


Navigating bereavement by suicide in later life: a qualitative analysis of health and social care professional perspectives

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ABSTRACT

Objectives: Older adults bereaved by suicide face unique challenges, including heightened stigma, trauma, and isolation, often compounded by limited social support. This study explores professionals' perspectives on supporting older adults bereaved by suicide, addressing a critical gap in public health.

Method: Semi-structured, in-depth interviews were conducted with professionals, including bereavement support workers, healthcare providers, and suicide prevention specialists. Data were analysed using a reflexive, inductive thematic approach.

Results: Four key themes emerged: (1) navigating the complexities of traumatic loss by suicide in later life, (2) the role of community and family support in grief management, (3) professional roles and challenges in providing support, and (4) opportunities for community engagement and meaning-making. Findings emphasise the need for community-centred, culturally sensitive bereavement care that empowers older adults to navigate grief openly.

Conclusion: Reducing stigma around suicide, recognising the impact of traumatic loss, and addressing factors that exacerbate grief are crucial to supporting mental health in older adults bereaved by suicide. Integrating bereavement support into community spaces and offering peer-support options can help alleviate isolation and trauma. Health and social care policies should prioritise improving access to services and promoting an inclusive and trauma-informed approach that meets the unique needs of this population.

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Introduction

Suicide bereavement is a profoundly complex, traumatic, and often stigmatised experience, affecting individuals and communities in ways that extend far beyond conventional grief (Levi-Belz et al., 2023). In recent years, support for those bereaved by suicide has become integrated into suicide prevention strategies (e.g. McGill et al., 2023; Mirick et al., 2023). Multi-agency suicide prevention partnerships are crucial to ensure coordinated processes are in place to identify and provide opportunities for people bereaved or affected by suicide to access support (NICE, 2019). Recent research and policy guidance emphasise the importance of tailored support in suicide prevention strategies, highlighting the need for support plans that address the unique requirements of various demographic groups, including older adults (Bartels et al., 2024; Hybholt, Buus et al., 2020; Scottish Government, 2022; UK Government, 2023). Similarly, the Support After Suicide Partnership (SASP) has introduced quality standards defining essential service requirements to support individuals bereaved by suicide, aiming to improve the quality and accessibility of these services (Harmless, 2024). However, less is known about how responses to bereavement by suicide vary across different contexts, generations, or cultures (Colucci, 2006; Kasahara-Kiritani et al., 2017).

Literature on suicide bereavement reveals that survivors often experience significant stigma, trauma, and mental health

challenges (Hafford-Letchfield et al., 2023), which shape their grief in complex and isolating ways (Cvinar, 2005; Harwood et al., 2002; McIntosh, 1993). Although society has become increasingly aware of suicide as a major public health concern [World Health Organization (WHO), 2021], the stigma associated with suicide bereavement may now manifest in more subtle forms, such as societal omission and a lack of specific support resources, leaving survivors without adequate outlets for processing their grief (Feigelman et al., 2009). Such circumstances often give rise to experiences of complicated and disenfranchised grief, where individuals feel a deep, prolonged sense of isolation and loss that goes unacknowledged by those around them (Ferlatte et al., 2019; Hanschmidt et al., 2016).

Research suggests that high levels of complicated grief symptoms may increase the risk of suicidal ideation, particularly among older adults, underlining the need for early identification and targeted support for those showing signs of complex grief (Conwell & Caine, 1991). By recognising the nuanced and often hidden challenges faced by survivors of suicide bereavement, there is a greater opportunity to develop support frameworks that address the unique needs of this group, ultimately helping to alleviate the complex psychological burdens that suicide bereavement can entail (Simon & Shear, 2024).

Later life can be a time of significant transition, which can negatively affect a person's well-being, where adjustment to

bereavement may require different types of support (Bauger & Bongaardt, 2018; Hybholt, Buus et al., 2020). A subsequent qualitative empirical study of the experiences of people bereaved by suicide in later life identified a broken notion of living, where older people had reduced possibilities for restoring and reorienting their future lives, complicated by age-related factors such as reduced social interaction, lack of structure, cumulative losses, and changes to health (Hybholt, Berring et al., 2020). Despite this, there remains a lack of understanding about how professionals or service providers are addressing the needs of older adults bereaved by suicide in later life.

The aim of this study was to explore the experiences and perceptions of health and social care professionals (hereafter referred to as 'participants') in supporting older adults bereaved by suicide in later life across the UK. This research is critical for understanding how professionals approach the unique challenges faced by older adults in navigating suicide-related bereavement, which often involves stigma, social isolation, and a lack of accessible support networks. The objectives of this study were to investigate participants':

1. Understanding of the needs of older adults bereaved by suicide,
2. Perceptions of their roles in supporting older adults bereaved by suicide,
3. Experiences of providing support to older adults following a bereavement by suicide,
4. Perceptions of optimal support approaches for older adults bereaved by suicide.

In alignment with these objectives, the study makes reference to Trauma-Informed Care (TIC), which focuses on recognising understanding and responding to the effects of trauma, particularly in vulnerable populations such as older adults bereaved by suicide (Berring et al., 2024). TIC emphasises the importance of creating supportive environments that avoid re-traumatisation, foster healing, and provide compassionate, person-centred care. (Kusmaul & Anderson, 2018).

Methods

Design

The study employed an in-depth qualitative design, utilising semi-structured interviews to explore participants' experiences and insights into supporting older adults bereaved by suicide. Semi-structured interviews were chosen for their flexibility, allowing researchers to follow an interview guide while adapting questions based on the participants' responses (Karunaratna et al., 2024). This approach enables participants to share personal stories and perspectives in their own words, facilitating the emergence of nuanced insights that may not surface in more structured or quantitative research methods (Merriam & Tisdell, 2015).

Recruitment and sampling

To maximise diversity, participants were recruited through various channels, including targeted social media campaigns and direct outreach *via* email and newsletters to health and social care organisations and bereavement support agencies across the UK. This recruitment strategy ensured visibility among

professionals likely to engage with issues surrounding mental health, bereavement, and support for older adults. Additionally, professional networks and word-of-mouth referrals were utilised to reach individuals who might not have otherwise encountered the recruitment materials. Eligibility required participants to be UK-based professionals in roles related to bereavement support or suicide prevention, such as health and social care providers, service coordinators, commissioners, and policymakers, ensuring a wide spectrum of perspectives relevant to the study.

Of the twenty-eight individuals who responded, fifteen were recruited. This reflected issues of time constraints, role misalignment and being able to follow-up communications in research participation for busy professionals. Written consent was obtained from each participant prior to the interview, alongside verbal consent at the beginning of each recorded interview session. This sample size met our initial aim, which was to recruit 12 participants, following recommendations by Hennink and Kaiser (2022), who suggest that this number allows for in-depth qualitative exploration while ensuring each participant's voice is thoroughly represented, allowing for rich, detailed insights into individual experiences and perceptions, especially in studies with specific, complex topics.

After conducting interviews with the initial 12 participants, an interim analysis was undertaken to evaluate the adequacy and depth of the data collected in relation to our research aims (Guest et al., 2006). This analysis revealed that, while substantial information had been gathered, certain developing themes would benefit from additional perspectives to further consolidate and deepen our understanding. Although the initial sample provided a strong foundation, additional interviews were deemed necessary to capture greater nuance and clarity regarding the complexities of bereavement support for older adults following a suicide. By incorporating three more participants, bringing the final sample size to 15, we achieved 'thematic sufficiency', where themes were sufficiently developed to support a comprehensive analysis (Braun & Clarke, 2021a, 2021b). The added perspectives reinforced the major themes that had been identified, providing richer insights into the unique challenges faced by professionals working with this population. This iterative and flexible approach aligns with qualitative best practices, as it allows data collection to be responsive to the study's emerging findings, thereby enhancing the credibility and robustness of the outcomes (Braun & Clarke, 2024). Ultimately, these additional interviews contributed to a more nuanced and complete understanding of the study's major themes, ensuring that the data had sufficient depth for meaningful analysis.

Topic guide

The topic guide, designed to facilitate an in-depth exploration of participants' experiences and perceptions, was informed by a comprehensive literature review and shaped through consultation with the research team and a study steering group which included older adults with lived experience of bereavement by suicide. This guide included open-ended questions aimed at capturing the complex and sensitive challenges and needs of older adults bereaved by suicide, focusing on several key areas. First, participants were encouraged to reflect on their perceptions of the grief and bereavement needs of this demographic, particularly any unique aspects of their experience compared to other types of bereavement or grief at different life stages. The guide also examined participants' roles and responsibilities

as support providers, probing into the challenges they faced in their work and how equipped they felt to meet the specific needs of older adults in this context. Additionally, questions addressed barriers to accessing support, exploring obstacles older adults might encounter, such as social stigma, geographic limitations, or health-related challenges that could hinder their engagement with bereavement services.

Another area of focus was existing resources and ideal support provisions, where participants were invited to reflect on the types of support currently available and to suggest additional resources or services, they believed would benefit older adults bereaved by suicide. The guide also covered interpersonal dynamics and family support, recognising the influence of social networks on the grieving process and exploring how family, community, or religious groups may shape an individual's experience, including the effects of stigma within these circles.

Finally, cultural sensitivity and inclusivity were addressed to acknowledge the diverse backgrounds of older adults. Participants discussed the need for culturally and religiously sensitive support services and how these factors might affect grieving practices and support needs. This comprehensive topic guide allowed participants to share detailed insights and personal observations, supporting a thorough understanding of the complexities surrounding support for older adults bereaved by suicide.

Data analysis

Interviews were transcribed verbatim by a professional transcription service under a data-sharing agreement. Data analysis followed reflexive, inductive thematic analysis as outlined by Braun and Clarke (2006, 2019, 2021a, 2021b). This flexible, iterative process allowed for themes to emerge from the data without predefined categories. Initially, the lead researcher familiarised themselves with the transcripts to gain an understanding of each participant's narrative. Two researchers independently coded the transcripts in Microsoft Word, identifying recurrent patterns across participants' accounts. This coding process spanned six weeks, in line with Braun and Clarke (2023) emphasis on active data engagement.

To ensure rigour, all transcripts were independently coded by a third researcher, and any discrepancies were discussed within the research team. Using mind-mapping techniques (Braun & Clarke, 2006, 2019, 2021a, 2021b; Fearnley, 2022), the team organised codes into broader, interconnected themes, refining the thematic structure collaboratively. Reflexive discussions were held throughout the process to challenge assumptions and interpretations, enhancing the credibility of the analysis (Braun & Clarke, 2023). To maintain transparency, an audit trail documented all decisions and analysis steps, facilitating the traceability of the study's progression. This, alongside debriefing and cross-checking, increased the credibility and rigour of the findings, adhering to COREQ guidelines (De Kleijn & Van Leeuwen, 2018; Tong et al., 2007).

Ethical considerations

Prior to the conduct of the research, ethical approval was granted by the University's ethics committee (Ref: UEC21/10). Participants received written information about the study and were given the opportunity to ask questions before providing informed consent. Confidentiality and data protection

measures were strictly observed, with assurances provided to participants. Given the sensitive nature of bereavement by suicide, a debrief letter was offered after each interview, including contact details for organisations offering support following bereavement. The study protocol also included provisions for reflection and debriefing sessions for research team members, ensuring their well-being when handling emotionally sensitive topics. Pseudonyms are used in the reporting of results to protect participants' anonymity.

Results

Participant characteristics

A total of fifteen participants were included in the study, representing diverse professional backgrounds: bereavement support ($n=4$), suicide prevention services ($n=2$), healthcare settings ($n=5$), psychology ($n=3$), and social care services ($n=1$). Participants were based across the UK, with ten from England, two from Scotland, one from Wales, and two from Northern Ireland. Each participant had a minimum of three years' experience working with older adults, with an average of 13.9 years (range: 3–30 years). Detailed sample characteristics are presented in Table 1.

Qualitative themes

The analysis yielded four major themes that illuminate the challenges and complexities faced by professionals in supporting older adults bereaved by suicide. The four themes developed were: (1) navigating the challenges associated with traumatic loss by suicide in later life; (2) role of community and family support in grief management; (3) professional roles and challenges in supporting older adults, and (4) opportunities for community engagement and meaning-making (see Table 2).

Theme one: navigating the challenges associated with traumatic loss by suicide in later life

Participants highlighted the complex grief experienced by older adults bereaved by suicide, viewing it as a unique and often

Table 1. Participant characteristics.

Variables	n	Variables	n
Bereavement support / service provider		Ethnicity^a	
Bereavement support team leader	1	Asian, Indian	2
Bereavement support group facilitator	1	White, British	3
Service manager	1	White, English	7
Suicide bereavement service liaison worker	1	White, Irish	1
Suicide prevention services		White, Scottish	1
Clinical network manager	1	White, Welsh	1
Operational director	1	Location of participants	
Health Care Settings		England	10
Counsellor	1	Scotland	2
Suicide liaison service lead	1	Wales	1
Mental health nurse	2	Northern Ireland	2
Consultant old age psychiatrist	1		
Psychology			
Consultant clinical psychologist	2		
Therapeutic counsellor	1		
Social care services			
Group manager, adult health and social care (prevention, personalisation and direct care)	1		

^aParticipants were asked to select their ethnic group. Groups were based on the 2011 Census for England Wales.

Table 2. Thematic table.

Theme	Description
Navigating the Challenges Associated With Traumatic Loss By Suicide in Later Life	<ul style="list-style-type: none"> • Societal stigma and generational taboo around suicide often lead to shame, trauma, and isolation. • Older adults may experience guilt or self-blame, complicating their ability to seek support. • A sense of duty to remain strong for their families often results in emotional suppression.
Role of Community and Family Support in Grief Management	<ul style="list-style-type: none"> • Reduced social networks limit access to practical and emotional support during bereavement. • Community-based resources like peer-support groups and activity gatherings are valuable. • Cultural and religious beliefs can shape grief experiences and may limit available support.
Professional Roles and Challenges in Supporting Older Adults	<ul style="list-style-type: none"> • Professionals primarily signpost older adults to external services rather than provide direct care. • Lack of specialised training creates uncertainty in addressing the needs of bereaved older adults. • Collaboration between bereavement services and primary care is crucial for cohesive support.
Opportunities for Community Engagement and Meaning-Making	<ul style="list-style-type: none"> • Volunteering and community initiatives offer solace and purpose to bereaved older adults. • Meaningful activities, like suicide prevention efforts, can help older adults cope and heal. • Engagement in these activities fosters agency, connection, and emotional healing.

traumatic form of loss. The suddenness, stigma, and unanswered questions surrounding suicide were seen as distinguishing it from other bereavements, leaving older adults with feelings of guilt, confusion, and unresolved grief. While some were able to adjust over time, many struggled deeply with the loss, hindered by both internalised stigma and various external barriers. Participants felt the traumatic nature of suicide heightened the need for older adults to talk openly about the deceased and the circumstances of their death. However, societal expectations and a reluctance to 'burden' others often prevented these conversations. This hesitation was rooted in longstanding stigma surrounding suicide, which, in the past, was not only morally condemned but also criminalised. For some older adults, this historical context created a persistent sense of shame, making it difficult for them to openly process their grief. Participants emphasised the importance of using non-criminalising language when discussing suicide, as such language can help reduce stigma and facilitate more open, compassionate conversations about the loss.

I think, as we might say, older people have a range of views which are kind of, linked to times where, you know, you did commit suicide, it was considered to be a bad thing, it's a stigmatised thing. And I think, being bereaved, you know, when you're over 60, and nobody spoke about suicide, it can be desperately shaming and desperately hard to understand, simply because of the stigma associated with it. [Nadeem, Consultant Clinical Psychologist]

Participants reflected on experiences where religious or traditional values further complicated the grieving process for older adults bereaved by suicide, making the traumatic loss even more challenging to discuss within certain social or faith-based circles. Many leaned on their religious communities for support in other areas of life but felt uncomfortable or unable to share a bereavement by suicide, fearing judgement or

withdrawal of support. This added another layer of isolation to an already stigmatised and traumatic experience.

Particularly, in relation to religion and the stigma associated with someone committing suicide within the church. A lot of older generation lean towards that community for support in most life situations, but I think there's a concern that that support wouldn't be available from people within their local congregation after a death by suicide. [Naomi, Group Manager, Adult Health and Social Care]

In addition to the stigma and trauma of the loss itself, participants noted that older adults often felt overlooked by family and friends, especially when they did not hold a primary role in the deceased's life, such as being a grandparent rather than a parent. This generational expectation often led older adults to assume the role of the 'strong' family member, attempting to support others while suppressing their own grief and trauma. Participants described this as a generational coping style where older adults felt responsible for being the steady, resilient figure in times of family crisis.

There's a generational kind of style really, of communicating, with older people feeling like they have to be the strong matriarch, patriarch...may not want to talk and worry their loved ones. [Diana, Community Mental Health Nurse]

Beyond psychological and social barriers, participants identified several practical obstacles that hindered access to bereavement support for older adults experiencing this traumatic loss. Limited services in rural areas and inadequate public transport posed significant barriers. Additionally, the 'digital divide' restricted access to online support resources for older adults who were less familiar with technology. Physical and cognitive impairments, such as mobility challenges or hearing loss, further complicated participation in both in-person and virtual support groups. While some organisations attempted to accommodate these needs, participants noted persistent gaps in service accessibility for this demographic.

When you're looking for support and putting support in place, it becomes really difficult...and if you add a disability on top of that, whether that be a mobility or a hearing difficulty, you're struggling there. [Martina, Bereavement Support Team Leader]

Theme two: role of community and family support in grief management

Participants believed it was important for older adults bereaved by suicide to have social networks to provide emotional and practical support. However, they felt many older adults may have fewer social connections, either due to geographic distance from family or a reluctance to 'burden' loved ones with their needs. If the person who died by suicide was considered by participants as the primary source of support for the older adult, this was deemed an additional challenge, as leaving the bereaved individual without essential assistance for daily tasks.

He had a son who took his own life, and his son was really, really supportive with him...Now, his son's no longer there and able to help him do those things. [Alison, Community Mental Health Nurse]

Participants felt that older adults often sought out support groups and/or bereavement support either on their own or through referrals from primary health and social care providers. Meeting others who had experienced similar losses was seen as beneficial for older people bereaved by suicide, particularly when family or friends were unavailable for support. However,

barriers such as feelings of shame, stigma, lack of internet access, or limited availability of local services were believed to restrict older people's access to these groups.

We've got quite rural populations as well... Unless you've got a post in each area, which can be difficult, I think sometimes people can be excluded from those services. [Alex, Therapeutic Counsellor]

Theme three: professional roles and challenges in supporting older adults

Participants felt their role in supporting older adults bereaved by suicide was referring them to specialised bereavement services. Many participants felt they were limited to provide direct care due to a lack of specialised knowledge and/or training or resources to support this population adequately. General practitioners (GPs) were viewed as ideally positioned to be the initial point of contact for older adults, but participants highlighted the need for GPs to have greater awareness of available support services to improve referrals.

Quite often the GPs are the go-to people. The older generation view GPs as the all-knowing oracle...It would help if they [GPs] knew where to send them [older adults] to. [Adrienne, Bereavement Support Group Facilitator]

Participants emphasised it was necessary for professionals to use open and clear language when discussing suicide with older adults. This included acknowledging the person that died by suicide and recognising this as being a traumatic loss without imposing judgment. Encouraging older adults to share their experiences was seen as a way to help them navigate their grief.

Is there something around that the everyday lay person...almost needs the tools on how to actually talk to or have a conversation with someone. [Cassandra, Suicide Liaison Service Lead]

Theme four: opportunities for community engagement and meaning-making

Participants considered the potential of community engagement as a meaningful pathway for older adults bereaved by suicide to navigate their grief. Many participants reported that older adults often seek a renewed sense of purpose after experiencing bereavement by suicide, with some finding solace and agency through volunteer work or other forms of community involvement. Volunteering with suicide prevention and bereavement support organisations, for example, was perceived to provide these individuals with the opportunity to connect with others and to make a positive contribution, which they believed was a way of honouring the memory of their loved one.

One participant felt that for many older adults, involvement in community work was a way to transform their grief into action, allowing them to feel their experience could help others.

Many older adults want to help ensure that others don't feel alone in their loss. Through volunteering, they find a way to process their grief while feeling they're making a real difference. [Paul, Old Age Psychiatrist]

For some older adults, community engagement was perceived as not only emotional support but also a platform for personal healing. Engaging in meaningful activities, whether related directly to bereavement services or other community-based projects, were considered by participants as helpful

for older adults to feel connected and to rebuild their lives around positive, impactful work.

When older adults participate in community projects, they often find a renewed sense of purpose and connection, which significantly aids their healing process. [Sam, Clinical Psychologist]

Participants reflected that older adults bereaved by suicide who engaged in activities such as support groups, community gardening, or even advocacy efforts, reported feeling less isolated and more capable of managing their grief. It was the view of professionals that older adults benefitted from seeking opportunities to give back by volunteering with suicide prevention services. This involvement was considered to allow older adults to process their grief while helping others and contributing to a generational shift toward openness about mental health.

If you help someone else, you're helping yourself...It makes you feel that your loved one didn't die in vain, but you're creating change. [Florence, Operational Director]

Discussion

This study illuminates the complex and multifaceted experiences of older adults bereaved by suicide, as perceived by health and social care professionals. The findings emphasise the challenges that older adults experience in navigating traumatic loss, the critical yet often limited role of family and community support in grief management, the unique professional roles and challenges in providing bereavement support, and the value of community engagement and meaning-making as pathways for healing.

Similar to earlier research (Carr & Mooney, 2021; Ding & Kennedy, 2021; Hafford-Letchfield et al., 2022, 2023), participants recognised bereavement by suicide in later life as a deeply traumatic experience, often amplified by generational stigma surrounding mental health and suicide. The sudden and stigmatised nature of suicide grief was perceived as distinct from other types of bereavement, leading to complex grief responses, such as self-blame, guilt, and isolation. Participants shared that older adults often struggle to discuss their grief openly, due in part to cultural and generational attitudes toward suicide that view it as a shameful or taboo subject (Hafford-Letchfield et al., 2022, 2023; Hybholt, Berring et al., 2020; McGill et al., 2023). Previous research has reported that stigma, internalised over a lifetime, creates significant barriers to accessing support, as older adults may feel reluctant to share their feelings, fearing judgment or burdening family members (Cvinar, 2005; Ferlatte et al., 2019; Pitman et al., 2014; Van der Burgt et al., 2021; Young et al., 2012). Participants reported that for some older adults, religious or traditional beliefs further complicated their grief, as suicide may conflict with faith-based views on life and death. This layer of social and cultural stigma highlights the need for care providers to take a trauma-informed, culturally sensitive approach to suicide bereavement (Aeschlimann et al., 2024), which could help address feelings of shame and allow older adults to process their grief in a supportive, non-judgmental environment (Michaud-Dumont et al., 2020).

Community and family support were recognised as critical to grief management, yet participants noted that many older adults lack strong support networks. Geographic distance from family members, reduced social circles, and the societal tendency to overlook older adults' emotional needs were seen to

contribute to this isolation (Figueiredo et al., 2012). For older adults, this is further compounded by the loss of a close confidante, especially when the deceased was their primary source of support (Michaud-Dumont et al., 2020). Participants indicated that without this essential support, older adults may struggle with practical and emotional aspects of grief, which can lead to prolonged and complicated bereavement (Aoun et al., 2018). Research suggests that grief outcomes improve when bereaved individuals feel supported by family and friends, highlighting the importance of social support in grief adjustment (Aoun et al., 2018; Bottomley et al., 2017; Thoits, 2011).

Support groups, particularly peer-support, were cited as valuable resources where older adults can connect with others who have experienced similar losses. However, participants acknowledged that practical barriers, such as transportation issues, limited local services, and digital literacy challenges, restrict access to these community-based support options for many older adults which can increase social isolation. These findings align with research indicating that social isolation and lack of peer connection are major risk factors for mental health and suicidal ideation among older adults bereaved by suicide (Beghi et al., 2021; De Mendonça Lima et al., 2021; Paquet et al., 2023). To bridge these gaps, initiatives aimed at facilitating social connections such as activity-based gatherings and local support networks may offer older adults a more accessible avenue for grief support within their communities ((Michaud-Dumont et al., 2020); Smith & Barnes, 2011).

The participants in this study largely saw their roles as signposting older adults to specialist bereavement services rather than providing direct emotional support. Participants expressed concerns about the limitations of their own knowledge, training and resources in addressing the unique needs of older adults bereaved by suicide. They noted that primary care providers, especially GPs, are often the first point of contact for bereaved older adults, yet without specialised training in grief, mental health and trauma, GPs may lack the skills to provide adequate support or appropriate referrals (Gellert et al., 2021).

The findings indicate a clear need for specialised training for health and social care professionals on how to support older adults through complex grief associated with bereavement by suicide. This includes training in trauma-informed approaches, awareness of ageism and cultural sensitivity to encourage compassionate and open conversations about suicide, mental health and bereavement. Strengthening collaboration between primary care providers and community-based bereavement support services would also enable a more holistic and consistent support pathway for older adults navigating this challenging form of grief. Community engagement emerged as a significant opportunity for older adults to find meaning and purpose following a suicide loss. Participants observed that many older adults bereaved by suicide seek to transform their grief into action, finding comfort and a sense of purpose through volunteer work, advocacy, or other forms of community involvement. Engaging in meaningful activities not only provides emotional support but also allows older adults to create a positive legacy for their lost loved one, facilitating healing and a renewed sense of agency (Andriessen et al., 2019). Opportunities for community involvement, such as volunteering with suicide prevention organisations or participating in peer-support initiatives, were seen to benefit older adults by fostering social connection and reducing feelings of isolation. As found in earlier work (Hafford-Letchfield et al., 2022; Hybholt, Berring et al., 2020). Participants' noted, however, that barriers,

such as limited mobility, transportation issues, and a lack of local engagement opportunities, continue to hinder participation. For older adults in rural or underserved areas, expanding community engagement options, such as through mobile outreach programs or partnerships with local organisations, may increase accessibility and help more individuals find a pathway to healing through connection and service.

Limitations

The study relies on the views of professionals which aims to complement studies based on the voices of older adults who have experienced bereavement by suicide (refs). Care providers offer critical insights and more direct comparison with accounts from bereaved older adults could further illuminate specific needs and challenges. Furthermore, recruitment *via* social media and professional networks may have resulted in sample bias, as those already inclined to reflect on bereavement may have been more likely to participate. This could have influenced the scope of perspectives included, potentially under-representing viewpoints from professionals in less connected or rural regions, as well as from marginalised populations. Additionally, the racial and ethnic composition of the sample may not fully capture the diverse experiences of older adults from different cultural backgrounds, whose experiences of grief and bereavement may differ significantly. Finally, while the study highlights barriers related to geographic location, technology access, and stigma, these factors may vary across cultural and demographic contexts, limiting the transferable insights of the study to diverse populations.

Additionally, the institutional context of the study should be noted. The recruitment across the UK included a variety of professionals working in different regions, allowing for a diverse range of perspectives from both urban and rural settings. However, this distribution may not fully capture the experiences of professionals or bereaved individuals from more marginalised or less connected communities. Furthermore, the study's reliance on professional networks means that the voices of those without access to such networks, or who are less likely to engage with mental health and bereavement services, may have been under-represented. Despite these limitations, the study's rigorous approach to data collection and reflexive thematic analysis provides a valuable foundation for informing postvention support for older adults and identifying areas where improvements are needed.

Implications & recommendations

Future research should aim to compare the lived experiences of older adults bereaved by suicide and compare these with those of professionals to enhance understanding of the emotional, social, and practical challenges, thus enabling more tailored, person-centred interventions (Westcott et al., 2024). Given the importance of social connection, studies could also examine the effectiveness of peer-support models like activity-based groups, intergenerational projects, and digital options to reduce isolation (Andriessen et al., 2019; Aoun et al., 2018; Bottomley et al., 2017; Higgins et al., 2022; Young et al., 2012). Training primary care providers in trauma-informed care and cultural sensitivity is essential to support older adults in managing complex grief, fostering compassionate discussions, and facilitating effective referrals to community support (Arowosegbe & Oyelade, 2023; Bell et al., 2024; Gellert et al.,

2021). To address structural barriers to participation such as limited transportation, digital literacy challenges, and inadequate rural services, future practice should develop mobile outreach and community partnerships, as well as digital literacy programs to enhance older adults' access to online bereavement and mental health resources (Clarke & Wrigley, 2004; Engel et al., 2023; Monaghan et al., 2024; Selman et al., 2023; Shah & Meeks, 2012). Direce engagement of older adults in developing services such as peer support can address the impact of ageism including internalised self-stigma.

Conclusion

The death of a loved one to suicide is a profoundly traumatic experience, with grief often complicated by intense emotions, stigma and unique mental health challenges. For older adults, this bereavement brings additional complexities, including generational stigma surrounding mental health, shame, social isolation, and limited access to targeted support services. Care providers who work with this population report that older adults grieving a suicide often require specialised mental health support, yet face significant barriers to accessing it, such as limited mobility, technological gaps, and societal taboos. Through the perspectives of care providers, this study highlights the importance of a comprehensive, inclusive approach to postvention support that addresses the distinct needs of older adults coping with suicide bereavement. It emphasises the crucial role of both specialist and primary care support in providing compassionate, trauma-informed, and accessible mental health services that are essential in their healing process.

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Authors' contributions

THL conceptualised the study. Ethics approval was completed by THL and JRH. JRH coordinated and conducted data collection. Data analysis was led by NC and JRH, with substantial contributions from THL, SM, and SR. NC took the lead in drafting the manuscript, with THL and JRH providing significant input. All authors reviewed and critically revised the manuscript. All authors have reviewed the manuscript critically for clarity and intellectual content, provided revisions, and have approved this version.

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Data availability statement

The data that support the findings of this study are available at the University of Strathclyde, repository and available on reasonable

request from the first author. The data are not publicly available due to privacy and ethical restrictions. The study passed ethical committee review from University [Ref: UEC21/10].

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References

- Aeschlimann, A., Heim, E., Killikelly, C., Arafa, M., & Maercker, A. (2024). Culturally sensitive grief treatment and support: A scoping review. *SSM - Mental Health*, 5, 100325. <https://doi.org/10.1016/j.ssmmh.2024.100325>
- Andriessen, K., Kryszinska, K., Hill, N. T., Reifels, L., Robinson, J., Reavley, N., & Pirkis, J. (2019). Effectiveness of interventions for people bereaved through suicide: A systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. *BMC Psychiatry*, 19(1), 49. <https://doi.org/10.1186/s12888-019-2020-z>
- Aoun, S. M., Breen, L. J., White, I., Rumbold, B., & Kellehear, A. (2018). What sources of bereavement support are perceived helpful by bereaved people and why? Empirical evidence for the compassionate communities approach. *Palliative Medicine*, 32(8), 1378–1388. <https://doi.org/10.1177/0269216318774995>
- Arowosegbe, A., & Oyelade, T. (2023). Suicide risk assessment and prevention tools in the UK: Current landscape and future directions. *Psychiatry International*, 4(4), 354–369. <https://doi.org/10.3390/psychiatryint4040032>
- Bartels, S. J., Blow, F. C., Golden, R., Donnan, L., Keefe, B., & Emery-Tiburcio, E. (2024). State policy academies on mental health, substance use, and aging. *Public Policy & Aging Report*, 34(2), prae006–48. <https://doi.org/10.1093/ppar/prae006>
- Bauger, L., & Bongaardt, R. (2018). Structural developmental psychology and health promotion in the third age. *Health Promotion International*, 33(4), 686–694. <https://doi.org/10.1093/heapro/daw104>
- Beghi, M., Butera, E., Cerri, C. G., Cornaggia, C. M., Febbo, F., Mollica, A., Bernardino, G., Piscitelli, D., Resta, E., Loggrosino, G., Daniele, A., Altamura, M., Bellomo, A., Panza, F., & Lozupone, M. (2021). Suicidal behaviour in older age: A systematic review of risk factors associated to suicide attempts and completed suicides. *Neuroscience and Biobehavioral Reviews*, 127, 193–211. <https://doi.org/10.1016/j.neubiorev.2021.04.011>
- Bell, J., Cunnah, K., & Earle, F. (2024). Understanding impact and factors that improve postvention service delivery: Findings from a study of a community-based suicide bereavement support service in England. *Mortality*, 1–15. <https://doi.org/10.1080/13576275.2024.2417299>
- Berring, L. L., Holm, T., Hansen, J. P., Delcomyn, C. L., Søndergaard, R., & Hvidhjelm, J. (2024). Implementing trauma-informed care-settings, definitions, interventions, measures, and implementation across settings: A scoping review. *Healthcare (Basel, Switzerland)*, 12(9), 908. <https://doi.org/10.3390/healthcare12090908>
- Bottomley, J. S., Burke, L. A., & Neimeyer, R. A. (2017). Domains of social support that predict bereavement distress following homicide loss: Assessing need and satisfaction. *Omega*, 75(1), 3–25. <https://doi.org/10.1177/0030222815612282>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589–597. <https://doi.org/10.1080/2159676X.2019.1628806>
- Braun, V., & Clarke, V. (2021a). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, 18(3), 328–352. <https://doi.org/10.1080/14780887.2020.1769238>
- Braun, V., & Clarke, V. (2021b). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, 13(2), 201–216. <https://doi.org/10.1080/2159676X.2019.1704846>
- Braun, V., & Clarke, V. (2023). Is thematic analysis used well in health psychology? A critical review of published research, with recommendations for quality practice and reporting. *Health Psychology Review*, 17(4), 695–718. <https://doi.org/10.1080/17437199.2022.2161594>

- Braun, V., & Clarke, V. (2024). Reporting guidelines for qualitative research: A values-based approach. *Qualitative Research in Psychology*, 1–40. <https://doi.org/10.1080/14780887.2024.2382244>
- Carr, D., & Mooney, H. (2021). Bereavement in later life. In *Handbook of aging and the social sciences* (pp. 239–254). Academic Press.
- Clarke, C. S., & Wrigley, M. (2004). Suicide-related bereavement and psychiatric morbidity in the elderly. *Irish Journal of Psychological Medicine*, 21(1), 22–24. <https://doi.org/10.1017/S0790966700008119>
- Colucci, E. (2006). The cultural facet of suicidal behaviour: Its importance and neglect. *Australian e-Journal for the Advancement of Mental Health*, 5(3), 234–246. <https://doi.org/10.5172/jamh.5.3.234>
- Conwell, Y., & Caine, E. D. (1991). Suicide in the elderly chronic patient population. In E. Light & B. D. Lebowitz (Eds.), *The elderly with chronic mental illness* (pp. 31–52). Springer Publishing Co.
- Cvinar, J. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care*, 41(1), 14–21. <https://doi.org/10.1111/j.0031-5990.2005.00004.x>
- De Kleijn, R., & Van Leeuwen, A. (2018). Reflections and review on the audit procedure: Guidelines for more transparency. *International Journal of Qualitative Methods*, 17(1), 1609406918763214. <https://doi.org/10.1177/1609406918763214>
- De Mendonça Lima, C. A., De Leo, D., Ivbijaro, G., & Svab, I. (2021). Suicide prevention in older adults. *Asia-Pacific Psychiatry*, 13(3), e12473.
- Ding, O. J., & Kennedy, G. J. (2021). Understanding vulnerability to late-life suicide. *Current Psychiatry Reports*, 23(9), 58. <https://doi.org/10.1007/s11920-021-01268-2>
- Engel, L., Brijnath, B., Chong, T. W. H., Hills, D., Hjorth, L., Loi, S., Majmudar, I., Mihalopoulos, C., & Gerber, K. (2023). Quality of life and loneliness post-bereavement: Results from a nationwide survey of bereaved older adults. *Death Studies*, 47(9), 994–1005. <https://doi.org/10.1080/07481187.2022.2155887>
- Fearnley, C. J. (2022). Mind mapping in qualitative data analysis: Managing interview data in interdisciplinary and multi-sited research projects. *Geo: Geography and Environment*, 9(1), e00109. <https://doi.org/10.1002/geo.2.109>
- Feigelman, W., Gorman, B. S., & Jordan, J. R. (2009). Stigmatization and suicide bereavement. *Death Studies*, 33(7), 591–608. <https://doi.org/10.1080/07481180902979973>
- Ferlatte, O., Oliffe, J. L., Salway, T., & Knight, R. (2019). Stigma in the bereavement experiences of gay men who have lost a partner to suicide. *Culture, Health & Sexuality*, 21(11), 1273–1289. <https://doi.org/10.1080/13691058.2018.1556344>
- Figueiredo, A. E. B., Silva, R. M. d., Mangas, R. M. d N., Vieira, L. J. E. d S., Furtado, H. M. J., Gutierrez, D. M. D., & Sousa, G. S. d. (2012). Impact of suicide of the elderly on their families. *Ciencia & Saude Coletiva*, 17(8), 1993–2002. <https://doi.org/10.1590/S1413-81232012000800010>
- Gellert, P., Lech, S., Kessler, E.-M., Herrmann, W., Döpfmer, S., Balke, K., Oedekoven, M., Kuhlmei, A., & Schnitzer, S. (2021). Perceived need for treatment and non-utilization of outpatient psychotherapy in old age: Two cohorts of a nationwide survey. *BMC Health Services Research*, 21(1), 442. <https://doi.org/10.1186/s12913-021-06384-6>
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59–82. <https://doi.org/10.1177/1525822X05279903>
- Hafford-Letchfield, T., Hanna, J. R., Ellmers, T. J., Rasmussen, S., Cogan, N., Gleeson, H., Goodman, J., Martin, S., Walker, P., & Quaipe, M. (2022). Talking really does matter: Lay perspectives from older people on talking about suicide in later life. *Frontiers in Psychology*, 13, 1009503. <https://doi.org/10.3389/fpsyg.2022.1009503>
- Hafford-Letchfield, T., Hanna, J., Grant, E., Ryder-Davies, L., Cogan, N., Goodman, J., Rasmussen, S., & Martin, S. (2022). "It's a living experience": Bereavement by suicide in later life. *International Journal of Environmental Research and Public Health*, 19(12), 7217. <https://doi.org/10.3390/ijerph19127217>
- Hafford-Letchfield, T., Hanna, J. R., Grant, E., Ryder-Davies, L., Cogan, N., Goodman, J., & Rasmussen, S. (2023). "It's like an oak tree growing slowly across a barbed wire fence": Learning from traumatic experience of bereavement by suicide in later life. *International Journal of Population Studies*, 10(2), 44–60. <https://doi.org/10.36922/ijps.0777>
- Hanschmidt, F., Lehnig, F., Riedel-Heller, S. G., & Kersting, A. (2016). The stigma of suicide survivorship and related consequences—A systematic review. *PLoS One*, 11(9), e0162688. <https://doi.org/10.1371/journal.pone.0162688>
- Harmless. (2024). *Suicide bereavement quality standards and their relevance*. harmless.org.uk
- Harwood, D., Hawton, K., Hope, J., & Jacoby, R. (2002). The grief experiences and needs of bereaved relatives and friends of older people dying through suicide: A descriptive and case-control study. *Journal of Affective Disorders*, 72(2), 185–194. [https://doi.org/10.1016/s0165-0327\(01\)00462-1](https://doi.org/10.1016/s0165-0327(01)00462-1)
- Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine* (1982), 292, 114523. <https://doi.org/10.1016/j.socscimed.2021.114523>
- Higgins, A., Hybholt, L., Meuser, O. A., Eustace Cook, J., Downes, C., & Morrissey, J. (2022). Scoping review of peer-led support for people bereaved by suicide. *International Journal of Environmental Research and Public Health*, 19(6), 3485. <https://doi.org/10.3390/ijerph19063485>
- Hybholt, L., Berring, L. L., Erlangsen, A., Fleischer, E., Toftgaard, J., Kristensen, E., Toftgaard, V., Havn, J., & Buus, N. (2020). Older adults' conduct of everyday life after bereavement by suicide: A qualitative study. *Frontiers in Psychology*, 11, 1131. <https://doi.org/10.3389/fpsyg.2020.01131>
- Hybholt, L., Buus, N., Erlangsen, A., & Lauge Berring, L. (2020). Older adults bereaved by suicide: A systematic literature search identifying zero studies. *Archives of Suicide Research: Official Journal of the International Academy for Suicide Research*, 24(1), 119–124. <https://doi.org/10.1080/13811118.2018.1509751>
- Karunaratna, I., Gunasena, P., Hapuarachchi, T., & Gunathilake, S. (2024). The crucial role of data collection in research: Techniques, challenges, and best practices. *Uva Clinical Research*, 1–24.
- Kasahara-Kiritani, M., Ikeda, M., Yamamoto-Mitani, N., & Kamibeppu, K. (2017). Regaining my new life: Daily lives of suicide-bereaved individuals. *Death Studies*, 41(7), 447–454. <https://doi.org/10.1080/07481187.2017.1297873>
- Kusmaul, N., & Anderson, K. (2018). Applying a trauma-informed perspective to loss and change in the lives of older adults. *Social Work in Health Care*, 57(5), 355–375. <https://doi.org/10.1080/00981389.2018.1447531>
- Levi-Belz, Y., Kryszynska, K., & Andriessen, K. (2023). What do we know about suicide bereavement, and what we can do to help suicide-loss survivors? *International Journal of Environmental Research and Public Health*, 20(8), 5577. <https://doi.org/10.3390/ijerph20085577>
- McGill, K., Bhullar, N., Batterham, P. J., Carrandi, A., Wayland, S., & Maple, M. (2023). Key issues, challenges, and preferred supports for those bereaved by suicide: Insights from postvention experts. *Death Studies*, 47(5), 624–629. <https://doi.org/10.1080/07481187.2022.2112318>
- McIntosh, J. L. (1993). Control group studies of suicide survivors: A review and critique. *Suicide and Life-Threatening Behavior*, 23(2), 146–161. <https://doi.org/10.1111/j.1943-278X.1993.tb00379.x>
- Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. John Wiley & Sons.
- Michaud-Dumont, G., Lapierre, S., & Viau-Quesnel, C. (2020). The experience of adults bereaved by the suicide of a close elderly relative: A qualitative pilot study. *Frontiers in Psychology*, 11, 2331. <https://doi.org/10.3389/fpsyg.2020.538678>
- Mirick, R. G., McCauley, J., & Bridger, J. (2023). Integrating trauma-informed principles into suicide prevention, intervention, and postvention. *Practice Innovations*, 8(4), 305–316. <https://doi.org/10.1037/pri0000212>
- Monaghan, C., Avila-Palencia, I., Han, S. D., & McHugh Power, J. (2024). Procrastination, depressive symptomatology, and loneliness in later life. *Ageing & Mental Health*, 28(9), 1270–1277. <https://doi.org/10.1080/13607863.2024.2345781>
- Paquet, C., Whitehead, J., Shah, R., Adams, A. M., Dooley, D., Spreng, R. N., Aunio, A.-L., & Dubé, L. (2023). Social prescription interventions addressing social isolation and loneliness in older adults: Meta-review integrating on-the-ground resources. *Journal of Medical Internet Research*, 25, e40213. <https://doi.org/10.2196/40213>
- Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *The Lancet. Psychiatry*, 1(1), 86–94. [https://doi.org/10.1016/S2215-0366\(14\)70224-X](https://doi.org/10.1016/S2215-0366(14)70224-X)
- Scottish Government. (2022). *Creating Hope Together: Suicide prevention action plan 2022 to 2025*. Retrieved November 6, 2024, from <https://www.gov.scot/publications/creating-hope-together-scotlands-suicide-prevention-action-plan-2022-2025/>

- Selman, L. E., Sutton, E., Medeiros Mirra, R., Stone, T., Gilbert, E., Rolston, Y., Murray, K., Longo, M., Seddon, K., Penny, A., Mayland, C. R., Wakefield, D., Byrne, A., & Harrop, E. (2023). 'Sadly I think we are sort of still quite white, middle-class really'—Inequities in access to bereavement support: Findings from a mixed methods study. *Palliative Medicine*, 37(4), 586–601. <https://doi.org/10.1177/02692163221133665>
- Shah, S. N., & Meeks, S. (2012). Late-life bereavement and complicated grief: A proposed comprehensive framework. *Aging & Mental Health*, 16(1), 39–56. <https://doi.org/10.1080/13607863.2011.605054>
- Simon, N. M., & Shear, M. K. (2024). Prolonged grief disorder. *The New England Journal of Medicine*, 391(13), 1227–1236. <https://doi.org/10.1056/NEJMcp2308707>
- Smith, R., Barnes, M. (2011). Lifelines: An evaluation of a prevention programme with older people. UOB [WWW document]. Retrieved August 21, 2012, from http://www.brighton.ac.uk/sass/research/publications/Lifelines_findings.pdf
- Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior*, 52(2), 145–161. <https://doi.org/10.1177/0022146510395592>
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*, 19(6), 349–357. <https://doi.org/10.1093/intqhc/mzm042>
- UK Government. (2023). *Suicide prevention in England: 5-year cross-sector strategy*. <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy>
- Van der Burgt, M. C., Beekman, A. T., Hoogendoorn, A. W., Berkelmans, G., Franx, G., & Gilissen, R. (2021). The impact of a suicide prevention awareness campaign on stigma, taboo and attitudes towards professional help-seeking. *Journal of Affective Disorders*, 279, 730–736. <https://doi.org/10.1016/j.jad.2020.11.024>
- Westcott, J. B., Fullen, M. C., Tomlin, C. C., Eikenberg, K., Delaughter, P. M., Breedlove Mize, M. C., & Shannonhouse, L. R. (2024). 'We all have a stake in this': a phenomenological inquiry into integrating suicide intervention in home-delivered meal service contexts. *Aging & Mental Health*, 28(5), 762–770. <https://doi.org/10.1080/13607863.2023.2282681>
- World Health Organization (WHO). (2021). *Suicide*. Retrieved July 30, 21, from <https://www.who.int/news-room/fact-sheets/detail/suicide>
- Young, I. T., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience*, 14(2), 177–186. <https://doi.org/10.31887/DCNS.2012.14.2/iyoung>