's relationship to the person who had died by suicide; this was to ensure the results collected were from 'self-defined family members' (Appendix C). The second, and final amendment (Appendix D), was to request a change in language use throughout the study from *'completed suicide'* to *'died by suicide'*. This was following feedback from the second supervisor, who attended the most recent International Association for Suicide Prevention conference, whereby the most up-to-date consensus was that 'died by suicide' is the preferred term by those most closely affected. Ethical considerations informed each stage of this research study.

Informed Consent. Once accessing the questionnaire link, via the recruitment poster (Appendix E), participants were provided with a Participant Information Sheet (Appendix F), in which it was clearly explained that their participation was entirely voluntary, and they could stop answering the questions online at any point of their choosing, though the answers were automatically saved and so could not be removed once they had moved on to the next question. After the Participant Information Sheet, participants wishing to continue provided their informed consent (Appendix G).

Confidentiality and Anonymity. Also on the Participant Information Sheet, participants were informed that all data collected during the study would be kept strictly confidential. Any details that could identify them or loved ones, such as names, would be

anonymised before analysis. It was explained that the anonymised data would be stored electronically in a password-protected file on the University OneDrive, while the data was being analysed and the findings shared, and that once the primary researcher completed the Clinical Psychology Doctorate Programme, the data would be securely destroyed. Participants were also informed that only the primary researcher and the two named supervisors would have access to the raw data. Finally, participants were informed that the data collected would not be used in any further studies.

Participant Protection. Research has indicated that talking about a bereavement can be a cathartic experience for individuals, yet the sensitive nature of suicide bereavement means that some participants may find the process distressing (Bosticco & Thompson, 2005; Gibson et al., 2014). For this reason, participants were provided with contact details for relevant support services (Appendix H). This list of contact details was developed in collaboration with EbEs. Discussions with EbEs and the research team also highlighted the need to ensure that participants felt they were in a safe and appropriate setting to complete the online questionnaire. The first question, therefore, explicitly asked *'Do you feel you are in a safe and appropriate environment to share your experiences today?'* Participants who selected 'no' were redirected to support services rather than continuing with the questionnaire. EbEs additionally contributed to reviewing the questionnaire to ensure that the wording and tone were suitably sensitive for individuals bereaved by suicide. Finally, at the end of the questionnaire, all participants were provided with a debrief sheet (Appendix I). This ensured that everyone received clear information about the aim of the study and where they could access further support if required, irrespective of the participant's distress levels. Again, this document was constructed alongside consultation with EbEs.

Researcher Protection. There were also considerations of the potential distress the lead researcher might experience from engaging with an emotive topic, such as suicide bereavement, and analysing the data in isolation. Research has suggested that researchers working in fields where traumatic experiences are shared, may be subject to experiencing secondary trauma (transference of trauma from the original event(s), either through the verbal re-telling of the experience, or at the point of data analysis (Drozdzewski & Dominey-Howes, 2015; Williamson et al., 2020). It is advised that researchers in this position receive regular supervision (Dickson-Swift et al., 2007; van der Merwe & Hunt, 2019). As such, the lead researcher met with the primary supervisor for monthly supervision, whereby the researcher could discuss how they were feeling and if anything was impacting their mental wellbeing as a result of their involvement within this research. Keeping the reflective journal (excerpts have been included throughout this thesis) was an important tool for the researcher to step back and reflect on the impact of the process and consider how this might influence subsequent decisions. Reflective journaling has been recognised as a positive coping strategy for researchers (Rager, 2005).

3.5 Participants and Recruitment

3.5.1 Sampling

Participants were recruited through purposive and snowball sampling. Purposive sampling (whereby participants are recruited intentionally as they have specific experience in the area being researched) was considered the most appropriate approach for this research study (Robinson, 2024). This is because it enabled access to a population that can be 'hard-to-reach', while ensuring that the inclusion and exclusion criteria were applied by sharing the recruitment poster with individuals who met these requirements and excluding those who did not (Campbell et al., 2020; Pitman et al., 2014; McDonnell et al., 2022). Snowball sampling

was also used, as it allowed anyone who came across the recruitment poster to share the study information within their networks, helping to reach additional eligible individuals who might not otherwise have been identified (Parker et al., 2019).

3.5.2 Inclusion and Exclusion Criteria

The inclusion and exclusion criteria are outlined in Table 14.

Table 14

Inclusion and Exclusion Criteria for Participant Recruitment

Inclusion Criteria	Exclusion Criteria
Participants must be over the age of 18 years old	The suicide must not have occurred within the past six months.
Participants must identify as a 'self-defined family member' of the person who completed suicide	
Participants must be living in the UK	
Participants must be able to read English; it does not need to be their first language	

Participants were required to be over 18 years old. This research study focused on adults bereaved by suicide, not because children require less support, but because their support needs differ (Auman, 2007). Limiting the sample to adults allowed the questions to

be tailored to their specific experiences and acknowledged the distinct social contexts (such as work and financial commitments, roles within the family, social expectations) that shape adult bereavement.

As in High (2024), this study also recognised that the emotional impact of suicide extends beyond biological relatives. For this reason, any adult who identified as a self-defined family member (i.e. as a close friend) was eligible to participate.

Research has indicated that allowing at least six months to pass after a bereavement gives time for the most acute reactions to lessen, supporting participants' emotional wellbeing and reducing the likelihood of re-traumatisation (Ribeiro et al., 2018; Lindh et al., 2018). More recent work has also demonstrated that providing a longer period for individuals to process their grief can improve data quality, as participants tend to offer more detailed and reflective accounts (Wittkowski & Scheuchenpflug, 2021; Ribera-Asensi et al., 2023). For these reasons, the bereavement must have occurred at least six months ago for individuals to be eligible to participate.

Participants were required to be living in the UK to ensure the findings would be more grounded in the UK's postvention systems, policies, and cultural context, and consequently be positioned to address the research question, which focused specifically on suicide bereavement support within the UK.

3.5.3 Participant Recruitment

Between June and November 2025, the primary researcher contacted 12 charities, organisations, and social media groups across the UK to request their support in circulating the participant recruitment poster (Appendix E). Social media was selected as a recruitment method, as research has reported this to be a successful method for suicide bereavement

research and 'hard-to-reach' populations (McDaniel et al., 2022; Kayrouz et al., 2016). One organisation replied that they were unable to help due to limited staffing, and two others explained that they were currently only supporting recruitment for research taking place within their own services. One organisation confirmed that they had shared the poster and study details in their newsletter and monthly email updates to their readers. Four organisations expressed interest but requested more information before sharing the poster, either in the form of an MS Teams meeting, or wanted the recruitment poster sent in a different size or format for social media distribution. One Facebook support group agreed to share the recruitment poster in their group; their name has remained anonymous. Three organisations did not respond to two contact attempts. Gratitude is extended to the organisations whose support in recruiting participants was essential to the completion of this research: The National Suicide Prevention Alliance, The Ollie Foundation, Lifecraft, Suicide and Co, and Violet Project CIO. The lead researcher decided not to offer monetary incentives to participants in order to avoid unduly persuading individuals who may be experiencing grief-related vulnerability to take part (Surmiak, 2020).

3.5.4 Participant Sample Size

Although this study used a mixed-methods design, a statistical power calculation (a method used to calculate the minimum number participants a study needs to reliably detect an effect, if that effect exists) was not required, as the quantitative data were descriptive rather than inferential, and the study was not designed to test a hypothesis (Browne, 1995; Maxwell et al., 2017; Brysbaert, 2019). The University of Hertfordshire Ethics Committee required this study to provide a minimum and maximum number of participants to be recruited. In order to provide these numbers, the overall decision was made by the lead researcher, following discussions with the research team and consulting the following literature.

When working with qualitative data, it can be accepted that there are enough participants when the data reaches 'information redundancy', and this is likely to be a minimum of 12 participants (Guest et al., 2006). However, as data analysis for this research study did not begin until all the data was collected, data redundancy (sometimes described as 'data saturation') could not be used as the only guide for participant size. To strengthen the scientific justification for the sample size in this study, evidence from a range of peer-reviewed literature and studies have been drawn upon. Malterud et al. (2016) curated a focus on 'information power', meaning *'the more information the sample holds, relevant for the actual study, the lower amount of participants is needed.'* Malterud et al. (2016) proposed a model whereby researchers assess their study across five dimensions in order to justify their sample size. These dimensions, along with an understanding of how they influence sample size, and how these dimensions apply to the current study, are presented in Table 15.

Table 15

Malterud et al. (2016) Dimensions Informing Sample Size

Dimensions of Power	**Influence on Sample Size (general)**	**Influence on Sample Size for the Current Study**
The aim of the study	Narrow → fewer participants Broad → more participants	Narrow → fewer participants The aim of the current study explores a specific experience (suicide bereavement support)
Sample specificity	Specific → fewer participants	Specific → fewer participants

Dimensions of Power	Influence on Sample Size (general)	Influence on Sample Size for the Current Study
	Sparse → more participants	This study is focused on one population (self-defined family members bereaved by suicide). Breuning et al. (2024) conducted a study with a specific population (family caregivers of cancer patients), also using inductive content analysis to identify themes within the data, and utilised 30 participants.
Use of established theory	Applied → fewer participants None → more participants	Applied → fewer participants Suicide bereavement theories, frameworks and research have informed this study.
Quality of dialogue	Strong → fewer participants Weak → more participants	Moderate The study uses a combination of tick-boxes (weak) and open text boxes (stronger), so it is positioned in the middle of this scale.

Dimensions of Power	Influence on Sample Size (general)	Influence on Sample Size for the Current Study
Analysis strategy	Case → fewer participants Cross → more participants	Cross → more participants This study incorporates many accounts of experiences to identify patterns (concepts) across the data. Hagaman and Wutich, (2017) reported that in qualitative research, if overarching themes (or concepts) are to be identified, 20-40 participants are required.

Although this framework does not provide an exact number of participants, it can be utilised to provide justification for the chosen sample size (Malterud et al., 2016).

Taking the framework by Malterud et al. (2016) and guidance from previous researchers into consideration, this study aimed to recruit between 24 (12 per stream) and 60 (30 per stream) participants - 'streams' of participants are described in detail in section 3.6.2. This reflects Guest et al.'s (2006) numerical guidance on the minimum of 12 participants, and takes into consideration recommendations from Hagaman and Wutich, (2017), and Breuning et al. (2024).

3.6 Data Collection

3.6.1 Question Formats

The questionnaire completed by participants in this study was exploratory in nature, with a combination of both open and closed-ended questions, with several closed questions followed by exploratory open-ended follow-up questions, to gather both qualitative and quantitative data (Tracy, 2024; Fadele & Rocha, 2025). The questionnaire used a mix of question formats: Likert-style rating scales (with six response options ranging from *'strongly disagree'* to *'strongly agree'*, including *'neutral'* and *'not applicable'* options), multiple-choice/tick-box items, and open-ended free-text questions. Using a combination of question formats aimed to ensure the questionnaire was able to produce reliable, comparable quantitative data while also capturing the depth, nuance, and contextual detail that structured items alone could not provide (Curry et al., 2019; Dawadi et al., 2021; Fraser, 2024).

3.6.2 Questionnaire Development

The questionnaire items were initially constructed by the lead researcher, before then consulting with the research team and the EbEs. Two of the EbEs supported by reviewing the language and phrasing of the questions, and the other two EbEs supported at a later stage by completing the questionnaire as a pilot run-through to assess how the questionnaire was received, and to assess whether they felt the questions allowed for experiences to be shared.

Previous research suggested that longer questionnaires tended to lower response rates, although the length of a questionnaire did not appear to affect the accuracy of the findings (Kato & Miura, 2021). Sharma (2022) suggested that well-designed questionnaires typically contain no more than 25-30 items. For these reasons, the present study kept the number of

questions *as low as possible,* and below this threshold, while still including enough items to produce data that could adequately address the research question. There were two 'Streams' of questions, dependent if participants had (Stream A), or had not (Stream B), received any support following their bereavement. Stream A consisted of 12 questions, and Stream B consisted of 10; these are further explained in the next paragraph. The questionnaires can be viewed in Appendix J.

All Participants. All participants were presented with the same first two questions. The first question, as previously mentioned, served as a safety check-in question for the participants before proceeding to the next question. The second question represented a branching point within the questionnaire, filtering participants into Stream A, those who engaged in support from a suicide bereavement service, and Stream B, those who did not.

Both streams asked about preferred modes of accessing support (face-to-face, telephone, video call, or a blended remote/in-person approach). A recent study reported that bereavement services experienced both benefits (such as increased access in rural areas, shorter waiting lists, and better engagement from younger people and men) and limitations (such as challenges for some individuals with communication difficulties, older people, and those in deprived areas, which led to decreased engagement from these individuals) with remote support, and that people's preferences differed greatly, influencing whether they engaged and how satisfied they felt (Selman et al., 2025). This made it feel important to explore preferred methods of engaging in suicide bereavement support.

Despite pledges to expand suicide-bereavement support across the UK, there are still no clear national guidelines on *when* this support should be offered (Department of Health and Social Care, 2019). Asking participants about their preferred timing, therefore, felt important, as it aims to ensure that the views of those most likely to use these services

directly inform the shaping of support pathways. Consequently, this closed-ended question was posed to all participants.

All participants were asked how much time had passed since they were bereaved by suicide. The purpose of this was two-fold. Firstly, it was ensuring that none of the responses were provided by participants who had been bereaved by suicide within the past six months, one of the exclusion criteria. Secondly it allowed responses to be considered alongside how experiences of accessing and engaging with support may have changed over time, recognising that individual bereaved at different points may have encountered different support systems, and practices and policies.

Finally, to conclude the questionnaire, all participants were asked a series of demographic questions such as age, gender, geographical location (e.g., Northwest/Southeast) and religion, to address diversity within the participant pool.

Stream A Participants. Stream A questions focused on what support participants had received, how they accessed it, how well it met their needs, and what shaped their experience of using the services. It explored the types of support offered, whether it was provided proactively or found independently, participants' views on its effectiveness, any barriers they encountered, and which elements they considered helpful or unhelpful. To explore the barriers and challenges that existed, several questions were informed by, and subsequently adapted from, established research questionnaires such as those by Clement et al. (2012) and Heath (2020).

Stream B Participants. Stream B questions explored whether support had been offered, reasons for not engaging, how beneficial support was perceived to be, whether participants sought help independently, what barriers they encountered, and their views on how support could have influenced their wellbeing or eased difficulties after the

bereavement. It also asked participants to suggest improvements or additional types of support that should be available in the future.

3.6.3 Questionnaire Procedure

All participants accessed the questionnaire, hosted on the Qualtrics platform, using the same link, either by clicking directly on the link or by scanning the QR code on the recruitment poster (Appendix E). After reading the Participant Information Form (Appendix F) and providing their consent to participate, participants were asked the aforementioned safety question *('Before we begin, we want to make sure you're comfortable. Do you feel you are in a safe and appropriate environment to share your experiences today?')*. Participants who selected 'no' were redirected to support services rather than continuing with the questionnaire. Participants who selected 'yes' moved on to the second 'branching' question ('*After you were bereaved by suicide, did you engage in support from a suicide bereavement service at any point?').* Participants who selected 'yes' were led to the questions for Stream A, and those who selected 'no' were led to Stream B questions.

Participants in Stream A (participants who did receive support following their bereavement) were presented with a total of 12 questions. Nine of these questions were collecting purely quantitative data, two were collecting only qualitative data, and one question collected both quantitative and qualitative data (by a closed-then-open question, e.g. *'Would you recommend the suicide bereavement support service you accessed to others? Yes/No, Why?'*).

Participants in Stream B (participants who did not receive support following their bereavement) were presented with a total of 10 questions. Five of these questions collected only quantitative data, one collected only qualitative data, and four collected both quantitative and qualitative data.

After answering the respective Stream-specific questions, all participants were asked demographic questions, including their age, gender, geographic location and their religion. Finally, participants were provided with a debrief sheet (Appendix A), including signposting to relevant services.

Chapter Four: Findings

4.1 Chapter Overview

This chapter provides the findings derived from the mixed-methodology analysis, outlined in Chapter Three. Unless otherwise indicated, all participants responded to the questions associated with the findings reported. For sections involving content analysis, the 'occurrences' presented reflect the number of instances in which relevant concepts appeared across the dataset for each corresponding question. Where illustrative quotations have been included, ellipses ("…") denote the removal of non-essential wording for clarity, and square brackets ("[ ]") indicate the replacement of personal names to preserve the participants' and their families' anonymity. In keeping with the American Psychological Association (APA) 7 guidelines, percentages are reported as whole numbers, whilst other forms of descriptive statistics (such as means and standard deviations) have been reported to two decimal places (American Psychological Association (APA), 2019).

4.2 Data Cleansing

A total of 60 people visited the questionnaire. Prior to conducting the analysis, the lead researcher completed data-cleansing. This step was essential because data-cleansing has been shown to enhance the accuracy and overall reliability of the dataset by identifying and correcting errors, resolving inconsistencies, and addressing missing information (Ridzuan & Zainon, 2019; Rahm & Do, 2000). During this stage, nine participants were excluded from the analysis because they had substantial missing data, having exited the questionnaire immediately after completing the informed-consent section. An additional five participants were removed after selecting *"I'll come back later"* in response to the safety check-in question that followed the consent process. This resulted in a total of 46 participants whose data were included in the analysis.

4.3 Participant Demographics

Of the 46 participants, 42 described themselves as female (Stream A: n = 27; Stream B: n = 15), three as male (Stream A: n = 2; Stream B: n = 1), and one participant declined to answer.

Across all participants, they ranged in age from 22 to 72 years old, the mean age was 45.36 years old, and the median age was 46 years. In Stream A, participants ranged from 22 to 72 years old, the mean age was 45.69 years old, and the median age was 47 years. In Stream B, participants ranged from 25 to 65 years old, the mean age was 42.69 years old, and the median age was 39 years.

The participants' relationships with the individuals who died by suicide included:

- Their spouse, n = 6 (Stream A: n = 2; Stream B: n = 4)
- Their parent, n = 12 (Stream A: n = 10; Stream B: n = 2)
- Their child, n = 11 (Stream A: n = 9; Stream B: n = 2)
- Their sibling, n = 12 (Stream A: n = 6; Stream B: n = 6)
- Extended family (including grandparents and in-laws), n = 2 (Stream A: n = 1; Stream B: n = 1)
- Close friend, n = 3 (Stream A: n = 1; Stream B: n = 2).

Participants responded from across the UK, with two choosing not to share their geographic location. To protect anonymity in areas with lower response rates, neighbouring regions were grouped together. Tables 16 and 17 present the distribution of respondents by geographical region and their religious affiliation. When selecting religion, four participants chose the '*other'* option and specified 'Spiritualism', and thus this is reflected in the table.

Table 16

Participant Demographics - Geographic Region

Location	Stream A	Stream B	Total
England – South (East and West, including London)	15	8	23
England – Midlands (East and West)	6	5	11
England – North (East and West)	1	5	6
Wales	2	1	3
Scotland	0	1	1
Prefer Not to Say	1	1	2

Table 17

Participant Demographics - Religion

Religion	Stream A	Stream B	Total
Christian	8	4	12
Muslim	0	1	1
No Religion	18	9	27
Other – Spiritualism	3	1	4
Prefer Not to Say	0	2	2

Most participants resided in the South of England (50%), with the remaining half located across other regions of the UK. The majority of participants reported having no religious affiliation (59%). The most common relationships to the person who died by suicide were parent (26%) and sibling (26%), followed closely by child (24%).

Time Since Bereavement by Suicide. Overall, most participants reported being bereaved between 1 and 5 years ago (55%), with smaller proportions in both groups experiencing more recent or more distant bereavements. Stream B (those who had not accessed support) contained a higher proportion of participants bereaved 6–10 years (20%) and more than 10 years ago (20%) compared with Stream A (4%; 7% respectively). These findings are reported in Table 18.

Table 18

Time Since Bereavement by Suicide, Presented as Percentages

Time Since Bereavement by Suicide	Stream A	Stream B	Total (weighted per cent)
6 months – 1 year	26%	20%	24%
1 – 5 years	63%	40%	54%
6 – 10 years	4%	20%	10%
More than 10 years	7%	20%	12%

Note. Three participants within Stream B declined to answer this question and thus the reported percentages exclude this missing data.

4.4 Stream Branching and Support Offering

59% of participants had engaged in some form of support following their bereavement (Stream A participants), with just 22% of these being offered the support and the remaining 78% searching for the support themselves. Of the 41% of participants who did not receive any support (Stream B participants), 21% were offered support but did not engage. Reasons provided for not engaging in support were due to not meeting the eligibility criteria of the support service, such as not being a '*first degree relative*', or feeling as though the support was offered to soon after their bereavement. When Stream B participants were asked *'On a scale of 0 to 10, how helpful do you think it would have been to receive support after your*

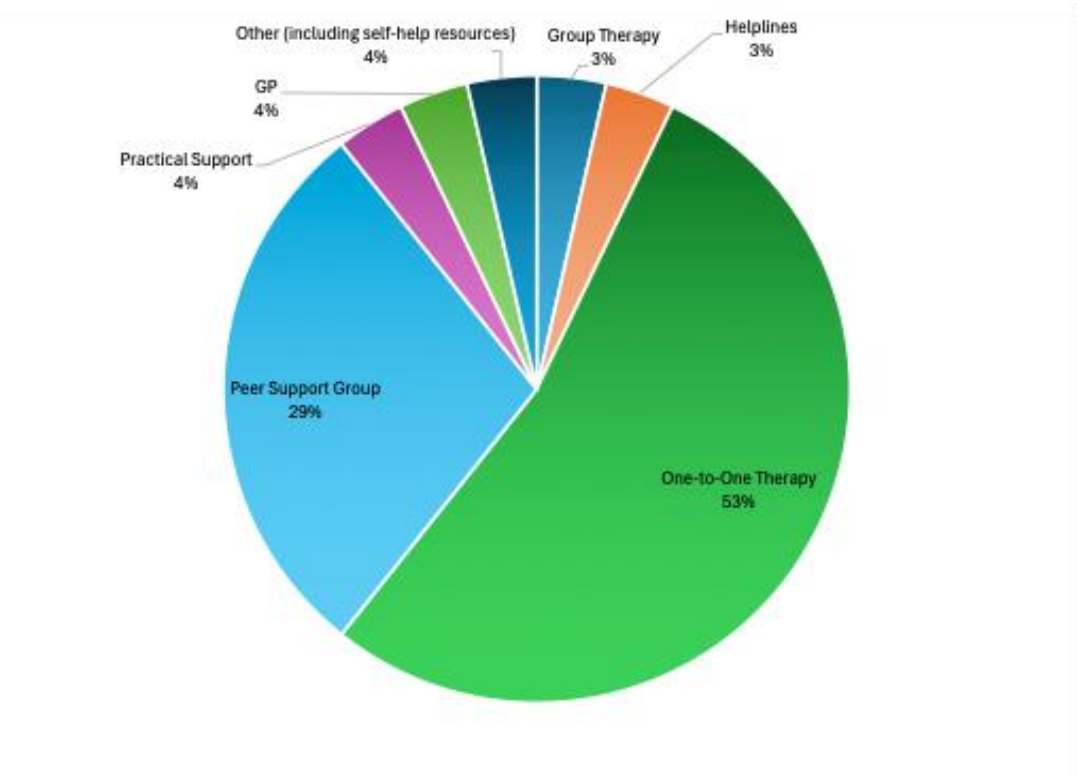
bereavement? (10 being most helpful)', responses ranged from 0 to 10, the mode was 10, and the mean was 7.26 (SD = 2.99).

Type of Support. 82% of Stream A participants received support from a third-party organisation, 7% from the NHS, 7% shared they received support from other services (such as the police, and private therapy), and 4% were unsure of who provided the support.

Of the participants who had support, 63% received it from multiple sources. These participants were asked to select the one support option they felt best met their needs at the time. Figure 2 presents the type of support participants referred to when answering the remaining questionnaire items.

Figure 2

Type of Support Stream A Participants Received and Completed Questionnaire Items Based Upon



Just over half of the participants (53%) in Stream A reported on one-to-one therapy that was best able to meet their needs at the time of their bereavement, while just under a third (29%) reported on a peer-support group. The remaining forms of support, whilst being reported to meet needs, were used less frequently, with each accounting for approximately 3-4% of responses.

4.5 Experience of Engaging in Support.

All results reported in section 4.5 were derived from responses from Stream A participants (those who received support).

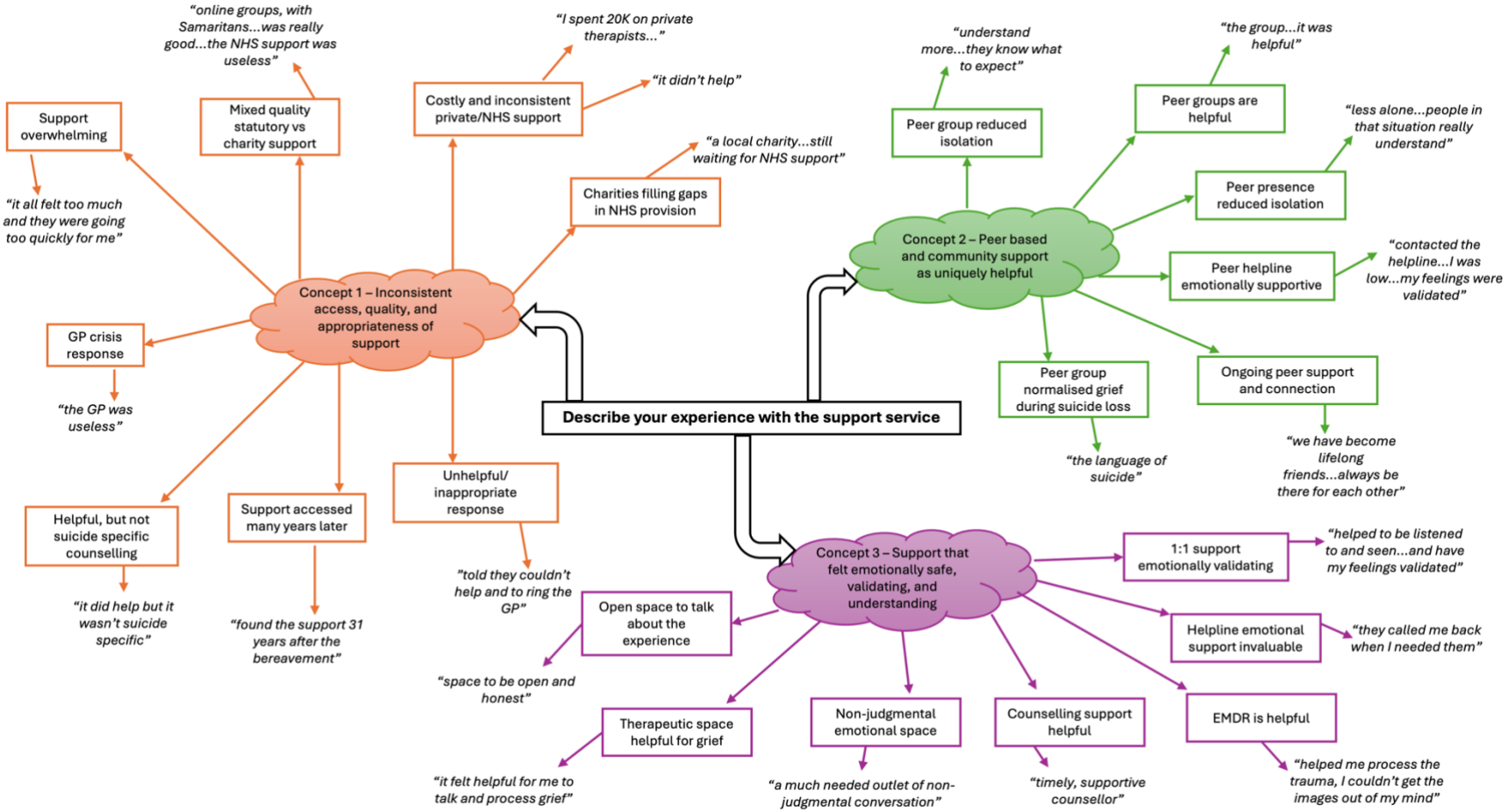
89% of Stream A participants provided responses on how much they felt the support met their needs at the time, from a scale of 1 to 10 (being the most). Answers ranged from 1 to 10, the mode was 10, and the mean was 7.71 (SD = 2.82).

89% of the participants would recommend the support service they used to others, the remaining would not.

When participants were asked to broadly describe their experience with the support service, three overarching concepts were identified and developed; these are illustrated in Figure 3 as a concept map. These are then described in depth. Please see Appendices K and L for a breakdown of concept and code development by the lead researcher, from the raw data.

Figure 3

Concept Map



1) Inconsistent access, quality, and appropriateness of support (nine occurrences) -

Experiences of accessing and receiving support varied amongst participants. Access to support appeared frequently as a barrier, with issues such as long NHS waiting lists, lack of suicide-specific provision, and being redirected at moments of distress: *"the NHS was absolutely rubbish…I'm still on the waitlist…10 months ago.", "told they couldn't help and to ring the GP",*

2) Peer-based and community support as uniquely helpful (six occurrences) -

Participants highlighted the sense of understanding and connection that came from interacting with others who were bereaved by suicide: *"only people in that situation really understand."* Participants explained that peer support groups helped them feel *"less alone."* Structured peer groups were frequently mentioned as invaluable support for understanding *"the language of suicide"* and *"understanding more about inquests and what to expect."* Participants also reflected on the benefits of informal peer-support, having described forming long-term friendships: *"we have become lifelong friends…we will always be there for each other"*. There were, however, two references which described mixed experiences and feeling overwhelmed by hearing others' grief: *"the second session was too sad for me…I felt I couldn't truly open up"* and *"listening to others…it was sometimes too much"*.

3) Support that felt emotionally safe, validating and understanding (eight

occurrences) – Participants emphasised the importance of being able to speak openly about their loss and feeling heard. Support was described as *"a much-needed outlet of non-judgemental conversation"* and *"dedicated time and space to think about the person I've lost and express how I feel."* Emotional validation also felt central, with one participant who noted *"it really helped to be listened to, seen and have my feelings validated by someone who*

understood". Furthermore, specific therapeutic support was also described positively, such as a participant explaining that EMDR (Eye Movement Desensitisation and Reprocessing) *"helped me process the trauma…I couldn't get the images out of my mind"* and others valuing regular one-to-one therapy sessions, describing them as *"timely," "supportive"* and *"giving me space to be open and honest."*

Through the analysis of the data generated from asking participants what they found helpful or unhelpful about the support they received, the researcher constructed three key concepts.

The most frequently reported concept was the value of specialist, understanding and non-judgemental support (18 occurrences). Participants described the most helpful support as that coming from individuals with suicide-specific knowledge or lived experience, offering a safe and confidential space to talk openly (*"space to delve into your real experiences… without fear of being judged"*), and providing consistent, compassionate listening (*"found [name of organisation] non-judgemental and highly supportive"*).

The second concept was situated around the extent to which support following suicide bereavement reduced isolation and created meaningful connections with others (14 occurrences). Participants frequently highlighted that meeting others with shared experiences of suicide bereavement, being able to talk freely, and feeling understood helped reduce the loneliness of suicide bereavement (*"it made me feel less alone in a journey that felt incredibly lonely and isolating."*).

The final concept was the inconsistencies or negative experiences within support services (seven occurrences). There were descriptions of support being unhelpful or distressing, including breaches of trust (*"they abused my trust in a vulnerable time,")* feeling ignored or unsupported (*"I was sat alone the whole time and felt worse when I left")*, and

receiving support that was not suicide-specific or appropriate (*"a counselling service…but the information given was not always appropriate or helpful"*).

These concepts indicated that participants found the most helpful support was specialist, understanding, and non-judgemental, particularly when it reduced the isolation of suicide bereavement and fostered meaningful connections with others, whereas unhelpful experiences stemmed from inconsistencies in support, feeling ignored, or receiving support that was not suicide specific.

4.6 If Stream B Participants Had Received Support.

Sixty per cent of Stream B participants felt that receiving support could have impacted their wellbeing following their bereavement (34% were unsure; 7% did not think it would have impacted their wellbeing).

When asked to provide more information on whether receiving support might have impacted their well-being following their bereavement, two clear concepts emerged: needing support but not knowing where to go, and the absence of support contributing to greater isolation and reduced understanding surrounding the death.

The first concept, reflecting needing support but not knowing where to go, was often intensified by being in shock. 57% of participants described uncertainty about how to access support: *"I didn't know where I could go, who I could ask…"*); whilst some described being in *"deep deep shock"* whilst they were seeking support. Other participants reported actively seeking support but being turned away: *"having doors closed to me…at a time when I was desperate for support."*

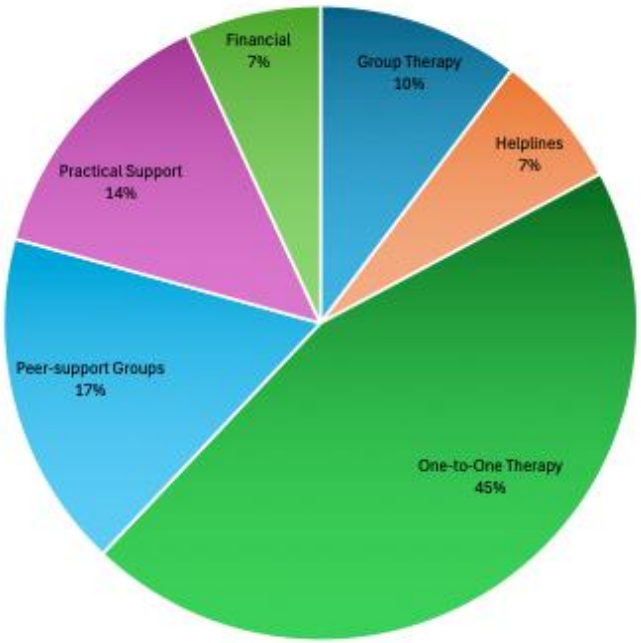
The second concept related to how the absence of support contributed to greater isolation and reduced understanding surrounding the death. Participants explained that support could have helped them "*feel less alone"* and how it might have helped them *"understand the choice that my [family member name] made."* These two concepts suggested that participants felt support could have positively influenced their well-being, but that both emotional and structural barriers limited access to the support.

73% of participants in Stream B believed that receiving support could have alleviated some of the difficulties they experienced following their bereavement (the remaining 27% did not believe it would have helped).

Furthermore, Stream B participants were asked, *"What type of support do you think would have been most beneficial for you?"*; their responses are presented in Figure 4. Similar to Stream A, one-to-one therapy was the most frequent response, accounting for 45%, followed by peer-support groups (17%), practical support (14%), group therapy (10%), financial support (7%), and helplines (7%). Given the similarity in preferences for the type of support between Stream A participants and Stream B participants (Stream A one-to-one support: 53%; Stream B one-to-one support: 45%), this may suggest that people have a good sense of what support would benefit them, even if they have not accessed support themselves.

Figure 4

Type of Support Stream B Participants Would Have Wanted



4.7 Challenges with Accessing Support.

Stream A Participants. When exploring which factors made accessing support feel most challenging for those in Stream A, the most frequently reported challenge was a *lack of knowledge about what services were available*. The next most commonly selected barrier, based on the proportion selecting *Agree* and *Strongly Agree*, was *stigma surrounding suicide* and the third most commonly selected was *uncertainty about how effective the service would*

be. The percentages for these are presented clearly in Table 19, and a full breakdown of participant responses for all proposed challenges can be seen in Appendix M.

Table 19

Most Agreed-Upon Challenges to Accessing Support Among Participants Who Received Support (Stream A)

Factor	Strongly Agree (as a percentage)	Agree (as a percentage)	Total (as a percentage)
Lack of knowledge of what services are available	52%	33%	85%
Stigma surrounding suicide	52%	26%	78%
Uncertainty about the effectiveness of the service	22%	56%	78%

Stream B Participants. 32% of participants sought out support but this did not lead to engagement with that provision. Participants did not provide reasons for why this did not lead to receiving support when asked directly; however, some responses in other parts of the questionnaire offered insights that may relate to barriers to accessing support (such as in section 4.6: "*having doors closed to me…at a time when I was desperate for support*).

4.8 Improvements to Support Services.

In order to consider what improvements could be made to support services, informed by those with lived experience of suicide bereavement, Stream A participants were asked *'What improvements to the support offered or additional types of support do you believe would benefit others bereaved by suicide?'* and Stream B were asked *'What improvements to existing support provisions, or different types of support do you think should be made available to people bereaved by suicide in the future?*.'

Although one set of data came from Stream A participants and one set from Stream B, the analysis produced the same four core concepts across both groups:

1) Access, Timeliness and Availability
2) First-contact Response and Signposting
3) Suicide-specific and Tailored Support
4) Peer Support and Support Format Improvements

The consistency of these concepts, as evidenced in Table 20, strengthened the evidence that these concepts reflected shared system-wide needs for support amongst people bereaved by suicide.

Table 20

Occurrences of Concepts Amongst Participants

Concept	Stream A Occurrences	Stream A and B Occurrences
Access, Timeliness and Availability	10	14
Signposting and First-contact Response	6	12
Suicide-specific and Tailored Support	9	12
Peer Support and Support Format improvements	9	10

The most frequent concept was access, timeliness and availability of support. Participants described long waits for therapy and inconsistent provisions across the regions. Many felt overwhelmed by the effort required to receive support at a time of distress: it would be beneficial during bereavement *"not having to search so hard for help,"* whilst others described having to wait too long: *"10 months and still waiting for NHS bereavement therapy…it's just not good enough."* Others emphasised the need for affordable therapeutic options and follow-up around significant dates, such as *"follow up on the first anniversary or a birthday would be amazing."* Some also highlighted the emotional impact of delayed or absent support, explaining, *"I couldn't cope…I was completely lost at that point with no support."*

The second concept that emerged surrounding recommendations was focused on signposting and first-contact response (professionals who might be present or contactable in the immediate aftermath of a suicide bereavement). Participants highlighted perceived gaps in police practice, noting that officers often did not offer guidance or resources, with one participant stating, *"Police should have provided a list of organisations that can offer support."* Others described dismissive or unhelpful interactions with health professionals, including being told by a GP, *"What do you expect me to do?"* and another recalling that the GP *"gave me sleeping tablets and a leaflet…that was it."* Participants also emphasised the need for practical guidance on coronial or court processes, explaining that *"support on the process… would have been very beneficial."* This suggests clearer information, better communication and more compassionate first-contact responses from police and health professionals might help reduce the confusion, the stigma, and isolation people experience in the immediate aftermath of a suicide bereavement.

Participants also expressed a need for suicide-specific and tailored support. Many felt that generic bereavement services did not meet their needs, emphasising that suicide loss carries unique emotional, social and relational challenges. With participants stating that *"there needs to be specific support for suicide bereavement…you are treated like you failed as a parent,"* and *"that lady was useless, she was a general therapist that mainly dealt with relationship counselling,"* while another explained the emotional complexity of the experience, saying *"it needs to be very gentle…you are looking for answers you won't find."* This tailored support might also reflect relationship-sensitive support, with some participants calling for support tailored to siblings, parents, partners or young children, and some highlighting barriers to support such as next-of-kin rules: *"being able to access services even when not a first-degree relative…would have prevented my own crisis"* and *"[they] were married but separated, I was his mum but not next of kin….I was completely ignored."*

These reflections point to the importance of specialist provision that recognises the distinct nature of suicide grief, the different ways it affects relatives, and the nebulous definition of 'next of kin' which can act as an inclusion/exclusion criterion for access to support.

The final concept that developed following analysis was peer support and support format improvements. Participants highlighted the value of connecting with others who have experienced suicide bereavement, and how this can be present in various ways. One participant shared, *"I would have benefited from having a lived-experience buddy initially,"* whilst other participants focused more on better facilitation of peer-support groups: *"more mediated peer-led support groups…more guidance."* Other participants emphasised the importance of practical help, such as *"practical help with moving things…it was difficult and expensive,"* and made the request for face-to-face support, *"it's strange to talk about it over the phone.*" Participants felt they wanted support that was better facilitated and offered in formats that felt more appropriate to their needs.

Format of Accessed Support. All participants were asked various questions regarding their preferred format of support. In Stream A, over half of respondents (51%) selected a preference for face-to-face support, followed by combining face-to-face and remote provision (41%). In contrast, participants in Stream B most commonly preferred a combination of face-to-face and remote support (53%), with face-to-face support as the next most selected option (26%). A breakdown of responses, presented as percentages, is provided in Table 21.

Table 21

Percentage Breakdown of Support Format Preferences Amongst Participants

Format of Support	**Stream A: *'How was your support offered?'***	**Stream A: '*What would be your preferred way of accessing support?'***	**Stream B: *'How would you want support to be provided?'***
Face-to-face	48%	51%	26%
Video Call	19%	4%	21%
Telephone	7%	4%	0%
Combination of face-to-face and remote	26%	41%	53%

Timing of Support. All participants were asked to indicate when they felt support should be provided following a suicide bereavement. Across both streams, those who had received support and those who had not, there was general agreement that support should be offered within the first 0–6 months after the loss (Stream A: 82%; Stream B: 53%). However, participants who had not received support also expressed a preference for support to be available at later time points than those who had received support (such as 13 - 18 months post-bereavement). No participants felt that support should wait more than a year and a half after the bereavement. A breakdown of responses, presented as percentages, is provided in Table 22.

Table 22

Percentage Breakdown of Timing of Support Preferences Amongst Participants

Timescale	**Stream A: *'How soon after your bereavement did you start receiving support?'***	**Stream A: '*How soon after your bereavement would you have liked to receive support'***	**Stream B: *'How soon after bereavement do you think support should be offered?'***
0 – 6 months	79%	82%	53%
7 – 12 months	7%	18%	34%
13 – 18 months	7%	0%	13%
19 months +	7%	0%	0%

Chapter Five: Discussion

5.1 Chapter Overview

This chapter opens by providing essential contextual information to help frame the interpretation of the study's results. It then positions these findings within the wider literature. Following this, the chapter explores the main strengths and limitations of the study. It proceeds on to outline the clinical implications and potential avenues for future research that arise from the study, before concluding with a critical evaluation of the study as a whole.

5.2 Interpreting the Findings

This research utilised a mixed-methodology approach to answer the research question:

What support do self-defined family members bereaved by suicide want, and would engage in?

In line with the theoretical positioning outlined in Chapter One, the findings from this research have been interpreted through the lenses of critical realism and social constructionism. As such, the experiences described by participants have been understood as stories that illicit both the wider factors influencing suicide bereavement support, and the personal ways people make sense of their loss. In this approach, the narratives shared by participants have been shaped by cultural views of suicide, the relationships and settings in which bereavement occurs, and the systems that affect access to support. This perspective recognised the emotional, social, and practical impacts of suicide bereavement, while also

acknowledging that how participants described these experiences was shaped by the norms and conventions that influence how suicide bereavement is spoken about.

The research question was addressed with findings derived from quantitative descriptives and qualitative concepts (through inductive conceptual content analysis). To provide an in-depth discussion of the key areas identified as shaping the participants' experiences of support following suicide bereavement, what support they want to see and would engage in, this discussion has been structured with the following thematic sections:

1) Conditions Shaping Access to Support
2) Early Interactions and the Construction of Meaning
3) The Need for Suicide-Specific Support
4) Peer Support as a Space for Shared Understanding and Connections
5) Preference of Format and Timing of Support

5.3 Situating the Findings within Existing Literature

5.3.1 Conditions Shaping Access to Support

Previous studies have highlighted that access to support for people bereaved by suicide requires improvement, particularly through proactive outreach and clearer pathways into support (Pitman et al., 2017; Pitman et al., 2018). Yet the findings from this research suggest that these recommendations have not translated into practice. Participants' experiences of long waiting lists, regional inconsistencies, and the emotional effort required to navigate services may reflect wider structural pressures within bereavement support and mental-health systems (Punton et al., 2022; Selman et al., 2023). These systemic constraints can create environments where support is technically available but practically difficult to

reach, placing the burden of coordination and persistence on individuals at a time when their emotional and cognitive resources may already be depleted (Zisook & Shear, 2009). This was reflected in the finding that 82% of participants received support from third-sector organisations or charities, compared with just 7% who accessed NHS provision, suggesting that statutory services were not positioned to offer equitable or timely support to those bereaved by suicide. This pattern also sat uneasily alongside national policy commitments, as mentioned in Chapter One; the NICE Suicide Prevention Quality Standard (QS189) (2019) stated that *"personalised bereavement support will be available on the NHS in England to care for people after a relative or friend's suicide."* Yet, six years on, this did not appear to be reflected in practice. Given that 89% of participants who received support had been bereaved between six months and five years ago, they represented the very cohort who should have been able to access NHS-delivered postvention support, but the data suggested that this was not occurring.

Furthermore, this research focused on 'self-defined' family members, reflective of the understanding previously outlined, recognised in the NICE Suicide Prevention Quality Standard (QS189) (2019), and specified by High (2024), that the emotional impact of suicide bereavement extends beyond direct biological relatives. On this basis, any adult who defined themselves to be as close as family was eligible to participate. Although this approach aimed to be inclusive, the findings showed that restrictive and traditional definitions of "family" continue to shape access to support. Next-of-kin rules acted as barriers to care, with participants explaining that *"being able to access services even when not a first degree relative…would have prevented my own crisis"* and *"[they] were married but separated, I was his mum but not next of kin…I was completely ignored."* These experiences echo findings from McDonnell et al. (2022), which emphasised that *"postvention efforts need to acknowledge the death of a friend by suicide as a significant loss."*

Some participants described receiving no support at all following the suicide, despite actively seeking help. A participant reflected, *"I was completely lost at that point with no support."* Their description illustrated how the absence of support can leave individuals emotionally unsettled at a time of acute vulnerability. The Meaning Reconstruction Model helps to explain this experience: the model emphasises that people bereaved by sudden or violent deaths often depend on relational and narrative scaffolding to help them make sense of the loss and begin rebuilding coherence in their lives by reconstructing meaning (Neimeyer, 2001; Gillies & Neimeyer, 2006). When barriers, such as lack of knowledge of what services are available, long waits, or strict exclusion criteria, prevent individuals from accessing support, they are effectively left to navigate this meaning-making process alone. This may result in individuals remaining in a place of uncertainty or unresolved meaning, which the Meaning Reconstruction Model suggests could heighten vulnerability to complicated or prolonged grief (Neimeyer, 2019). This also connects with the research, discussed in Chapter One (section 1.5.1), that individuals bereaved by suicide are more likely to attempt suicide themselves than individuals bereaved by other means, and thus without adequate service provisions, complicated and prolonged grief can be fatal for those bereaved by suicide (Cerel et al., 2016; Pitman et al., 2016; Young et al., 2012; Wilson et al., 2020). This highlights that the conditions shaping access to support not only influence service uptake; they actively shape the psychological environment in which those bereaved by suicide attempt to process and interpret their loss.

This theme, along with existing literature and frameworks, showed that what self-defined family members bereaved by suicide want from support, and what they feel able to engage in, are connected to the conditions that shape their access to support. Participants' preferences did not emerge in silo; they were formed in response to the awareness of, availability, and responsiveness of the systems they encountered. For many, long waits,

inconsistent provision, or the absence of coordinated support pathways meant that even when they actively sought help, it was simply not accessible to them. Others were pushed towards third-sector or private organisations because these were the only providers offering immediate or meaningful support, though these were still not without some barriers (such as who could access the support). The theme of *Conditions Shaping Access to Support* directly presents what participants wanted and would engage in: support that is timely, clearly signposted, and without barriers to access.

5.3.2 Early Interactions and the Construction of Meaning

Participants' accounts of their first interactions with police, GPs, and other professionals demonstrated that these early encounters played a central role in shaping how they began to understand the suicide and their place within the time immediately afterwards. Taking a social constructionist lens, these initial experiences and interactions were framed by the understanding that meaning was not generated independently, but was co-constructed through social interactions, institutional practices, and the language used by others (Burr, 2015).

For some participants, the absence of guidance or signposting from the police may have communicated a powerful message about the visibility and legitimacy of their grief. Practical support was the third most frequently requested support type in this research study from participants who did not receive support, and just 4% of participants who did receive support shared their experiences of it. One participant explained that *"Police should have provided a list of organisations that can offer support",* illustrating how silence or omission from the police constructed suicide bereavement as something individuals were expected to navigate alone. This reflected wider findings that institutional 'non-response' could reinforce feelings of marginalisation among people bereaved by suicide (Peters et al., 2016). Similarly,

dismissive or minimising responses from health professionals, such as being told by a GP, *"What do you expect me to do?"* and being given *"sleeping tablets and a leaflet",* did not merely reflect a lack of resources but shaped participants' interpretations of their own needs. This demonstrated how institutional language and behaviour constructed grief as a private, medicalised issue rather than a relational trauma requiring coordinated support. These findings echoed concerns raised in previous research that GPs felt undertrained to support people bereaved by suicide, with Foggin et al. (2016) suggesting greater support and training for GPs supporting those bereaved by suicide, including evidence-based-theory driven approaches.

Additionally, when participants described experiences such as *"support on the process… would have been very beneficial"* in relation to court or coronial procedures, this may have highlighted the absence of a shared narrative of support. Police Family Liaison Officers (FLOs), offering connection to relevant support services (such as Victim Support) and direction on processes, do exist when the police have been involved at the scene of some deaths, such as road-traffic accidents; however, it is not currently routinely in place for deaths by suicide (National Police Chiefs' Council (NPCC), 2020). Without the clear and compassionate communication that participants were seeking, they were left to construct their own meaning in a vacuum, potentially just drawing on culturally available narratives surrounding suicide bereavement, of guilt, stigma, and confusion (High, 2024; Wertheimer, 2013; Alves Anet et al., 2026).

Early Interactions and the Construction of Meaning was a permeant theme within the findings of this research study. When initial responses from police or healthcare professionals were absent, unclear, or dismissive, participants described feeling unsupported and unsure how to navigate their bereavement. These early encounters, therefore, had an impact on the

support, if any, the participants engaged in. The findings suggest that self-defined family members bereaved by suicide want early professional contact to be validating, informative, and to offer practical guidance.

5.3.3 The Need for Suicide-Specific Support

The findings from this research study highlighted that generic bereavement support services do not meet the distinct emotional and relational challenges that can be associated with bereavement by suicide. These findings align with existing research that, as discussed in Chapter One: Introduction, explains that suicide bereavement is distinct from other forms of bereavement, often characterised by heightened guilt, stigma, shame, and a feeling of being judged by others (including by professionals) (Pitman et al., 2014; Pitman et al., 2016; Alves Anet et al., 2026). This was echoed by participants in this study who described being *"treated like you failed as a parent."*

Bjornsdottir et al. (2024) emphasised that those bereaved by suicide are confronted with profound meaning-making and existential questions that cannot be answered because the person who could answer them has died. This dynamic reinforces findings from this research study, when participants described that the support *"need(s) to be very gentle…you are looking for answers you won't find."* This unresolved questioning is more common in suicide bereavement than in some other natural forms of bereavement, where the circumstances of the death are clearer (Bottomley et al., 2018; Castelli Dransart, 2013). This questioning, one aspect associated with 'complicated grief', is also more significant in those bereaved by suicide than those experiencing complicated grief due to other reasons, including sudden deaths/accidents (Shear & Shair, 2005; Tal et al., 2016). The combination of unanswered 'why' questions, challenged assumptions about the world, the emotional intensity surrounding suicide, heightened by the intentionality or perceived volitional nature of the

death, distinguishes suicide from most other types of death that are expected, accidental, or medically explained (Bellet et al., 2018; Castelli Dransart, 2013; Jordan & McIntosh, 2011). This therefore helps explain why generic bereavement support is not what is being asked for by those bereaved by suicide, and instead why something more specific and attuned to the distinctive features of suicide bereavement is required.

A further dimension of suicide-specific support highlighted by participants was the need for proactive follow-up around significant dates, with one participant describing *"follow-up on the first anniversary or a birthday would be amazing."* The ongoing, cyclical re-emergence of emotional distress around anniversaries (birthdays, date of death, inquests, and other emotionally charged milestones) when experiencing suicide bereavement can feel more intense than other forms of bereavement, due to the previously mentioned reasons (unanswered questions, stigma, etc.) as well as the traumatic imagery and potential sense of preventability (Feigelman et al., 2009; Quayle et al., 2023). Thus, suicide-specific support that incorporates proactive check-ins on these dates reflects the specific needs of those bereaved by suicide. However, it is worth acknowledging evidence stating that, despite the overall heightened risk of self-harm and suicide among those bereaved by suicide, this risk does not necessarily intensify at key dates such as anniversaries or birthdays (Pitman et al., 2023).

The findings from this study indicate that those bereaved by suicide have a *need for suicide-specific support* which is closely attuned to the unique emotional journey of suicide bereavement. The participants emphasised the importance of '*gentle'* support delivered by practitioners who understand the complexities of suicide bereavement and do not reproduce feelings of judgement. Participants also expressed a desire for proactive contact, particularly around emotionally significant dates. Thus, these findings suggest that those bereaved by

suicide would prefer to engage with support that is specialised, compassionate, anticipatory, and grounded in an understanding of the distinctive challenges of suicide bereavement.

5.3.4 Peer Support as a Space for Shared Understanding

Both the qualitative and quantitative data from this research identified peer support as a particularly meaningful form of support following a suicide bereavement. Peer support was the second most commonly used form of support (29%) among those who engaged in support, and the second most frequently selected option of support wanted (17%) among those who had not engaged in any support but indicated what they would have wanted, both following one-to-one therapy as the number one option. Participants' comments that *"only people in that situation really understand"* and requests for a *"lived-experience buddy",* illustrated how peer spaces can offer a form of recognition. Participants voiced a desire for relational spaces where the complexities of suicide bereavement can be shared without fear of judgement, thus enabling individuals to articulate experiences that may feel unspeakable elsewhere, including navigating inquests or *"the language of suicide."* These findings reflect the existing body of research, which suggests that peer support groups following a bereavement by suicide positively impact individuals by reducing isolation, stigma, self-blame, grief symptoms, and increasing their self-worth, overall well-being and feeling connected to others (Bartone et al., 2017; Higgins et al., 2022; High, 2024). These benefits of peer support groups also connect with the Dual Process Model of Coping with Bereavement (DPM; Stroebe & Schut, 1999). The DPM explains that an individual processing grief oscillates between two stressors - loss and restoration-oriented, meaning that at some points the individual confronts their grief and at other times avoids it (Stroebe & Schut, 1999; Stroebe & Schut, 2010). Peer groups may help restore this balance by offering a space for loss-focused expression while simultaneously supporting restoration-oriented coping through

shared practical knowledge and developing new social connections (Barlow et al., 2010; Bartone et al., 2017; Ali & Lucock, 2020; Higgins et al., 2022). Participants' descriptions of forming *"lifelong friends…we will always be there for each other"* demonstrate how peer relationships can support reconnection and adjustment after suicide bereavement.

Alongside these benefits, a few participants noted moments of emotional overload, such as a peer support session being *"too sad"* to engage with. This aligns with the DPM, which emphasises that sustained immersion in grief (remaining in the loss-focused space) without opportunities to step back can be difficult to navigate (Stroebe & Schut, 1999). These experiences point to the value of well-designed, sensitively facilitated peer groups, which was echoed in participants' requests for *"more mediated peer-led support groups…more guidance."* Research has shown that when peer group facilitation is lacking, the group processes can become unbalanced, with issues such as limited oversight of online discussions, unaddressed distress in the group, dominant members monopolising discussions, consequently reducing the sense of safety and prompting some individuals to disengage entirely (Feigelman et al., 2008; Bailey et al., 2017; Higgins et al., 2022).

Peer Support as a Space for Shared Understanding was clearly identified as a form of support that participants wanted, with many describing it as a place where their experiences felt recognised. Similarly, for those who did not engage in support, it was a space that they reported wanting. With that said, participants' accounts showed that peer support is most valued when it is appropriately and sensitively facilitated. Overall, the findings point to a strong desire for peer-based support that offers genuine connection while being guided in ways that keep the space safe and supportive.

5.3.5 Preferences of Format and Timing of Support

Participants also shared their preferences on how support should be offered. Participants who engaged in support shared that they would prefer face-to-face support (51%), with the second most preferred option being a combination of face-to-face and remote support (41%), whilst the participants who did not engage in support selected the combination (face-to-face and remote) as their first preference for support (53%) and face-to-face as their second preference (26%). The differences in preference on how support should be offered between those who did and did not engage in support might suggest that previous experiences with support shape preferences, with those who had not accessed help appearing to want a more blended approach to their support. A combination of formats may also feel more accessible and less intimidating, reducing practical and emotional barriers to engaging in support (Higgins et al., 2022). From a trauma-informed perspective, offering multiple formats of support increases choice and control, which are perceived to be essential for creating safe and responsive postvention support (Scottish Government, 2021; Mirick et al., 2023).

Furthermore, the findings from this research indicated a preference for postvention support to be offered relatively soon after a bereavement by suicide, with most participants selecting 0-6 months as the most appropriate time to receive support (those who engaged in support: 82%; those who did not engage in support: 53%). This need and preference, for early support is consistent with wider research. Given the risks of adverse mental health outcomes following a bereavement by suicide, as previously discussed (in section 1.5.1), early outreach and support is widely accepted as a key component of suicide bereavement support (Pitman et al., 2014; Grafiadeli et al., 2021; Cerel et al., 2016; Pitman et al., 2016). The findings also showed that support needs to extend beyond the early months. Participants who had not

engaged in support expressed a desire for services to remain available into the 13–18-month period. Research on postvention services similarly highlights the importance of ongoing, proactive contact and flexible access, noting that people may seek help at different times depending on their emotional readiness or the recurrence of distress (Bell et al., 2024). This connects directly to section 5.3.3, where participants described the value of suicide-specific follow-up around key dates such as anniversaries or inquests.

Overall, participants indicated that they want support delivered primarily through face-to-face or blended formats and wanted this support to begin within the first six months after their bereavement, but to remain available into the following year (and beyond), reflecting both the need for early outreach and the importance of continued, responsive support around key dates.

5.4 Strengths and Limitations

Strengths. The current research study addressed a gap in the literature that was identified in the scoping literature review and by High (2024), by exploring what support adults in the UK who have been bereaved by suicide want and would engage in. The findings generated all derived from perspectives shared by self-defined family members bereaved by suicide, offering insight into the types, formats, and timings of support that would feel meaningful and accessible to those most affected. If NHS providers, identified in policy documents as key deliverers of postvention (Department of Health and Social Care, 2023; NICE Suicide Prevention Quality Standard (QS189), 2019), and third-sector organisations were to use these insights to inform service design and delivery, the landscape of suicide bereavement support in the UK could become more responsive, inclusive and accessible to a wider range of people affected.

A strength of the current study is the use of a mixed-methods design, which aligned well with the epistemological positioning. Drawing on both quantitative and qualitative data enabled a more comprehensive exploration of suicide bereavement support experiences than either method may have provided alone. Combining methods allowed the study to capture both the socially constructed nature of participants' narratives of suicide bereavement support and the broader patterns that may reflect deeper systemic influences. For example, quantitative descriptive statistics showed that 21% of Stream B participants (those who did not access support), were offered or sought out support, but were not able to engage for reasons such as the eligibility criteria. Additionally, 60% of Stream B participants felt that receiving support could have impacted their wellbeing following their bereavement and were able to explain, through open-text boxes (qualitative data), that the absence of support contributed to greater isolation and reduced understanding surrounding the death. This integration strengthened the depth of the findings, thus offering a more nuanced understanding of suicide bereavement than may have been possible through a single-method approach.

Reflexivity throughout the process was a strength of this study, demonstrated through ongoing critical reflections on the research process as a whole by the lead researcher. This reflexive practice enabled the researcher to identify and question their own assumptions and potential biases that may have influenced the direction of the study. By acknowledging these influences, the researcher strengthened the transparency of the choices made. This reflexivity also potentially supported more thoughtful decision-making by encouraging, and being used as a tool, to help reassess methods, interpretations and ethical considerations.

Another important strength of this study is the involvement of the second supervisor, Dr Katie High, a researcher who is embedded within suicide bereavement research. Her

expertise has been an invaluable source of support for the lead researcher. Drawing on insights and lessons from her own suicide bereavement research, she provided practical guidance that helped the lead researcher to carefully and appropriately shape the methodological and ethical direction (such as suggesting the initial safety check-in question for the participants) of this study. Through her established relationships with charities and organisations, the lead researcher could develop early connections that supported the recruitment of both EbEs and participants. Dr High's attendance at suicide related conferences across Europe also ensured that this research was informed by up-to-date knowledge and the needs of those working within suicide bereavement support, increasing the study's relevance for those working in the field and ensuring there is an audience ready to receive the findings.

Finally, a strength of this study was the decision to gather data through an online questionnaire link rather than through face-to-face interviews. Research suggests that people are more forthcoming about sensitive or stigmatised experiences when completing self-administered, anonymous questionnaires (Durant et al., 2002; Murdoch et al., 2014). In the context of this study, the anonymous online format may have helped to create an environment that felt "safe enough" for participants to engage with the topic. The inclusion of the safety question at the very start of the questionnaire offered participants a clear, judgement-free opportunity to withdraw if they felt the need to. Providing this "easy exit" aimed to reinforce emotional safety for participants. Together, these design choices helped to establish a supportive atmosphere in which participants could share their experiences at their own pace.

Limitations. Although the *Fit for the Future: 10 Year Health Plan for England* (Department of Health and Social Care, 2025a) does not explicitly mention suicide postvention, it does emphasise the need to reduce health inequalities, noting that "*people in working class jobs, who are from ethnic minority backgrounds, who live in rural or coastal areas or deindustrialised inner cities, who have experienced domestic violence or who are homeless are more likely to experience worse NHS access, worse outcomes'.* Whilst the current study did not collect these demographics, it did collect geographical location and gender data. Half of the participants resided in the South of England (50%), with the remaining half located across other regions of the UK, though it was not clear if participants lived in '*rural or coastal areas or deindustrialised inner cities.'* However, widening this focus to suicide bereavement is relevant, as research shows that while men and women experience similar emotional impacts after a suicide bereavement, men are significantly less likely to receive support (Erlangsen et al., 2017). Males are also less likely to participate in suicide bereavement research (Andriessen et al., 2019; Whitebrook et al., 2025). Unfortunately, the current research study reflects this pattern, with a marked gender disparity in responses (Females: 91%; Males:9%), highlighting the ongoing challenge of ensuring that suicide bereavement postvention services, and the research informing them, reach groups who are currently engaging the least with them.

In line with the approval provided by the Ethics Committee, the Qualtrics questionnaire was configured to close automatically once data from 60 participants had been recorded. A participant was counted at the point they had read, signed, and submitted the online consent form. On reflection, it would have been more appropriate to define a participant as "counted" only once they had completed a minimum proportion of the questionnaire. Furthermore, none of the five individuals who indicated they would come back later returned to complete the questionnaire. Had this approach been taken, the nine

individuals who exited immediately after providing consent, as well as the five who withdrew following the initial safety question, would not have occupied participant places. This would have allowed additional participants to enter the study before the questionnaire closed. Future studies might consider implementing a reminder system, such as an automated follow-up email after a set period, to remind re-engagement from participants who exit early, should they wish to (with no obligation to re-engage emphasised).

Data for the time since bereavement and completing this questionnaire was collected, with the aim of identifying possible recall bias (as explained in section 3.6.2) but ultimately not utilised as a covariate, as the data showed that a large proportion of participants (79%) reported that their bereavement had happened between six months and five years prior to completing the questionnaire, thus displaying very little variation on this variable. Whilst existing literature does not provide a universal numerical threshold that defines 'low variability', it does share that highly concentrated response patterns in a question represents restricted variability (Norman, 2010). When a variable has restricted variability, it may not meaningfully help explain differences in the results (as a limited range may weaken possible relationships between variables) (Franco-Martínez et al., 2022; Sackett & Yang, 2000). This may have been due to reasons such as not having a large enough sample size, or due to the methods of recruitment of participants (mostly via charities) (Krithikadatta, 2014). These sample-related factors may also provide an explanation as to why most participants resided in the South of England (50%), with the rest of the UK less represented. Nonetheless, it is important to acknowledge that people may have different support needs at different points in their bereavement journey (Ross et al., 2019). Whilst the data collected in this study did not allow for exploration of these potential differences, future research could consider these factors.

Finally, whilst EbEs were actively involved in this research and offered valuable contributions (as described in section 3.3), they were not involved in the initial stages of designing the study, such as the decision to have the data collected via an online questionnaire; instead, this decision was led by the lead researchers' understanding of the research literature (as outlined in section 5.4.1). If EbEs had been involved earlier in the process, the research may have moved closer to a position of *true co-production*, whereby the power is held equally between researchers and EbEs (Batalden et al., 2019; Farr, 2018). This would have positioned the research on the higher levels of 'Arnstein's Ladder of Participation', whereby decisions are more collaborative in nature rather than consultative (Arnstein, 1969). Earlier involvement of EbEs in this research may have influenced various aspects of its design, from the construction of the research question(s), to the decision of how to collect the data (questionnaire/interviews). Research surrounding co-production in healthcare suggests that the closer research sits to co-production, the more positive the outcomes for service development and the impact the research may have, and as such, this is a limitation of the current research (Bovaird & Loeffler, 2012; Voorberg et al., 2014).

5.5 Clinical Implications and Potential Future Research

A small proportion of participants who engaged in support received this support directly from NHS services (7%). This is important to note, given the NHS's commitment to provide dedicated suicide bereavement support within England (NICE Suicide Prevention Quality Standard (QS189), 2019; Department of Health and Social Care, 2023). As these services continue to be embedded across the regions, it will be important to see if access to support (and specifically NHS support) improves. Monitoring support offerings and engagement could help indicate whether national initiatives are resulting in better quality and more accessible support provision for individuals bereaved by suicide.

As part of the *10 Year Health Plan for England: fit for the future* (Department of Health and Social Care, 2025a), there was a clear aim to make the NHS 'digital-first', part of which includes sending text (or email) reminders for appointments and prevention services (such as weight management) (NHS England Digital, 2026). The findings from this study suggest that being proactively offered 'check-ins' on significant dates (such as anniversaries or birthdays) would be supportive. This is a type of support that could be incorporated into the already existing NHS digital system.

The findings from this study help to give a clearer picture of the kinds of support that self-identified family members bereaved by suicide both want and would engage in. Services offering this support (across the third sector, voluntary organisations, the NHS, and private providers) should take these insights seriously and use them to shape how support is designed and delivered, making sure it reflects what people bereaved by suicide actually say they want.

Given the limited number of male participants in the current study, the findings should be generalised cautiously. A recent Australian study by Andriessen et al. (2026) explored the barriers and enablers of men's engagement with suicide bereavement support. They identified four overarching themes: '*(i) internal and gendered barriers to help-seeking, (ii) motivators for engagement with formal supports and services, (iii) access, affordability, and service navigation, and (iv) peer connection and lived experience. Participants called for ongoing offers of support, accessible entry points, and emphasised the value of active outreach and peer support.'* Overall, the study concluded that appropriate support for men bereaved by suicide remains underdeveloped and requires further development (Andriessen et al., 2026). These findings closely mirror those of the current study, suggesting a consistent pattern across contexts. Nevertheless, there is a clear need for future UK-based research to focus specifically on the support needs of men bereaved by suicide. Targeted recruitment

through male-specific suicide support organisations across the UK may help to reach individuals who are currently underrepresented in research and whose perspectives are essential for developing inclusive postvention support. Monetary reimbursement for participation in research studies has been reported to be an effective means to increase questionnaire response rates; thus, this is something which could be considered to increase future participation (Abdelazeem et al., 2023).

Individuals with neurodevelopmental disorders (NDDs) were not specifically included in the current study (they were neither included nor excluded), meaning the findings may not fully reflect their experiences of bereavement. Research shows that grief often goes *'unrecognised'* in individuals with NDDs (Mair et al., 2024). Research also suggests that some people with NDDs may find the grieving process particularly challenging due to difficulties with change, transitions, and emotional processing (Gaines, 2022; Mair et al., 2024). As a result, the support they require may differ from that typically offered to neurotypical individuals. Given these distinct needs and the current lack of representation in grief research, future studies may wish to explore neurodivergent experiences of suicide bereavement specifically, as this group may require support approaches that differ from those currently offered.

5.6 Critical Appraisal

As used to appraise the existing literature in the scoping literature review (Chapter Two), due to the mixed-methods nature of this study, the MMAT alongside the CASP ethical considerations were used to critically appraise this study. To reduce potential bias, the appraisal was completed by the lead researcher and independently reviewed by another member of the research team. This study received *"yes"* ratings on every criterion from both

reviewers (the lead researchers and the other member of the research team), indicating it was appraised as high quality. This is presented in Table 23.

Table 23

Quality Appraisal Summary of the Current Research

Categories	Quality Criteria	Quality Approval
Screening questions	Are there clear research questions?	Yes
	Do the collected data allow to address the research questions?	Yes
Qualitative	Is the qualitative approach appropriate to answer the research question?	Yes
	Are the qualitative data collection methods adequate to address the research question?	Yes
	Are the findings adequately derived from the data?	Yes
	Is the interpretation of results sufficiently substantiated by data?	Yes

Categories	Quality Criteria	Quality Approval
	Is there coherence between qualitative data sources, collection, analysis and interpretation?	Yes
Quantitative Descriptive	Is the sampling strategy relevant to address the research question?	Yes
	Is the sample representative of the target population?	Yes
	Are the measurements appropriate?	Yes
	Is the risk of nonresponse bias low?	Yes
	Is the statistical analysis appropriate to answer the research question?	Yes
Mixed Methods	Is there an adequate rationale for using a mixed methods design to address the research question?	Yes

Categories	Quality Criteria	Quality Approval
	Are the different components of the study effectively integrated to answer the research question?	Yes
	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes
	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Yes
	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Yes
Ethics	Have ethical issues been taken into consideration?	Yes
	Was informed consent obtained from participants?	Yes

Chapter Six: Conclusion

6.1 Chapter Overview

This final chapter shares information relating to the dissemination and impact of this research, before providing a final concluding passage.

6.2 Dissemination and Impact

Although the direct impact of this study cannot be assessed within the scope of this singular project, the findings from it have the potential to influence clinical practice. By sharing the findings with charities and organisations, they will be able to reflect on whether any of the expressed needs can be incorporated into their services. This creates the possibility for future improvements in service provisions, whereby they can monitor how any changes are received by those bereaved by suicide accessing their services. Furthermore, by sharing the findings in an accessible way (possibly via a poster or infographic), with participants (via charities and social media groups), this may help participants feel listened to, potentially encouraging future engagement with research, ultimately helping to strengthen the evidence base in suicide bereavement support. The use of infographics may also help those who were not participants, but who have been bereaved by suicide, to see what has helped others in similar situations, so that they may better know where to look for support and feel encouraged to access it.

The findings from this study shall be disseminated as follows:

- Summary of findings, in an accessible format, to be shared amongst the charities, organisations and social media groups that supported with recruitment for this study.
- SLR manuscript published within a peer-reviewed journal.
- Empirical study manuscript published in a peer-reviewed journal.

- Poster presentation sharing findings at the DClinPsy conference at the University of Hertfordshire in September 2026.

6.3 Conclusion

This study aimed to gain a deeper understanding of what support self-defined family members who have been bereaved by suicide want and would engage in to help them through their grief. This stemmed, alongside the findings from the scoping literature review, from research conducted by High (2024), who identified that '*services within the UK need to ensure that they have a clear understanding of what specific support survivors need*.'

With data collected using a mixed methodological approach, five key areas were discussed that encapsulate what support self-defined family members bereaved by suicide want: the conditions shaping access to support, early interactions, suicide-specific support, peer support as a space for shared understanding and connections, and preferences for the format and timing of the support.

The findings can be utilised to offer a clearer framework for services seeking to improve their support for people bereaved by suicide, and for newly established services. Whilst the study presented some limitations, there were noteworthy strengths, and the findings pointed to several avenues for potential future research, which were also discussed.

As previously discussed (section 1.5), if postvention is prevention in itself, then the findings of this study, built upon the voices of those most affected, offer an opportunity to shape support that truly meets the needs of self-defined family members bereaved by suicide.

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Appendices

Appendix A - Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

Section	Item	PRISMA-ScR Checklist Item	Reported
		Title	
Title	1	Identify the report as a scoping review.	Yes
		Abstract	
Structured summary	2	Provide a structured summary that includes (as applicable) : background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	Yes
		Introduction	
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	Yes
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	Yes
		Methods	

Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	No – Not pre-registered.
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	Yes
Information sources	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	Yes
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Yes
Selection of sources of evidence	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	Yes
Data charting process	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	Yes
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	Yes

Critical appraisal of individual sources of evidence	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	Yes
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	Yes
		Results	
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	Yes
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	Yes
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	Yes
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	Yes
Synthesis of results	18	Summarise and/or present the charting results as they relate to the review questions and objectives.	Yes
		Discussion	

Summary of evidence	19	Summarise the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	Yes
Limitations	20	Discuss the limitations of the scoping review process.	Yes
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	Yes
		Funding	
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	Yes

Appendix B – Confirmation of Ethical Approval

To: Anna Brooks-Fahy

Your application for an amendment of the existing protocol listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Seeking Support: Uncovering the needs of self-defined family members bereaved by suicide.

Your UH protocol number is: **0522 2025 Jun HSET**
This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 30/04/2026

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

Appendix C - Confirmation of Ethical Approval following First Amendment

To: Anna Brooks-Fahy

Your application for ethics approval for the study listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Seeking Support: Uncovering the needs of self-defined family members bereaved by suicide.

Your UH protocol number is: **0522 2025 Feb HSET**
This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 30/04/2026

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

Appendix D - Confirmation of Ethical Approval following Final Amendment

To: Anna Brooks-Fahy

Your application for an amendment of the existing protocol listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Seeking Support: Uncovering the needs of self-defined family members bereaved by suicide.

Your UH protocol number is: **0522 2025 Jun HSET**
This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 30/04/2026

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

Appendix E – Recruitment Poster



Appendix F – Participant Information Sheet

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS

('ETHICS COMMITTEE')

PARTICIPANT INFORMATION SHEET

1 Title of study

Seeking Support: Uncovering the needs of self-defined family members bereaved by suicide.

2 Introduction

Thank you for considering participation in this research study, which is part of a Doctoral research study.

Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully.

Please ask about anything that is not clear or for any further information you would like to help you make your decision.

Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link: https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs (after accessing this website, scroll down to Letter S where you will find the regulation)

About the researchers: My name is Anna Brooks-Fahy, and I am conducting this research as part of my Doctorate in Clinical Psychology at the University of Hertfordshire. This project is supervised by Dr Jennifer Heath (Principal Lecturer at the University of Hertfordshire), and Dr Katie High (Clinical Psychologist at Great Ormond Street Hospital).

3 What is the purpose of this study?

This research study aims to gain a deeper understanding on what support self-defined family members bereaved by suicide want, and would engage in. For the purpose of this research, 'self-defined family members' is used to describe any individuals who feel close to each other. This definition has been lifted from Dr Katie High's research (*Unspoken Stories: exploring the narratives of self-defined family members who have experienced suicide bereavement*), which identified that 'services within the UK need to ensure that they have a clear understanding of what specific support survivors need.' This research aims to uncover what support those bereaved by suicide want.

4 Do I have to take part?

No, it is completely up to you whether you decide to take part in this study.

If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to stop answering the questions at any point. Please note that your answers are automatically saved and so cannot be removed once you have moved on to the next question.

5 Are there any age or other restrictions that may prevent me from participating?

This research study is open to any self-defined family members bereaved by suicide in the UK. You must be over the age of 18 years to participate and, be able to read English.

The only exclusion we have, is that we ask those who have been bereaved by suicide in the past six months do not complete the survey.

6 How long will my part in the study take?

If you decide to take part in this study, you will be asked to complete an online survey which takes approximately ten to twenty minutes to complete, though you can take as long as you feel you need to answer each question.

7 What will happen to me if I take part?

You will first be asked to provide your informed consent to participate in the study. You will then be presented with a series of questions, one at a time. The questions will be themed around what professional support (if any) you may have received following your bereavement. Questions will focus on what support you think would have been, or was, helpful.

8 What are the possible disadvantages, risks or side effects of taking part?

Being asked questions about this topic may bring up memories related to your bereavement. If you find this distressing, you are free to stop at any point.

Information about sources of support are provided at the end of this information sheet, and will be provided again at the end of the survey.

9 What are the possible benefits of taking part?

Some possible benefits include:

- An opportunity to be a part of a research study which focuses on an area of emerging interest in the UK.
- An opportunity to share part of your experience.
- This research hopes to influence the support being offered to people bereaved by suicide in the UK.

10 **What will happen to the data collected within this study?**

All information collected will be kept strictly confidential.

Any information you provide which could make you identifiable (such as names), will be anonymised.

The anonymised, collected data will be stored electronically in a password-protected file whilst the data is analysed and findings are disseminated. Once the primary researcher (Anna Brooks-Fahy) has completed their Clinical Psychology Doctorate Programme, they will ensure the data is securely destroyed.

Raw data will be visible only to the primary researcher (Anna Brooks-Fahy), and the supervisors (Dr Jennifer Heath and Dr Katie High).

11 Will the data be required for use in further studies?

The data collected will not be used in further studies.

12 Who has reviewed this study?

This study has been reviewed by:

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.

The UH protocol number is 0522 2025 Jun HSET.

13 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please contact me via email: a.k.brooks-fahy@herts.ac.uk

Supervisor's contact details:

Dr Jennifer Heath – j.heath@herts.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar

University of Hertfordshire

College Lane

Hatfield

Herts

AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Please see below for a non-exhaustive list of services and organisations that offer support for suicide bereavement:

Service	Contact Details	Location	Website
Samaritans	116 123 (freephone)	Nationwide	samaritans.org
Papyrus HOPELINEUK	0800 068 41 41	Nationwide	papyrus-uk.org
Mind (Local Branches)	0300 123 3393	Various locations across England and Wales	mind.org.uk
Maytree Suicide Respite Centre	020 7263 7070	London	maytree.org.uk
James' Place	0151 303 5757 (Liverpool)	Liverpool, London, Newcastle	jamesplace.org.uk
Sane	0300 304 7000	Nationwide	sane.org.uk
Shout	85258 (text SHOUT)	Nationwide	giveusashout.org
NHS 111 (England)	111	England	nhs.uk
NHS 111 (Wales)	111	Wales	nhsdirect.wales.nhs.uk
Survivors of Bereavement by Suicide (SOBS)	0300 111 5065	Nationwide	uksobs.org
The Compassionate Friends	0345 123 2304	Nationwide	tcf.org.uk
If U Care Share Foundation	0191 387 5661	County Durham	ifucareshare.co.uk
Cruse Bereavement Care	0808 808 1677	Nationwide	cruse.org.uk

Appendix G – Participant Consent Form

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS

('ETHICS COMMITTEE')

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here*, *in BLOCK CAPITALS]*

……

…

of *[please give email address]*

…..……

…

hereby freely agree to take part in the study entitled *[Seeking Support: Uncovering the needs of self-defined family members bereaved by suicide.]*

……

…

(UH Protocol number: 0522 2025 Jun HSET)

1. I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people

and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2. I have been assured that I may withdraw from the study at any time whilst submitting my answers, without disadvantage or having to give a reason. I have been told that the answers I provide are saved automatically and that when I move to the next question, the previous will have been submitted and cannot be undone.

3. I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

4. I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Signature of participant_____

Date_____

Name of (principal) investigator: *ANNA BROOKS-FAHY*

Appendix H – List of Support Services for Participants

Service	Contact Details	Location	Website
Samaritans	116 123 (freephone)	Nationwide	samaritans.org
Papyrus HOPELINEUK	0800 068 41 41	Nationwide	papyrus-uk.org
Mind (Local Branches)	0300 123 3393	Various locations across England and Wales	mind.org.uk
Maytree Suicide Respite Centre	020 7263 7070	London	maytree.org.uk
James' Place	0151 303 5757 (Liverpool)	Liverpool, London, Newcastle	jamesplace.org.uk
Sane	0300 304 7000	Nationwide	sane.org.uk
Shout	85258 (text SHOUT)	Nationwide	giveusashout.org
NHS 111 (England)	111	England	nhs.uk
NHS 111 (Wales)	111	Wales	nhsdirect.wales.nhs.uk
Survivors of Bereavement by Suicide (SOBS)	0300 111 5065	Nationwide	uksobs.org
The Compassionate Friends	0345 123 2304	Nationwide	tcf.org.uk
If U Care Share Foundation	0191 387 5661	County Durham	ifucareshare.co.uk
Cruse Bereavement Care	0808 808 1677	Nationwide	cruse.org.uk

Appendix I – Participant Debrief Information Form

Thank you so much for participating in this research study.

For every person who dies by suicide, it has been estimated that 135 people are impacted in some way (Cerel et al., 2018). High (2024) identified that 'services within the UK need to ensure that they have a clear understanding of what specific support survivors need'.

Your contribution in answering this survey, will help identify exactly what support is wanted by those bereaved by suicide.

Whilst it can be completely normal and understandable to feel distressed after reflecting on a sensitive topic such as suicide bereavement, if these feelings persist, there are a number of services you may find supportive.

Service	Contact Details	Location	Website
Samaritans	116 123 (freephone)	Nationwide	samaritans.org
Papyrus HOPELINEUK	0800 068 41 41	Nationwide	papyrus-uk.org
Mind (Local Branches)	0300 123 3393	Various locations across England and Wales	mind.org.uk
Maytree Suicide Respite Centre	020 7263 7070	London	maytree.org.uk
James' Place	0151 303 5757 (Liverpool)	Liverpool, London, Newcastle	jamesplace.org.uk
Sane	0300 304 7000	Nationwide	sane.org.uk
Shout	85258 (text SHOUT)	Nationwide	giveusashout.org
NHS 111 (England)	111	England	nhs.uk
NHS 111 (Wales)	111	Wales	nhsdirect.wales.nhs.uk

Service	Contact Details	Location	Website
Survivors of Bereavement by Suicide (SOBS)	0300 111 5065	Nationwide	uksobs.org
The Compassionate Friends	0345 123 2304	Nationwide	tcf.org.uk
If U Care Share Foundation	0191 387 5661	County Durham	ifucareshare.co.uk
Cruse Bereavement Care	0808 808 1677	Nationwide	cruse.org.uk

Appendix J - Questionnaires

All participants:

1. Before we begin, we want to make sure you're comfortable. Do you feel you are in a safe and appropriate environment to share your experiences today? Please continue only if you feel you are ready to

   ☐I'm ready. ☐I'll come back later when I'm feeling safe to do so (survey will close for these participants)

2. After you were bereaved by suicide, did you engage in support from a suicide bereavement service at any point?

   ☐Yes (participants are led to Survey Questions A)

   ☐No (participants are led to Survey Questions B)

Survey Questions A: for participants who <u>did</u> receive support

1. What type of support were you offered (tick all that apply)

   ☐1-1 therapy, ☐group therapy, ☐peer support groups, ☐helplines, ☐practical or ☐financial, ☐Other____

2. Were you offered support directly or did you have to search for this support independently?

   ☐I was offered it, ☐ I searched for it

For the following questions, if you received more than one type of support please respond based on the support which you felt best met your needs. Please state the type of support here _____

3. On a scale of 1 to 10, how much do you think the support met your needs at the time?

4. Can you describe your experience with the support offered by the service?
5. Please rate how much you agree or disagree with the following factors being a challenge in accessing the support service:

Factor	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
Problems with transport or travelling to appointments	☐	☐	☐	☐	☐	☐
Previous experience with mental health services	☐	☐	☐	☐	☐	☐
Taking time out of work	☐	☐	☐	☐	☐	☐
The financial cost of the service	☐	☐	☐	☐	☐	☐
Stigma surrounding suicide	☐	☐	☐	☐	☐	☐
Lack of knowledge of what services are available	☐	☐	☐	☐	☐	☐
Feeling embarrassed or ashamed	☐	☐	☐	☐	☐	☐
Dislike of talking about your thoughts or feelings	☐	☐	☐	☐	☐	☐

Concerns about confidentiality or privacy	☐	☐	☐	☐	☐	☐
Cultural or language barriers	☐	☐	☐	☐	☐	☐
Difficulty in finding a service that feels trustworthy	☐	☐	☐	☐	☐	☐
Fear of being judged or misunderstood	☐	☐	☐	☐	☐	☐
Long waiting times for appointments	☐	☐	☐	☐	☐	☐
Complexity of the referral process	☐	☐	☐	☐	☐	☐
Previous negative experiences with healthcare providers	☐	☐	☐	☐	☐	☐
Uncertainty about the effectiveness of the service	☐	☐	☐	☐	☐	☐

6. Would you recommend the suicide bereavement support service you accessed to others?

   ☐Yes, ☐No, Why_____

7. What specific aspects of the support did you find most helpful or unhelpful?
8. Was your support offered ☐face-to-face, via ☐telephone, ☐video call, ☐ combination of remote and face-to-face?

9. What would be your preferred way of accessing support if you could choose? ☐face-to-face, via ☐telephone, ☐video call, ☐combination of remote and face-to-face, ☐ other, please state _____
10. What improvements to the support offered or additional types of support do you believe would benefit others bereaved by suicide?
11. How soon after the bereavement did you start receiving support? ☐0-6 months, ☐7-9 months, ☐10-12 months, ☐13-18 months, ☐19+ months, and how soon after your bereavement would you have liked to receive support: ☐0-6 months, ☐7-9 months, ☐10-12 months, ☐13-18 months, ☐ 19+ months,
12. How much time has passed since you were bereaved by suicide? ☐6 months – 1 year ago, ☐1 – 5 years ago, ☐6 – 10 years ago, ☐more than 10 years ago.

Survey Questions B: for participants who <u>did not</u> receive support

1. Were you offered support? ☐Yes ☐No, Why____? If you were offered support, why did you choose not to engage in it? _____
2. On a scale of 1 to 10, how helpful do you think it would have been to receive support after your bereavement? (10 being most helpful).
3. What type of support do you think would have been most beneficial for you? ☐one-to-one therapy, ☐group therapy, ☐peer-support groups, ☐ helplines, ☐practical, ☐financial, ☐other (please explain)?
4. Did you seek out any support on your own? (☐Yes/☐no)

a. If yes, what did you find?

b. Were there any challenges you faced in finding and/or accessing it?

5. Do you think receiving support could have impacted your well-being following your bereavement?

   ☐Yes/☐No/☐Not sure, Please explain_____

6. Do you believe that receiving support could have alleviated some difficulties you experienced after the bereavement?

   ☐Yes, ☐No. If yes, what kind?

7. What improvements to existing support provisions, or different types of support do you think should be made available to people bereaved by suicide in the future?

8. If you were to receive support, would you want support to be provided:

   ☐face-to-face, via ☐telephone, via ☐video call, or a ☐combination of remote and face-to-face?

9. How soon after the bereavement do you think support should be offered?

   ☐0-5 months, ☐6-9 months, ☐10-12 months, ☐13-18 months, ☐19+ months,

10. How much time has passed since you were bereaved by suicide?

☐6 months – 1 year ago, ☐1 – 5 years ago, ☐6 – 10 years ago, ☐more than 10 years ago.

Appendix K – Codes and Concepts

Concept One: Inconsistent access, quality, and appropriateness of support

Codes:

- Unhelpful/inappropriate support
- Support undertaken too early
- GP crisis response
- Helpful but non-suicide-specific counselling
- Mixed quality statutory vs charity support
- Support accessed many years later
- Costly and inconsistent private/NHS support
- Charities filling gaps in NHS provision
- Group support emotionally overwhelming

Concept Two: Peer-based and community support as uniquely helpful

Codes:

- Peer groups are helpful
- Peer helpline emotionally supportive
- Peer group normalised suicide loss
- Ongoing peer support and connection
- Peer presence reduced isolation
- Peer groups reduce isolation

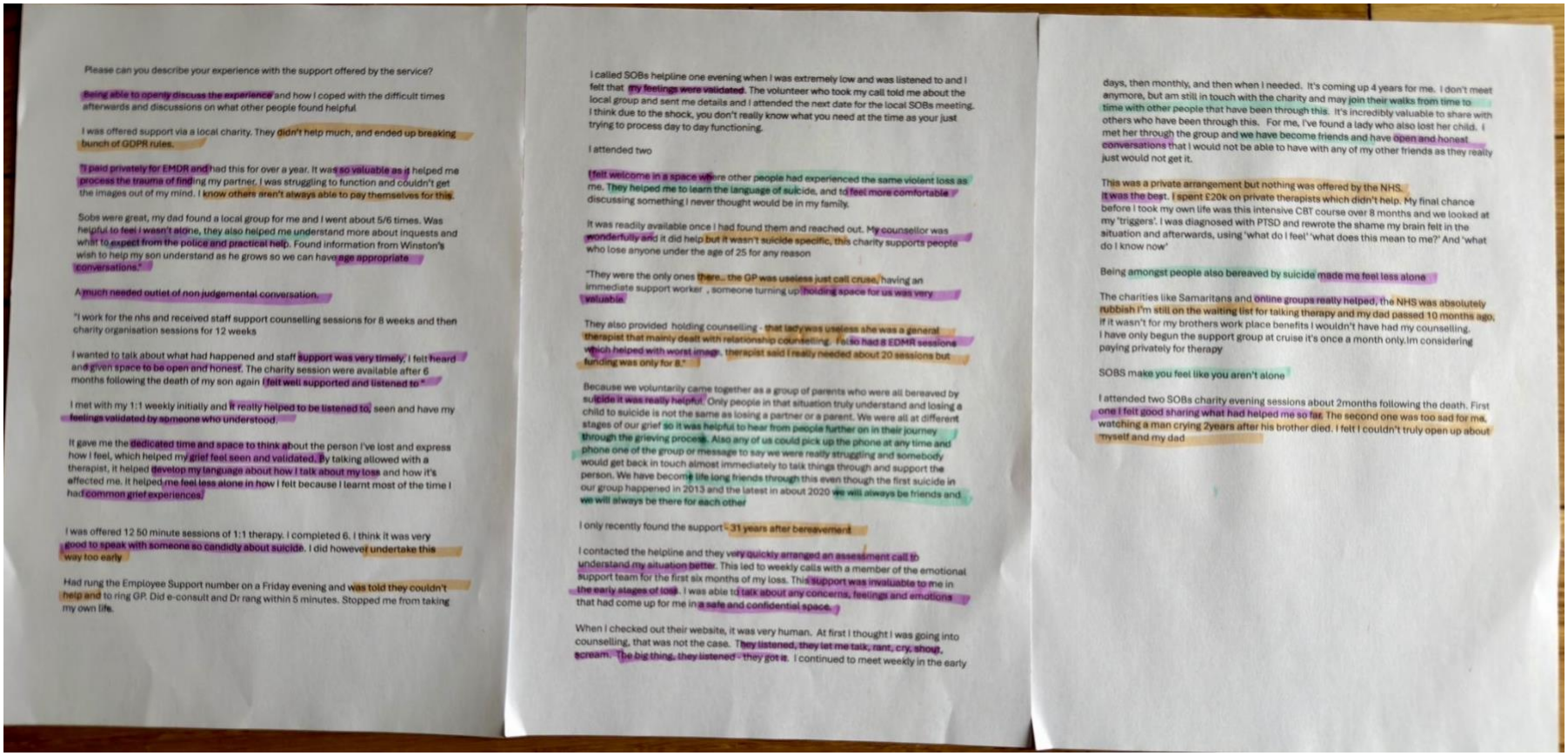
Concept Three: Support that felt emotionally safe, validating and understanding

Codes:

- Open space to talk about the experience

- Non-judgemental emotional space
- Counselling support helpful
- 1:1 support emotionally validating
- Therapeutic space helpful for grief
- EMDR helpful
- Helpline emotional support invaluable
- Charity emotional support and connection

Appendix L – Sample of Quotes Supporting Codes



Please can you describe your experience with the support offered by the service?

Being able to openly discuss the experience and how I coped with the difficult times afterwards and discussions on what other people found helpful

I was offered support via a local charity. They didn't help much, and ended up breaking bunch of GDPR rules.

"I paid privately for EMDR and had this for over a year. It was so valuable as it helped me process the trauma of finding my partner. I was struggling to function and couldn't get the images out of my mind. I know others aren't always able to pay themselves for this.

Sobs were great, my dad found a local group for me and I went about 5/6 times. Was helpful to feel I wasn't alone, they also helped me understand more about inquests and what to expect from the police and practical help. Found information from Winston's wish to help my son understand as he grows so we can have age appropriate conversations."

A much needed outlet of non judgemental conversation.

"I work for the nhs and received staff support counselling sessions for 8 weeks and then charity organisation sessions for 12 weeks

I wanted to talk about what had happened and staff support was very timely, I felt heard and given space to be open and honest. The charity session were available after 6 months following the death of my son again I felt well supported and listened to."

I met with my 1:1 weekly initially and it really helped to be listened to, seen and have my feelings validated by someone who understood.

It gave me the dedicated time and space to think about the person I've lost and express how I feel, which helped my grief feel seen and validated. By talking allowed with a therapist, it helped develop my language about how I talk about my loss and how it's affected me. It helped me feel less alone in how I felt because I learnt most of the time I had common grief experiences.

I was offered 12 50 minute sessions of 1:1 therapy. I completed 6. I think it was very good to speak with someone so candidly about suicide. I did however undertake this way too early

Had rung the Employee Support number on a Friday evening and was told they couldn't help and to ring GP. Did e-consult and Dr rang within 5 minutes. Stopped me from taking my own life.

I called SOBs helpline one evening when I was extremely low and was listened to and I felt that my feelings were validated. The volunteer who took my call told me about the local group and sent me details and I attended the next date for the local SOBs meeting. I think due to the shock, you don't really know what you need at the time as your just trying to process day to day functioning.

I attended two

I felt welcome in a space where other people had experienced the same violent loss as me. They helped me to learn the language of suicide, and to feel more comfortable discussing something I never thought would be in my family.

It was readily available once I had found them and reached out. My counsellor was wonderfully and it did help but it wasn't suicide specific, this charity supports people who lose anyone under the age of 25 for any reason

"They were the only ones there.. the GP was useless just call cruse, having an immediate support worker , someone turning up holding space for us was very valuable.

They also provided holding counselling - that lady was useless she was a general therapist that mainly dealt with relationship counselling. For so had 8 EDMR sessions which helped with worst image, therapist said I really needed about 20 sessions but funding was only for 8."

Because we voluntarily came together as a group of parents who were all bereaved by suicide it was really helpful. Only people in that situation truly understand and losing a child to suicide is not the same as losing a partner or a parent. We were all at different stages of our grief so it was helpful to hear from people further on in their journey through the grieving process. Also any of us could pick up the phone at any time and phone one of the group or message to say we were really struggling and somebody would get back in touch almost immediately to talk things through and support the person. We have become life long friends through this even though the first suicide in our group happened in 2013 and the latest in about 2020 we will always be friends and we will always be there for each other

I only recently found the support - 31 years after bereavement

I contacted the helpline and they very quickly arranged an assessment call to understand my situation better. This led to weekly calls with a member of the emotional support team for the first six months of my loss. This support was invaluable to me in the early stages of loss. I was able to talk about any concerns, feelings and emotions that had come up for me in a safe and confidential space.

When I checked out their website, it was very human. At first I thought I was going into counselling, that was not the case. They listened, they let me talk, rant, cry, shout, scream. The big thing, they listened - they got it. I continued to meet weekly in the early days, then monthly, and then when I needed. It's coming up 4 years for me. I don't meet anymore, but am still in touch with the charity and may join their walks from time to time with other people that have been through this. It's incredibly valuable to share with others who have been through this. For me, I've found a lady who also lost her child. I met her through the group and we have become friends and have open and honest conversations that I would not be able to have with any of my other friends as they really just would not get it.

This was a private arrangement but nothing was offered by the NHS.
It was the best. I spent £20k on private therapists which didn't help. My final chance before I took my own life was this intensive CBT course over 8 months and we looked at my 'triggers'. I was diagnosed with PTSD and rewrote the shame my brain felt in the situation and afterwards, using 'what do I feel' 'what does this mean to me?' And 'what do I know now'

Being amongst people also bereaved by suicide made me feel less alone

The charities like Samaritans and online groups really helped, the NHS was absolutely rubbish I'm still on the waiting list for talking therapy and my dad passed 10 months ago, if it wasn't for my brothers work place benefits I wouldn't have had my counselling. I have only begun the support group at cruise it's once a month only.Im considering paying privately for therapy

SOBS make you feel like you aren't alone

I attended two SOBs charity evening sessions about 2months following the death. First one I felt good sharing what had helped me so far. The second one was too sad for me, watching a man crying 2years after his brother died. I felt I couldn't truly open up about myself and my dad

Appendix M – Challenges to Accessing Support Among Participants Who Received Support (Stream A)

Factor	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Applicable
Problems with transport or travelling to appointments	26	11	19	19	15	11
Previous experience with mental health services	7	4	11	30	30	19
Taking time out of work	4	4	19	26	26	22
The financial cost of the service	4	19	19	7	22	30
Stigma surrounding suicide	11	4	7	26	52	0
Lack of knowledge of what services are available	4	0	11	33	52	0
Feeling embarrassed or ashamed	19	19	19	22	22	0

Factor	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Applicable
Dislike of talking about your thoughts or feelings	15	37.0	7	22	19	0
Concerns about confidentiality or privacy	22	30	26	15	7	0
Cultural or language barriers	11	37	22	0	4	26
Difficulty in finding a service that feels trustworthy	4	19	30	26	19	4
Fear of being judged or misunderstood	7	22	7	48	15	0
Long waiting times for appointments	4	15	22	26	26	7
Complexity of the referral process	0	22	22	19	26	11
Previous negative experiences with healthcare providers	7	19	19	33	22	0

Factor	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Applicable
Uncertainty about the effectiveness of the service	4	4	15	56	22	0

Appendix N – Personal Reflections

Reflection - Introduction

I noticed how deeply rooted the stigma around suicide bereavement still is. Even with growing awareness and support, it remains a topic many shy away from. When it came up in conversation because of this thesis, I noticed people responded with quiet acknowledgement for its need, but little engagement. It wasn't rejection, it was discomfort. That silence made me realise how far we still have to go in making space for open, compassionate dialogue around this kind of grief. Progress is happening, but the emotional barriers still feel very real. This only re-emphasised to me how important research in this field is, and to try to involve experts by experience to support with ensuring the language used didn't reinforce stigmatising perspectives.

Reflection - Introduction

Oh my gosh, I felt so frustrated trying to compile prevalence data across the UK. It's not that the information doesn't exist - it does, if you keep digging and know where to dig - but it's scattered, inconsistent, and often presented in ways that are hard to interpret. I kept asking myself: why isn't this data more accessible? If it's this difficult to pull together, how can we expect to have a clear picture of who needs support and where the gaps are? It shouldn't take hours of searching and decoding to understand something so vital. The lack of clarity feels like a barrier to meaningful action. This acted as a reminder to me, when it comes time to disseminate and share the findings from this research, it HAS to be accessible.

Reflection – Scoping Literature Review

Despite going through the search results so meticulously, I frequently doubted myself for not having identified any articles within the grey literature to use within this review. It made me wonder about some of the third-sector organisations and charities who I

knew were offering some kind of support but potentially did not have the resources to allocate time or staffing to capture this work they were doing. It left me reflecting on the potential gaps in knowledge: what valuable insights might be missing simply because they are not captured in accessible literature? Going forward I knew this meant it would be helpful to contact third-sector organisations and charities to support with recruitment to try to get these voices heard.

Reflection – Methodology

Although much of the literature often emphasised that content analysis should be replicable and valid, there was still considerable inconsistency in how different forms of content analysis were defined (Hsieh & Shannon, 2005; Krippendorff, 2019; Neuendorf, 2017). This made me question how often the methodology is actually carried out in a genuinely replicable way, and how I could ensure that this research study was conducted with that level of clarity and rigour.

Reflection - Methodology

The EbEs were offered online shopping vouchers as a way to acknowledge the time and effort contributed. However, recruitment of EbEs became more challenging than I had initially anticipated. Several charities/organisations were reluctant to circulate the invitation unless financial payment was available. This led me to reflect on the broader ethical landscape of involving people with lived experience in research. It raised questions about equity, accessibility, and whether I was unintentionally placing a burden on individuals who are already navigating suicide bereavement.

What stayed with me was that not all of the EbEs who took part chose to accept the voucher reimbursement. Several explained that their motivation came from wanting to improve support for others bereaved by suicide, rather than from receiving compensation. This made me reconsider my assumptions about incentives and reminded me that people engage in research for many different reasons.

Reflection - Methodology

I expected recruiting participants to have its challenges, so I was genuinely surprised by how willing people were to take part. What I didn't anticipate was how gatekept the whole process would feel. I understood the intention, to protect people who are already going through something difficult, but it created a real paradox. The individuals most eager to share their experiences were the ones most heavily shielded. It left me questioning when protection stops being ethical care and starts slipping into paternalism, and how much research with so-called "hard-to-reach" groups is limited not by the people themselves, but by the systems and institutions surrounding them.

Reflection - Findings

Despite doing the preparatory work on approaches to mixing quantitative and qualitative data, I was still surprised by how complex this process became in practice. The theory made it sound like a fairly straightforward process, but in reality it required a lot more thought and sensitivity than I expected.

What I found most challenging was trying to bring the two forms of data together in a way that genuinely made sense. It wasn't just about placing numbers next to narratives; it was about finding a way for them to speak to each other. I kept coming back to the question of how to tell the story of the findings in a way that felt coherent and digestible, without losing the depth or nuance of either dataset. That balancing act, honouring both forms of evidence while shaping a clear narrative, ended up being trickier than I had anticipated.

Conversations with my supervisors were particularly helpful during this stage, talking things through out loud often helped me clarify what I was really trying to do.

Reflection - Findings

As I read through the participants' responses, first taking in their words, then looking at them more analytically, I was struck by how strongly their emotions came through. There was a clear sense of frustration around long waiting lists, sometimes stretching over several years, and a deep disappointment in healthcare providers who weren't able to support them at moments of real need.

Alongside this, there were also moments of relief and connection. For those who had accessed support, there was some comfort in being understood and in meeting others who had lived through similar experiences. It felt significant that 89% of participants who received support said they would recommend it to someone else.

That figure made something important stand out: the issue isn't that the support itself is entirely inadequate. Instead, the real challenge lies in the barriers that prevent people from reaching it. This sense of uneven access, of a system shaped by something as arbitrary as a postcode, felt persistent and difficult to ignore.

Reflection - Discussion

I felt quite unsettled when I realised how few men had taken part in this study, especially knowing how stark the statistics are around male suicide. It hit me harder than I expected, and I felt a real sadness that this imbalance had carried through into this work. I kept replaying my recruitment choices in my mind and wondering whether I should have reached out more deliberately to male-focused suicide bereavement services or online spaces. I ended up stepping back from the research for a few days because I needed space to sit with those feelings and think honestly about what could be done differently in the future to make a meaningful difference to this. When I returned to my findings, I felt more grounded and connected to the importance of the voices that were present, and to the responsibility I had to carry their experiences forward.

Final Reflection

As I come to the end of this thesis, I've been thinking about the process. Pragmatically, this thesis has a clear end point: a submission, a final version, a line drawn under the work. But spending so much time engaging with the experiences of people bereaved by suicide has made the process feel far less tidy than that.

One thing that became clear throughout the research is that support for people bereaved by suicide isn't something that fits into a fixed timeline. It doesn't follow a predictable arc or reach a point where it can be considered "complete." It's something that shifts and reappears in different forms over time. In a way, that mirrors how this thesis has felt for me. Even though the thesis itself has a defined end, the learning hasn't been something I can neatly close off.

Finishing the written work is one thing, but the understanding I've gained doesn't stop at submission. It stays with me in a quieter, more ongoing way. The telic task is ending, but the awareness and reflection it prompted continue in the background, shaping how I think about this area of work