THE IMPACT OF TIME ON COMPLICATED BEREAVEMENT IN INDIVIDUALS BEREAVED BY SUICIDE DEATH

by

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DEDICATION

This work is dedicated to my brother and mother. They are this inspiration for this research and the reason for my passion. I will forever honor them and bring some meaning to their deaths. At the same time, I would also like to dedicate this work to my family. Without their constant support and belief in me, this paper would not be complete.

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ABSTRACT

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THE IMPACT OF TIME ON COMPLICATED BEREAVEMENT IN INDIVIDUALS BEREAVED BY SUICIDE DEATH

Under the direction of PAUL SMITH, PHD

Grieving is a natural process all people go through. However, the grieving process can become halted and unhealthy. This complicated bereavement can be a result of losing a loved one to suicide death. The goal of this study was to grasp the impact time since death has on the severity of complicated bereavement developed by those suffering from the death of a loved one via suicide. Utilizing the Prolonged Grief-13 Revised (PG-13-R) assessment and sample groups divided by time since death, an ANOVA was performed on the data to compare the between-group variance. Results of the ANOVA was utilized to understand the impact of time on complicated bereavement in people bereaved by suicide. The results of this data analysis will be reported and discussed. Further, implications and recommendations for on future research and upon the clinical field will be expanded upon.

CHAPTER 1

INTRODUCTION AND RATIONAL

Grief is a natural part of the human experience. Jackson-Cherry and Erford (2018) define grief as a feeling of significant loss, regardless of circumstance. This loss could be anywhere from losing a job to losing the chance at an opportunity. When this loss is specifically related to death it is called bereavement (Jackson-Cherry & Erford, 2018).

People can develop traumatic grief following a sudden loss. Specifically, sudden death or loss can be difficult for humans to endure and be traumatic in nature. Traumatic grief is defined by a diagnosis of persistent complex bereavement disorder (PCBD) along with symptoms of posttraumatic stress disorder (PTSD) after undergoing a traumatic loss due to death (Smid, Kleber, de la Rie, Bos, Gersons, & Boelen, 2015). A common cause of traumatic grief is death of a friend or family member due to suicide.

Suicide has a long history. Since there have been thinking people, there have been questions about whether life is worth living at all. Slaby (1999) points out we can see suicide questioned and debated by philosophers like Socrates, who declared suicide to be against natural law, and writers like Shakespeare who simply asks the question of if it is more noble to continue being or to die. Suicide has often been criticized and outlawed. In the past, Catholicism has been a staunch critic of suicide to the point those who died by suicide were said to have committed an unforgivable sin (Torgler & Schaltegger, 2014). Much of this sentiment still remains in western culture, but what makes suicide such a heated topic?

Background and Significance of the Problem

In the United States, one person kills themselves around every 11 minutes (Drepeau & McIntosh, 2020). One person every 11 minutes equates out to nearly six people an hour dying by

their own hands. Each of these deaths' leaves loved ones behind struggling to put their lives back together. Conservatively, there are about 1 in every 60 Americans significantly affected by suicide loss (Drepeau & McIntosh, 2020).

This statistic is a conservative estimate because suicide effects not just a social network, but a community as a whole (Feigelman, et al., 2019). When discussing the problem of suicide, clinicians and advocates can be taken in by the fallacy only people closest to the death are heavily affected. The myth of closeness being an indicator of how much one is or is not affected by death. This is not the case. People in the community can be impacted similarly as friends and family but may be missing the additional support from postvention aid, that is interventions implemented after a suicide has occurred (Bartik, Maple, McKay, 2020). Postvention being the treatment response after a suicide has occurred (Suicide Prevention Resource Center, n.d.). Meaning, this misconception of how suicide affects people could be impacting the ability for those impacted by the death receiving aid. By only focusing on close friends and family, postvention resources miss those people impacted on the outer levels of the social circle.

Due to these factors, the numbers on how many people are affected by a single death by suicide are not very clear. It can be difficult to understand the scope of one person's death and who is affected by the loss. However, utilizing these numbers, there are more than 5.4 million people in America suffering from bereavement via suicide (Drepeau & McIntosh, 2020).

Complicated Bereavement

As stated previously, grief is a natural part of life. Most individuals will follow the pattern of intense emotional response to death followed by a lasting sense of sadness that does not interfere with their lives. However, some people will get stuck in the intense emotions

following death. When this period of time lasts for 12 months or more, it is defined as complex grief or complicated bereavement (Jackson-Cherry & Erford, 2018).

People sometimes are trapped by their emotions after death. Not being able to move forward in life or having a perpetual yearning for the deceased is a hallmark of complicated bereavement (Iglewicz et al., 2020). As people are trapped by these emotions, there is no way for them to move forward in their lives. They are trapped by the pain of death, no longer being able to live happily or contently. Instead, they isolate themselves, show little interest in anything that used to bring them joy, and are imprisoned by their yearning for their loved one and missing that connection with them. This leaves a group of people in the perpetual state of surviving instead of living their lives.

Research Purpose

Most research on suicide has been focused on the short term after effects of suicide bereavement (Krysinska, 2003; Kealy et al., 2017; Feigelman et al., 2019; Bartik, et al., 2020). Yet, little research has been done on how suicide bereavement effects people throughout their lifetimes (Andriessen et al., 2019). What is known about the immediate after effects of suicide is the development of feelings of shame and guilt (Gall et al. 2014; Peters et al., 2016; Hunt et al., 2019), depression and anxiety (Nam, 2016; Scocco et al., 2019; Feigelman et al., 2019 Bartik, et al., 2020), and posttraumatic stress (Smid, 2015; Nam, 2016; Kealy et al., 2017, Feigelman et al., 2019). It leaves the question: what are the long-term effects of suicide bereavement and does this kind of bereavement get better?

With the significant impact of suicide death on those left behind, it is imperative to understand and explore the bereavement process for this population, including the typical period of heavy impact and what factors assist moving forward after this type of death has occurred.

Much of this research has either been quantitative in nature and focusing on the immediate aftermath (Spillane et al., 2018; Hamdan et al, 2020; Entilli et al., 2021) or has focused more on impact to the individual in years after the death (Gall et al., 2014; Andriessen et al., 2019; Hunt et al., 2019). However, by exploring further the impact of grief on people at different time intervals in the grieving process could provide a better understanding of treating this population.

Research Question

How does suicide bereavement impact people throughout different time periods after the suicide? Essentially, what is the relationship between severity of complicated grief and time since suicide death has occurred? Understanding how grief changes over time will be useful for researchers and clinicians. It could be helpful to be able to understand if their traumatic grief lessens or heightens years after the death has occurred. For this research, time periods will be broken down utilizing different time increments: 1-3 years, 4-6 years, 7-9 years, and 10+ years since death has occurred.

Hypothesis

Time will impact complicated grief. As time since death has occurred passes, symptoms of complicated grief will lessen.

Brief Overview of the Activity and Study

The researcher utilized the Prolonged Grief-13-Revised (PG-13-R; Prigerson et al., 2021) to score complicated grief experienced by those bereaved by suicide. This instrument is 13 questions long and utilizes a Likert score system to develop a score for complicated grief. As part of the demographic questions, the participants will be asked how long it has been since the death, if multiple deaths have occurred, how long it has been since the most recent death. The

time period since the death will be compared to the total scores on the PG-13-R and the relationship will be examined.

Significance of the Study

Many people undergoing bereavement due to suicide death feel isolated and alone (Oulanova, Moodley, & Séguin, 2014; Peters et al., 2016). They can feel as if they are meant to suffer and their life has no meaning. This research could assist with giving those suffering from this loss hope as well as providing some recommendations for counselors on how to work with clients in this population.

Definition of Terms

For the purpose of clarification, provided below is a definition of terms to being utilized in this paper:

Bereavement- Grief and loss of a loved one specifically related to death (Worden, 2008: Jackson-Cherry & Erford, 2018).

Complicated Bereavement- A period of intense grief lasting over 12-months (Jackson-Cherry & Erford, 2018) with the intensity of the grief at a level where the individual is overwhelmed and either resorts to maladaptive behavior or remains in the grieving process with no seeming end (Worden, 2008).

Grief- A strong, overwhelming feeling of significant loss of a person, object, or idea (Jackson-Cherry & Erford, 2018).

Suicide- "Death caused by self-directed injurious behavior with intent to die as a result of the behavior" (The National Institute of Mental Health, n.d.).

Suicide Survivor- A person who is bereaved by death from a loved one's suicide (Drapeau & McIntosh, 2020).

CHAPTER 2

LITERATURE REVIEW

This chapter will provide an overview of relevant literature associated with suicide bereavement and complex/complicated bereavement.

Effects of Suicide Bereavement

As of 2019, suicide is the 10th leading cause of death in the US and is the second leading cause of death for the age range of 15–24 year-olds (Drapeau & McIntosh, 2020). In those suicide deaths, 50.4% are carried out with firearms with suffocation/hanging being the 2nd highest method at 28.5% (Drapeau & McIntosh, 2020). Further, there is a gender difference in suicide statistics. Females are three times more likely to attempt suicide than males, but males have a higher chance of dying by suicide with 3.6 male deaths for every one female death (Drapeau & McIntosh, 2020). With all this death, how does it affect the people left behind?

As previously stated, a suicide survivor is a person bereaved by suicide (Drapeau & McIntosh, 2020). A suicide survivor has had a person in their life with whom they were close, die by suicide. Utilizing data gained through a general social survey, Feigelman, McIntosh, Cerel, Brent and Gutin (2019) propose three in every 100 people will suffer from the suicide of a close family member in their lifetime. The authors go further to say this number increases when considering friends since death by suicide typically leaves behind twice as many friends as it does family members (Feigelman, et al., 2019). Yet, researchers may never be able to quantify how many people are affected by one death by suicide, though it is estimated there are 5.4 million suicide survivors in the United States right now (Drapeau & McIntosh, 2020). Research has shown suicide survivors are significantly impacted by suicide loss, mentally, physically, and existentially.

Psychological effects

Mental health is significantly impacted by suicide bereavement. Suicide survivors are more likely to die by suicide themselves (Tal et al., 2017; Andriessen et al., 2019). This increased risk of death by suicide is thought to be due to the myriad of psychological stressors suicide survivors face after suicide death.

Depression, Anxiety, and Distress

According to Schneider et al. (2011), suicide survivors often have feelings of guilt and depression so significant they impact the survivor's everyday life. The author bases this assertion off of qualitative research the author conducted in Frankfurt, Germany. Utilizing a sample of friends and relatives of people who died by suicide between December 1999 and December 2000, a total of 163 suicides had people accounted for in the interview. While there was no exact number on how many people were interviewed, given there were 163 suicides accounted for, their sample would have to be at least 163. Through these interviews, the researchers found 89% of all suicide bereaved had emotions that occurred so often and so strongly that they had disturbed everyday life; depression, guilt and anxiety being the leading emotions (Schneider et al., 2011). These symptoms would cause things like not being able to leave the house, take care of hygiene, speak with other people, or basically just a shutting down of basic activities of living. It was shown in the research parents were the most impacted by these suicide deaths (Schneider, et al., 2011). These distressing feelings of depression, anxiety, and guilt make it difficult for the person to live and function in society; they have a hard time managing the pain and stress of the experience of death to be able to function in their everyday life.

Suicide bereavement increases survivors' levels of depression, stress, and psychological distress as well. Nam (2016) conducted a study with 859 participants who were bereaved by

suicide. Utilizing the Inventory of Complicated Grief and the Acceptance and Action Questionnaire, the researcher found avoidance in speaking about the deceased to increase feelings of depression, anxiety, and distress. This claim was further backed up by Kealy, et al. (2017) and their research involving 110 suicide survivors in a group therapy intervention. The authors found people suffering from suicide related bereavement also report more signs of psychological stress and complicated grief. The authors suspected these increased symptoms are in part due to not being able to talk about their grief, thus the reason behind their group therapy intervention. Then in 2019, Feigelman, et al. conducted a general social survey updated with questions surrounding suicide bereavement and mental health. The authors found bereavement from suicide being related to an increase feeling of depression, distress, emotional problems, and physical illness (Feigelman et al., 2019).

Tal et al. (2017) conducted a qualitative study comparing different types of bereavement based on method of death. Utilizing multiple different scales (Complicated Grief Clinical Global Impressions Scale-Severity, The Quick Inventory of Depressive Symptoms, Inventory of Complicated Grief, Work and Social Adjustment Scale, and Typical Beliefs Questionnaire) these researchers were able to compare how complicated grief presented based on type of death, that is suicide, accident/homicide, and natural death. While the researchers were unable to find a difference in the presence of complicated grief, they were able to find a difference in how the symptoms presented based on type of death. With suicide death there is a higher likelihood of suffering from a persistent lifelong depression. Further, suicide survivors are found to have more difficulty adjusting back to life after death. This difficulty was found to be consistent when accounting for type of death as well. Even when accounting for violent, sudden deaths, suicide

survivors had the most difficulty in adjusting back to life than any other group in the study (Tal et al., 2017).

Suicide in Survivors of Suicide. Researchers have shown a connection between survivors and suicidal thoughts and behaviors. Survivors have a more likely chance to end up dying via suicide than people who are bereaved by other types of death loss (Tal, et al., 2017; Andriessen et al., 2019). This population also reports higher levels of suicidal ideations and suicidal behaviors (Krysinska, 2003). Hamdan et al. (2020) backs this claim up in their research; in their quantitative study on suicide bereavement and the risk for suicide, the authors were able to have a sample of 180 participants having lost a loved one to suicide in the last 5 years. Using the Suicidal Behavior Questionnaire-Revised, the Multidimensional Scale of Perceived Social Support, and Inventory of Complicated Grief-Revised, they found suicide bereavement to have a higher risk of suicide than any other type of bereavement experienced. Further, the research suggested parents to be particularly vulnerable after losing a child to suicide (Hamdan, et al., 2020).

This increased risk of suicide is also consistent when looking at friend groups of those bereaved by suicide (Bartik, Maple, & McKay, 2020). In their research on suicide bereavement and suicide risk, Bartik et al. (2020) employed a qualitative design to understand the connection between suicide bereavement and suicide risk. Their participants were between the ages of 12 and 23 years old and had lost a friend to suicide. The researchers found these participants had more frequent thoughts about wanting to die along with higher levels of anxiety, depression, and alcohol use (Bartik, et al., 2020)

Social Stigma and Isolation

Another way suicide death affects those left behind is by contributing to isolation. Much research has been done on social stigma of suicide and how this stigma affects survivors. Levi-Belz (2016) utilized an analysis of covariance design to show how self-disclosure effects stress related growth. By instructing 145 participants to complete the Distress Disclosure Index, the Cognitive Emotion Regulation Questionnaire and the Stress-Related Growth Scale Survivors the researcher was able to analyze the effects of being able to talk about the suicide death on the participants post death growth. The researcher found one of the things negatively impacting growth after suicide death is fear of judgement from people around them (Levi-Belz, 2016). This fear of judgment leaves people isolated and without support.

This finding was further compounded by Andriessen et al. (2019). In a review of the literature centered around suicide bereavement, they were able to find isolation from friends, family, and community to be one of the prevalent consequences of bereavement by suicide. The avoidance or inability to speak on the death is one factor in continuing some of the emotional effects of suicide discussed earlier. If survivors are incapable of speaking, either through choice of staying silent or having no one with which they can speak, symptoms of depression, anxiety, and stress can potentially increase (Nam, 2016).

Some survivors may choose not to speak due to not feeling understood. Silvén Hagström (2017) analyzed chat records in internet forums dedicated to people who had lost parents to suicide. One of the common themes in these forums was social support versus otherness. When people were able to report social support, they were also able to report feeling better overall, physically and mentally. Others in the chat felt they had no social support; they felt they were seen as an oddity to be avoided or judged (Silvén Hagström, 2017).

Scocco et al. (2019) highlights how perception of social stigma impacts suicide survivors. In their study, these researchers had 240 participants bereaved via suicide. These participants completed three different assessments: the Beck Depression Inventory, the Stigma of Suicide Survivor Scale, and the Inventory of Complicated Grief. By analyzing the responses, the authors found the intensity of depression was positively correlated with perceived social stigma and perceived social stigma was positively related to a longer period of grieving (Scocco et al., 2019). Basically, the more social stigma a survivor thought they were encountering, the more depression they experienced and the long their grieving period lasted.

There can be a sense of "only someone who has went through this can understand me." This belief of not being understood could be due to shame and guilt experienced by survivors which will be reviewed more thoroughly later in this chapter. Regardless of if this stigma exists, people survivors are affected by it. Just the perceived social stigma is enough to isolate survivors by creating a feeling of otherness in people resulting in difficulty with sharing the loss (Levi-Belz, 2016; Andriessen, et al., 2019).

Much research has been conducted and found one of the most difficult things for survivors is actually sharing and talking about their loss (Silvén Hagström, 2017; Scocco et al., 2019). In Silvén Hagström's (2017) research, the author found the sense of "otherness" to stop people from reaching out and talking while in Scocco et al.'s (2019) research showed how the expectation of social stigma steers survivors away from expressing their loss.

Survivors simply feel that no one will understand their pain or will judge them for not doing enough to prevent the death. This isolation damages their connection to the outside world making them more likely to stay stuck in their grief. The loss of connection they experience is particularly concerning since research suggests survivors are benefited by being able to express

their loss. Oulanvoa et al. (2014) studied how peer support from an individual also grieving the loss of a loved one through suicide can impact a survivor. Their 15 participants spoke about how helpful it was to actually share their experiences with suicide. Further, the participants shared how their loneliness and isolation decreased by having a safe space they could talk about their experience without fear of being judged (Oulanvoa et al., 2014). There is the limitation in this study to consider, which is these participants where those who sought out opportunities to be able to talk about their experience which may not be translatable to those suffering from suicide bereavement not wishing to speak about their experience.

However, the assertion how helpful being able to speak about experiences of suicide bereavement can be to individuals is further backed up by the previously mentioned Silvén Hagström (2017) and Supiano et al. (2017). Supiano et al. (2017) designed a study to the effects of complicated grief group therapy on suicide survivors. There were 21 participants split between three groups with group leaders given training on how to run a group with the complicated grief group therapy intervention. At the end of the 16-week group, participants reported being able to speak about the death as a healing factor (Supiano et al., 2017). Overall, being able to speak about their experiences seems to help in eliminating the isolation and creates a sense of being understood in survivors.

Physical Effects

Along with the mental side effects caused by suicide bereavement, survivors often suffer from physical illness as well. In their social survey related to suicide bereavement Feigelman, et al. (2019) found respondents who were suicide survivors reported themselves to be less physically healthy than those respondents not bereaved by suicide. This social survey was a self-

report measure based off of the choices of excellent, good, fair, or poor, but it is further supported by other studies.

In 2018, Spillane et al. conducted a mixed methods study on the effects of suicide bereavement on overall health. While the quantitative data for how physical health was impacted by suicide bereavement was negligible, the qualitative data was robust. Participants reported a myriad of physical symptoms from suicide bereavement, symptoms such as: nausea, vomiting, breathlessness, numbness, memory loss, an inability to stand, increased heart rate, physical pain, severe abdominal pains, loss of appetite, low energy levels and an inability to sleep (Spillane et al., 2018). Some participants reported the symptoms fading over time, but one participant pointed out that they were still on blood pressure medication and are expected to be on it for the rest of their life (Spillane et al., 2018).

While there are studies about how physical health is impacted by suicide bereavement, there seems to a lack of quantitative data on this effect that future researchers could explore. Also, alcohol dependency can be a physical result of suicide bereavement. In reviewing friend groups of survivors, Bartik et al. (2020), found survivors of a friend's suicide were more likely to turn to alcohol to numb psychological stress.

Existential Issues

Existential issues involve issues surrounding death, purpose, responsibility, and meaning (Corey, 2017). Given the impact of suicide on survivors, existential conflicts are useful to explore in regard to suicide bereavement.

The Struggle with Why

Survivors often have difficulty understanding why their loved one decided to kill themselves. Gall et al., (2014) conducted a qualitative study with a participant sample of 11

people bereaved by suicide and 4 mental health workers with experience in working with suicide bereavement. The suicide survivors reported their struggles of not understanding how or why their loved one could kill themselves. One participant spoke about not understanding how someone could become so down as to actually take their own life (Gall et al., 2014). It is difficult to conceive of a loved one feeling so alone and isolated, he or she chooses to end their own life. While some participants were able to accept that the why would never be answered, for other participants that "why" is a question that has never ended.

One of the most common and reverberating questions surrounding this experience is 'why did this happen?' (Silvén Hagström, 2017). Unfortunately, this question is often left unanswered or answered in an unsatisfying way. This ambiguity can often lead survivors to either blame the deceased or even themselves (Silvén Hagström, 2017).

Responsibility. Guilt is also a common symptom suicide survivors experience (Schneider et al., 2011; Nam, 2016; Kealy, et al., 2017). As referenced before, Schneider et al. (2011) were able to conduct research on around 163 participants. A significant finding for their research was the amount of guilt and responsibility the survivors placed on themselves in the aftermath of suicide (Schneider et al., 2011) Similarly with Gall (2014), guilt and shame were large parts of the survivors' experiences. The participants reported thoughts such as "How could any father let his child take his life?" and "I must have had some input to this act; that is so hard for me to bear" while speaking in general of wishing they had just been enough to keep their loved one alive (Gall 2014). These feelings are not uncommon.

In the time after death, many survivors take on the role of being responsible for their loved one's death, feeling both shame and guilt. Hunt et al. (2019) conducted a qualitative study trying to understand the experiences of those bereaved by suicide. This research found feeling

responsible for the person's death to be a factor of unhealthy means of coping with the death (Hunt, Young, & Hertlein, 2019).

Further, people who have been affected by suicide often feel a sense of shame surrounding the death (Peters, Cunningham, Murphy, & Jackson, 2016). In their study, Peters et al. (2016) interview parents bereaved by suicide. Some participants find the shame to be so much, that they avoid talking about how their child died. "People look down on you when you tell them how he died" was a powerful statement by one parent, so powerful it ended up becoming the title of the study (Peters et al., 2016). Many people have thoughts of wishing they had done something different, or they feel they should have been able to stop the suicide. It is partially this feeling of responsibility that leads many survivors to experience the suicidal ideations discussed before (Hunt et al., 2019).

Meaning making. With the struggle with understanding the 'why' of their loved one killing themselves, it is understandable survivors have a difficult time with creating meaning after death. In exploring the experiences of suicide survivors, Silvén Hagström (2019) found the most positive impact for suicide survivors is to make meaning out of the death. The researcher found when children of parents who die by suicide are able to form their own understanding of what happened without blaming themselves, the survivors were able to overcome the negative effects of suicide death (Silvén Hagström 2019). If survivors are able to create meaning and work towards some sort of goal, they are able to move forward in life as opposed to becoming stuck in their bereavement. Iglewicz et al. (2020) compiled recommendations on working with suicide bereavement based complicated grief therapy. This evidenced-based guide emphasizes the importance of meaning making in working with suicide survivors. Iglexicz et al. (2020) recommend goal setting as helpful in creating meaning after death in survivors along with

focusing on what survivors can do to honor their loved ones. Iglexicz et al. (2020) found honoring loved ones to consist of telling stories about their lives, participating in activities that remind the bereaved of their loved one, and working to live life to the fullest while reconnecting with others.

Since meaning making has benefits towards mental and physical health (Gall et al., 2014; Kealy et al. 2017; Hunt, Young, & Hertlein, 2019), it is necessary for post-suicide interventions. As previously mentioned, Gall et al. (2014) conducted a qualitative study with both people bereaved by suicide and clinicians versed in working with suicide. In interviewing these clinicians, the researchers found being able to reframe thoughts around suicide can as useful to create meaning (Gall et al, 2014). Silvén Hagström (2019) found the individuals capable of reframing their thoughts on their parent's deaths to be more about the circumstances, were able to recover from the death more than those still stuck in blame and shame.

Further, instead of focusing on the loss of life, reframing can assist survivors in focusing on what they want to do after the death to honor their loved ones. In changing their thinking, survivors can learn how to reconnect with the memories they have locked away due to pain (Iglexicz et al., 2020). They can start remembering the person and the relationship. When our loved ones die, people can hold the idea that the relationship and connection with the deceased is also dead; that there is no longer any way to be connected with that person because they are gone. Clinicians working with suicide survivors can reframe these thoughts. Instead of the thought cycle of "my person is gone thus my connection to them is gone," clinicians can help survivors to see "my person has passed on, but my connection to them is still there and still important" (Iglexicz et al., 2020).

Being able to have this connection to the deceased still is a way of honoring them and assist with mitigating complicated grief. Oulanova et al. (2014) site the importance of speaking about the deceased as a way to connect. Suicide survivors should be encouraged to share their stories of the deceased, both happy and sad stories. Turner et al. (2019) support the importance of speaking about the deceased while also reporting on the importance of artifacts to sustain this connection. Things like photos, poems or stories written by the deceased, or even memorial videos can help rebuild that connection. An object can be a physical representation of the ongoing connection that defies death.

Additionally, part of making meaning out of loss is being able to speak about the loss. Being able to speak to the memories that still exist is an important part of meaning making. Kealy et al. (2017) support this in their findings on group therapy intervention. This research found the more they were able to induce survivors talking about their loved ones, the less psychological distress the group members felt (Kealy et al., 2017).

Bereavement

As humans, we are all susceptible to loss and grief is a natural and typical response to loss. When these feelings of loss and grief are specifically designated from death it is called bereavement (Jackson-Cherry & Erford, 2018). Typically, bereavement is characterized by acute loss with an intense emotional response that fades over time into a manageable level of sadness (Iglewicz et al., 2020). It is not that the sadness ever fully leaves, but it is no longer a hinderance to everyday life. However, this can become more complicated due to the type of death a person is grieving.

Suicide Bereavement

Feigelman et al. (2019) propose three in every 100 people will suffer from the suicide of a close family member in their lifetime. These researchers go further to say this number increases when considering friends since death by suicide typically leaves behind twice as many friends as it does family members (Feigelman, et al., 2019). Yet, researchers may never be able to quantify how many people are affected by one death by suicide. Experts report a conservative estimate of six people being significantly by one death by suicide (Drapeau & McIntosh, 2020). With this conservative number, it is estimated to be roughly 5.4 million suicide loss survivors in the United States as of 2019 (Drapeau & McIntosh, 2020).

Complicated Bereavement

Complicated bereavement is an intense emotional response to death lasting for 12 months or more (Jackson-Cherry & Erford, 2018). Complicated bereavement is characterized by an intense and persistent yearning for the deceased (Iglewicz et al., 2020). This yearning is not mitigated by the passage of time and stays extreme.

People experiencing this can experience prolonged and severe bereavement, self-blaming and shaming thoughts, and be compelled to compulsively avoid reminders of the deceased (Tal, et al., 2017). Essentially, those suffering under this condition have lost the ability to enter back into their lives before the suicide. Instead, they are stuck in the moment they found out their loved one had passed with all the turbulent emotions that entails, e.g. unable to think about the loss without weeping uncontrollably, staying stuck on the idea this is all a nightmare they will wake up from, anger at everyone including themselves and the person who died, etc.

Nam (2016) utilized the Inventory of Complicated Grief and the Acceptance and Action Questionnaire on 859 suicide bereaved participants. The researcher found complicated grief to be positively correlated with suicide bereavement (Nam, 2016). While correlation does not equate

to causation and not every person burdened by bereavement from suicide is going to experience complicated bereavement, many survivors will. This is further supported by Kealy et al. (2017), Tal et al., (2017), Scocco et al. (2019), and Hamdan et al. (2020). With all this research, it does not feel like a stretch to assert bereavement from suicide is a risk factor in developing complicated bereavement.

There has been increased interest over the years to include complicated bereavement in the Diagnostic and Statistical Manual of Mental Disorders as a way to give some credibility to the experiences of individuals suffering from this disorder (Worden, 2008). Some of the problem with this bereavement being taken seriously may have been the difficulty in differentiating it from the typical and normal grief people experience after a loved one passes. Throughout the years, this type of bereavement has been called many things, complicated grief, complicated bereavement, complex bereavement, traumatic grief, eventually an accepted term of use became complicated bereavement (Worden, 2008).

Yet, it was still not considered to be a diagnosable condition according to the DSM. However, in 2020 the American Psychological Association has approved a new diagnosis of Prolonged Grief Disorder (The Center for Prolonged Grief, 2020). This disorder is certainly a win for people fighting for this to be a recognized condition inflicting many individuals. The criteria center around persistent longing or yearning for the deceased along with at least three of the following eight characteristics; “disbelief, intense emotional pain, feeling of identity confusion, avoidance of reminders of the loss, feelings of numbness, intense loneliness, meaninglessness or difficulty engaging in ongoing life” (The Center for Prolonged Grief, 2020). The Prolonged Grief-13 Revised (PG-13-R; Prigerson et al., 2021) was developed to assist with

the problem of diagnosing prolonged grief. This assessment will be discussed in further detail during the methodology section of this paper.

As stated earlier, bereavement is a natural part of life. The problem comes from no longer being able to live life due to the severity of symptoms after death has occurred. If a person cannot move forwards from death, if they remain stuck in the first response to death, they are powerless to have agency in their lives. They are no longer living life, instead they are simply surviving.

Contributing Factors to Complicated Bereavement. Complicated bereavement can be induced by different factors, two examples being how the bereaved individual is told of the death (Stewart, 1999) and how the deceased individual died (Tal et al., 2017). In the case of death notifications, it is important to be aware of how the notification is delivered may effect the individual affected by the death. Some recommendations for delivering this news in a way to minimize the chance of complicated bereavement are providing professional resources for working through the death i.e., referrals for grief counselors, and providing follow-up after the news has been delivered (Stewart, 1999). The most appropriate form of follow-up depends on the individual, but follow-up in general can be helpful in providing assistance to people who may not have sought help themselves.

Sudden or violent death is one of the most common contributors to complicated bereavement (Paterson & Saleh, 2021). The abrupt and brutal ending of a loved one's life can leave people with an inability to understand and make sense of their life without this person in it. Along with how the death occurs, feeling responsible for the death or having feelings of guilt surrounding death can contribute to the development of complex/complicated bereavement (Li, Tendeiro, & Stroebe, 2019).

In their research, Li et al. (2019) found guilt to be a factor that remained a contributing factor while looking at time since death as well. This suggests it is not a matter of 'time heals all wounds' for people suffering from complicated bereavement; time, in this case, may cause even more harm if these feelings are not addressed. With the guilt that accompanies suicide survivors previously discussed, and the suddenness of suicide death, it makes sense survivors may have a significant chance of developing complicated bereavement.

Complicated Bereavement in Survivors. Suicide survivors are at a higher risk of developing complicated bereavement (Kealy, et al., 2017). Complicated grief in suicide survivors is thought to be partially triggered by the feelings of responsibility survivors feel in the death (Hunt et al., 2019) touched on earlier this chapter.

Suicide survivors are more likely to develop complicated bereavement than those bereaving other types of losses (Tal, et al., 2017). Tal et al. (2017) compared suicide survivors to survivors of other types of deaths. Their categories included: death by suicide, accident/homicide, and natural death. Tal et al. (2017) found a higher chance of developing complicated bereavement in those dealing with suicide death. So, not only is suicide bereavement a risk factor for complicated bereavement, this type of death is one that stands out from other types of death. This high risk creates even more of a necessity to thoroughly comprehend how this type of death impacts survivors.

Summary

Suicide is a considerable problem, not just due to the loss of life, but also to the impact it has on those surrounding the death. The effects it leaves on mental and physical health, along with the questions this death brings up about life can seem insurmountable. How does one

reconcile with this type of death? It is clear, bereavement due to suicide is difficult to endure and often halts the grieving process.

Survivors deal with high levels of depression, anxiety, stress, trauma, and suicidal ideations. Their physical health can be put under enormous strain. Additionally, they are assaulted with questions that are difficult to understand and forced to face the process of rebuilding themselves without satisfying answers to these questions. To compound it all, they have a harder time moving through the typical and healthy grieving process.

This research shows survivors as just that, people who are desperately trying to survive and live after their loved one's death.

Gaps

The research surrounding suicide bereavement is extensive, but there are still gaps to address. While much research has been done on the immediate effects of suicide death (Spillane et al., 2018) and in years after the death has occurred (Gall et al., 2014; Hunt et al., 2019; Bartik et al., 2020), not much research has been done on how suicide bereavement affects survivors throughout time since the death has occurred. The differences that years since death has occurred make have not been well researched. This means the gaps in this research show a deficiency in understanding the process of traumatic grief after suicide.

While we know the negative effects of suicide, how it halts the grieving process, how it affects mental and physical health, and even how people are able to heal from this, there are still unanswered questions regarding timing. How long does it take for the symptoms of complicated bereavement to start to dissipate? Is there a length of time post death where people typically see a decrease in symptoms? Does it take 2 years? 5 years? 10 years? This time scale is unknown, which is why it is important to investigate further.

CHAPTER 3

METHODOLOGY

Participants were asked to participate in a survey surrounding suicide bereavement on a survey platform. Participants will be completing an assessment focusing on prolonged grief, a social desirability scale, and demographic questions. This assessment data was be utilized to understand the process of grieving suicide death by comparing assessment scores based on time since death and how that time impacts the scores on the prolonged grief assessment.

Epistemological Assumptions

An important aspect of research to understand is the idea there are different paths to gathering and analyzing information. How data is understood is dependent upon through what lens a person is viewing it. To utilize the most proficiency in understanding the data this research collected, a pragmatic lens was utilized to gather and evaluate the gathered data. Creswell and Plano Clark (2018) define a pragmatic worldview by the emphasis in this view to use "what works" in data collection. The method to which the data is collected is not as important as the question being asked. Utilizing this view will allow interpretation of the data collected with an efficient and straightforward manner.

Bias

In the effort of full transparency, it is important to acknowledge the researcher's own bias in this research. The researcher has had four relatives die by suicide. Of these relatives, two were first-degree relatives, a mother and a brother. While not first-degree relatives, the importance of the researcher's uncle and cousin's death and the effects those deaths had on her cannot be understated. Because of these experiences, the researcher driven by the goal to assist other

people through the same pain she has endured. While possibly not a harmful bias, it is still a bias to be aware of while researching this topic.

Research Design

The question this project is attempting to answer is best suited for a quantitative design. The researcher wants to know what the grieving process looks like in suicide survivors. More specifically, to understand timeline when it comes to suicide bereavement and how long it takes, typically, for prolonged grief to start lessening. When does prolonged grief start to decrease in people bereaved by suicide so that it is no longer at a negligible level?

The way this question is being asked is what makes a quantitative design for this research the best fit. The ability of a quantitative design is to be able to numerically measure a construct and make inferences on what these numbers mean for the benefit of the mental health profession (Sheperis et al., 2017). This is why a quantitative method is the preferred design for this study. The researcher will be able to see objectively when the decrease in symptomology starts to happen.

Ethical Considerations

Due to the sensitive nature of this topic, that is bereavement from suicide death, participants were afforded multiple consent options. Before the assessment begins, participants were informed of the nature of the survey and be able to opt out or in. Participants were made aware of the ability to decline continuing the survey at any time. Further, the survey consisted of multiple mental health checks asking participants if they would like to opt out or continue with the survey. Finally, participants were asked at end of the assessment whether they would like to submit their answers or if they would like to decline to submit.

Method of Research

In order to answer the question of how time since death impacts prolonged grief, an analysis of variance (ANOVA) was utilized. An ANOVA is being applied as it will allow for a comparison of the four participant groups divided by years since death has occurred: 1-2 years, 3-5 years, 6-9 years, and 10+ years. Since this study has more than two sample groups needing to be compared an ANOVA will be able to compare the between-group variance in order to describe the difference between the means of all the groups at once (Steinberg, 2011).

Participants

Participants consisted of consenting individuals that met the inclusion criteria. Participants must have lost an individual they felt connected to, to suicide death. This death must have occurred at least a year ago and participants must be at least 18 years of age to participate. The cut off of one year is in deference to the 12 months of time to be considered complicated grief (Jackson-Cherry & Erford, 2018). Participants were asked to report time since the death occurred. If participants have had multiple deaths due to suicide in their lives, they were asked to report time since the death they felt had impacted them the most.

Data collection

Participant data was collected utilizing an assessment via online survey platform Qualtrics (https://www.qualtrics.com). The participants were gathered utilizing snowball sampling. The researcher sent out 450 recruitment emails to leaders of suicide survivor support groups. The group leaders were asked to spread the Qualtrics link to any member of their group wishing to participate. Names and emails of group leaders were obtained through three national organizations: the American Association of Suicidology, the American Foundation for Suicide Prevention, and Suicide Awareness Voices of Education.

Participants responded to the Prolonged Grief-13 Revised (PG-13-R; Prigerson et al., 2021) with the intent of comparing the mean scores of the participant groups based on time since suicide death has occurred. The purpose of this is to determine the impact of time since suicide death and the level of prolonged grief.

Instruments

Participants were asked a serious of demographic questions including gender, how many friends or family members they have had die by suicide, their relation to the deceased, how long ago the deceased died, and what month they died.

Participants were asked to respond to the PG-13-R (Prigerson et al., 2021; See Appendix A). The PG-13-R was designed as an assessment to measure the level of prolonged grief in an individual. It is a 13-item evaluation based on the proposed criteria for Prolong Grief Disorder to be added to the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Of the 13 items, 10 items are measured on a Likert scale ranging from 1- not at all to 5- overwhelmingly. An example question is as follows: “Do you feel yourself longing or yearning for the person who died?” Higher scores indicate higher levels of prolonged grief. The rage of scores for this assessment is 10 to 50 with 50 equaling to high amounts of prolonged grief. A PG-13-R score of 30 or more identifies a person with a diagnosable level of Prolonged Greif Disorder.

The PG-13-R shows to have convergent validity through the positive associations with symptoms associated with Major Depressive Disorder, Posttraumatic Stress Disorder, and Generalized Anxiety Disorder. The PG-13-R shows high internal consistency and reliability with a Cronbach’s alpha=0.83, 0.90 and 0.93 for the three samples the test was administered to for testing (Prigerson et al., 2021).

In an attempt to account for social desirability bias, participants were also asked to complete the Marlowe–Crowne Social Desirability Scale – Short Form (Reynolds, 1982; see Appendix B). This assessment is a shorter form of Marlowe and Crowne's original 33 item scale (1960). This scale was created to account for the tendency for participants to respond to assessments in a way that would make them seem more socially desirable. The short form of this scale is 13 items and follows the long form true/false as possible responses with True scored 1 and Fales scored 2. Reynolds (1982) compared the long form of this measurement to the short form and found the short form to be highly correlated with the long form, while also reporting a reliability at .76.

Limitations

This quantitative design is of a quasi-experimental nature. This is in hopes the data collected from the assessment will build a greater understanding of the problem of suicide bereavement as a whole. However, this design is not without flaws.

First, this sample has the potential of being biased. Since these participants are choosing whether they will participate, it is probable the sample will be skewed towards those more comfortable is speaking about their experiences. If this is the case, the assessment data may be missing a portion of this population for which grief has not died down over time.

A second limitation is the possibility social desirability bias. The respondents might want to assist with the research and answer in a manner in which they think may be of most assistance. Due to this, there are attempts to account for as much of this bias as possible. To do this, the researcher utilized the Marlowe–Crowne Social Desirability Scale – Short Form. With this, it may not be possible to account for all possible confounds, but it will be able to reduce the possibility of this interfering with the data.

Third is the researcher's own inherit bias. As a survivor, it is possible the researcher may read into the data more than is actually there in hopes of providing hope for people going through a similar situation to her own. This is in part why a quantitative design was chosen in hopes of eliminate as much of the subjective as possible and utilize the hard numbers instead. Regardless of these limitations, this design type has the ability to provide a greater understanding of suicide survivors.

CHAPTER 4

RESULTS

Suicide is a plague upon the lives of people left in the aftermath of this type of death. Having a loved one die by suicide makes one a survivor of suicide bereavement. With the negative impact suicide has on survivors, it is important to understand what the grieving process looks like year after year. How does this death impact others at various time scales since death has occurred?

The purpose of this research was to understand the impact of time on suicide bereavement. To be able to determine the typical course of bereavement for someone suffering under this specific type of bereavement. As mentioned in Chapter 1, there is much known about the immediate impact of suicide on those affected (Spillane et al., 2018; Hamdan et al, 2020; Entilli et al., 2021), and there is much known about how people cope years after the event (Gall et al., 2014; Andriessen et al., 2019; Hunt et al., 2019). The question still remains, what does that grief look like at different time periods therein. This research answers part of this by evaluating the level of grief at different time periods after suicide death as based on the PG-13-R.

This study was developed as a single phase of research, employing quantitative methods to reach a concrete conclusion about how time impacts level of grief after suicide death. This chapter begins with an overview of the preliminary analysis of the collected data. Next, the researcher will extrapolate on the data pertaining to the main analysis. The chapter will end with a conclusion of the research question based on the data analysis.

Data Analysis Procedure

Surveys consisting of the PG-13-R and the Marlowe-Crown Social Desirability Short Form were sent out and available for participants to complete for three weeks. All data was securely stored on the Qualtrics platform with only the researcher having access to the data via a password protected laptop and password protected account on Qualtrics. Participants were encouraged to complete both the PG-13-R and the M-C Short Form and were unable to continue with the survey without answering every question.

The PG-13-R (see Appendix A) consisted of 10 Likert-scale questions while the M-C short form (see Appendix B) consisted of 15 True/False questions. Questions separated based on the assessment and were randomized within these separations.

As mentioned previously, letter of solicitation (see Appendix C) was sent out to group leaders of suicide support groups explaining the reason for this research and to encourage support therein. Data was hosted on the Qualtrics platform and analyzed utilizing the SPSS (Statistical Package for Social Sciences), Version 28.0 for Windows software.

The primary research question was analyzed utilizing descriptive statistics including means and standard deviations. The mean was taken for the sum score on the PG-13-R based on independent variable of years since death to express what direction the scores changed, either increased or decreased, and the standard deviation was used to highlight the variation in the scoring data. The data was analyzed utilizing a one-way analysis of variance. This measurement is utilized to measure the variance between the means of two or more independent groups for statistically significant differences (Steinberg, 2011). In this study, the independent groups are 1-2 years since death, 3-5 years since death, 6-9 years since death, and 10+ years since death. Therefore, this study will be comparing the means of four independent groups. Further, this study uses an alpha level of .05 or less.

Demographic Data

Of the 301 participants, 79.47% reported to be female and 20.53% reported to be male. No participants reported being nonbinary or gender fluid. 30.2% of participants reported losing a child, 26.2% reported losing a parent, 18.6% reported the deceased as a romantic partner, 14.0% reported the loss as a sibling, 7.0% reported their loss as a friend, and 4% reported their loss being an other family member (cousin, grandparent, aunt, uncle, etc.; as seen in Table 1).

57.8% of the respondents reported this loss as being their only loss via suicide. 19.3% reported having two losses to suicide, 10.6% reported having three people in their lives die by suicide, 6% report four losses, 2.7% respondents report five losses by suicide, 2.3% report six people in their lives have died by suicide, .7% report eight losses, and .7% report more than 10 losses due to suicide (as seen in Table 2).

Table 1

Relationship

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Parent	79	26.2	26.2	26.2
	Sibling	42	14.0	14.0	40.2
	Child	91	30.2	30.2	70.4
	Partner	56	18.6	18.6	89.0
	Friend	21	7.0	7.0	96.0
	Other Family	12	4.0	4.0	100.0
	Total	301	100.0	100.0	

Note: This table displays the percent and frequencies of the respondents' relationship to the deceased individual.

Table 2

Number of Deaths via Suicide Experienced

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	One	174	57.8	57.8	57.8
	Two	58	19.3	19.3	77.1
	Three	32	10.6	10.6	87.7
	Four	18	6.0	6.0	93.7
	Five	8	2.7	2.7	96.3
	Six	7	2.3	2.3	98.7
	Eight	2	.7	.7	99.3
	Ten or more	2	.7	.7	100.0
	Total	301	100.0	100.0	

Note: This table displays the percent and frequencies of the number of deaths by suicide the respondents have experienced.

Preliminary Analysis

Once collected, data was downloaded from the Qualtrics survey into an SPSS file then cleansed of any missing data. One participant began the survey but did not proceed past the first mental health check point after answering demographic information. Due to this, this data was removed from the data set. There were no significant outliers in the data set. This resulted in a total of 301 participant responses able to be used in the final analysis.

To test for any confounding variables, the researcher conducted some analyses to find out if any of the demographic information could be contributing unduly to the scores on the PG-13-R. Utilizing an Eta Coefficient test, there was a positive correlation found between gender and score on the PG-13-R n =.11, n^2 = .01, however the association was weak. This indicates gender plays little effect on the variance in the scores on the PG-13-R. Utilizing this same test, there was found to be a positive correlation between month of death and score on the PG-13-R n =.19, n^2 =

.04, however the association was once again weak. This indicates the month of the death plays little effect on the variance in the scores on the PG-13-R.

Further, using an Eta Coefficient test there was a positive correlation found between number of deaths and score on the PG-13-R n =.14, n^2 = .02, however the association was weak. This indicates number of suicide deaths plays little effect on the variance in the scores on the grief assessment. Another Eta Coefficient test showed a positive correlation found between relationship to the deceased and score on the PG-13-R n =.18, n^2 = .03, however the association was weak. This indicates the type of relationship to the deceased plays little effect on the variance in the scores on the grief assessment.

On running the Marlowe-Crown Social Desirability there was a significant negative relationship between the scores on the PG-13-R and the M-C short form at the significance level of p=<.001. However, this relationship was weak r= -.33 indicating social desirability bias was unlikely to be confounding the results of the study.

Main Analysis

Previous research shows the PG-13-R to have a reliability between α = 0.83 and α = 0.93 (Prigerson et al., 2021). Upon running a reliability analysis on the 10-item scale for the current data, the value for Cronbach's Alpha for the survey was α = .93. Since the scale has proven to be reliable, further analysis can be conducted.

To test the primary research question, the researcher conducted a one-way ANOVA with the independent variable being time since death and the dependent variable the summed score of the PG-13-R. To start the analysis, a Levene's test for homogeneity of variances was conducted.

Levene's test showed that the scores for the PG-13-R equal, $F(3,297) = .6$, $p = .62$ (see Table 3). With this, the analysis was able to continue with the one-way ANOVA.

There was a statistically significant difference between the years since death determined by one-way ANOVA ($F(3,297) = 33.241$, $p = <.001$) as seen in Table 4. Utilizing a Tukey post hoc test, see Table 5, revealed a statistically significantly higher PG-13-R scores from 1-2 years after death (M=33.6, SD= 9.159) than 3-5 years after death (M=29.59, SD= 8.52) with a significance level of $p = .03$. Further there was statistically significant higher scores from 1-2 years after death and 6-9 years after death (M=27.7, SD= 8.77) with a significance level of $p = <.001$. Finally, there was statistically significant higher scores from 1-2 years after death and 10+ years after death (M=20.95, SD= 8.23) with a significance level of $p = <.001$. All this to mean, every group scored lower on the PG-13-R than the 1–2-year group. This indicates there is a higher level of grief for this group than any other year group.

Additionally, there was statistically significant lower PG-13-R scores from 10+ years after death and 3-5 years after death with a significance level of p = <.001, and between 10+ years after death and 6-9 years after death with a significance level of p = <.001. Meaning every other year group scored significantly higher than the 10+ year group, indicating the level of grief for this group is less than any other group.

Finally, there was no statistically significant difference between 3-5 years after death and 6-9 years after death ($p = .63$). Indicating there was no significant difference in the scores of those in the 3-5 years past death group or the 6-9 years past death group. Each group scored about the same on the PG-13-R. All means and standard deviations for these results can be found in Table 6.

The results of the ANOVA support the research question: time has an impact on the level of grief as measured by the PG-13-R, and as time passes the level of grief dissipates.

Table 3

Tests of Homogeneity of Variances

		Levene Statistic	df1	df2	Sig.
PG-13-R	Based on Mean	.596	3	297	.618
	Based on Median	.722	3	297	.539
	Based on Median and with adjusted df	.722	3	293.317	.539
	Based on trimmed mean	.643	3	297	.588

Note: This table shows the outcome for the Levene's test for homogeneity of variances. . Levene's test showed that the scores for the PG-13-R equal, $F(3,297) = .6$, $p = .62$.

Table 4

ANOVA

PG-13-R

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	7502.762	3	2500.921	33.241	<.001
Within Groups	22344.959	297	75.236		
Total	29847.721	300			

Note: This table shows the significant differences between the different groupings of years since death and the scores on the PG-R-13 with a significance level of $p = <.001$.

Table 5

Multiple Comparisons Utilizing Tukey HSD

Dependent Variable: PG-13-R

Tukey HSD

(I) How much time has passed since your loved one died?	(I) How much time has passed since your loved one died?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1-2 Years	3-5 Years	4.020*	1.425	.026	.34	7.70
	6-9 Years	5.912*	1.475	<.001	2.10	9.72

	10+ Years	12.668*	1.293	<.001	9.33	16.01
3-5 Years	1-2 Years	-4.020*	1.425	.026	-7.70	-.34
	6-9 Years	1.892	1.580	.629	-2.19	5.97
	10+ Years	8.648*	1.412	<.001	5.00	12.30
6-9 Years	1-2 Years	-5.912*	1.475	<.001	-9.72	-2.10
	3-5 Years	-1.892	1.580	.629	-5.97	2.19
	10+ Years	6.756*	1.462	<.001	2.98	10.53
10+ Years	1-2 Years	-12.668*	1.293	<.001	-16.01	-9.33
	3-5 Years	-8.648*	1.412	<.001	-12.30	-5.00
	6-9 Years	-6.756*	1.462	<.001	-10.53	-2.98

*. The mean difference is significant at the 0.05 level.

Note: This table show the results from the post hoc test Tukey HSD. This test shows a significant difference between the 10+ years after death and all other years at p= <.001, and a significant difference between 1-2 years post death and 3-5 years since death (p=.03) and 6-9 years post death (p= <.001). This test shows no difference between 3-5 years post death and 6-9 years post death (p= .63).

Table 6

Descriptives for PG-13-R Scores and Years Since Death

PG-13-R

					95% Confidence Interval for Mean			
	N	Mean	Std. Deviation	Std. Error	Lower Bound	Upper Bound	Minimum	Maximum
1-2 Years	88	33.61	9.159	.976	31.67	35.55	13	50
3-5 Years	64	29.59	8.515	1.064	27.47	31.72	13	46
6-9 Years	57	27.70	8.773	1.162	25.37	30.03	12	47
10+ Years	92	20.95	8.233	.858	19.24	22.65	10	43
Total	301	27.77	9.975	.575	26.64	28.90	10	50

Note: This stable shows the mean scores and standard deviations for PG-13-R scores for the different groups of years since death.

Summary

This chapter started with an overview of the data collected, including demographic information for the 301 viable participants. Following this, the chapter continued with an analysis of data, preliminary analysis to rule out confounding variables and the main analysis of

the primary research question. The primary focus of this research was to understand the impact time has on suicide bereavement.

The data suggests that there is a significant difference between the years since death has occurred and the level of grief as measured by the PG-13-R. The scores decrease as the time since death increases indicating the level of grief lessens over time. Meaning people bereaved by suicide loss tend to have a decrease in bereavement symptoms as the years go by.

The research findings of this study will contribute to the understanding of the grieving process as defined by suicide bereavement. This will assist clinicians in being able to understand the loss of those bereaved by suicide and educate suicide survivors on the typical path grief takes in this type of loss. Chapter 5 will move on to the implications of this data, both for clinicians and for research in this area as well as review limitations and future directions of research.

CHAPTER 5

DISCUSSION, INTERPRETATION, AND FUTURE RESEARCH

Suicide death is a burden on those grieving this type of loss. It is known that suicide bereavement is different from other types of bereavement (Tal et al., 2017). With the intense effects of this type of death, anxiety and depression(Schneider et al., 2011; Kealy et al. 2017; Bartik, et al., 2020), suicidal ideations and suicide behaviors (Krysinska, 2003; Hunt et al., 2019), physical health symptoms (Spillane et al., 2018; Feigelman et al., 2019), it is important for researchers and clinicians to understand all aspects of the bereavement process for this type of death.

To further this goal, this chapter will provide an overview of the interpretation of the research analysis and how this could impact individuals. Further, the chapter will contain a discussion on the research and clinical implications of the current research. Finally, the end of this chapter will conclude with limitations of the research and areas for future research.

Interpretation

The prevailing hypothesis when this research project was conceived of was that the level of grief as measured by the PG-13-R would lessen over time. It was believed between each of the year groups, there would be seen a significant decline in the scores on the PG-13-R. The hypothesis being time has an impact on grief; as time since death has occurred passes, symptoms of complicated grief will lessen. While this did occur in some sense, the analyzed data shows a more complex story than originally anticipated. The first two years post death are difficult, as shown by the high scores on the PG-13-R. After two years, this grieving dissipates by a statistically significant amount. The 1-2 year time frame was significantly different from 3-5

years since death, 6-9 years since death, and 10+ years since death. This mean the first two years are the most difficult for those bereaved.

By the time of 10 years and on since death, the scores one the PG-13-R are such that they are significantly lower than in every other year group yet still at a measurable level, possibly meaning that by that time period those bereaved by this death were able to manage their symptoms of grief and not feel as impaired. However, they were still impacted by their grief, even after so much time. In interpreting this data, it appears people at the 10+ years since death are at a place where they can interact with the world again, meaning they are not impaired by their grieving, no longer lost and unable to interact with others because of their grief. Unfortunately, this is unlike those in the 1-2 years since death group who are still struggling and have difficulty interacting with others due to their symptoms of grief.

As stated previously, it is not as simple as every year level of grief continues to decrease. There was some data that did not meet this expectation. There was no significant difference on the PG-13-R scores of 3-5 years since death and 6-9 years since death. It was expected that just like between 1-2 years since death and 3-5 years since death, the time period between 3-5 years since death and 6-9 years would continue to have decreasing levels of bereavement. The data did not show this reality. Instead, the data gathered seems to show a period of stagnation, where the grief is still present and is not decreasing. In fact, it looks like the grief decreases after two years and does not decrease again significantly until 10 years after death. What does this mean?

Research Implications

The results of this study appear to align with other studies based on bereavement. In a qualitative study analyzing maladaptive grief symptoms for participants divided between past

loss and recent loss, it was found of critical importance to target maladaptive grieving with those having a recent loss (1-2 years) as this period was found to be the most difficult (Schwartz et a., 2018).

With the results of this study, it seems there needs to be more research done into the time period between 3-9 years after death. This result is consistent with other research on bereavement. In a study on the long-term effects of grief on parents who had lost a child to cancer, it was found to not be unusual that even 5 years later there were still enough symptoms present for some of the participants to be diagnosed with traumatic grief (van der Geest et al., 2014). Yet, the question of what caused the stagnation in the 3–9-year time span is still unanswered. It is possible the time periods in the year groupings were too great to see much change.

This unanswered question makes it important to research further to find out if this period really is stagnant, and if it is, how to intervene to assist this group of the population work through this bereavement. A possible method of determining interventions could be through the use of the Traumatic Grief Inventory Self-Report (TGI-SR; Boelen & Smid, 2017). This instrument is 18 questions long and utilizes a Likert score system to develop a score for complicated bereavement and persistent grief disorder (Boelen & Smid, 2017). Due to the ability for this assessment to measure multiple concepts, it could be helpful for determining the specific level of functioning for the bereaved individuals which would highlight whether or not this period was truly stagnate.

As this data was gathered from suicide bereavement support groups, it brings into question, how helpful are these groups? It is known through previous research that suicide survivors report lessening of grief symptoms when they are able to speak openly with those that

understand them (Kealy et al., 2017; Supiano et al., 2017). Despite these participants being members in a support group their grief remained stagnant from in the 3-9-year time frame?

Possibly more work needs to be done on evaluating the effectiveness of group therapy for those bereaved by suicide. Then again, it is possible a more qualitative lens may be needed to view this period of time. Perhaps utilizing a method more focused on personal experience is needed to understand the nuances of this time frame in the grieving process.

Counseling Implications

Aligning with other research (Schneider et al., 2011; Bartik et al., 2020; Drapeau & McIntosh, 2020), this study indicated no difference in the type of relationship to the deceased and the grief that is felt. This indicates how important it is for clinicians to normalize the symptoms of grief regardless of if the death was that of a first degree relative or not. It is important to consider postventions, interventions after suicide death, not just for family, but also any who feel impacted by the death of the deceased. If a person feels bereavement from death, then they should be able to have access to help and assistance, not dismissed as not being a close enough relative.

Additionally, research indicates the first two years after the suicide of a loved one are of critical importance (Krysinska, 2003; Kealy et al., 2017; Feigelman et al., 2019; Bartik, et al., 2020). This time period is when the grieving is at its highest point. Based on previous research, we know that people who have had a loved one die by suicide are much more likely to die themselves (Tal et al., 2017; Andriessen et al., 2019). If people can make it past the first two years, it seems like their grief is able to stay at a steady point that is not as intense, and people are not as impaired by their grief.

However, this does not mean clinicians stop being concerned about people three years post death. The data shows that this level of grief is still significant and needs to be addressed. Possible more so that it is being currently due to the stagnation that is seeing in the 3-9 years past death data. Clinicians may want to encourage people in this stagnant period of bereavement to become more involved with support groups as the research shows being able to speak with someone about death diminishes the feelings of grief and isolation (Oulanvoa et al., 2014; Supiano et al., 2017). Additionally, clinicians could encourage these people to take a lead in a support group if already a part of one as this could boost the meaning making that is so important after death of a loved one (Silvén Hagström 2019; Iglewicz et al., 2020).

Yet, one of most important implications from this study is the fact that bereavement symptoms do weaken over time. Before this, there was not much research done on how suicide bereavement effects people throughout their lifetimes (Andriessen et al., 2019). Being able to know that if a person can make it through the first two years that things can become better could be a huge burst of hope to someone who has just lost someone and feels they will never be okay again. As it is known that those undergoing suicide bereavement are left with unanswered questions and difficulty understanding why this happened (Gall et al., 2014), being able to answer the question of how long the grief lasts could be of immense help.

Clinicians can explain the way in which this bereavement process typically goes which can be a relief during this time period. Being able to know after ten years, the pain is so much less could be a blessing to some people still struggling at 5 years. During this time, clinicians can point out that it is oaky to still be struggling during this time and that there is still much room for improvement could take some weight off of a person who feels they should already be better. Which may be the most important implication of this research.

Further, this research highlights the importance of meaning making in the healing process. Loss of meaning, identity, and connection with the deceased are core pieces of scoring highly on the PG-13-R (Prigerson et al., 2021). In order to lessen the scores, thus lessening the impact of grief symptoms, it would behoove clinicians to target these areas for interventions. This conclusion aligns with other research into interventions for those bereaving suicide reporting finding meaning and a goal after grief as a mitigating factor for development of prolonged grief (Gall et al., 2014; Kealy et al. 2017; Hunt et al., 2019).

Additionally, being able to focus on a change of thinking about death can be helpful for survivors (Iglexicz et al., 2020). Survivors being able to move from thinking their connection to their loved one is lost, to realizing the connection is still there but different, can assist with decreasing the severity of grief symptoms. Despite these potential interventions, there are some limitations and cause for future research.

Limitations and Future Directions

Upon reflection of this research, there are things the researcher would have done differently if given the ability to start anew. These things have contributed to the limitations of this work. The researcher attempted to account for people who have had multiple deaths by suicide in their lives, people like the researcher. However, on reviewing the participant answers, it seems like the instructions were not clear. People who had multiple deaths by suicide seemed answered the survey questions not based on the most significant lost like instructed, instead they answered based on their overall experience.

This difference in answering could be a confounding variable to the data, even though measures were taken to account for these confounds. In the future, it may be more beneficial to

give participants multiple questions about death, giving them four or more spaces to specify how many years since death and the relationship for each person they have lost. This way, their data could be analyzed more in this context. Another possibility would be asking participants to participate multiple times for each death they have experienced due to suicide. Either way, it is important to find a way to account for this in future research.

Another limitation of this data is the way in which the years since death are group together. In analyzing the data, the researcher realized there could be crucial periods missing due to the year groupings. While it was believed this would be the best way to group the years upon conceptualizing the study, upon completion it is the researcher's opinion it would be more useful the groups had been down to every 2 years being a single category: 1-2 years, 3-4 years, 5-6 years, 7-8 years, 9-10 years, and 11+ years. This would give a total of six sample groups that could potentially show some more nuanced understanding of the way grief diminishes over time. Of course, this would also necessitate a larger sample of individuals from this population completing the survey.

Finally, the way the demographic question surrounding time since death was set up could be a limitation in the fact that the variability in the 10+ years' time range is unknown. The 10+ year time frame could encompass decades of variation. Some participants emailed the researcher about their experience, and in these emails, one person expressed their partner had died 20 years ago. This means there are large gaps in the years after 10 years for which was unable to accounted. This potentially means the decrease in grief symptoms does not happen at 10 years. This decrease could happen at 15 or 20 years since death. This is unlikely due to the data at the 10+ years mark being normally distributed, but it is still a potential limitation of the study.

These limitations are also areas for future researchers to investigate. It may be beneficial for future researchers to consider the idea of conducting a study with smaller year groups to be able to see how grief diminishes over time within different time periods. Another way to do this could be a longitudinal study encouraging people to participate in this research once a year every years since death and compare the results. Further, while this data shows grief weakens over time, the current research does not expand upon the experiences of people's lessening bereavement.

It may behoove future researchers to consider conducting qualitative research on participants in different time periods of their grief. This could be done with either the same individual in different years, or with different participants each in a different year of time since death. Regardless, there is still much to be uncovered and understood about the process of bereavement from suicide death.

Conclusion

The purpose of this study was to understand how the bereavement process changed in the years after a suicide death. As suicide bereavement has a significant effect on those impacted, it seemed an appropriate a topic to expand upon for this project. To meet this end, the PG-13-R was utilized and compared different scores based on year groupings of years since death.

While the data shows that grief does diminish over time, there is still much research to be done as to what contributes to this decrease. Insights from this study show where further research could expand and growth. Discernments can be made from this study on how peace could be introduced to individuals going through the stormy seas of suicide bereavement. It is the hope of

the researcher that understanding this process more in-depth will lead to further advancements in being able to treat this population suffering from suicide bereavement.

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APPENDICES

Appendix A

Prolonged Grief Disorder 13 Revised (PG-13-Revised)

Answered on a scale: 1- Not at all, 2- Slightly, 3- Somewhat, 4- Quite a bit, 5- Overwhelmingly

1. Do you feel yourself longing or yearning for the person who died?

2. Do you have trouble doing things you normally do because you are thinking so much about the person who died?

3. Do you feel confused about your role in life or feel like you don't know who you are anymore (i.e. feeling like a part of you has died)?

4. Do you have trouble believing the person who died is really gone?

5. Do you avoid reminders that the person who died is really gone?

6. Do you feel emotional pain (e.g., anger, bitterness, sorrow) related to the death?

7. Do you feel you have trouble re-engaging in life (e.g., problems engaging with friends, pursuing interests, planning for the future)?

8. Do you feel emotionally numb or detached from others?

9. Do you feel life is meaningless without the person who died?

10. Do you feel alone or lonely without the deceased?

Appendix B

Marlowe-Crowne Social Desirability – Short Form

Answered True or False

1. It is sometimes hard for me to go on with my work if I am not encouraged.

2. I sometimes feel resentful when I don't get my way.

3. On a few occasions, I have given up doing something because I thought too little of my ability.

4. There have been times when I felt like rebelling against people in authority even though I knew they were right.

5. No matter who I'm talking to, I'm always a good listener.

6. There have been occasions when I took advantage of someone.

7. I'm always willing to admit to it when I make a mistake.

8. I sometimes try to get even rather than forgive and forget.

9. I am always courteous, even to people who are disagreeable.

10. I have never been irked when people expressed ideas very different from my own.

11. There have been times when I was quite jealous of the good fortune of others.

12. I am sometimes irritated by people who ask favors of me.

13. I have never deliberately said something that hurt someone's feelings.

Appendix C

Recruitment Email

Invitation to Participate in Research

Greetings,

My name is Mindie M. Blackshear, and I am a doctoral candidate at Mercer University studying bereavement via suicide. This is an important topic to me as I am also a survivor of suicide loss. I would like to invite you to help me in furthering the research on how suicide loss affects those impacted by their loved one's death.

Please consider taking my survey and sharing this survey with your group members to further the research in this area.

In this research, there will be an online survey that includes a brief demographic questionnaire, and a prolonged grief assessment called the Prolonged Grief-13 (PG-13-Revised). The survey should take 10-15 minutes.

This study has been approved by Mercer University's Institutional Review Board

If you would like to participate in this study, please click on the link below. It will direct you to online survey tool that includes the informed consent form, a demographic questionnaire and PG-13-Revised.

https://merceruniversity.co1.qualtrics.com/jfe/form/SV_bQsQH37EqmsAbzg

Thank you for considering participating in this research opportunity.

Sincerely,

Mindie M. Blackshear, M.S, LPC, NCC

Doctoral Candidate, Counselor Education and Supervision

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