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Title	Utilization of postvention supports: a national cross-sectional survey of adults bereaved by suicide
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Title: Utilisation of postvention supports: A national cross-sectional survey of adults bereaved by suicide.

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Conflict of interest: One author (FT) is affiliated with Healing Untold Grief Groups (HUGG), a registered charity providing peer support to people who have been bereaved by suicide in Ireland. No other competing interests were disclosed.

Ethical approval: The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013. All procedures involving human participants were approved by the Clinical Research Ethics Committee of the Cork Teaching Hospitals [ECM 4 (j)10/8/2021 & ECM 3 (rr) 07/09/2021]. Written informed consent was obtained from all participants.

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Abstract

Background: Deaths by suicide have significant impacts on those bereaved. This study examined the utilisation of supports by adults bereaved by suicide and associations with personal growth.

Methods: Data on adults bereaved in a personal capacity were obtained from the Irish Suicide Bereavement Survey. Regression analyses identified factors relating to the utilisation of both informal and formal supports and the relationship between utilisation of supports and personal growth.

Results: Of the 2,059 participants, three-quarters of participants (74%) were female, and the mean age was 41 years. Most participants were family members of the deceased (73%), while one-quarter were friends or acquaintances (27%). Informal supports were received by most participants (85%), while two-thirds (67%) accessed formal support. Greater perceived social support was positively associated with utilisation of both formal and informal supports. Men, those from ethnic minorities and non-family members were less likely to access formal supports. Having received informal support emerged as the strongest predictor of formal support utilisation. Utilisation of informal supports was associated with positive personal growth among men.

Conclusions: Having access to multiple forms of support is a critical feature of postvention. Future research should consider the development of proactive outreach and signposting for hard-to-reach groups.

Keywords: Suicide bereavement, postvention, gender, support utilisation, personal growth

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Introduction

It is estimated that for each person who dies by suicide, between six family members and up to 135 individuals are impacted (1). A death by suicide can have significant impacts on those bereaved, including psychosomatic and physical health impacts (2) and complicated grief reactions (3,4). Furthermore, suicide bereavement is a risk factor for future self-harm or suicide (5–7). To this end, those bereaved by suicide are an important group for suicide prevention. Appropriate and timely supports and interventions are required to support their needs and reduce risk of suicide (8).

Research on the support needs of those bereaved by suicide show that people often report specific and diverse needs for their grief and psychosocial functioning, which can be unique to the specific bereavement process and reflective of the person's perceived informal support. These include include support on coping with grief and health reactions, coping strategies, meaning making and personal growth (9). Despite this, previous research has shown that they are less likely than people bereaved by other causes to seek help, either through social support in their networks, or through formal health services, and delays in accessing or receiving support are more commonly reported (10). In addition, support from social networks is more often valued than formalised supports (11–13). Suicide-related stigma, specifically perceived stigma, has been a factor identified as having a role in limiting access to support among people bereaved by suicide (10,12).

Related to this, a recent scoping review found that few studies have identified the specific factors which are associated with bereaved individuals seeking help, either via informal social supports from family, friends and colleagues or information resources, or via more formal supports such as specialised services or health professionals (9). The review found that a lack of social support, consequences of grief, along with attitudes towards health services can all impact on help-seeking for those bereaved by suicide. In addition, studies to date have primarily focused on immediate family members, and little is known about help-seeking behaviour in friends and other acquaintances (9).

Research on supports for those bereaved by suicide has tended to focus on more formalised models of support, including peer support (14), grief and psychosocial interventions (15,16) and community-based models (17). More recently, the use of online resources by those bereaved by suicide has been examined (18). There is varying evidence for the effectiveness of these supports, with most reporting some improvements in terms of features of grief, and mental and psychosocial outcomes.

While much of the suicide bereavement research has focused on outcomes relating to grief reactions and psychosocial outcomes, researchers in the past decade have explored posttraumatic or personal growth – the positive psychological changes that can occur in the aftermath of a traumatic life event – among people bereaved by suicide (19,20). A systematic review has identified a number of factors associated with the development of personal growth among people bereaved by suicide

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including increasing time since loss and interpersonal factors such as resilience and positive coping strategies (21). Interpersonal factors such as the self-disclosure and receipt of social support were also associated with personal growth. Social support was related to personal growth in cross-sectional (21–24) and longitudinal studies (25). However, there have been mixed associations between the use of formal supports and personal growth. One study found that within five years of the loss, professional support was negatively associated with personal growth while attending support groups was positively associated with personal growth (26). The previous studies have limited geographical spread and further research is needed to examine the relationship between support accessed and personal growth in different cultures and to specifically examine the potential differential impacts of formal supports compared to informal supports, in order to improve responses to suicide bereavement at a population level along with improving service delivery.

The aim of the current study was to describe the utilisation of supports by adults bereaved by suicide, using data from the Irish Suicide Bereavement Survey (27). Specifically, we had the following research questions:

1. What factors are associated with reported receipt of informal and formal supports?
2. Is the utilisation of informal and formal supports associated with personal growth?

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Materials and methods

Study design and participants

The Irish Suicide Bereavement Survey was an online, cross-sectional survey, open for participation between October 2021 and February 2022 (28). Participants were recruited in several ways, including social media messaging and targeted advertisements, dissemination in print and digital media, and though organisations involved in supporting people bereaved by suicide. Particular efforts were made to recruit male participants and other hard-to-reach groups. This included directly engaging with organisations representing men, the Irish Traveller community, and the LGBITQA+ community. In addition, we developed a media campaign to directly engage male participants, which included tailored social media posts, radio interviews and newspaper articles (27,28).

Inclusion criteria involved: people aged 18 years and over, residing in Ireland, and identifying as being bereaved or affected by suicide (29,30). Where participants had experienced multiple bereavements, they were asked to fill out the survey regarding the bereavement which had impacted them the most. The full survey methodology has been previously published (27).

Data items

The survey contained both open and closed questions and consisted of four main sections: sociodemographic information; information about the death by suicide and its impact, current mental wellbeing of participants, and utilisation of support services following bereavement. The sociodemographic information used for this study included: gender, age, ethnicity, area of residence, employment status, relationship status, religious beliefs, living arrangements, and sexual orientation.

Details of the bereavement included: relationship to the deceased, time since bereavement, and perceived impact of the bereavement. Impact of the bereavement was measured on a four-item scale, ranging from 0 (no impact) to 3 (major impact) and was dichotomised for the current study (no/little impact and moderate/major impact).

A three-item version of the Multidimensional Scale of Perceived Social Support (31,32) was used to measure perceptions of social support from family, friends and others. Data for this measure were dichotomised based on the median score.

Outcome measures

Utilisation of supports was examined in relation to receipt of both informal and formal support. Participants were asked to identify sources of support from an extensive list of supports and services. Our classification was based on a previous UK survey (10), whereby informal supports included support from participants' social network and information resources and more formal supports

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included from professionals or specialised services (including both clinical and non-clinical forms of support).

Personal Growth was measured using the 12-item Personal Growth Subscale from the Hogan Grief Reaction Checklist (33), which measures "spiritual and existential awareness, including a sense of becoming more forgiving, caring, compassionate, hopeful, and tolerant of self and others" (p. 17). This measure was only completed by participants who had been bereaved for at least 12 months at the time of completing the survey. Scores range from 12-60 and there was high internal consistency (α=0.969).

Statistical analysis

Descriptive statistics were used to examine the characteristics of participants. Proportions are reported for categorical variables and the mean and standard deviation or median and interquartile range are reported for continuous variables. Differences in categorical variables between groups were examined using chi-square tests. Factors related to the receipt of informal and formal supports were identified using Poisson regression models, with incidence rate ratios (IRRs) and their 95% Confidence Intervals (95% CIs) reported. Robust standard errors were used. All variables with a crude association in the unadjusted models ($p<0.2$) were included in the adjusted models. Differences in mean scores for personal growth were examined using tests of difference. The relationship between personal growth and support utilisation was examined using linear regression models. These models were stratified by gender, given the reported differences in utilisation of supports for men and women. All analyses were conducted using Stata/IC Version 16.1.

Ethical approval

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013. All procedures involving human participants were approved by the Clinical Research Ethics Committee of the Cork Teaching Hospitals [ECM 4 (j)10/8/2021 & ECM 3 (rr) 07/09/2021]. Written informed consent was obtained from all participants.

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Results

Sample demographics

In total, 2,055 participants experienced the loss of a loved one, friend or acquaintance to suicide. Most participants were women (n=1,515; 73.6%), with an average age of 41 years (SD=19.9). Most were employed at the time of completing the survey (n=1,641; 81.3%), residing in a city area (1,581; 77.1%) and identified as being 'White Irish' (1,617; 78.9%). Most participants identified as being religious/spiritual (1,107; 68.8%), of heterosexual orientation (1,553; 92.9%) and more than two-thirds were in a relationship or married (1,175; 69.8%). Most participants reported living with others (1,439; 86.7%).

Approximately half (1,009; 49.0%) of participants had experienced multiple bereavements to suicide. When considering the bereavement that the participant had identified as having the most impact on them, almost three-quarters had reported losing a family member or partner (1,493; 73.4%), while one-quarter (541; 26.6%) had lost a friend or other acquaintance. Approximately two-thirds of participants (1,399; 67.9%) had experienced their bereavement within the past ten years and the mean age at the time the death occurred was 34 years (SD=13.4). Almost all participants (1,947; 94.6%) stated that the bereavement had a moderate or major impact on their lives and 43.6% (863) indicated that they had thoughts of harming themselves or of taking their own life as a result of the death (See Table 1).

[Insert Table 1]

Utilisation of informal and formal supports

The majority of participants had accessed some form of informal support (1,746; 84.8%), either support from family and friends (1,712; 83.1%) or accessing information resources (745; 36.2%). Approximately two-thirds had accessed some type of formal support (1,380; 67.0%), including accessing support from a professional working in the community (1,125; 54.6%) or through a specialised service (968; 47.0%). Nearly two-thirds of participants had accessed a combination of informal and formal supports (1,333; 64.7%).

Of those who had accessed some type of specialised support, one-third (343; 33.6%) reported to have accessed the support within one month of their bereavement, 29.7% (303) between one and six months, and 36.7% (374) more than six months following their bereavement. More than half (398; 58.4%) of those who accessed counselling/group support reported to have waited more than one month for their first appointment from the point of seeking help, with more than one-quarter (205; 30.1%) waiting more than six months. Over half of those engaged with counselling/support groups engaged with the support for less than one month (367; 54.7) while one 20.1% (140) engaged for between and six months and 24.4% (164) engaged for more than six months.

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Factors associated with utilisation of supports

The factors which were associated with accessing informal supports included having more positive perceived social support (IRR=1.04, 95% CI=1.02-1.07) and perceiving the bereavement to have had a moderate or major impact on their lives (1.16, 1.03-1.31). Those bereaved in more recent years (10 years or less: 1.07, 1.04-1.10) were more likely to access informal support, while friends or acquaintances of the deceased were less likely to access informal support than family members or partners (0.94, 0.90-0.97; See Table 2).

The strongest predictor of accessing formal supports was receiving informal support (1.71, 1.34-2.19). In addition, those bereaved in more recent years (10 years or less: 1.14, 1.06-1.22), those with more positive perceived social support (1.10, 1.04-1.16) and those separated/divorced or widowed (1.10, 1.02-1.19) were more likely to access formal supports. Men (0.88, 0.82-0.95) and those from ethnic backgrounds other than 'White Irish' (0.83, 0.70-0.99) were less likely to access formal supports, as were friends or other acquaintances (0.82, 0.75-0.89; see Table 2).

[Insert Table 2]

Relationship between utilisation of support and personal growth

Personal growth scores were recorded for 1,416 (68.8%) of the overall sample, 72.8% (1,031) of whom were female. The mean personal growth score was 39.7 (95% CI: 39.2-40.2). Mean scores were higher for women (40.5, 39.9-41.0) than men (37.7, 36.7-38.8) [$t=-4.7184(1403)$, $p<0.001$]. In the unadjusted models, there was a positive association between the access of both informal (+2.48, 0.49-4.48) and formal supports (+1.32, 0.18-2.46) and personal growth (Table 3). When adjusted for the factors associated with support access, the relationship with informal supports held (+2.49, 0.56-4.42).

When stratified by gender, positive personal growth was associated with both access of informal (+5.44, 2.35-8.52) and formal supports (+3.01, 0.84-5.19) for men only. In the fully adjusted models, the association with informal supports held for men (+5.53, 2.34-8.72) while the association with formal supports did not remain statistically significant (+2.21, -0.24-4.66) (Table 3; Figure 1).

[Insert Table 3]

[Insert Figure 1]

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Discussion

This study comprehensively examined the factors which contribute to help-seeking behaviour among those bereaved by suicide. Accessing informal supports was the strongest predictive factor of accessing formal supports. Those who perceived the bereavement to have had a moderate or major impact were more likely to access informal supports, while those outside the immediate family were less likely to access informal supports. Men, non-family members and those from ethnic minority groups were less likely to access formal supports.

The proportion of participants reporting having accessed some form of support (85%) was higher than other studies. An Italian study of suicide bereaved found that 57% had accessed some form of professional support (11). A UK survey of bereaved adults found that 72% of suicide bereaved participants had accessed either formal or informal support (10), while a more recent UK survey found that 40% of participants had accessed a support (formal or informal) following their loss (35). An older US study found that lower rates of support utilisation were likely to reflect cultural differences related to stigma, general help-seeking behaviour and availability of appropriate supports, particularly as utilisation of supports was more prevalent for those more recently bereaved (36).

The findings from this study indicate that receiving informal support is an important element of postvention, and an important mechanism for further help-seeking. This suggests that consistent offering of support is an important element of postvention. In particular, early community-led structures which operate an outreach model, facilitate signposting and offer multiple options for support, should be further implemented within postvention models (37). These community-based models have been shown to facilitate contact with support services that might not have otherwise been achieved (38, 39).

The observed association between positive perceived social support and help-seeking (formal and informal) is in line with existing research. For example, Entilli and colleagues found that participants reporting high perceived social support were more likely to seek assistance from a range of different people while those experiencing low perceived social support primarily sought support online and from GPs. These findings led the authors to posit that perceived stigma may limit support access among people with low perceived social support (11)~~, while other research has identified the potential role of stigma in limiting access to support among people bereaved by suicide (10,12).~~ In our study, receiving informal support was the most important factor for the utilisation of formal supports. Other research has shown that informal supports can be helpful with regards to signposting and practical assistance (9). However, our study also found that informal support was associated with personal growth in men, while the association of formal support and personal growth did not hold in the adjusted analysis. This association between use of informal support and personal growth in men may also be explained by stigma. A previous study found that higher perceived stigma was associated

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with lower personal growth and that this association was fully mediated by secrecy, that is hesitancy about disclosing suicide bereavement to other people (40). Our study in conjunction with others highlights the importance of challenging stigma and encouraging informal support to foster personal growth among those bereaved by suicide. However, further longitudinal research is needed to identify the direction of the reported relationships and to capture the active ingredients of social support to inform practical recommendations (41). The fact that those outside the immediate family circle were less likely to access supports may relate to lower support needs of this group but also signals a need for increased research on this group to identify any potential unmet needs of this group. From a research and policy perspective, approaches which address confidence, knowledge and skills among the general population in supporting someone bereaved by suicide should be explored in terms of their efficacy as a postvention component. Such approaches may by help to reduce stigma, encourage openness and facilitate help-seeking.

Despite a majority of participants accessing formal supports, our findings suggest that there was variation in the experiences of accessing and engaging with formal supports. There were challenges with regards to timely access, with similar proportions of participants accessing specialised supports within one month of bereavement, between one- and six-months later and after six months. More than a quarter of participants reported waiting times of six months or more from the point of help-seeking to access therapeutic support such as individual therapy or group support, which may in part reflect certain criteria for engaging in more intensive therapeutic interventions. Nevertheless, this variation in the timeliness of accessing support may have implications for the impact of formal support on personal growth as previous research has indicated that those who engaged with therapy earlier reported greater benefits (42). There was also variation in the length of engagement with therapeutic supports, with just under two-thirds engaging with the supports for less than six months. The formal supports in this study consisted of many types, including generalist providers in the community such as General Practitioners (GPs) or other healthcare providers, emotional or instrumental support via voluntary agencies, support groups and individual therapy or counselling. Previous research suggests that there may be differences in the impact of these supports on personal growth, for example with professional support from mental health services being negatively associated with personal growth and support groups being positively associated with personal growth (26). Within the broader literature, there remains limited understanding of the effectiveness of suicide bereavement supports and the conditions under which they are effective (15). It is important to further understand factors affecting access to supports and the most effective models of support to address the needs of those bereaved by suicide.

We identified non-family members, men and those from ethnic minorities as being less likely to access formal supports. Help-seeking in general was lower in men, but those who did access support from informal or formal sources reported higher personal growth scores, suggesting that men

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in particular may benefit from at least some form of support following a suicide bereavement. Given the higher risk of suicidal behaviour in suicide-bereaved men (7), future research should consider how to encourage their help-seeking behaviour, explore opportunities for professionals to identify men who may require support, and consider what type of supports may be acceptable for them.

Strength and limitations

We used data from a large national survey, which sought to capture experiences of adults bereaved by suicide, regardless of perceived closeness or kinship. The study adopted a comprehensive recruitment strategy, and there was good representation across key demographic groups, with a higher male response rate than might be expected in similar suicide bereavement and health-related research. Nevertheless, this method of recruitment is likely to have resulted in a selection bias and so the sample may not be fully reflective of individuals bereaved by suicide. The cross-sectional survey design meant we were not able to establish a causal association between the utilisation of informal and formal supports, or between help-seeking and personal growth. We also didn't have access to information on help-seeking of participants prior to their bereavement.

Conclusion

This study identified variation in access to informal and formal supports following suicide bereavement based on sociodemographic factors and features of bereavement experiences. Despite the traumatic nature of suicide bereavement, different forms of support, both formal and informal, have an important role, and activities which aim to increase reach and decrease stigma should be prioritised as part of postvention responses. Supports should be accessible at multiple time points and should be acceptable to those who access them.

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Declaration of interest: One author (FT) is affiliated with Healing Untold Grief Groups (HUGG), a registered charity providing peer support to people who have been bereaved by suicide in Ireland. No other competing interests were disclosed.

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Table 1. Demographics of participants (n=2,055)

	N (%)
Gender	
Male	528 (25.6)
Female	1,515 (73.6)
Other gender	8 (0.4)
Age in years (SD)	41 (19.9)
Employment status	
Employed	1,641 (81.3)
Unemployed	29 (1.4)
Other	348 (17.2)
City resident	1,581 (77.1)
Ethnicity	
White Irish	1,617 (78.9)
Other	433 (21.1)
Religious	1,107 (68.8)
Sexual orientation	
Heterosexual	1,553 (92.9)
Other	119 (7.1)
Relationship status	
In a relationship	1,175 (69.8)
Single	354 (21.0)
Divorced/widowed	155 (9.2)
Living with others	1,439 (86.7)
Multiple bereavements	1,009 (49.0)
Relationship to the deceased	
Family/ partner	1,493 (73.4)
Friend/ acquaintance	541 (26.6)
Time bereaved	
Less than ten years	1,399 (67.9)
Ten years or more	660 (32.1)
Age bereaved in years (SD)	34 (13.4)
Bereavement impact	
None/ minor	111 (5.4)
Moderate/ major	1,947 (94.6)
Suicidal thoughts as a result of bereavement	863 (43.6)

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Table 2. Factors associated with utilisation of both informal and formal supports.

	Informal supports			Formal supports		
	N (%)	**Adjusted IRR (95% CI)**	**p-value**	**N (%)**	**Adjusted IRR (95% CI)**	**p-value**
Age bereaved (group)						
18-34 years	864 (82.5)	0.99 (0.97-1.01)	0.411	654 (62.5)	0.96 (0.91-1.02)	0.196
35+ years	882 (87.1)	1.00	Ref	726 (71.7)	1.00	Ref
Gender						
Male	424 (80.3)	0.99 (0.96-1.02)	0.585	302 (57.2)	0.88 (0.82-0.95)	**0.001**
Female	1,309 (86.4)	1.00	Ref	1,068 (70.5)	1.00	Ref
Ethnicity						
White Irish	1,522 (94.1)	1.00	Ref	1,225 (75.7)	1.00	Ref
Other background	217 (50.1)	0.95 (0.88-1.02)	0.150	151 (34.9)	0.83 (0.70-0.99)	**0.041**
Relationship status						
Single	323 (91.2)	0.98 (0.94-1.02)	0.247	268 (75.7)	1.06 (0.99-1.14)	0.083
Separated/divorced/widowed	143 (92.3)	0.96 (0.92-1.01)	0.151	127 (81.9)	1.10 (1.02-1.19)	**0.019**
Married/in a relationship	1,116 (95.0)	1.00	Ref	870 (74.0)	1.00	Ref
Living alone					-	-
Yes	201 (90.9)	1.02 (0.97-1.06)	0.497	169 (76.5)		
No	1,357 (94.3)	1.00	Ref	1,075 (74.7)		
Perceived social support						
High	887 (87.3)	1.04 (1.02-1.07)	**<0.001**	719 (70.8)	1.10 (1.04-1.16)	**0.001**
Low	842 (82.6)	1.00	Ref	646 (63.3)	1.00	Ref
Multiple bereavements						

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No	913 (87.0)	1.00	Ref	724 (70.0)	1.00	Ref
Yes	833 (82.6)	0.98 (0.95-1.00)	0.064	656 (65.0)	0.99 (0.94-1.04)	0.715
Relationship to deceased						
Family member/ partner	1,319 (88.4)	1.00	Ref	1,093 (73.2)	1.00	Ref
Friend/ acquaintance	408 (75.4)	0.94 (0.91-0.97)	**<0.001**	269 (49.7)	0.82 (0.75-0.89)	**<0.001**
Time bereaved						
10 years or less	1,217 (87.0)	1.07 (1.04-1.10)	**<0.001**	986 (70.4)	1.14 (1.06-1.22)	**<0.001**
More than 10 years	529 (80.1)	1.00	Ref	394 (59.7)	1.00	Ref
Bereavement impact						
No / minor impact	58 (52.2)	1.00	Ref	40 (36.0)	1.00	Ref
Moderate / major impact	1,689 (86.7)	1.16 (1.03-1.31)	**0.012**	1,340 (68.8)	1.19 (0.96-1.47)	0.121
Informal support accessed		-	-			
No				47 (15.0)	1.00	Ref
Yes				1,333 (76.4)	1.71 (1.34-2.19)	**<0.001**

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Table 3. Associations between utilisation of supports and personal growth for all and according to gender.

	Unadjusted model			Adjusted model		
All						
	β (95% CI)	**Standard error**	**p-value**	**β (95% CI)**	**Standard error**	**p-value**
Informal support[1]	+2.48 (0.49-4.48)	1.017	0.015	+2.49 (0.56-4.42)	0.985	0.012
Formal support[2]	+1.32 (0.18-2.46)	0.580	0.023	0.99 (-0.22-2.21)	0.620	0.109
Men						
Informal support[1]	+5.44 (2.35-8.52)	1.569	0.001	+5.53 (2.34-8.72)	1.623	0.001
Formal support[2]	+3.01 (0.84-5.19)	1.105	0.007	+2.21 (-0.24-4.66)	1.247	0.078
Women						
Informal support[1]	+0.23 (-2.26-2.72)	1.271	0.857	+1.98 (-0.96-4.92)	1.498	0.187
Formal support[2]	0.07 (-1.24-1.38)	0.669	0.919	+0.29 (-1.07-1.69)	0.714	0.681

[1]Adjusted for perceived social support, relationship to deceased, time bereaved, and bereavement impact.

[2]Adjusted for age at bereavement, gender, ethnicity, relationship status, perceived social support, relationship to deceased, time bereaved and utilisation of informal supports.

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Figure 1. Mean personal growth scores by gender, according to utilisation for (a) informal and (b) formal supports.

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