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"It's like an oak tree growing slowly across a barbed wire fence:" Learning from traumatic experience of bereavement by suicide in later life

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Abstract

Bereavement by suicide is a traumatic and life-changing experience. However, little is known about the lived experiences of people bereaved by suicide themselves, and older people's voices are notably absent from the current suicide prevention and intervention strategies. This paper seeks to understand the different individual experiences and pathways arising from the suicide research for people in later life who have been bereaved by suicide through the lens of transformational learning. Using a qualitative paradigm, we explored the critical themes and features evident in the meaning making, coping, and adaptation needs of 24 people aged 66 – 92 years who were bereaved by suicide. In-depth interviews led by researchers with lived experience generated two themes on the centrality of experience: Critical reflection and meaning making in later life following suicide trauma; and the journey of discovery and how this interacted with social and political rights. Findings suggest that further research is necessary to generate practice-based evidence, which identifies the impact of bereavement by suicide on people in later life and how their needs for support might be unique when being assessed and identified; and how to respond more holistically to older people with psychosocial problems, which stem from these learning experiences. Recommendations consider the potential for developing more service user-led social, community-based, and therapeutic interventions, which utilizes the authentic knowledge of older people with lived experiences.

Keywords: Bereavement; Suicide; Later life; Transformational learning; Peer support

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1. Introduction

Suicide is recognized globally as a public health priority (the World Health Organisation, 2014; 2021), warranting a multisectoral public health approach to strengthening suicide prevention strategies (United Nations, 2015; World Health Organization, 2019, 2021). In the United Kingdom, suicide rates are highest in midlife (45 – 54 years) (UK Parliament, 2022), and many who die by suicide may leave behind a bereaved older parent, carer,

or loved one. Bereavement by suicide has been shown to be a traumatic and life-changing experience (Arbuthnott & Lewis, 2015) and is a known risk factor for suicide of the bereaved-by-suicide person (Pitman *et al.*, 2016).

The experiences of suicide bereavement of those in later life however remain a significantly under-researched area. In this paper, a person bereaved by suicide in later life refers to someone who has lost a significant other (or a loved one) by suicide, is aged <60 and whose later life is changed due to the loss (Andriessen *et al.*, 2009).

A systematic review of studies of older adults bereaved by the loss of a significant other to suicide found that none fulfilled the inclusion criteria (Hybolt *et al.*, 2020a). Two subsequent qualitative empirical studies in Denmark (Hybolt *et al.*, 2020b) and the UK (Hafford-Letchfield *et al.*, 2022b) investigated the unique age-related factors for participants impacted by suicide and their re-orientation to life after such a devastating loss. These empirical studies, a broader review of suicide and aging research (Hafford-Letchfield *et al.*, 2022a), and a review of the validated screening tools used to assess for self-harm and suicide in later life (Gleeson *et al.*, 2022) have all highlighted the importance for unifying suicide bereavement research with policy themes on well-being and aging (UN, 2020), including how these interact with ageism (Burnes *et al.*, 2019). Emerging recommendations advocate for the greater use of community participatory research methods and expansion of our understanding of social and environmental determinants of thoughts and actions related to suicide, including bereavement (see also Hafford-Letchfield *et al.*, 2022b). Other evidence has shown that people in later life have increased resilience and emotional control if they have had more experience with death and are better prepared to cope with bereavement in comparison with younger people (Shah & Erlangsen, 2014). However, less is known about the underlying mechanisms and correlates that contribute to different bereavement outcomes in later life. Findings from a large population-based closed survey (Pitman *et al.*, 2019) to capture the use of a wide range of formal and informal support sources of people bereaved by suicide and any inequities in support could only be generalizable to young, bereaved women due to the age range sampled (18 – 40 years).

While it has been suggested that referral to specialist bereavement counseling and support can be helpful for people who actively seek it (De Groot *et al.*, 2007), knowledge about the efficacy of such interventions is currently limited (McDaid *et al.*, 2008). The involvement of peers and peer-led interventions is well-acknowledged in health and social care policy discourse (Collom *et al.*, 2019; Sun *et al.*, 2022) including those bereaved by suicide (Higgins *et al.*, 2022; Hybolt *et al.*, 2022). Achieving a deeper understanding of these different individual experiences and pathways, which are informed by the voices of older people and their advocates within suicide research, points to the potential for developing more service user-led, possibly age-related, and social and therapeutic interventions (Kashaniyan & Khodabakshi Koolaee, 2015; Heisel *et al.*, 2020; Hafford-Letchfield *et al.*, 2022b) that can be combined with medical and non-pharmacological interventions (Wand *et al.*, 2022). In summary, little is known about the lived experiences of people bereaved by suicide themselves, and older people's voices are notably absent from the current suicide prevention and intervention strategies (Andriessen *et al.*, 2019; Linde *et al.*, 2017). Further or wider research is required to generate practice-based evidence, which identifies the impact of bereavement by suicide on people in later life. This includes how their needs for support are currently assessed and identified and how to respond more holistically to people with psychosocial problems stemming from such experiences (Hybholt *et al.*, 2022), particularly those in a population with a high risk of comorbidities which may impact them differently to younger population groups (Linde *et al.*, 2017). In this paper, we suggest that looking at these issues through the lens of transformational learning theory may be a useful approach for understanding this potential to capitalize on the knowledge and experience of people with lived experiences in later life, and how they make meaning of these to enhance options for developing improved bereavement support that is tailored to their specific needs.

1.1. Contribution of lifelong learning to care in later life

We draw on educational gerontology to enable critical discussion of the implications for future research, policy, and practice, and focus on the application of transformation learning theory to examine traumatic bereavement experiences more closely. Using a problematic frame of reference can help to challenge any assumptions and expectations such as habits of mind, meaning perspectives and mindsets. Within ageing studies, educational gerontology brings very specific approaches to aging and learning and can be a valuable resource for considering how learning, particularly informal learning, facilitates more inclusive, discriminating, and open and reflective experiences that may generate beliefs and opinions that can be used to guide future action (Mezirow, 2003, pp. 58-59). Informal learning in this paper refers to the learning resulting from daily life activities, which may be related to work, family, or leisure. Informal learning may be intentional but in most cases is not so.

Based on hitherto unreported data from a qualitative in-depth study of the experiences of people in later life

who had been bereaved by suicide (Hafford-Letchfield *et al.*, 2022b), we have explored the potential of informal learning for developing and promoting the impact of research and associated community-based social support. The convergence of the lifelong learning agenda with social policy and social care has been shown to have potential by increasing interrelated and overlapping activity in both future policy and practice (Hafford-Letchfield, 2010; 2016), particularly given the emphasis on engaging with lived experience (NSUN, 2015). Given the continuous challenge of sustainability in the care and support of older people and the economic and mental health impact of the COVID-19 pandemic (Wand *et al.*, 2020), meaningful engagement with a holistic perspective and different strategies is required to shape and drive social change. Learning theorists for example have explored the way in which learning take place and seek to locate learning within its social, economic, and political context (Jarvis, 2001; Soulsby, 2014). Learning in later life is often put forward as product of interaction and as an interactive and interpretation process (Percy, 1990), which makes it useful for achieving a genuine participatory approach toward the quality of experience of older people using social care. Grappling with how people voice the sophistication of their desires around the themes of independence, dependence, and interdependence is one way of operationalizing concepts of lifelong learning. Further, recognizing and valuing learning as a means of improving the quality of support and through participation has been asserted as an under-explored means to demonstrate transformational change (Hafford-Letchfield & Formosa, 2016; Hafford-Letchfield, 2010; 2016).

The following questions were formulated: (i) How do older people bereaved by suicide describe any process of learning from their traumatic experiences? (ii) What process of transformation, if any, was evident as they adapted to this specific traumatic experience in later life and where there was evidence of transformation, what factors shaped the transformational learning process? (iii) How can transformative learning theory, practice, and research help to understand the support needs of people bereaved by suicide in their later life and if so, what are the implications for development of practice and research in suicide prevention? These questions were used as guidelines to explore the data for critical themes and features evident in the meaning making, coping, and adaptation needs of people in later life who have been bereaved by suicide.

1.2. Background to the study

The study was conducted in 2021 and explored the perspectives and experiences of 24 bereaved-by-suicide people aged 60 – 94 years, and how this impacted their specific support needs and help-seeking in later life. Some of the key themes have been reported elsewhere (Hafford-Letchfield *et al.*, 2022b), documenting the moral injury in the aftermath of experiencing a loss by suicide, distressing psychological, social, and behavioral impact on experiences. These themes captured the negative reactions from people in the bereaved person's network and the impacts on significant others in the immediate aftermath and longer-term, and the poignant and significant experiences in the personal journey of the bereaved person in later life. Within these reported themes, participants shared reflections about their own future, motivation, mortality, and accounts of help seeking and how they navigated transition and adaptation while still "living with the experience" in later life (Hafford-Letchfield *et al.*, 2022b).

In this paper, we returned to this latter area and conducted further analysis on the subthemes of "transformation" which often coincided with individuals' sense making of their experiences and their articulation of these alongside themes of activism and leadership with their peers through shared lived experience of being bereaved by suicide. The analysis and discussion drew on Mezirow's theories of transformational learning (Mezirow, 2000; Mezirow & Taylor, 2009), specifically "perspective transformation" as a reference for illustrating the potential of learning from within a critical paradigm of social care and social support to bring about change. Given the documented experiences of navigating and adapting to traumatic loss, we considered how the centrality of experience, critical reflection, meaning making, and the importance of relationships interacted with this journey and intersected with participants aging experiences.

2. Data sources and methods

This was a qualitative study which adopted a thematic analysis based on descriptive phenomenology (Sundler *et al.*, 2019) to explore the substantive issues. This research adopted collaborative study design and involved two trained peer researchers aged <60 years with lived experience of bereavement by suicide to conduct interviews. The researchers were equal partners in data analysis as well as reporting and discussion of the themes. The richness from the expertise by experience provided a deeper understanding to generate and enable findings that could promote the accessibility of research by grounding data collection in the experiences of those being researched and producing more relevant and practice-oriented knowledge (Berring *et al.*, 2016; Devota *et al.*, 2016; Faulkner *et al.*, 2021; MacIntyre *et al.*, 2019).

2.1. Sample and data collection

The target population of this study comprised people living in the UK, with experience of the loss of a significant other

by suicide at least 12 months before engaging in the research interview. Table 1 shows details of the 24 participants. As the study took place during the COVID-19 lockdown period, purposive and opportunistic sampling were deployed by recruiting through bereavement services, social media, and research networks and contacts with aging services. All interviews were conducted virtually by phone or video conferencing and were audio-recorded. Afterward, the interviews, each lasted for an average of 58 min, were professionally transcribed. Participants were inquired for the time since their suicide bereavement, since having endured bereavement for a minimum of 2 years is one of the inclusion criteria. This was collated and separated from the data.

Areas covered were the individual's experience of support after their loss at different time points, the sources of support identified, their own help-seeking and self-identified needs, and how these impacted their aging experiences. This flexible approach to interviewing encouraged reflective thinking and effort to explain their situation and response to it (Sandelowski, 2001).

2.2. Data analysis

Descriptive phenomenology was used as a framework for analyzing participants' lived experiences (Ozuem *et al.*, 2022; Sundler *et al.*, 2019). Emphasis was placed on openness, questioning pre-understandings, and adopting a reflective attitude throughout the research process. The conceptual confluence between thematic analysis and descriptive phenomenology is a theoretically rich construct for understanding and making sense of qualitative data (Ozem *et al.*, 2022). Two researchers read and coded every transcript and met on Zoom to discuss each transcript as well as identify and reflect on preliminary themes. In the transcripts, we looked for complex ideas, particularly age-related issues, metaphors, and critical moments and focused on understanding the breadth of experiences to build a picture of bereavement by suicide, and the meaning-making of participants in relation to their later life grounded in their own narratives. A series of team meetings took place where the whole team came together to present and discuss their analysis until we had worked through every transcript. These meetings were audio-recorded and the transcriptions were used to verify and report on the main themes. These processes provided a robust and rich source of reflection to illuminate and understand aspects of participant's experiences which were inclusive of insights from lived experience. The team also noted the contextual features of participants experience in relation to influences such as age, health, and well-being. We discussed the social and economic factors impacting participants' experiences and how they

Table 1. Characteristics of the 24 participants included in the study

Variable	N
Gender of participant	
Female	21
Male	3
Age of participant (years; mAvg = 72.0)	
60 – 64	6
65 – 69	4
70 – 74	7
75 – 79	3
80 – 84	2
85 – 89	1
90 – 44	1
Relationship to the deceased	
Aunt/Uncle	1
Grandparent	1
Parent	15
Parent-in-law	1
Sibling	2
Spouse/Partner	4
Sexual identity of participant	
Bisexual	2
Heterosexual	22
Time elapsed between the death and interview (between 1 and 20 years; mAvg = 6.8 years)	
Ethnicity of participant	
Black, African	1
White, British	1
White, English	13
White, European	2
White, Northern Irish	1
White, Scottish	5
White, Welsh	1
Disability	
Yes	3
No	21
Religion/Belief of participant	
Buddhism	1
Christianity	11
Judaism	1
No religion	9
Prefer not to say	1
Quaker	1
Location of participant in UK	
England	17
Northern Ireland	1
Scotland	5
Wales	1

perceived their situated relationships and networks in both personal and professional settings (Matua & Van de Wal, 2015). This constant comparison (Miles & Huberman, 1994) helped uncover participants' meanings and further understandings toward phenomenology (Charmaz, 2006). The team observed data saturation after approximately 17 interviews. While some participants did talk about the time that elapsed since the bereavement spontaneously in their interview, this was not a direct question and, in hindsight, this would be a variable useful for describing different experiences.

2.3. Ethics

Ethical approval was provided by the University of Strathclyde Ethics Committee. A key ethical consideration was the impact of talking about bereavement and suicide on researchers and participants (McKenzie *et al.*, 2017). The protocol drew on established guidance for working with people bereaved by suicide (Samaritans, 2020), which included a structured debriefing and signposting support for participants. We established processes for the peer researchers through training on interviewing techniques and data analysis. One team member was a digital artist, and the team concluded the project with a workshop using visualization techniques to debrief and share their experiences of working with sensitive and distressing experiences. Team members also had access to a clinical psychologist. The team established a project advisory group comprising members working in suicide prevention, bereavement support, mental health social work, and a lay older person. This group reviewed the research protocol and tools and commented on the findings from the interim report (Hafford-Letchfield *et al.*, 2022b). Six weeks after the interviews took place, we invited participants to complete a short survey on their experiences of taking part in the research and 16 people responded.

3. Key findings

Here, we discuss the data that underpinned two relevant themes addressing the research questions: (i) the centrality of experience, critical reflection, and meaning making in later life following suicide trauma and (ii) the journey of discovery and how this interacted with social and political rights in later life.

3.1. The centrality of experience, critical reflection, and meaning making in later life following suicide trauma

As shown in Table 1, participants had experienced bereavement by suicide in different points in their lives. Their narratives were dynamic with constant emerging and changing perspectives – about the person who died, their own identities and how they negotiated different relationships with their loved ones – which were often combined with the necessity of taking up new roles, although not always voluntarily, to support those left behind.

The temporality of their experience appeared to follow phases commonly described in bereavement and trauma research. There gave rise to rich, vivid, and visceral descriptions of the participants learning about the suicide and its immediate aftermath such as severe shock, numbness, and sometimes disembodied experiences due to acute psychological trauma (Neimeyer & Sands, 2017). Some participants reflected critically on the content of the grief itself, focusing on (Jordan, 2001) how it was dramatically different from their other experiences of bereavement and loss experience through embodiment. These often involved agonizing self-questioning, self-stigmatization, and isolation, and the significance of such a life-changing event in their life course. Many reflected on whether it was possible to ever get back to the person that they were:

> *"Something that is really pissing me off at the moment is this thing about post-traumatic growth. And, you know, it's these little memes, you know, that imply you've come of it better and stronger, you know, or a nicer person…. But I just think, I was quite a nice person before, you know? I didn't need this to make me grow….the way I would describe getting over [Name 55:14]'s death is, you know, if you see a tree that's grown next to a barbed wire fence, and it sort of grows across, so that the barbed wire's going through the middle of it, and it comes out either side?……that's what it feels like to me. So, on the outside it's all healthy, but inside that barbed wire will always be there….and trees grow quite slowly."* (Grandmother, 60 – 64 years old)

This participant's suicide loss had coincided with her plans for retirement and alongside other participants, she reflected a mixture of anger, despair, and anxiety about the constant presence of psychological pain and her loss of control over her future. Other elements of her narrative on her expressive needs illustrated an intolerance of being subject to what she considered to be inauthentic communication from others which belied a discomfort or dismissal of her experience and her need to internalize and manage the effects as a result.

When reflecting on their individual potential for recovery and the investment and learning needed to develop better coping strategies going forward, another said:

> *"Well, I was thinking about this thing about being over 60 because I'm just wondering if age, I mean there are*

some things that are age specific, like I said to you about the interplay of the physical and emotional health, and how much time you've got to, I wouldn't say recover, I'd say make some accommodation, you know, enough to do different things?" (Parent, 65 – 69 years old)

This theme on expectations of how (later) life will go on following the loss was not only just about what the individual could learn or do or to adapt, but also grappling with the idea of accepting that there may be *limited time* to adapt and/or limited resources or recourses available to people in later life. Where these coincided with a potential loss of health and wellbeing, sometimes directly related to the loss for example in relation to a deterioration of mental health, there was a cumulative effect. The anticipation of getting support from the person who had died for their own future and reversal of caring roles for those left behind and a general diminishing of other networks of social support which could be dramatic. As one participant stated:

"I was thinking, it really is key I think, that you don't try and get back to who you were, "cause you're not who you were, you must accept who you are now……. I think that's definitely the older a person is, when the bereavement happens, I think the more age does have an impact from isolation point of view, or lack of grand-children, or lack of somebody coming in to do your washing for you, or whatever it might be. The older you are, the less time you've got to sort of get your life back together again in some way or other." (Parent, 75 – 79 years old)

A few participants compared their sense of isolation since the death of their loved one to the experiences of people during the lockdown conditions of the COVID-19 pandemic and some felt validated for the first time and able to share valuable insights and coping mechanisms:

"Welcome to my world, it's been like this for, you know, since my son died. And you're sort of not being able to see anybody, not being able to go out, not being able to do this, or whatever. I haven't wanted to. And, you know, now everybody was in the same boat in a way." (Parent, 70 – 74 years old)

There were several instances where individuals questioned their ability to survive and looking for meaning in their motivation to survive, particularly in relation to what they described as 'losses of the future' and regrets:

"I'm okay today, but I think last weekend, I sometimes feel I can drive my car into a wall. I just get fed up with it, I can't take anymore. Aye, I think of suicide a lot. I don't think I'd do it, but I sometimes wish I wasn't here." (Partner, 84 – 85 years old)

3.2. Sense of self-worth in later life and the impact of external and internal influences

Many interviewees were forced to re-evaluate previously taken-for-granted relationships. The reaction of friends and family, both immediate and long-term, for example, was key to how individuals coped and expressed their loss. For example, almost everyone referred to friends avoiding them physically and the emotional neglect, they experienced where there was a lack of insight or understanding of what they were going through. This often forced people to look elsewhere for support, and a theme of peer or alternative networks of support started to emerge:

"Because with my friends I tended not to weep and wail and gnash my teeth, the only people I've cried, really cried, in front of are the ones who are also bereaved who completely get it." (Parent, 65 – 69 years old)

Others made conscious decisions to terminate their relationships with friends who they may have felt let down by, in some instances, long-term or significant friends from whom they experienced disappointments when looking for support. There were observations on the feeling of invisibility as an older person which manifested itself by having to prioritize the needs of those who subsequently became dependent on them, often at the expense of their own expressive and coping needs. This repositioning of self and relationships, which can feature in transformative learning, can become evident especially when significant people no longer share or even oppose a person's newly adopted world view (Sand & Tenant, 2010).

Relationships with professionals following a suicide also varied. Nearly, all the participants yearned to know every detail of their loved one's interactions and actions leading up to their death and were constantly questioning and seeking very detailed information from professionals who may have been involved. This led to many examples of disappointment in professionals, personal anger, and frustration where professionals withdrew after the death was reluctant to be in contact or to share information. This reflected a defensive culture which provided the conditions for conflict and suspicion and served to complicate the participant's bereavement further:

"Obviously I had to tell the hospital, the (name) and the consultant there just shut off all communication completely. The mental health team that came didn't come on the Friday afternoon all came to the funeral, the three nurses. But trying to have any correspondence with him, you couldn't speak to him, his secretary wouldn't put you through to him and he didn't reply to correspondence, and I thought that was poor". (Partner, 75 – 79 years old)

This refusal or inability to share information from professionals did not help with bereaved person's comprehension of what had happened. One participant who lost his wife referred to how his wife's psychiatrist used to regularly assess her suicide risk using a scale to score her risk factors:

> *"But he never, at any point, said to me, just be careful, you know, keep your eye out, do this, do that. There was no kind of protocol to the carer, to the partner, which I thought was a massive gap in what could easily have been provided."* (Partner, 84 – 89 years old)

This individual, like many other participants researched, read widely and cited their attempts to rapidly familiarize themselves with guidance, knowledge, and skills used by professionals to benchmark and understand what had occurred in their own situations and scenarios. They were extremely active in trying to make sense of what might have gone wrong for their loved ones or to use their sources of information to directly challenge the way in which services had dealt with the individuals, rightly or wrongly. There were significant and vivid experiences described of poor interaction with professionals particularly around the time of the death even where these had occurred many years earlier. These involved either being given inappropriate information in an insensitive way or being denied some basic communication on the circumstances that prevailed or what they could expect in terms of support. These poignant moments provided a trigger several years later for participants actively taking up causes where they were determined that another person would not have to have the same experience:

> *"In my letter back to the chief exec who said, if you have any further questions, I thought, yes, I do, I've said, how are you going to change your organization's culture of blame and judgment and lack of learning?"* (Mother, 60 – 64 years old)

A key professional that virtually all participants named as someone they inevitably talked to in their journey was the family doctor. Many felt that their general practitioner should be proactive in contacting bereaved people if they knew the person who died by suicide. The general practitioner was someone who was viewed as both an objective expert in offering support and advice as well as being known more intimately to both the person who died by suicide or bereaved person and any assertive outreach or proactive recognition of the suffering caused was highly valued:

> *"Yeah, yeah. I mean, when I went to the doctors for something, I had a little health issue not long afterward and she said, have you got PTSD? And I went, don't be daft. And she looked at me and she went, well, you do know if you need to tell you can come talk to me. I went, bye. But I wouldn't've said I had at the time, but apparently some… I don't know the circumstances and I know you can't say how… You've lost somebody, but she said, well, the way you found your husband, she said, that's not nice."* (Partner, 60 – 64 years old)

Likewise, some expressed a distinct lack of agency or resilience in dealing with the challenges that followed a suicide loss and described external and internal influences around ageism and sensitivities to their socioeconomic status that provided further barriers to seeking and receiving support. The following participant tried to seek solace by volunteering at a local stable but ended up being bullied:

> *"No, because they're really upmarket and they're really, like, semi-professional quite a lot of them and because I'm an oldie, with my wee horse and I'm not very experienced, I don't know why, but they don't invite me out with them. And that hurts me. And, as I said again, I keep saying, my daughter she says, well, you just to have accept these things Mum and so I, kind of, gave up trying. So, I'm not one to go in and asking them but if they don't ask me, I just get hurt. I'm…I'll tell you what's happened since the death, I am so easy hurt, I'm so sensitive. You know, to everything in life. I feel like I can't take on anything else."* (Mother, aged 70 – 74 years old)

3.3. The journey of discovery and how this interacted with social and political rights in later life

This theme captured participants new perspectives and meaning making from their direct experiences particularly in relation to challenging the stigma of suicide and self-discovery where participants actively used their experiences to influence and support others in the field of suicide bereavement. For at least a third of our participants, this gave rise to expressions of hope and optimism, particularly in relation to how their own learning and actions would benefit of others with whom they could had identified as having shared experiences. This activism at different levels led to direct offers of support or guided actions that were often practical, tangible, and inspirational.

One person whose daughter died on the railway had a very bad experience of how she was given news of her daughter's death by the British Transport Police. At the time of the interviews, she had been invited to rewrite guidelines for the police on how to "give bad news" and recorded a podcast. She had also been involved in developing an information sticker for police to place on the dashboards of their vehicles with concrete tips in working with people bereaved by suicide. She had some valuable insights to share:

"But I think they are also very uncomfortable and that's why they come out with these things like, "I'm delivering the dead message," all that sort of stuff is just because of their discomfort. And we're not good at sitting with people's pain and that's what we need to learn to do, we can't fix it so we couldn't try?" (Mother, 70 – 74 years old)

One woman who was an activist earlier in life when working with HIV/AIDS utilized her skills to get involved with a bereavement organization and it took some time for her to recognize and value the contribution she was making:

"I said, if there is anything I can do? And in fact, I've sort of become, I don't know what I am really. I am on their steering group, and I keep saying, but you don't ask me to do anything, I think I'll step down. And they keep saying, no, no. And I think I'm just a wise old woman. And I said to somebody once, I think that's what I've done, I've surrounded myself with AA, TCF, the Quakers, Proud to Be, which is the LGBT group, with people who know about fragility and vulnerability." (Mother, 80 – 84 years old)

Becoming active in the community also appeared to coincide with some participants own help seeking, self-care and self-compassion, by taking up opportunities for counseling and therapies, often for the first time since the suicide and after a significant time had already passed:

"I think one of the other most…again this is for me… one of the other most helpful things I've done is to give myself full compassion. And in fact, it was when I did it, it was the few years…it wasn't immediately, but it was incredibly cathartic on the course. It was like there was this deep well I realized which I'd never really allowed myself to look into." (Parent, 70 – 74 years old)

3.4. Reassessing one's experiences of later life

A subtheme in this journey of discovery was the temporal nature of adapting to grief and how this interacted with any changes in health and well-being as people got older. Many participants naturally attributed negative changes in their physical health to their bereavement and accepted this as a natural consequence of grief.

"Well, I find sometimes that something's bothering me or upsetting me, or I'm feeling down, I think well is this [Name 40:49] or is just getting old? I think, am I attributing all of this to the bereavement, when in actual fact, I'd be feeling like this anyway?… you can't rush grief… But, at the same time, I'm conscious of the fact that if I don't try, I'm not going to finish grieving before I die." (Grandparent, 60 – 64 years old)

Becoming more active in processing or engaging with grief reactions was related to an increasing awareness of one's own mortality and making the most of opportunities:

".what I worry about is that, that when I do get older, and I get, I mean, I kind of, if I do realize, if I get to that chance to realize my mortality, and you know, I'm reaching the end of my existence, that I'll start to become more mentally challenged… Because my belief is that if you suppress it, it doesn't go away, it just goes deep, and when you get older, it then begins to come out, in all sorts of ways." (Parent, 70 – 74 years old)

In short, many of the impetus to getting involved in relevant organizations, help seeking, and peer support were in response to participants' own wish for a more structured and organized response to the aftermath of suicide, something they felt they had been denied but was a right they wanted to fight for on behalf of others. These included signposting, information in writing that they could revisit after the initial trauma of suicide that provided relevant contacts and support. They also fought for the availability and time given by people attending the suicide to be recognized in relation to other sudden deaths in society.

3.5. Engagement with peer support

Approximately one-third of our participants were actively engaged in peer support at the time of interview. This was an area where participants spoke passionately and earnestly about any transformational turns in their journey with suicide bereavement in later life. Engaging with relevant groups and organizations provided a vehicle for voicing their loss and an opportunity to challenge stigma of suicide through public discourse to raise awareness about suicide.

"But almost by example they can see that you've…and lots of people have said this to us, well actually talking to you and realizing that you have lived through this, and you can come through it different, you will forever be changed, but it's about that little bit of hope really." (Parent-in-law, 60 – 64 years old)

One participant was very active in his local suicide action group, using his professional skills in networking and fundraising after retirement through which he successfully helped several relevant charities. Others found immense relief through opportunities for peer group work which focused on well-being initiatives, such as meditation, group therapies, and special interest groups that encouraged new hobbies and interests.

"Nobody tried to stop it, nobody tried to comfort me, it was like I was just being held in a loving whirl of compassion. They didn't ask…I didn't have to talk about it, they just let me get on with it." (Parent, 64 – 69 years old)

Some individuals provided detailed descriptions of transformation moments in which they were actively

reflecting and taking purposeful action to improve their own well-being:

> *"It was a combination of all the different things I was doing. I think it was a combination of talking to my counselor, talking to friends, going to (name of organization). Clearing some people out of my life who I felt were not being helpful. Exercise helped me as well and when I say exercise, let's be sensible, walking, walking the dog."* (Aunt, 80 – 84 years old)

The bereaved person often commented on their motivation to honor the person they lost to suicide and how their sense of guilt of having failed that person could be readdressed through the act of giving something back and to replace negative emotions and memories with more positive ones:

> *"Well, I wish with every fiber of my being that I hadn't had to live through this. I also feel that everything I do now around suicide bereavement postvention all those…suicide bereavement support and postvention and all that stuff, I do to make meaning and to keep [name]…to make meaning of what she did, to keep…it's a way of honoring her. I wish I did…I wish I hadn't had to do this, but I often think I wonder what she'd think about it, would she think, oh mum why is you doing this? But I hope she would be okay with it. I hope she'd be okay with. I think she probably would be; I think she probably is. I think as I say it's my way of honoring her and giving something…making…not letting her last…if you like it's not letting her lasting legacy be just tragedy but of providing some hope and support for other people."* (Parent, 65 – 69 years old)

This sense of agency transformation was also evident in someone who had since trained as a mental first aider:

> *"So, from my brother's death, what has…it's…I have transformed my life in a positive way, because people come to me all the time now that have problems. And I'm not…and I can't fix them because I'm not a professional, but I talk about my experience or where they may be able to go to get help, which is what being a mental health first-aider is."* (Sibling, 80-84 years old)

This recognition of making meaning through traumatic experience, the coming together of pain and optimism by giving oneself over to finding motivation for living and utilizing their experiences in different ways was succinctly expressed by another individual as follows:

> *"A lot of my life seems to be spent around suicide now and there are times when I think I need to step back for a while. Fortunately, the other people I work with who help me with facilitating the group, we're a really good team and we all look after each other. And sometimes I'll put a message on WhatsApp saying I've just had a really difficult phone call or whatever it might be and they just…they're always there, they're always there, and we're always there for each other sort of thing. So that's been…I have to say it's been a real privilege to meet some of the people who've lost somebody and to realize how…and everybody does it their own way and it's just…but it is unbelievably painful. I wish I wasn't doing any of this because I wish I didn't know about it, but in some way, it's given me some meaning in life."* (Partner, 80 – 84 years old)

This was not true for everyone as some participants talked of a lack of feeling any empathy or compassion toward other older people, and four participants talked about the constant battle with their own suicide thought but with the benefit of insight into what this would mean for others. The changing nature of their emotional pain was one that changed over time but one they became more familiar with and developed strategies to live with it as the following metaphors illustrate:

> *"So, I said, well, I'm packing up my anger and I'm sticking it under this bench and I'm not coming back to pick it up again, and I left it there. So, I had so much to support me because I think people want the truth and they want justice and they want accountability and I had that, I had the truth. I don't ever use the word, closure."* (Parent, 65 – 70 years old)

4. Discussion

This paper drew on data from a study that explored how those bereaved by suicide construct meaning about the impact of the death on their later life and how they make sense of their ongoing role with their families, support networks, their own sense of time remaining, their health and well-being, and the value of their contribution to society alongside meeting their own coping and expressive needs. While some of their experiences were found to be in common from what we already know about suicide bereavement experiences in younger groups, there were many age-related experiences worthy of comment here.

4.1. Learning from traumatic experiences of people in later life bereaved by suicide

Rich accounts were provided on how individuals bereaved by suicide describe their traumatic experiences and share about how they adapted. Those interviewed demonstrated a range of informal learning from coping and expressive needs to more transformational learning experiences in which they harnessed their knowledge to support

themselves and others, moved from introspection and for some to taking up a leadership role. Grief is often referred to as a process of adaptation (Sand & Tenant, 2010) over time periods in which those impacted revisit and rework their loss experiences, make sense of them, and cope with them eventually (Hybholt, *et al.*, 2020b).

In our study, the trajectory of the individual's lifespan and the impact of other significant life events (such as going through a divorce, retirement, other bereavements, or deterioration in their physical health) varied through different stages of participants getting older. These influenced the range of recourses that they had to draw on and to navigate more traumatic bereavement experience. Given that older people tend to have more or cumulative experiences of bereavement, participants made connections with how this process can be complicated by ageism where less value may be given to the person's loss or how they are expected to deal with it (Hafford-Letchfield *et al.*, 2022). Participants referred to periods where they did not question changes to their physical and mental health or actively seek help but instead, they tended to internalize the impact, and the result of which was adopting a reduced expectation about their quality of life going forward. Relevant to our participants, and different to younger cohorts, Fegg *et al.* (2016) have documented that in later life, chronic physical and mental health are a contributing factor to suicide.

Participants' expressive needs were often curtailed by others due to their perceived position in society, for example, by taking on new caring roles, hiding or burying their own feelings to protect others. There was a decline in opportunities for social activities for those who had lost a child, who expressed feelings of invisibility and even becoming avoidant with their own peers who had children and grandchildren. This self-silence or the recognition of societal taboos were sometimes connected with wider structural influences which marginalize people in later life (Naef *et al.*, 2013). These experiences highlight generational differences in dealing with traumatic events as our participants revealed more stoic or adopted avoidant coping styles as well as finding comfort through open dialogue (Chatterji *et al.*, 2015). Other studies have noted that contrastingly, younger individuals tended to conceal their emotions and suffering. Further, younger people may be more likely to turn to the internet and be more active in reaching out to their peers (Koo *et al.*, 2016; Hafford-Letchfield *et al.*, 2022). Knowing these points on the journey might highlight gaps and needs where earlier interventions can be targeted and understanding these different experiences is a first step toward developing the nuances required in responding to older people who have experienced bereavement by suicide which might harness their sense of agency and wider structural influences for learning. Some people in this study were able to clearly articulate their needs from interrogating their own experiences but had fewer actual vehicles for engagement in support. Providing opportunities for enabling people to develop their potential from the perspective of service providers means also not making assumptions about aging, and levels of motivation to learn (Withnall, 2010).

There are a wide range of learning practices which recognize that learning takes place right through life and is life-wide. These take place in everyday contexts and need to be enduring and connective at both personal and community levels (Burke & Jackson, 2007). This is noteworthy given that suicide prevention is under-developed for older people where strategies for younger people have been given much more attention (Hafford-Letchfield *et al.*, 2021; 2022).

4.2. Evidence of transformation in adapting to traumatic experience in later life and the factors shaping the transformational learning process

Looking at these accounts through the lens of learning demonstrated a clear conscious process and/or state of critical consciousness on behalf of the older person when faced with change or new situations following the suicide trauma and challenges of later life. Other methods such as the assimilation model (Stiles & Brinegar, 2007) describe a developmental sequence. Within this latter approach, psychological experiences are treated as agentic internal voices through which the mechanism of psychotherapy enables assimilation of emotional and cognitive review. Individuals are then enabled to develop insight and provided a meaning bridge between problematic experience and the larger community of voices within the person. However, transformational learning enables the experience of what Jarvis calls this "disjuncture" (Jarvis, 2009), through the rapid need to reassess one's expectations and perspectives on current and future later life. This demands reflection, reflexivity, and support so that meaning could be attributed and provide the conditions for potential transformation and continuing positive engagement in society. Cranton (2006) suggests that learning occurs when "an individual encounters an alternative perspective and prior habits of mind are called into question;" and it occurs as a dramatic event or a "gradual cumulative process" (p. 23). For Mezirow, transformative learning "may be epochal, a sudden, dramatic, reorienting insight, or incremental, involving a progressive series of transformations in related points of view that culminate in a transformation in habit of mind" (2000, p. 21). These were evident in the experience of those who became more active and even political, in using

their experience to benefit others and their own selves in the process illustrating that transformative learning can be as much a process of everyday occurrences as it is what Dirkx (2000; 2006) termed a "burning bush" phenomenon. This latter concept refers to the deeply emotional learning experiences that can evoke powerful feeling, such as fear, grief, loss, regret, and anger, but also joy, wonder, and awe and the sense that we cannot go back to the way we were before the experience. This "messy work" (Kegan & Lahey, 2009, p54) of the trials and tribulations that participants were navigating both at micro and macrolevels helped to progress more complex ways of adapting to such a traumatic event as suicide bereavement in the life course. In this regard, transformative learning theory is most interested in the cognitive process of learning, the mental constructions of experience, and the creation of meaning. Similarly, Jarvis (2009) theory of the experience of disjuncture from which people learn can occur in the cognitive, emotive or action domains, and questioning and analyzing experiences can spark the reaction to learn and to restore.

Less was discovered about the factors which shaped these different processes in the context of what is known about transformation learning theory, practice, and research to help understand the support needs of people bereaved by suicide in their later life and its messages for suicide prevention. Further, research is necessary to generate practice-based evidence which identifies the impact of bereavement by suicide on people in later life; how their needs for support are currently assessed and identified; and how to respond more holistically to people with psychosocial problems which stem from these experiences (Hybholt *et al.*, 2020a). Prevention of complicated grief may be successful in this population with high risk for comorbidities (Linde *et al.*, 2017) by capturing and building on the knowledge and experience of people with lived experiences. In a smaller study with nine older adult participants, Moon (2009) affirmed that perspective transformation can occur through late life bereavement characterized by an oscillatory process shaped by biographical and life stage developmental contexts. Given what is known about the loss of autonomy and physical conditions or worrying about their coming and impact as risk factors for suicide in later life, it is important that those in contact with older people bereavement by suicide investigate the possible presence of suicidal ideation (see also Hafford-Letchfield *et al.*, 2022). Medical practitioners especially who are likely to be more in touch with isolated older people should conduct suicide risk assessment in addition to identification of physical illnesses (Chatterji *et al.*, 2015). Further, providing learning and development opportunities through signposting and taking an interest in people's experiences can encourage those who want to be active in supporting others. Barlow & Coleman's (2003) evaluation of a peer support program developed for survivors of suicide suggested that an intervention protocol that is collaboratively developed and delivered by peer supporters and professionals can offer cost-effective person-centered support. These economic arguments are also highly relevant in the context of debates about the rising costs of supporting people in later life and how best to invest in prevention.

While support to those bereaved by suicide is included in suicide prevention strategies, they have been treated as a homogenous group without distinguishing between different age groups. The intensification of time pressure in later life reflected by participants had both negative and positive impacts on how the process of living beyond the bereavement played out and heightened suicide thoughts in some (Hafford-Letchfield *et al.*, 2022). Some studies (Pitman *et al.*, 2017) have supported specific associations between suicide bereavement and suicide-related outcomes, justifying the inclusion of people bereaved by suicide in national suicide prevention strategies. Most of this research has examined this in relation to younger people. Participants in our study demonstrated a greater awareness of their own end of life, associated with later life and possibly with a reduced fear of death or wish to die made more explicit in relation to their loss and potential losses. There is little acknowledgment in suicide prevention services that that older people who may experience a higher prevalence of being alone, being a carer, and long-term health conditions or comorbidities that may be unable to access current resources and networks or need something that draws on their peer experiences. It would be useful to capture in future research some of the nuances between the different age groups (Koo *et al.*, 2017).

Illeris (2007) defines the concept of learning as "any process that in living organisms leads to permanent capacity change and which is not solely due to biological maturation or aging" thus implying that learning is something much broader and more complicated. Learning also integrates two very different processes, between the learner's internal psychological process of elaboration and acquisition with their social, cultural, or physical environment. Both are significant and useful to consider when looking at how people interact with services in later life (Hafford-Letchfield, 2016). This interactive dimension (Illeris, 2009) takes place as perception, transmission, experience, imitation, activity, participation, *etc.*, and serves the personal integration in communities and society and thereby also builds up the sociality of the learner (p11). Investment in these community networks through

suicide prevention strategies would be key to engage in the potential for peer support and advocacy in later life. This offers a different lens to understanding the assimilation model referred to earlier (Stiles & Bringar, 2007), which utilizes a continuous developmental and therapeutic process. Assimilation seeks to join the problematic voice with the community of voices, which also opens the possibility of joint action, thus turning the problem into a resource. The potential of learning offers greater extension to this process, and this study is the first in our knowledge to explore the potential of transformation learning theory for understanding bereavement by suicide in later life.

Mezirow defined transformational learning as the process by which "we transform problematic frame of reference to make them more inclusive, discriminating, open reflective, and emotional able to change" (2000, p92) and these were in evidence for participants at different levels. Transformations may be epochal and often associated with a significant life crisis such as bereavement by suicide. They may also be cumulative with a progressive sequence of insights, for example, where participants had to reimagine their aging future, reconsider their networks of support, and discover new motivations and strengths such as those many brought to the peer support community. These are all central to the initiation of the transformational process (Sand & Tenant, 2010). Again, there may be some important messages for suicide prevention strategies in this strength-based approach to providing community-based support. Given that peoples experiences of bereavement by suicide in later life has been hitherto neglected in suicide research and practice, Mezirow's theories of transformational learning (2000, 2009) provide a useful reference for illustrating the potential of learning from within a critical paradigm of social care to bring about change. The concept of perspective transformation coheres with idealized aspects of professional practice with older people that emphasize the centrality of experience, critical reflection, meaning making, and the importance of relationship, which, in this study, was the exactly opposite of what happened to individuals in many cases. Participants found that both professionals, friends, and family turned away from them. Finding the right design of services and methods to engage people in suicide bereavement support can be a powerful way of bringing older people's voices in to capitalize on the assets that they themselves bring. In Mezirow's formulation, the process of transformative learning commences with a "disorienting dilemma," which leads to a self-examination with others (in mutual dialogue), a critical assessment of internalized assumptions, and finally to a "perspective transformation" or new "meaning perspective" that are more inclusive, discriminating, and reflective: "Such frames of reference are better than others because they are more likely to generate beliefs and opinions that will prove more true or justified to guide action" (Mezirow, 2003, pp. 58-59).

Fielden (2003, p82) talks about the "moving on mode" in which people bereaved by suicide came to realize the finality of their loved one's death and to develop an acceptance that their own life could never be as it was before the suicide. Some participants moved clearly from their survival mode and from searching mode in which they wanted answers to ask why their significant other had suddenly died. They began to focus their attention outward again by looking forward and participation. These strengths should be recognized and harnessed within ageing and well-being strategies.

4.3. The role of transformative learning theory, practice, and research in understanding the support needs of people bereaved by suicide in their later life and the implications for development of practice and research in suicide prevention

The UK national suicide prevention strategies (Department of Health and Social Care, 2012; 2019; UK Parliament, 2023) have repeatedly stated that those bereaved by suicide should be provided with better information and effective, timely support. As demonstrated in this study, the experience of difficult emotions increases risk of several negative outcomes for the bereaved person. For those bereaved by suicide in later life, there are particular, but often unacknowledged, challenges including a reduced and limited social network, a greater degree of emotional and social loneliness (Shah & Meeks, 2012), and problems with recovery and restorative tasks which can also be hindered by the physical and cognitive impact of disabilities and long-term health conditions that sometimes accompanies aging (Hansson & Stroebe, 2007). Many of our participants had lost a child, and this has been shown to result in psychiatric morbidity and precipitate the person's own suicide (Clarke & Wrigley, 2004). This unique population is likely to present to care services in different ways, and not always directly, for example, with medically unexplained symptoms, self-neglect, and problematic substance use (Hashim *et al.*, 2013). At the same time, the strengths and resilience of this group of people may be unrecognized and under-utilized in postvention strategies (activities developed by, with, or for suicide survivors, to facilitate recovery after suicide and to prevent adverse outcomes). While this study was conducted in the UK, it illustrates how people in later life can be marginalized from suicide prevention policies despite a global rise in their suicide rates.

At the heart of using learning theory or educational gerontology in social care is the potential for democratization

of knowledge production and using this democratization process to improve well-being in later life (Nind, 2017; Hafford-Letchfield, 2016). To the best of our knowledge, this is the first study that has examined the role of learning theory to nuance our understandings and capitalize on people's experiences of bereavement in later life. This was further supported by the adoption of participatory research methods which helped to envision experience and provide a more nuanced understanding of the complexity of suicide bereavement and discover knowledge that might otherwise go unnoticed (Faulkner *et al.*, 2021). There were also challenges in relation to process to build into the project design and timeline, sufficient resources to provide authentic and realistic support for peer researchers who were coming from a different learning standpoint themselves in terms of rigor and keeping an audit trail regarding data analysis, which some projects are not able to do.

4.4. Limitations

This study has several limitations. First, the participants in this study came from a UK context which may not be translatable to other global regions. Second, the recruitment took place through established contacts and through social media which may have influenced the participant sample to those with existing access. Third, in hindsight, we did not ask participants directly about the time that elapsed since the bereavement in their interview which could have been a useful variable to explore different experiences over time in relation to the research questions.

5. Conclusions

This study enabled an in-depth understanding of the lived experiences of people bereaved by suicide and examined these through the lens of transformational learning to articulate new meanings on how people in later life can adapt and navigate their way through traumatic experiences. To the best of our knowledge, it is the first study that has examined the role of learning theory as a means of nuancing this understanding which was enhanced by the use of participatory research methods and brought added benefits in being able to articulate findings through the added lens of those who also had lived experience. Findings suggest that further research is necessary to generate practice-base evidence, which identifies the impact of bereavement by suicide on people in later life and how their needs for support can be better understood to improve assessment and support. By capitalizing on informal and formal learning opportunities, a more holistic response could lead to developing more service user-led social, community-based, and therapeutic interventions, which utilize the authentic knowledge of older people with lived experiences.

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Conflict of interest

The authors declare no conflicts of interest.

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Ethics approval and consent to participate

This study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of The University of Strathclyde (UEC21/10). Informed consent was obtained both written and verbally from the study subjects before their participation in the study.

Consent for publication

Informed consent was obtained from study subjects for publishing their data in an anonymized form.

Availability of data

Data can be made available on reasonable request from the corresponding author.

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