Received: 13 March 2022 | Revised: 15 July 2022 | Accepted: 16 August 2022

DOI: 10.1111/jpm.12866

REVIEW ARTICLE

WILEY

Trying to keep alive a non-traumatizing memory of the deceased: A meta-synthesis on the interpretation of loss in suicide-bereaved family members, their coping strategies and the effects on them

Rafailia Zavrou[1,2] | Andreas Charalambous[2] | Evridiki Papastavrou[2] | Anna Koutrouba[2] | Maria Karanikola[2]

[1]Division of Nursing, Cyprus Mental Health Services, Paphos, Cyprus

[2]Department of Nursing, Cyprus University of Technology, Limassol, Cyprus

Correspondence
Maria Karanikola, Department of Nursing, Cyprus University of Technology, 15, Vragadinou str 3041, Limassol, Cyprus.
Email: maria.karanikola@cut.ac.cy

Accessible Summary

What is known on the subject?

- Losing a family member due to suicide has been described as a traumatic experience, as suicide-bereaved relatives grapple to accept the particular character of death and the core elements of guilt, self-criticism and stigma it inflicts.
- There are long-term consequences for those who bereave due to the suicide of their beloved on, a high risk for mental and physical health problems included.
- Feelings of guilt and self-stigma influence help-seeking behaviour among suicide-bereaved individuals.

What the paper adds to existing knowledge?

- Coping mechanisms adopted by suicide-bereaved individuals mediate the impact of suicide on their family, and especially on the quality of relationships among them.
- Supporting others in need can help alleviate guilt and self-blame for the suicide while it enables the bereaved to fulfil their need to keep a non-traumatizing, or even positive bond with the deceased.

What the implications for practice are?

- Nursing interventions to facilitate suicide-bereaved family members' participation in self-help support groups and promote their engagement in supporting others in need are important.
- Mental health nurses need to facilitate the replacement of dysfunctional coping strategies, such as substance use or self-blame with more adaptive ones focused on the personal needs of the bereaved, in order to help them embrace a non-traumatizing memory of the deceased while being in peace with the social environment.
- Screening for mental health problems and management of shame, self-stigma and guilt during the grieving period needs to be a priority in nursing interventions.

Abstract

Introduction: Losing a family member to suicide is a traumatic experience which includes guilt and self-stigma. Yet, there is lack of data synthesis on the survivors' experience.

Aim: A meta-synthesis of qualitative data on the interpretation of loss in suicide-bereaved family members, their coping strategies and the effects on family.

Method: A meta-ethnographic synthesis following a systematic literature search and evaluation of the methodological quality of the selected studies was applied.

Results: The narratives of 326 individuals (parents/siblings/children/spouses) reported in sixteen studies were analysed. Trying to achieve a balance between keeping alive a non-traumatizing memory of the deceased, destigmatizing and liberating themselves from self-blame, self-criticism and guilt while being able to transform this experience into support towards others in need, was identified as the essence of the experience of the bereaved.

Discussion: Although suicide within a family is a traumatic experience, spiritual and existential implications among the bereaved have been reported; their coping mechanisms mediate the impact of suicide on family sustainability.

Implications for practice: Nursing interventions to facilitate adoption of coping strategies centred on keeping a non-traumatizing memory of the deceased among the bereaved and promote their participation in self-help groups and activities to support others in need are important.

KEYWORDS

carers/families, coping, family members, grief, lived experience, loss and grief, meta-synthesis, meta-synthesis, suicide, suicide bereavement

1 | INTRODUCTION

Approximately 700,000 people die by suicide every year; moreover, suicide is the fourth leading cause of death among teenagers aged 15 to 19 years (WHO, 2021). The COVID 19 pandemic also had a significant impact on mental health (Cénat et al., 2021), and there are concerns that it may have contributed to a rise in suicide rates in vulnerable populations (Gunnell et al., 2020).

The impact of suicide extends beyond the deceased to members of the family. Preceding studies demonstrated the long-term consequences for those who bereave due to the suicide of their beloved (Andriessen & Krysinska, 2012; Jordan & McIntosh, 2011; Spillane et al., 2018). For every individual who dies by suicide, approximately 135 individuals experience the impact of this suicide (Cerel et al., 2019). Moreover, almost 21% of the general population will experience the suicide of a relative or a partner during life span (Andriessen, Rahman, et al., 2017), while other researchers support even higher rates of suicide-bereaved survivors (Berman, 2011; Cerel et al., 2013; Cerel et al., 2019).

Suicide of a child is a hugely traumatic event for parents, putting them at a higher risk for psychological and somatic morbidity, compared to other causes of child loss (Erlangsen & Pitman, 2017; Pitman et al., 2014). Furthermore, mothers who have experienced the loss of their child due to suicide are at higher risk for suicide than mothers who have lost a child due to other causes (Pitman et al., 2016).

Despite the severity of the impact of suicide on bereaved survivors, there is lack of synthesis of qualitative data on their interpretations regarding the effects of suicide on familial level. Specifically, synthesis of evidence on the way bereaved family members signify the suicide and experience its impact on them, may provide important data on their needs and expectations. Furthermore, synthesis of qualitative data on their coping strategies and supportive systems is expected to highlight the mechanisms and factors which facilitate or inhibit the bereaved survivors' adaptation in the period following the suicide. Therefore, such data may be helpful in policy making, and particularly in enhancing effective supportive systems; revising unhelpful ones; and developing preventive measures towards adverse implications of suicide in suicide-bereaved family members. Finally, data shows only limited effectiveness of existing supportive or counselling programs on reducing the risk for complicated grief, suicidal ideation or depression in suicide-bereaved relatives (de Groot et al., 2007; Wittouck et al., 2014). This supports the need for deeper insight into existing evidence on survivors' needs, their coping strategies and supportive systems through a novel synthesis of data.

2 | AIM

The purpose of this study was to synthesize the results of qualitative studies on the way in which suicide-bereaved family members: (a) interpret and signify the event of suicide, (b) experience the impact of the event on themselves and their family, and (c) describe their coping strategies and the quality of support they receive (helpful-unhelpful) by providing a higher level of analysis.

3 | METHODS

This study included three separate phases: (a) systematic literature search to identify relevant studies, (b) critical evaluation of the selected studies, and (c) meta-ethnographic synthesis of the results reported in the reviewed studies (Noblit & Hare, 1988).

3.1 | Literature search

A pre-planned, comprehensive search of the literature (August 2021–December 2021) was performed in the databases in which peer-reviewed journals of mental and psychological health allied sciences are indexed, i.e., Pubmed, Medline, PsychInfo, CINAHL and Scopus. The keywords "family", "lived experience", "suicide", "completed suicide", "qualitative studies", "bereavement", "mourning", "grief", "parents", "siblings", in all possible combinations (Figure 1).

The search was applied independently by two authors (MK and RZ) and validated by a specialist librarian (EK), who independently rescreened to assess the rigour of the procedure.

3.2 | Selection criteria

The inclusion criteria for the search of relevant empirical studies were as follows: (a) date of publication between 2000 and 2021, to identify the most recent results, (b) English language of publication, (c) qualitative design, aiming at investigating the experience of individuals (spouses, children, siblings) who had lived or encountered the suicide of a family member, irrespective of their age. The excluded studies: (a) investigated the experience of suicide in different target populations, e.g., health professionals (Gill, 2000), or the factors associated with suicide (Gaynes et al., 2004; Li et al., 2008), and (b) were postgraduate and undergraduate dissertations, for which there was no access. Case studies were also excluded due to absence of triangulation of their results. All retrieved studies were screened by their title, abstract and full text if they applied to the inclusion criteria by two independent researchers (RZ, MK). Figure 2 presents the selection strategy regarding the included studies, based on the PRISMA guidelines (Page et al., 2021).

Each study was independently reviewed by two researchers (MK, RZ) in line with the variables presented in Table 1. A relevant extraction sheet was used for this purpose. These data were extracted from the "Methods" section of the reviewed studies (target population/sample, study design, aim, data collection process, setting). When all the inclusion and exclusion criteria had been considered, 16 manuscripts comprised the study sample (Table 1).

3.3 | Critical evaluation of selected studies

The studies which met the inclusion criteria, were assessed for their methodological rigour before being included in the final

DOMAIN	KEYWORDS
Suicide- related terms	"suicide" OR "complete suicide"
AND	
Experience- related terms	"lived experience" OR "experience"
AND	
Survivors-related terms	"suicide survivors" OR "family" OR "family members" OR "siblings" OR "parents"
AND	
Bereavement- related terms	"bereave*" OR "mourn*" OR "grief"
AND	
Qualitative Research-related terms	"Qualitative study" OR "ethnograph" OR "qualitative" OR "phenomenolog*" OR "grounded theory" OR "content analysis" OR "thematic analysis" OR "theoretical sampl*" OR "focus group*" OR "hermeneutic" OR "narrative analy*" OR "mixed methods"

FIGURE 1 Description of the literature search with the search terms

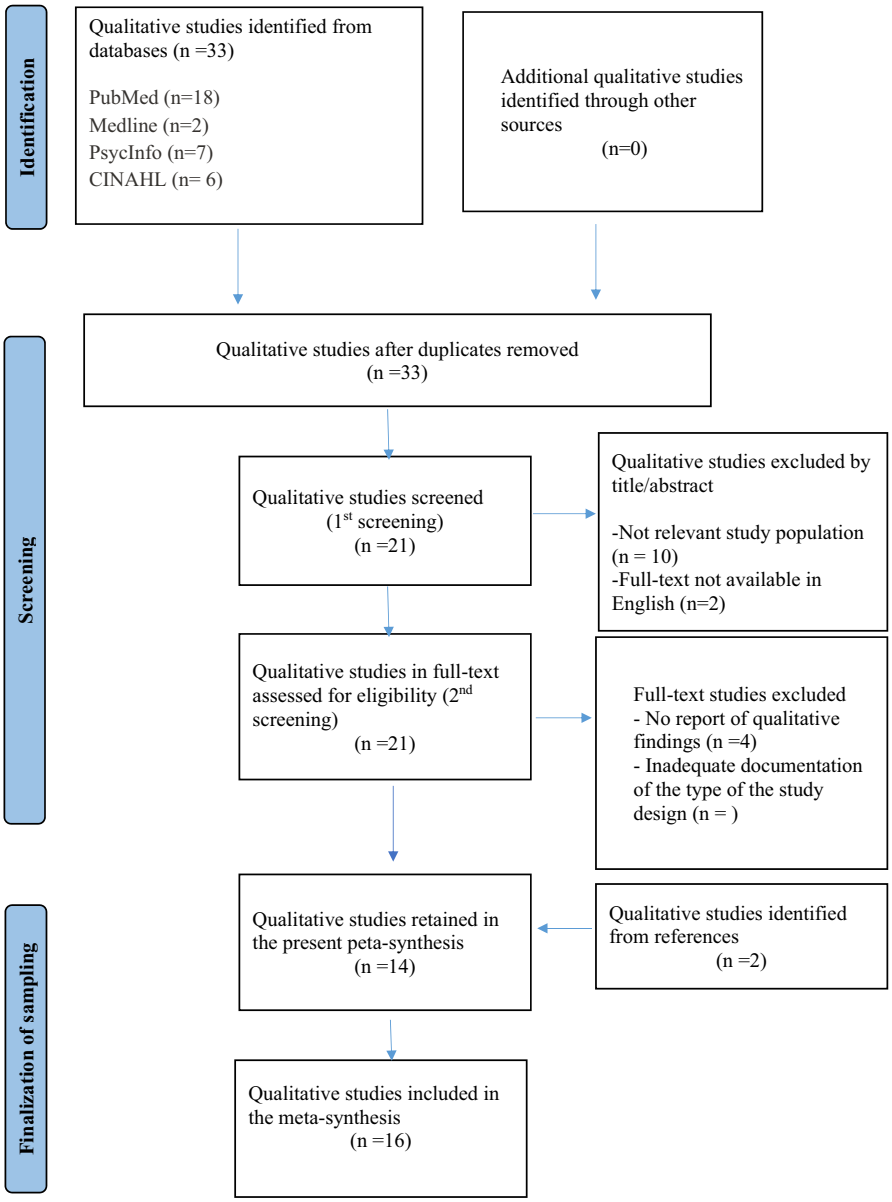

FIGURE 2 Presentation of the flowchart regarding the selection strategy of the sample of the present meta-synthesis

sample. The checklist of consolidated criteria for reporting qualitative research (COREQ) was applied. Among numerous, well-validated tools for the appraisal of the methodological rigour of qualitative studies, the COREQ instrument was applied herein because it is simple to use, widely applied across disciplines, and, most importantly, it addresses issues of both methodology and relevance. The COREQ tool, comprises a checklist of 32 questions designed to help readers assess qualitative research reports in terms of rigour, credibility and relevance. These questions are grouped into three domains: (i) research team and reflexivity, (ii) study design and (iii) data analysis and reporting. Based on these criteria, all studies were assessed against their theoretical framework, the method and setting of participant selection, method of data collection and analysis, and reporting of the results. A special extraction sheet was developed for this purpose as depicted in Table 2. These data were derived from studying the entire context of the reviewed manuscripts. Initially, three independently working researchers assessed the studies against the COREQ questions. Then, the researchers met to document the identification of key issues and reach an agreement on the studies that met the criteria for inclusion in the meta-synthesis (Table 2). There were no excluded studies based on this assessment.

Subsequently, the measures included in the objectives of this meta-synthesis, i.e., interpretation of suicide (aetiology/related factors), suicide impact, coping and quality of support received were reported on a data sheet relevant to Table 3. These data which were extracted from the "Findings" section of the reviewed studies, aimed at providing a higher level of analysis. The "Discussion" and "Conclusion" sections were also reviewed to preserve the potential to develop new theory, while keeping the originality of the initial evidence.

3.4 | Meta-ethnographic synthesis

Meta-ethnography is an interpretive approach which has the potential to provide a higher level of analysis and generate new theory, based on previously reported evidence while preserving the interpretive properties of primary data (Dixon-Woods et al., 2004; Noblit & Hare, 1988; Paterson, 2011). This method of data synthesis was chosen against others (e.g., thematic synthesis) because of its ontological position on idealism, which involves the social and cultural context in which phenomena take place (Pohontsch et al., 2021). The seven-step process for performing a meta-ethnography as outlined by Noblit and Hare (1988) and further informed by Britten et al. (2002) was applied herein by two researchers (RZ and MK), as follows:

a. articulation of the aim and objectives of the study,
b. determination of the scientific material in terms of qualitative studies according to a set of criteria and the objectives of the study,
c. study and thorough examination of the scientific material to determine the primary concepts in each qualitative study,
d. assessment of the way studies are associated (roughly similar, contradictory, build a line of argument) by comparing them through the identification of common, recurrent and uncommon concepts among the studies,
e. translation (reciprocal, refutational) of the studies into one another by developing new groups of the common concepts identified in the previous step, and assigning relevant constructs to them (or providing explanations for contradicting relations),
f. synthesis of translations by identifying the relationships connecting the newly developed groups from the previous step (line-of-argument synthesis),
g. presentation of the synthesis by writing the results.

Step (b) as presented above was reflected on the process of systematic literature search and critical evaluation of the selected studies. In turn, steps (c), (d), (e) and (f) were applied during the data analysis process. Identification of the main concepts in each study was achieved by reviewing line by line the results reported in each manuscript (text, quotations) and searching for common concepts across studies. Specifically, a deductive approach was applied, and pre-existing concepts in the reviewed studies were recorded; new concepts were also created to reflect new insight into the data (Table 3). This was the first order of analysis. Since the studies were directly comparable (roughly similar), a reciprocal translation was achieved, and a novel grouping of the identified (common and uncommon) concepts was attained in a new meaningful way (Britten et al., 2002) (Table 4). This resulted in the second order of the analysis. The relationship between the new interpretations generated the synthesis of translations and the third order of the analysis (Table 5).

4 | RESULTS

The included studies had a variety of designs; most of them used the phenomenological approach ($n = 6$), one was an ethnographic study ($n = 1$), two were based on grounded theory approach ($n = 2$) and four on thematic analysis ($n = 4$). Two followed the narrative approach ($n = 2$) and one applied mixed methods approach ($n = 1$). The present results were based on the narratives of 326 individuals who were parents, siblings, children or spouse to the deceased. The referred "participants" in the reviewed studies and the present study came from different cultural environments and geographical regions; they were African Americans, Chinese, Japanese, Swedish, Irish, English, Koreans, Icelanders, Danish, Brazilians and Australians (Table 1).

Overall, the way in which individuals perceived and interpreted the suicide of a family member reflected a complex phenomenon, mainly described as a traumatic experience. The need to pull through the devastation, gradually, led the participants to try to achieve a balance between keeping alive a non-traumatizing memory of the deceased while destigmatizing and liberating themselves from self-blame, self-criticism and guilt; in parallel, they sought catharsis by transforming their experience into support towards others in need. This synthesis was identified as the essence of the experience of suicide-bereaved family members.

4.1 | Interpretations of the experience of surviving the suicide of a family member

The interpretation of the experience of surviving the suicide of a family member revolved around the participants' meanings about the aetiology and the factors associated with the event. The description of suicide as an incomprehensible act was in the core of these perceptions. The participants, desolated by the nature of the loss, were engaged in incessant thoughts about the event as they could not find any satisfactory reason for it (Barnes, 2006; Begley & Quayle, 2007; Dutra et al., 2018; Entilli et al., 2021; Hybholt et al., 2020; Kawashima & Kawano, 2017; Lee et al., 2019; Lindqvist et al., 2008; Ross et al., 2018; Shields et al., 2019; Sugrue et al., 2014; Tzeng et al., 2010; Wainwright et al., 2020). Most of the times, the need for evidence and fulfilling answers was not met; even the existence of a suicide note was not enough to provide satisfactory answers to the family members regarding the reasons why their loved one was driven to suicide.

> It was question after question. I was awful about questions. I wanted answers. I wanted help with answers. Tell me why my son died. (Shields et al., 2019, p. 11)

Furthermore, in the study by Lindqvist et al. (2008), it was described that it was difficult for the parents of teenagers who completed suicide to comprehend the problems that troubled their children and the

TABLE 1 Main features of the studies included in the current meta-synthesis

Researchers/date	Study environment/region	Aim	Design	Sample	Data collection
Barnes (2006)	Not mentioned USA	Investigation of the effects of suicide in African-American families	Ethnographic study	**Size:** 19 African-American suicide-bereaved family members (12 mothers, 3 brothers, 2 spouses, 2 children) **Source:** Support programs	• Individual interviews (in person or via telephone) • 2–3 years after suicide
Begley and Quayle (2007)	Participant's houses Ireland	Exploration of the experience of suicide-bereaved family members	Phenomenological methodology	**Size:** 8 family members (2 fathers, 1 brother, 3 sisters and 2 mothers) (3 males, 5 females) **Source:** Support programs	• 4 Individual and 2 group interviews • 12 months after the suicide
Lindqvist et al. (2008)	Participant's houses Northern Sweden	Exploration of the experience of the relatives of adolescents who completed a suicide	Grounded theory	10 families (biological parents, stepfathers/stepmothers, siblings) **Source:** Department of Forensics, Umea	• Semi-structured, individual interviews with open-ended questions • 15 to 25 days after the suicide
Maple et al. (2010)	Participants' preference sites Australia	Exploration of parents' experiences following the suicide death of their young adult child	Narrative approach	**Size:** 22 suicide-bereaved parents (16 mothers and 6 fathers) **Source:** The study was advertised in local media	• Individual audio-recorded interviews and 1 telephone interview • 6 months to 26 years after suicide
Tzeng et al. (2010)	Medical centre seminar room Taiwan, China	Investigation of the experience of suicide-bereaved family members, with focus on the impact of suicide on family relationships	Phenomenological methodology	**Size:** 13 suicide-bereaved relatives (children, siblings, grandchildren, other) (3 males, 10 females) **Source:** Not mentioned	• Individual audio-recorded interviews • 2 months to 40 years after the suicide
Sugrue et al. (2014)	Participant's home or a private counselling room Ireland	Exploration the experience of mothers following their child's death by suicide	Interpretative phenomenology	**Size:** 7 biological mothers **Source:** National suicide-bereaved support organization	• Semi-structured individual interview • 2 to 5 years after suicide
Kawashima and Kawano (2017)	Not mentioned Japan	Investigation of the meaning of reconstruction process after offspring loss due to suicide	Narrative approach	**Size:** 1 bereaved mother, who lost her eldest son **Source:** She had participated in a previous study	• Life-story interview using open-ended questions • 4 years after suicide
Lee et al. (2017)	Participant's home or public place South Korea	Exploration the experiences of suicide-bereaved family members, with focus on family relations and coping strategies to overcome family struggles	Interpretative phenomenological analysis	**Size:** 11 participants (4 spouses, 4 children, 2 parents and 1 sibling) (9 females, 2 males) **Source:** Support groups	• In-depth individual interviews • 4 months to 18 years after suicide
Dutra et al. (2018)	Participants' preference sites Brazil	To understand the experience of suicide-bereaved family members	Grounded theory	**Size:** 7 family members (3 children, 1 wife, 1 aunt, 1 sister and 1 mother) **Source:** not mentioned	• Individual interview • 4 months to 11 years after suicide

(Continues)

TABLE 1 (Continued)

Researchers/date	Study environment/region	Aim	Design	Sample	Data collection
Ross et al. (2018)	Prinate, neutral, room Australia	Exploration of the experiences of suicide-bereaved mothers and fathers	Thematic analysis	**Size:** 73 participants (49 mothers and 24 fathers) **Source:** Part of a large-scale longitudinal study	• Semi-structured individual interviews • 6 to 12 months after suicide
Spillane et al. (2018)	Participant's home, university research offices and neutral locations selected by participants Ireland	Exploration of how suicide-bereaved family members have been physically and psychologically affected, with focus on their needs	Mixed-methods study	**Size:** 18 family members (7 spouses, 5 parent, 2 siblings and 4 children) **Source:** Suicide Support and Information System	• Semi-structured individual interviews • 6 to 21 months after suicide
Lee et al. (2019)	Participant's home or public place South Korea	Exploration of the characteristics of post-traumatic growth arising from losing an immediate family member due to suicide	Phenomenological analysis	**Size:** 11 participants (4 spouses, 4 children, 2 parents and 1 sibling) (9 females and 2 males) **Source:** Support groups	• In-depth individual interviews • 4 months to 18 years after suicide
Shields et al. (2019)	Not mentioned Ireland	Exploration the experiences of suicide-bereaved mothers, with focus on support groups during the meaning-making process	Interpretative phenomenology	**Size:** 4 mothers **Source:** Support groups	• In-depth individual interviews • 3 to 11 years after suicide
Hybholt et al. (2020)	Participants' homes, except for one person Denmark	Investigation of how older adults bereaved by suicide conducted their everyday life during the first 5 years after the loss of a loved one	Thematic analysis	**Size:** 20 participants (10 parents, 2 children, 4 spouses, 1 parent-in-law and 3 grandparents) **Source:** non-governmental organizations, mental health services, advertisement at websites, conferences, social media	• Semi-structured individual interview • 7 to 66 months after suicide
Wainwright et al. (2020)	Participants' homes England and the Midlands	Explore the perspectives, experiences and support needs of parents bereaved by suicide	Thematic analysis	**Size:** 29 parents (13 mothers, 4 fathers, 6 joint interviews). Joint interviews, 3 were with the mother and father of the deceased, 2 were with the father and stepmother, and 1 was with the mother and stepfather **Source:** Posters/advertisements, GP surgeries, pharmacies, local newspaper; suicide bereavement self-help groups	• Individual interviews • 2 to 10 years after suicide
Entilli et al. (2021)	Not mentioned Australia	Explore the parents' experiences at 24 months—taking into consideration the overall 2-year window and the 3 separate time observations of parents at 6, 12 and 24 months after the suicide of their child	Thematic analysis	**Size:** 73 parents (49 mothers and 24 fathers) **Source:** Part of a large-scale longitudinal study, Queensland Suicide Register, a suicide mortality database	• Semi-structured interviews • 12 and 24 months after suicide

TABLE 2 Criteria of the COREQ tool as applied on the studies of the current meta-synthesis

	Barnes (2006)	Begley and Quayle (2007)	Lindqvist et al. (2008)	Maple et al. (2010)	Tzeng et al. (2010)	Sugrue et al. (2014)	Kawashima and Kawano (2017)	Lee et al. (2017)	Dutra et al. (2018)	Ross et al. (2018)	Spillane et al. (2018)	Lee et al. (2019)	Shields et al. (2019)	Hybholt et al. (2020)	Wainwright et al. (2020)	Entilli et al. (2021)
1. Interviewer/ Facilitator	V	NR	V	V	V	V	V	V	V	V	V	V	V	V	V	V
2. Credentials	NR	V	V	V	NR	V	NR	V	V	V	V	NR	V	V	NR	V
3. Occupation	V	NR	V	V	NR	V	V	V	V	V	V	V	V	V	NR	V
4. Gender	V	V	V	V	V	V	V	V	V	V	V	V	V	V	NR	V
5. Experience and training	V	NR	V	V	NR	NR	NR	NR	NR	V	NR	NR	NR	NR	V	V
6. Relationship established	V	NR	V	V	NR	NR	V	NR	V	V	NR	V	V	V	V	NR
7. Participant knowledge of the interviewer	V	NR	V	V	V	NR	V	V	NR	V	NR	V	V	V	V	V
8. Interviewer characteristics	NR	NR	V	V	V	NR	V	V	NR	V	V	V	NR	V	NR	NR
9. Methodological orientation and Theory	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
10. Sampling	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
11. Method of approach	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
12. Sample size	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
13. Non-participation	NV	NV	V	NV	NV	NV	NV	NV	V	V	NR	NV	NR	NR	NV	NV
14. Setting of data collection	V	NR	V	V	V	V	NR	V	V	V	V	V	V	V	V	NR
15. Presence of non- participants	NR	NR	V	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	V
16. Description of sample	V	V	V	V	V	V	V	V	NR	V	V	V	V	V	V	V
17. Interview guide	NV	V	V	V	V	V	V	V	NR	V	NV	V	V	V	NV	NV
18. Repeat interviews	V	V	NR	NR	NR	NR	NR	V	NR	V	NV	V	NR	NR	V	V
19. Audio/visual recording	V	V	NV	V	V	V	V	V	V	V	V	V	V	V	V	V
20. Field notes	NR	V	V	NR	V	V	V	NR	NR	V	V	V	V	V	NR	NR
21. Duration	V	V	V	V	V	V	V	V	V	V	V	V	V	V	NR	V

(Continues)

TABLE 2 (Continued)

	Barnes (2006)	Begley and Quayle (2007)	Lindqvist et al. (2008)	Maple et al. (2010)	Tzeng et al. (2010)	Sugrue et al. (2014)	Kawashima and Kawano (2017)	Lee et al. (2017)	Dutra et al. (2018)	Ross et al. (2018)	Spillane et al. (2018)	Lee et al. (2019)	Shields et al. (2019)	Hybholt et al. (2020)	Wainwright et al. (2020)	Entilli et al. (2021)
22. Data saturation	NR	NR	NR	NR	V	NR	NR	NR	V	V	NR	NR	NR	NR	V	V
23. Transcripts returned	NR	NR	NR	NR	V	V	NR	NR	NR	NR	NR	NR	NR	NR	NR	V
24. Number of data coders	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
25. Description of the coding tree	V	V	NV	NR	NV	NV	V	NV	V	NV	NV	NV	NR	NV	NV	V
26. Derivation of themes	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
27. Software	NV	NV	NV	NV	NV	NV	NV	NV	V	V	V	NV	NV	NV	NV	V
28. Participant checking	NV	NV	NV	NV	NV	NV	NV	NV	NV	NV	V	NV	NV	NV	NV	NV
29. Quotations presented	V	V	V	NV	V	V	V	V	V	V	V	V	V	V	V	V
30. Data and findings consistent	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
31. Clarity of major themes	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V
32. Clarity of minor themes	V	V	V	V	V	NV	V	V	V	V	V	V	V	V	NV	V
Total	23 V	19 V	25 V	22 V	22 V	20 V	22 V	22 V	22 V	28 V	22 V	23 V	22 V	23 V	18 V	25 V

Note: The quality of each study was determined by the sum of valid items, as follows: good quality ≥25 items, moderate quality: 17 to 24 items, poor quality: 9 to 16 items and very poor quality ≤8 items. Only studies of good quality were included in the present meta-synthesis.

Abbreviations: NR, not reported; NV, not valid; V, valid.

TABLE 3 Main concepts in each study and common/uncommon concepts across studies (first order analysis)

RESULTS						
			(C) Coping and Perceptions on support received			
					Interpretation of supportive systems	
Researchers, date and country	(A) Interpretation of the experience of surviving the suicide of a family member	(B) Impact of suicide on the bereaved family members	Personal coping strategies	Supportive systems	Helpful	Unhelpful
Barnes (2006) USA	Incomprehensible act Others' fault (family members)	Pain, distress, turmoil Social isolation Social stigmatization Transformation of their worldview	Going through the grieving process alone	Friends Family members Church	X X	 X
Begley and Quayle (2007) Ireland	Incomprehensible act Participants' fault Undiagnosed mental disorder and psychological difficulties	Severe pain, distress, guilt, fear and turmoil, both at individual and family level Limitation of social relations to avoid discussions on the subject Redefining of the meaning of life and worldview transformation.	Questioning prior relationship with the deceased, blaming the deceased	Professional support Support group	X X	
Lindqvist et al. (2008) Northern Sweden	Incomprehensible act Lack of knowledge on suicide warning signs and risk factors, including challenges faced by adolescents (e.g., broken love affair, fear of pregnancy)	Guilt, shame Difficulty to return to a normal life Prolonged tension due to unanswered questions	N/M	Friends Church Mental health Professionals	X X X	
Maple et al. (2010)	N/M	Social stigmatization Social isolation	Silence, avoiding suicide topic	N/M	N/M	N/M
Tzeng et al. (2010) Taiwan, China	Incomprehensible act Participants' fault Others' fault (family members)	Pain, confusion, guilt Avoiding one another, strained family relationships. Being blamed by others	N/M	Family members	X	
Sugrue et al. (2014) Ireland	Incomprehensible act Lack of knowledge on suicide warning signs and risk factors, including challenges faced by adolescents (e.g., bullying)	Mental health problems (depression, nightmares, insomnia, poor concentration, numbness, shock) Suicidal behaviour (thoughts/attempts) Suffering and sorrow Loss of faith and belief Change of worldview	Keep emotion and pain hidden Forgiveness	N/M	N/M	N/M
Kawashima and Kawano (2017) Japan	Incomprehensible act Participants' fault	Feeling responsible for the suicide	Reconstruction of a bond with the deceased Keep feelings hidden	Husband	X	

(Continues)

TABLE 3 (Continued)

RESULTS						
			(C) Coping and Perceptions on support received			
					Interpretation of supportive systems	
Researchers, date and country	(A) Interpretation of the experience of surviving the suicide of a family member	(B) Impact of suicide on the bereaved family members	Personal coping strategies	Supportive systems	Helpful	Unhelpful
Lee et al. (2017) South Korea	Participants' fault Others' fault (family members)	Family conflicts Disturbed social relation because of trying to find someone to blame	Forgiveness	Health professional	X	
Dutra et al. (2018) Brazil	Incomprehensible act	Intrusion of images of the deceased Social criticism Financial problems Difficulties in family relations Mental health problems	Stick to God & isolation	Neighbours Friends Health professionals	X X X	
Ross et al. (2018) Australia	Incomprehensible act Undiagnosed mental disorder and psychological difficulties Participants' fault Others' fault (healthcare professionals).	Pain, change of priorities Placing more value on life and not taking everyday things for granted	Avoiding suicide topic Alcohol misuse Writing letter to their child Visiting the cemetery. Offering help to others. Celebrating child's birthday.	Support groups Partner/spouse Family members Friends	X X X X	
Spillane et al. (2018) Ireland	N/M	Physical, psychological and somatic problems Guilt, blame, shame, sadness and relief Loss of future perspective	Big life changes (moving, changing job, disengaging from the work environment) Walking Gardening Yoga Alcohol misuse	Family members Friends Support groups	X X X	
Lee et al. (2019) South Korea	Incomprehensible act Participants' fault Lack of knowledge on suicide warning signs and risk factors	Severe pain Social stigma Changed priorities. Stronger relationships	N/M	Family members Partner/spouse Support groups	X X X	
Shields et al. (2019) Ireland	Incomprehensible act Participants' fault Others' fault (family members, healthcare professionals/system)	Pain and anger towards medical staff, guilt Feeling alone and isolated	Suppressing feelings and emotions Internalizing and externalizing the blame	Support group Neighbours	X X	
Hybholt et al. (2020) Denmark	Incomprehensible act Lack of knowledge on suicide warning signs and risk factors, including challenges faced by adolescents (e.g., divorce in the family).	Unable to return to everyday life	Concealment of grief and sorrow Scrutinizing problematic events in everyday life with the deceased	Professional support Peer support groups	X X	

TABLE 3 (Continued)

RESULTS					
			(C) Coping and Perceptions on support received		
				Interpretation of supportive systems	
Researchers, date and country	(A) Interpretation of the experience of surviving the suicide of a family member	(B) Impact of suicide on the bereaved family members	Personal coping strategies	Supportive systems	Helpful	Unhelpful
Wainwright et al. (2020) England, Midlands	Incomprehensible act	Social isolation Social stigmatization.	N/M	Support group Professional support	X X	
Entilli et al. (2021) Australia	Incomprehensible act Others' fault (healthcare professionals) Undiagnosed mental disorder and psychological difficulties	Pain, blame, fear, anger, depression, shock, confusion Transformation of their worldview	Avoidance of the topic Alcohol misuse Writing letter Mental health care Hobbies	Family members Friends Church Support group Professional support	X X X X X	

Abbreviations: N/M, not mentioned; X, reported.

circumstances that led them to it. The challenges of this age period, including issues with sexual relationships, unwanted pregnancy and problems with peers, were some of the possible factors described to justify suicide.

Additionally, trying to give a meaning to the event, the participants interpreted suicide as an impulsive act in response to a single event leading the person to consider that he/she had no choice. The belief that suicide might also have been the result of an undiagnosed mental disorder was also revealed (Begley & Quayle, 2007).

> I don't know why. We'll never know why. Just how [...], I'd say someone hurt him that night. [...] He couldn't handle it. That's the kind of guy he was. He wasn't depressed or anything. (Begley & Quayle, 2007)

Since the majority of participants were not able to identify any sufficient reasons for the suicide, they blamed either themselves or others (Barnes, 2006; Kawashima & Kawano, 2017; Lee et al., 2017; Ross et al., 2018; Shields et al., 2019; Spillane et al., 2018; Tzeng et al., 2010), while they kept wondering if they could have done something to prevent the tragedy. An interaction between self-blame and self-torture was grounded on the basis of lack of logical explanation for the act. Characteristically, most of the participants believed that suicide was their fault, taking full responsibility for not preventing it, even if they had not noticed any warning signs, or were not aware of any suicide risk factors (Kawashima & Kawano, 2017; Ross et al., 2018; Spillane et al., 2018; Tzeng et al., 2010). Specifically, when the deceased was a teenager, the participant mothers considered that they were responsible for their child's suicide, which indicated a lack of confidence in themselves. This interpretation was constantly breeding feelings of guilt and a perception of failure as a parent (Begley & Quayle, 2007; Lee et al., 2019; Shields et al., 2019).

> It happened because I didn't do my best. (Tzeng et al., 2010, p. 192)

> When writing my personal experiences [...] I realized that I am responsible for the event. Me, his mother. I couldn't save his life [...], I will never forgive myself. (Kawashima & Kawano, 2017, pp. 364–365)

Furthermore, there were participants who described a number of challenges related to parenthood, which eventually hindered them from being able to prevent the suicide (Barnes, 2006). Blaming other family members, or even accusing those relatives who completed suicide in the past as having imposed a catastrophic influence upon the family, was also reported.

> My father was very stubborn. He put a lot of pressure on my brother and made him feel restricted [...]. (Tzeng et al., 2010, p. 192)

TABLE 4 Concepts identified across the studies and grouped into new categories (second order of analysis)

	Barnes (2006)	Begley and Quayle (2007)	Lindqvist et al. (2008)	Maple et al. (2010)	Tzeng et al. (2010)	Sugrue et al. (2014)	Kawashima and Kawano (2017)	Lee et al. (2017)	Dutra et al. (2018)	Ross et al. (2018)	Spillane et al. (2018)	Lee et al. (2019)	Shields et al. (2019)	Hybholt et al. (2020)	Wainwright et al. (2020)	Entilli et al. (2021)
Interpretation of the experience of surviving the suicide of a family member																
Endless searching for answers and Interpretation of the aetiology																
Incomprehensible act	x	x	x		x	x	x		x	x		x	x	x	x	x
Participants' fault/ Inadequate parenthood		x			x		x	x		x		x	x			
Others' fault (family members, healthcare professionals/ system, peers, etc.)	x				x			x		x			x			x
Undiagnosed mental disorder & psychological difficulties		x								x						x
Lack of knowledge on suicide warning signs and risk factors, including challenges faced by adolescents (e.g., sexual difficulties, problems with peers)			x			x						x		x		
Impact of suicide on bereaved family members																
Psychological status																
Pain	x	x	x		x				x		x	x	x			x
Lament	x	x	x		x							x	x			
Distress	x	x	x		x						x		x			
Fear	x		x		x							x	x		x	x
Anger										x			x			x
Turmoil	x	x	x		x						x					x
Shame					x	x					x		x		x	
Confusion										x						
Shock						x			x	x	x		x			x
Anxiety			x			x					x				x	

TABLE 4 (Continued)

	Barnes (2006)	Begley and Quayle (2007)	Lindqvist et al. (2008)	Maple et al. (2010)	Tzeng et al. (2010)	Sugrue et al. (2014)	Kawashima and Kawano (2017)	Lee et al. (2017)	Dutra et al. (2018)	Ross et al. (2018)	Spillane et al. (2018)	Lee et al. (2019)	Shields et al. (2019)	Hybholt et al. (2020)	Wainwright et al. (2020)	Entilli et al. (2021)
Guilty		x	x				x		x		x		x			x
Perception of failure as a parent		x					x									
Inability to express feelings		x		x		x	x									
Everyday life																
Positive impact on one's life (re-evaluation of life)	x	x								x	x	x	x			x
Unable to return to everyday life/ Difficulty regaining functionality											x			x		
Social interactions																
Social isolation	x	x	x	x			x		x			x	x		x	
Criticism from others		x							x			x				
Social stigmatization	x			x					x			x			x	
Family interactions																
Overprotection		x														
Dysfunctional communication/ No sharing feelings														x		
Fear of distressing others													x			
Coping and Perceptions on support received																
Coping strategies (cognitive, spiritual, mental and behavioural processes)																
Avoiding suicide topic				x						x			x			x
Alcohol use										x	x					x
Physical and mental health care										x			x	x		x
Writing letter to their child										x						x
Visiting the cemetery										x						

(Continues)

TABLE 4 (Continued)

	Barnes (2006)	Begley and Quayle (2007)	Lindqvist et al. (2008)	Maple et al. (2010)	Tzeng et al. (2010)	Sugrue et al. (2014)	Kawashima and Kawano (2017)	Lee et al. (2017)	Dutra et al. (2018)	Ross et al. (2018)	Spillane et al. (2018)	Lee et al. (2019)	Shields et al. (2019)	Hybholt et al. (2020)	Wainwright et al. (2020)	Entilli et al. (2021)
Offering help to others										x		x				
Celebrating child's birthday										x				x		
Faith/ religion										x						x
Being occupied and maintaining a routine/ having hobbies										x				x		x
Forgiveness						x										x
Gardening/Yoga/ Walking											x					
Supportive systems (external to the individual)																
Family members	x	x	x		x		x			x	x	x	x			x
Church	x		x							x			x			x
Friends/Neighbours	x		x				x		x	x			x			x
Professional support			x				x		x	x				x	x	x
Supportive groups	x	x								x	x	x	x		x	x
Interpretation of support received from other family members																
Helpful/ A means of relief	x	x	x		x			x	x		x	x				x
Unhelpful/ Being perceived as an obligation		x														
Interpretation of support received from groups																
Helpful	x	x						x	x		x	x	x	x	x	x
Providing empathy/ Non-critical attitude	x	x							x				x	x	x	x
Consequences of receiving no support																
Anxiety	x															

TABLE 5 Synthesis of data in the first, second and third order analyses

First order analysis		Second order analysis	Third order analysis
Interpretation of the experience of surviving the suicide of a family member	Endless searching for answers	Trying to find someone, or something to blame	Trying to achieve a balance between keeping alive a non-traumatizing memory of the deceased, while being destigmatized and liberated from self-blame, self-criticism and guilt, being able to transform this experience into support towards others in need
	Interpretation of the aetiology		
Coping & perceptions on support received	Coping strategies applied (cognitive, spiritual, mental and behavioural processes)	Keeping the memory of the deceased	
	Supportive systems (External to the individual)	Being alleviated from pain, and liberated form self-stigma, social stigma	
	Interpretation of the support received from family/groups (Helpful/Unhelpful)		
	Consequences of receiving no support		
Impact of suicide on bereaved family members	Psychological status	An existential lurch	
	Everyday life	Constant effort to regain normality	
		Change of worldview	
	Social interactions	Supporting others	
		Loss of social activities due to social stigma	
	Family interactions	Need to protect other suicide-bereaved family members	
		Dysfunctional communication	

> Auntie (father's sister) called and accused my mother of killing our father. (Lee et al., 2017, p. 693)

Finally, the healthcare system's inability to provide optimal care and insufficiency of supportive and preventive mechanisms were also labelled as accountable for the suicide of their beloved family member by the participants in four studies ($n = 150$) (Entilli et al., 2021; Ross et al., 2018; Shields et al., 2019; Tzeng et al., 2010).

> I just feel as though he was neglected. You know, I feel as though it was the medication he was on, that caused all that agitation. Because that wasn't there before he went to hospital. (Shields et al., 2019, p. 9)

In conclusion, the participants' need for someone to "take the responsibility and the blame" (themselves or others) for the suicide, and their strong necessity to "free themselves from guilt and stigma as ineffective or inappropriate relatives" were clearly linked (Barnes, 2006; Begley & Quayle, 2007; Lee et al., 2017; Ross et al., 2018; Tzeng et al., 2010), showing that liberation from the need to blame somebody or themselves would eventually release them from self-stigma or the necessity to stigmatize others.

4.2 | Coping strategies and perceptions on support received

Five out of sixteen of the reviewed studies clearly reported data on the participants' coping strategies (Dutra et al., 2018; Lee et al., 2017; Ross et al., 2018; Shields et al., 2019; Sugrue et al., 2014). In terms of locus and dynamics, these strategies were addressed as personal, cognitive and behavioural, or as interpersonal supportive systems, external to the suicide-bereaved family members, as well as functional or dysfunctional and helpful or unhelpful, respectively.

Avoidance of the suicide topic was noted by the participants in four studies ($n = 170$) (Entilli et al., 2021; Maple et al., 2010; Ross et al., 2018; Shields et al., 2019), claiming they were feeling uncomfortable to discuss the loss of their beloved to suicide with other family members, including their partners. Others described their

disappointment because their relatives refused to open up to them after the suicide. Misuse of alcohol on a daily basis was included in the participants' narratives. According to their confessions, alcohol helped them either forget or fall asleep. In any case, dysfunctional coping strategies resulted in further difficulties regarding the participants' effort to return to normalcy.

> I can come home, and I get very, very depressed, very much like my son. If I come home and I have two drinks, and I feel—I love living, I love life, so happy. But then I just, that experience, I just like having a few more and a few more and a few more. (Entilli et al., 2021)

In most cases, the participants' coping strategies reflected their need to maintain a bond with the deceased, as were the visitations to the grave. Others described that their faith and subsequent religion-related activities helped them not only cope but also achieve a new, non-traumatizing bond with their loved one (Dutra et al., 2018; Ross et al., 2018). A participant from Japan spoke of the importance of spirituality in overcoming daily pain during difficult days (Lee et al., 2019).

> A fortune teller told me that my son is no longer my son. He's somewhere watching me from above. I felt like I was saved by this story. (Lee et al., 2019, p. 367)

Furthermore, participants who received early support from family members, friends and significant others, felt grateful and considered it a helpful factor in the process of their mourning. Similarly, those who externalized "their inner world" to other members of the family described feelings of relief (Barnes, 2006; Begley & Quayle, 2007; Dutra et al., 2018; Kawashima & Kawano, 2017; Lee et al., 2019; Lindqvist et al., 2008; Ross et al., 2018; Tzeng et al., 2010).

Equally, participating in self-help support groups was described as a healing process, since the attendee gained solidarity and the empathy they had not received form their social network (Barnes, 2006; Begley & Quayle, 2007; Dutra et al., 2018; Hybholt et al., 2020; Lee et al., 2017, 2019; Ross et al., 2018; Shields et al., 2019; Spillane et al., 2018; Wainwright et al., 2020).

> We found it very useful … everyone tells their story and you can open up and they tell you things. You stop feeling like you are the only unlucky people in the world. That it does happen to other people as well, even if it's a small number. You're not the only ones, which is comforting to know that there's other people (in the same position) (Ross et al., 2018, p. 5).

Nevertheless, this sense of belonging following participation in self-help support groups, was evidently working as a buffer system against the feeling of loneliness, clearly described as a result of suicide on bereaved relatives.

Additionally, as part of self-help groups, the participants were able to freely express their feelings and thoughts, knowing in advance that neither the deceased nor themselves would be criticized and disgraced. Given that the participants felt accepted, destigmatized and valued, they also felt less vulnerable (Barnes, 2006; Begley & Quayle, 2007; Hybholt et al., 2020; Lee et al., 2017, 2019; Ross et al., 2018; Shields et al., 2019; Spillane et al., 2018; Wainwright et al., 2020).

> I went initially because you want a sort of validation that you are OK, you are not a bad parent, it's not what you've done. So, I went to this group, and you look at all these people who have been grieving the same thing—some of them are parents, some of them are partners, some of them are siblings—and you just think to yourself 'well these all look like decent people, it's happening' … (Wainwright et al., 2020)

Overall, participation in self-help support groups facilitated the participants' coping with dysfunctional perceptions that hindered them from moving on; not only did it help them manage their vulnerability, but it also addressed their need to keep the memory of their loved one in a non- distressing way.

> You don't want to be better. You think if you get better, you'd be forgetting your son. I thought I had to live with pain for the rest of my life. But you learn through the group that you don't have to live with their pain. We let go of their pain. We still carry the pain of their loss, but mentally it helps you being in the group. (Shields et al., 2019, p. 13)

Moreover, especially parent participants were eager to help others who had recently experienced the suicide of a family member, particularly those who were unable to receive support. Specifically, they felt compelled to reciprocate the help that they had received from long-term suicide survivors or support groups, by supporting others in distress.

> […] Helping people go forward, to me is a great thing […]. (Ross et al., 2018, p. 6)

> I want to help other suicide survivors because I know that even a little care means a lot to them. (Lee et al., 2019, p. 14)

The impact of helping other suicide-bereaved individuals was threefold as concluded by the study. Firstly, it facilitated self-growth and meaning-making about the loss, secondly, it was deemed as a means for self-forgiveness and a way to forgive the deceased, and lastly, the participants liberated from guilt and self-blame seemed to gain relief.

> I do not want my husband's death to be meaningless and I became more mature through this experience, and I want to support other survivors of suicide. I think it is the way I can forgive myself and forgive my husband who left us [...] it seems that in the end, the ultimate goal towards which we need to strive as survivors of suicide is forgiving ourselves and forgiving each other. (Lee et al., 2017, p. 10)

By contrast, for those who did not receive any kind of support, the process of mourning tended to evolve into dysfunctional grief as they were unable to come to terms with their loss. Specifically, since the suicide, these participants had been living by refusing to express their feelings and moved on with their lives according to suggestions by other family members. Some of these participants had been hospitalized due to anxiety symptoms related to post-traumatic stress disorder. Others described depression, nightmares and insomnia, poor concentration, and numbness or shock, as well as cardiovascular problems and eating disorders (Sugrue et al., 2014).

> The (deceased) son came in … and he was asking me what I was doing …] he was talking to me, I was talking to him, he was there like, do you know what I'm saying … I thought he was, I was out of my bed and the whole lot. (Spillane et al., 2018)

4.3 | The complex impact of suicide and the link with coping strategies

In terms of the impact of suicide on the participants, the effects were described at individual, familial and social level. Most importantly, an interplay was revealed between the aftereffects of suicide on the participants' family members and their coping styles.

Intense pain, grief, anguish, insecurity, guilt and self-stigma were described in suicide-bereaved family members (Barnes, 2006; Begley & Quayle, 2007; Dutra et al., 2018; Entilli et al., 2021; Lee et al., 2019; Lindqvist et al., 2008; Tzeng et al., 2010).

> It's despairing, I've lost my father, I've lost my mother, I felt bad, but my brother's suicide was horrible, it seems like my world fell apart, we didn't know what to think, we didn't know what to say, it was a very horrible thing, terrible feeling. (Dutra et al., 2018, p. 2149)

In line with these feelings, suicide-bereaved parent participants described an intense fear of subsequent suicides in the family.

> For three months every night, at 1:00, 2:00, and 3:00 in the morning (I was) looking in to see, was he (the other son) alright? (Begley & Quayle, 2007, p. 29)

As a result, they often took the role of "protector," adopting an "overprotective" behaviour towards other family members in an effort to cope with their distress (Begley & Quayle, 2007).

Corresponding with their need to protect their family members, the participants also confessed that they avoided expressing their feelings to them because they did not want to upset them or have their role as a parent challenged by their surviving children. Pretending that everything was quite good was described by the participants as a coping strategy to protect their integrity.

> I don't cry in front of my other children [...] I remain the mother to my daughters even though I lost my son. So, I have to be careful not to be sad in front of them [...]. (Lee et al., 2019, p. 366)

> I had to keep myself in check and did not want to lay my grief on them [other adult children]. (Sugrue et al., 2014, p. 119)

Difficulties in communication were clearly reported because of the participants' coping strategy to hide their painful feelings in an effort to protect others. Their constant concealment of true emotions seemed to lead to communication breakdown, conflicts among family members, but most importantly to an escalation of psychological distress and intense adverse feelings.

> [...] the whole family tries to guess each other's feelings in fear of hurting one another [...]. It is hard to be lying. When communication among family members is difficult, we misunderstand each other and the gaps only grow [...]. I feel like the pain increases and becomes worse. Because of the shock and devastation experienced, everyone is so sensitive and conflict is easily created. (Lee et al., 2017, p. 693)

The participants' perception of personal responsibility or self-accusation for the death of their loved one hindered even more the expression of their true feelings to other grieving family members (Begley & Quayle, 2007; Lee et al., 2019).

> Why he did it, is there something I should have noticed, something I should have done? I have not talked about this [...] she talks to her brothers and sisters, but I can't do that yet. (Begley & Quayle, 2007, p. 29)

Overall, family relations were described as strained, as if each member ignored the existence of the other, with participants using the term "invisible family" to describe the new dynamic of their family after suicide. Not only had the bereaved family members lost their loved one, but also the quality of their relationships thus leading themselves to more intense pain (Tzeng et al., 2010).

> My older sister's suicide has affected us all quite a bit. Before the incident, my father and I were on good terms. Now our relations are totally cold. When we meet, we ignore each other and face each other like we're invisible. We have a blood connection, but we don't talk to each other. For more than 10 years no one had the guts to talk about my sister. We became very distant. (Tzeng et al., 2010, p. 190)

Additionally, it was reported that suicide brought to the surface pre-existing family problems and triggered tensions, even violent behaviours, within the family, mainly between bereaved parents.

> After the suicide, differences in coping with the loss ensued in anger and conflict, and resulted in my father using violence, and now our parents are not on speaking terms and I have not contacted my father since his violence towards my mother. I think the problems that were plaguing my family surfaced after my brother's death. (Lee et al., 2017, p. 694).

Overall, the impact of dysfunctional communication schemas on the sustainability of family cohesion was evident, supporting again an association between coping styles and the aftereffects of suicide on the family dynamics. Poor coping with the loss produced dysfunctional communication patterns which affected the quality of family relations. The opposite was also evident, since the participants who described an open communication style among family members experienced relief and alleviation from pain.

> I've got a good supportive family group. I think I have a good enough family and friendships to be able to share thoughts and feelings … and I can talk openly with them. (Ross et al., 2018, p. 5)

Furthermore, in the aftermath of the suicide of their family member, the participants described that they were struggling hard to move on with their lives. Almost all participant–parents thought it was impossible to return to normalcy as they admitted that not a single day would pass without thinking about their child's suicide (Hybholt et al., 2020; Lindqvist et al., 2008; Spillane et al., 2018). It was further reported that suicide-bereaved survivors had difficulty in participating in social activities and maintaining social relationships, let alone romantic ones, leading them to social isolation (Barnes, 2006; Begley & Quayle, 2007; Lee et al., 2019; Lindqvist et al., 2008; Maple et al., 2010).

> My life is changed in the line of going out here and there, I am not interested in any type of (social) things or matches or anything like that. (Begley & Quayle, 2007, p. 31)

Some participants stressed the inability of the social environment to show empathy very early on after the death of their relative resulted in feelings of loneliness and subsequent social withdrawal (Lindqvist et al., 2008). They moved away from friends and the wider family, especially when asked to forget the suicide of their beloved and move on.

Others described that the experience of suicide within the family was a private and highly domestic issue, making it difficult for them to externalize their feelings and thoughts to their milieu. This "suffering in silence" was also a strategy to avoid criticism and stigmatization by others, also keeping them away from social life (Begley & Quayle, 2007).

> I don't tell people he died of suicide. It's strictly personal information to say that someone died of suicide. I think it's the fear of the prejudices people hold about this matter or what they think right away or whether they judge. (Begley & Quayle, 2007, p. 30)

Contrariwise, some participants reported that it was indifferent to them what people thought, because they had to fight with their own guilt and shame, leaving social stigma aside (Lee et al., 2019; Lindqvist et al., 2008). Interestingly, a study in African-American suicide-bereaved survivors revealed that suicide was perceived as an individual "failure" and the inadequacy of the entire community, thus mainly blaming and stigmatizing the community (Barnes, 2006). This finding highlighted cultural differences regarding both interpretation of suicide and the process of mourning (Barnes, 2006; Lee et al., 2019). Despite cultural differences, the need for a sufficient mourning period was described as necessary.

> There is a need that I feel that is not recognized. People need to grieve, either because they lost their home, (…) or because they lost their job … whatever … but we, as Negroes, tend not to. (Barnes, 2006, p. 20)

Furthermore, the participants described different mourning experiences in different time periods and emphasized that grieving and meaning-making was an individualized process (Barnes, 2006; Begley & Quayle, 2007; Ross et al., 2018; Tzeng et al., 2010).

> My answers probably would have been different six months ago, but now I'm … like I'm resigned to the fact that she's not coming back obviously. It's just, as time passes the pain doesn't go away but it gets easier. (Ross et al., 2018, p. 4)

> I am not at the end of my grieving process, probably, so I don't really want to start talking about it. (Begley & Quayle, 2007, p. 30)

The participants also described a positive impact of suicide on them. For example, African Americans reported that they tried to see their perspectives differently and set new priorities while others described

a transformation in their worldview and their attitudes (Barnes, 2006, Begley & Quayle, 2007, Lee et al., 2017, 2019; Wainwright et al., 2020).

> […] he's changed so much since the suicide, he's much more open now. (Begley & Quayle, 2007, p. 91)

> I realized the most important value after losing the most important thing. (Lee et al., 2019)

> Before, my mother always obediently followed my authoritarian father's and grandparents' opinions. But now, after my mother lost her son to suicide, she does not want to live like this anymore. So, she started advancing and following her own opinions rather than her husband's blindly. (Lee et al., 2017, p. 694)

Overall, the participants described how their loss helped them re-evaluate their life and endorse their emotional and spiritual growth. Mainly, the participants stated that they had gained awareness towards those in need of assistance, and that they were more attentive and open to listen and offer help to others; orientation towards others in a meaningful way was enhanced. Eventually, a transformation of the traumatic impact of the suicide into an existential re-evaluation of life constituted an important coping strategy towards managing their grief.

> For me it was cathartic (offering help). It helped me have a purpose. As I say I've probably readdressed quite a few things in my life, or we both have. Helping people go forward, to me is a great thing and certainly helping any young person deal with the uncertainties of life. (Ross et al., 2018, p. 6)

Most importantly, by ultimately reaching catharsis, the process of releasing and gaining relief from strong emotions, the participants would liberate themselves from haunting thoughts and needs such as who to blame as well as stigma.

5 | DISCUSSION

As far as the authors are aware, this work provides the first meta-synthesis of qualitative research exploring the experiences of suicide-bereaved relatives by addressing an important gap in the suicide-related literature. Losing a family member to suicide was described as a traumatic experience, characterized by intense and enduring pain, with spiritual and existential implications. Self-criticism and guilt, were revealed as core elements of the familial suicide, and further recognized as the protagonists in the developmental process of the participants' recovery.

The revelation of the existential need for suicide-bereaved relatives to balance between keeping alive a non-traumatizing memory of the deceased and feeling liberated from self-criticism, guilt and stigma, thus enabling themselves to transform their encounter into supporting others in need, was ultimately regarded as the essence of the participants' experience. Specifically, the majority of the themes in the reviewed studies focused on the participants' need to be liberated from self-blame, and the deep sense of responsibility they felt for their relative's suicide, as well as social criticism.

Characteristically, their constant and distressing effort to comprehend the motives which led to the suicide of their beloved yielded psychological distress and grief full of tension, guilt, shame and anger with crucial consequences on family dynamics. The participants described that, eventually, by engaging in adaptive coping strategies helped them to alleviate these adverse emotions so as to be able to come to terms with the loss, keep a peaceful bond with the memory of the deceased and achieve healing inter-family relations. The participants' inner need to release themselves from self-blame for the suicide compelled them to engage in a spirit of support for others in need. Indeed, the participants described their intense inner wish to support their beloved or their children. Furthermore, by showing empathy to other suicide survivors, attending to their needs and helping them to cope, the participants described their healing relief from the emotional burden impacted by the suicide. This coping strategy, not only was it central in helping the participants regulate their adverse emotions, regain self-worth and every-day routine, but it also underpinned a state of elevation and self-growth by transforming their traumatic experience of loss into empathy and support for others in need.

Although engagement in meaningful activities and provision of support to others in need have been described as effective coping strategies in the literature (Lee et al., 2019; Pritchard & Buckle, 2018; Ross et al., 2018), the present synthesis underlined the qualities of the process which enables the bereaved to fulfil their need to keep a non-traumatizing, positive bond with the deceased. Specifically, engaging in activities of supporting others in need is an imortant process that promotes the essential coping elements of self-growth and self-esteem enhancement in the suicide-bereaved relatives.

An additional important finding was the interplay between the participants' coping strategies and the impact of suicide on their families. Specifically, coping mechanisms adopted by the participants seemed to mediate the impact of suicide on the quality of family relationships. Consequently, interventions aiming at facilitating the adoption of coping strategies to transform adverse beliefs and emotions into positive energy, as well as enhancing effective communication styles in surviving families are vital. Identifying the coping mechanisms adopted by suicide-bereaved family members and by further replacing the maladaptive with functional ones may moderate the impact of suicide on family dynamics.

Regarding adverse feelings in bereaved relatives, data show that those who have lost a loved one to suicide experience high levels of guilt, blame and responsibility (Sveen & Walby, 2008; Tal et al., 2017), also confirmed herein. In their effort to cope with their loss, suicide-bereaved family members either internalize or externalize the blame for the incident. According to Dunn and Morrish-Vidners (1987), the process of externalization of blame towards others may be helpful at first, since it gives suicide-bereaved relatives a sense of control

and absolves them of their own guilt, but it also negatively redirects their resentment of the deceased towards others. Instead, the present meta-synthesis has shown that liberation from the need to blame somebody or oneself is expected to alleviate self-stigma and the necessity to stigmatize others from suicide-bereaved relatives. Consequently, it is underlined that this vulnerable population needs absolute comprehensive and systematic support to replace negative coping mechanisms with positive ones, focused on keeping a non-distressing memory of the deceased while being in peace with the social environment. By comparing the present results on suicide-bereaved family members with the existing literature on suicide-bereaved non-family members (Bartik et al., 2013; Pitman et al., 2018), it becomes apparent that both family and friends may avoid talking about the event due to shame and stigma associated with suicide, and in some situations, they may even accuse those close to the deceased of failing to help them in any way. Moreover, both study populations describe to some extend that traditional social support networks for those who have survived the suicide of a close friend or family member may not exist or they may be dysfunctional (Andriessen, Krysinska, & Grad, 2017; Barnes, 2006; Ferlatte et al., 2019; Shields et al., 2019). The same has been reported by parents whose children died from drug overdoses (Feigelman et al., 2011).

By comparing the present results on suicide-bereaved family members with the existing literature on suicide-bereaved non-family members (Bartik et al., 2013; Pitman et al., 2018), it becomes apparent that both family and friends may avoid talking about the event due to shame and stigma associated with suicide, and in some situations, they may even accuse those close to the deceased of failing to help in some way. Moreover, both study populations describe to some extend that traditional social support networks for those who have survived the suicide of a close friend or family member may not exist or they may be dysfunctional (Andriessen, Krysinska, & Grad, 2017; Barnes, 2006; Ferlatte et al., 2019; Shields et al., 2019). The same has been reported by parents whose children died from drug overdoses (Feigelman et al., 2011).

However, suicide-bereaved family members' inner need to release themselves from self-blame has been manifested more intensely in this study population than in those who bereave due to other type of loss (Chapple et al., 2015; Pitman et al., 2016, 2018; Shear & Zisook, 2014; Young et al., 2012). According to a review on perceived stigma, as the subjective awareness of others' stigmatizing attitudes, the most heavily stigmatizing loss among all kinds of sudden losses, is that of suicide bereavement (Pitman et al., 2016). This comes to verify the central theme of the present meta-synthesis that suicide-bereaved family members are constantly trying to achieve a balance between keeping alive a non-traumatizing memory of the deceased, while becoming destigmatized and liberated from self-blame, self-criticism and guilt.

Additionally, data show that suicide-bereaved relatives who are not supported in managing their grief are more susceptible to symptoms of depression and post-traumatic stress disorder (Hensley et al., 2009), which was also reported herein. Thus, early screening for mental health problems, as well as management of shame, self-stigma and guilt during the grieving period need to be a priority in relevant nursing interventions.

Confirming previous data, the participants herein although they were deeply affected by their loss, they also described a clear need to return to a seemingly normal family life, highlighting the need for support during this process from church, healthcare professionals, the wider family and friends. Mainly, support from self-help groups was described as particularly helpful, since it addressed the participants' need to have someone close to them to express their emotions without being judged (Lee et al., 2019). Thus, nursing interventions to facilitate participation in self-help groups are important. Experiences of social isolation due to social stigma following familial suicide render the latter invaluable.

Yet, despite the fact that social isolation was the most common impact reported by the participants herein, Asian studies have not addressed this topic either at all (Tzeng et al., 2010) or in depth (Kawashima & Kawano, 2017). This may denote a significant cultural difference between Western countries and Eastern countries in terms of the factors that influence the experience of suicide bereavement. Specifically, since the studies conducted in China and Japan (Kawashima & Kawano, 2017; Tzeng et al., 2010) did not provide any data on social isolation, social criticism and stigmatization, this may suggest that research participants in these studies did not feel comfortable to express relevant thoughts and emotions, or they may have thought that this was not culturally accepted. In that case, the cultural value attached to maintaining the good image of the family in society may have played an important role in this attitude. One may conclude that suicide in collective countries, such as Japan and China, not only is it an individual failure of the deceased to cope with the problems but also a collective one, reflecting a defeat of the community to support those in need (Kawashima & Kawano, 2017; Tzeng et al., 2010).

Similarly, the study by Barnes (2006) in a sample of African-American suicide-bereaved family members also highlighted the lack of social support within the black compared to the white community, a finding yet attributed to different cultural factors. Specifically, the author reported that suicide-bereaved family members in African-American communities are expected to "continue their lives" and that there is little room for mourning, and subsequent social support during grieving thus making it difficult for them to go through the bereavement process. Additionally, it shows the necessity of addressing and managing those cultural factors which may hinder suicide-bereaved family members' willingness to ask for help, by mental health professionals.

Furthermore, a particularly painful experience described herein was the participants' inability to find a reason why the suicide occurred, as it was beyond their understanding. According to their descriptions, gaining insight into the cause of suicide would probably liberate them from feeling responsible for it and enable them to move on with their lives, at least physically. One way to facilitate this is to engage suicide-bereaved relatives in structured educational programs about suicide, focused on its pathophysiology

and associated factors, in combination with cognitive-behavioural techniques (Hatzioannou et al., 2021). Through such educational interventions, mental health nurses are expected to challenge dysfunctional interpretations or attitudes in suicide-bereaved relatives.

Additionally, the process of meaning-making is crucial towards adjustment to loss, especially by suicide and its challenging experience (Begley & Quayle, 2007). In the present study, it appeared that participation in support groups aided the meaning-making process by allowing participants to take off the mask they had to wear in front of others and share their experiences in a non-judgmental, accepting context. In this environment, participants described that they were able to freely express their feelings, cry and discuss the most painful aspects of their loss knowing that no one would criticize them. Baddeley and Singer (2009) suggest that the ability to share the bereavement story with others is vital to adapt to a new perspective by reconstructing self-identity and re-defining life's purpose. However, studies show that suicide-bereaved relatives receive limited social support compared to those who have lost loved ones due to other causes (Oexle & Sheehan, 2020; Pitman et al., 2018). Additionally, most suicide-bereaved people do not seek support from mental health services although they believe that they would benefit from it (Chapple et al., 2015; Cvinar, 2005; Pitman et al., 2016; Spillane et al., 2017). One explanation based on the present results may be that due to the strong social stigma associated with suicide, the bereaved family members are reluctant to expose the real cause of death and so they refrain from opening up to both their family and social network or seeking for professional help. Additionally, this population is not easily accessible to healthcare professionals. Thus, targeted strategies are needed to identify suicide-bereaved relatives and facilitate their referral to support groups. District and community mental health nurses who have direct access to families can act as intermediaries between them and mental health services.

Furthermore, data show that complicated grief is more likely to occur in adolescents and young adults as a result of the suicide of a family member or partner. Complicated grief has also been associated with a fivefold risk of developing suicidal ideation in adolescents and young adults who survived the suicide of a family member, while this risk is about tenfold in adults (Mitchell et al., 2005). Thus, suicide-bereaved family members need to be screened for suicidality. Healthcare practitioners, mainly mental health nurses, should assist them with reconstructing their lives after the suicide by adjusting to changes and challenges related to the loss of their loved one in a non-judgmental way. The present results focus on destigmatizing the bereaved relatives while supporting them to adopt those coping strategies which will allow them to move on and keep a non-destructive memory of their loved one.

The proximity of the relationship between the deceased and the bereaved individuals is deemed a central factor among those which influence the bereavement process and coping mechanisms in dealing with the loss (Neimeyer et al., 2006; Shields et al., 2019). In the present meta-synthesis, it was shown that the participants with the closest relationship with the deceased, especially parents, wanted to continue the bond between them by talking to the deceased, writing a letter and frequently visiting the cemetery. Indeed, research on the bond which is developed with loved ones after their passing away, reveals that this bond serves as an essential adaptive mechanism by preserving a psychological rather than a physical connection with the deceased (Neimeyer et al., 2006; Shields et al., 2019). Thus, strategies towards preserving a bond with the deceased in a meaningful, non distressing way are crucial.

Overall, the distinction between sudden loss of loved ones to suicide and loss caused by chronic illness, as well as the detrimental accompanying roles of social stigma and self-blame need to be clearly taken into account during counselling, as addressed herein confirming previous reports (Skehan et al., 2013; Sveen & Walby, 2008). Similarly, there is need for skilled clinicians, adequately trained to recognize anxiety and depressive symptoms and suicidal behaviour at all levels of healthcare services, and able to provide postvention support to this vulnerable population group (Fukumitsu & Kovács, 2016). Mental health nurses should develop and lead relevant educational programs for clinicians in both mental and non-mental health services.

6 | LIMITATIONS AND CLINICAL IMPLICATIONS

One limitation of this meta-synthesis was the small number of studies reviewed. This indicates that suicide-bereaved family members continue to be under-researched. It is important to underline that this population may be difficult to reach, due to its challenging identification in healthcare services, mainly resulting from the social stigma following suicide in many cultures (Sveen & Walby, 2008). Additionally, this limitation highlights the low number of qualitative studies on the topic, especially in siblings and parents of the deceased, and in terms of the interpretation of the event and relevant coping strategies. Most studies on the topic follow a quantitative approach, mainly focused on the impact of suicide on the bereaved survivors, systematic reviews included (Feigelman et al., 2009; Levi-Belz et al., 2021; Spillane et al., 2017).

Additionally, although the reviewed studies were conducted in multiple countries, namely Sweden, China, Ireland, Japan, England, Korea, Brazil, Denmark, Australia and the United Stattes, there were no studies identified in Mediterranean or Middle Eastern countries. Thus, the results of this meta-synthesis need to be generalized with caution. Yet, although the reviewed studies were conducted in different health systems and social structures, the results indicate homogeneity, especially with regard to the experience of self-blame and social stigma, regardless of the different cultural contexts from which the participants came. An additional limitation may concern the fact that we reviewed data reported exclusively in English, and between 2000 and 2021. Probably, studies published in a different

language, before 2000, or indexed in data bases other than those searched herein, may show contradictory results. However, there were adequate data to address common themes among the reviewed studies, and further to develop second and third-order syntheses.

Overall, the experience of people who have lost a family member to suicide seems to take a variety of dimensions. However, few studies have examined this experience via qualitative methodology. Therefore, further qualitative studies are proposed, exploring the experience of specific cultural groups, such as siblings or parents, or addressing gender differences in relation to the grieving process and coping mechanisms. Moreover, studies following a participatory action research design are proposed to revise existing supportive mental health services, or develop new ones. Additionally, since there are no standardized guidelines for the care of grieving people due to suicide of a family member, relevant studies on this topic are also proposed.

Most importantly, the present results highlight the need to promote empowerment in suicide-bereaved family members, through facilitating their connection with the deceased in a non-traumatizing manner, while being able to continue their life destigmatized and relieved from self-blame. Nursing interventions towards this goal in personal or familial level are crucial.

Practice nursing interventions at community level are equally important to reduce social stigma towards those surviving the suicide of a family member. Enhancement of healthcare professionals' literacy on the needs and coping strategies of this particular population is also of paramount importance (Nunes et al., 2016).

In line with this, mental health nurses need to be better educated in monitoring, early detection, assessment, and management of the challenges and requirements of suicide-bereaved family members. Moreover, nurses need to be adequately prepared to support them in the process of making sense of their loss. Specifically, topics for nurses' advanced education may include supporting survivors via structured educational programmes: (a) to manage their adverse feelings and cope with pain and self-stigma, (b) to adopt ways to keep the memory of the deceased alive in a non-distressing way, (c) to transform their worldview and their daily routine to incorporate the new dynamic of the family and their changing needs, (d) to replace dysfunctional communication patterns with functional, and further to rebuild their relationships with other family members in a more authentic way, by allowing emotions and thoughts to be expressed. Indeed, data show that many therapists lack specialized training in suicide loss (Sanford et al., 2016).

Nevertheless, in terms of policy making, we need to introduce more mental health services with focus on early identification of suicide-bereaved family members and procedures on how to effectively promote their access to mental health services when needed. Given the fact that according to a recent meta-analysis (Wagner et al., 2020) more than half of all bereaved people use digitally provided services and applications within the grief therapy context, specifically designed for suicide-bereaved family members should be incorporated in current mental health services. Moreover, mental health services are expected to benefit from the inclusion of mental health professionals who not only possess advanced education in suicide bereavement, but who are also psychologically empowered to safely address the advanced needs of the group under study (Norton, 2017). Finally, mental health professionals, engaged in supporting suicide-bereaved family members, need themselves also to be psychologically prepared and continuously supported in order to provide genuine, compassionate care to mental health service users (Canning & Gournay, 2014).

7 | CONCLUSIONS

The experience of suicide-bereaved relatives is shaped by their attempt to comprehend this act and their effort to manage and even overcome the consequences that suicide inflicts upon their daily lives, their family and wider social relationships. Additionally, support, whether it comes from within the family or healthcare professionals, is helpful when it facilitates de-stigmatization and healing from self-blame, self-criticism and guilt, and the promotion of the sense of self-value. Overall, the experience of loss of a loved one due to suicide is a traumatic event for most family members, and highlights the need for relevant supportive nursing interventions.

AUTHOR CONTRIBUTIONS

This study is part of the PhD work of Rafailia Zavrou, who participated in study design, data collection and data analysis, and drafted the manuscript. Maria Karanikola is the supervisor of this PhD work, and participated in study design, data analysis, manuscript writing and interpretation of the results. Andreas Charalambous and Evridiki Papastavrou are members of the supervisory team of this PhD work, and participated in data interpretation and critical review of the final manuscript. Anna Koutrouba participated in data analysis, data interpretation and critical review of the final manuscript. All authors have read and approved the final manuscript.

ACKNOWLEDGEMENTS

Nothing to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

No ethics committee evaluation was required because of the study's design. The researchers declare no conflict of interest.

RELEVANCE TO MENTAL HEALTH NURSING

Nursing interventions towards empowerment of suicide-bereaved family members, through facilitating their connection with the

deceased in a non-traumatizing manner, while being able to continue their life destigmatized and relieved from self-blame are crucial. Nursing interventions at community level are equally important to reduce social stigma towards suicide-bereaved family members. Enhancement of healthcare professionals' literacy on the needs and coping strategies of this population is also important. Consequently, mental health nurses need to be better educated on the challenges and requirements of suicide-bereaved family members to support them in making sense of their loss and regain a perception of self-efficacy.

ORCID

Rafailia Zavrou https://orcid.org/0000-0001-7599-3519
Maria Karanikola https://orcid.org/0000-0003-2708-1851

REFERENCES

Andriessen, K., & Krysinska, K. (2012). Essential questions on suicide bereavement and postvention. *International Journal of Environmental Research and Public Health*, *9*(1), 24–32.

Andriessen, K., Krysinska, K., & Grad, O. T. (2017). Current understanding of suicide bereavement. In K. Andriessen, K. Krysinska, & O. T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 3–16). Hogrefe.

Andriessen, K., Rahman, B., Draper, B., Dudley, M., & Mitchell, P. B. (2017). Prevalence of exposure to suicide: A meta-analysis of population-based studies. *Journal of Psychiatric Research*, *88*, 113–120.

Baddeley, J. L., & Singer, J. A. (2009). A social interactional model of bereavement narrative disclosure. *Review of General Psychology*, *13*(3), 202–218.

Barnes, D. H. (2006). The aftermath of suicide among African Americans. *Journal of Black Psychology*, *32*(3), 335–348.

Bartik, W., Maple, M., Edwards, H., & Kiernan, M. (2013). The psychological impact of losing a friend to suicide. *Australasian Psychiatry*, *21*(6), 545–549.

Begley, M., & Quayle, E. (2007). The lived experience of adults bereaved by suicide: A phenomenological study. *Crisis*, *28*, 26–34.

Berman, A. L. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life-Threatening Behavior*, *41*(1), 110–116.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy*, *7*(4), 209–215.

Canning, P., & Gournay, K. (2014). The impact of patient suicide on community mental health teams. *British Journal of Mental Health Nursing*, *3*(5), 235–240.

Cénat, J. M., Blais-Rochette, C., Kokou-Kpolou, C. K., Noorishad, P. G., Mukunzi, J. N., McIntee, S. E., Dalexis, R. D., Goulet, M. A., & Labelle, P. R. (2021). Prevalence of symptoms of depression, anxiety, insomnia, posttraumatic stress disorder, and psychological distress among populations affected by the COVID-19 pandemic: A systematic review and meta-analysis. *Psychiatry Research*, *295*, 113599. https://doi.org/10.1016/j.psychres.2020.113599

Cerel, J., Brown, M. M., Maple, M., Singleton, M., van de Venne, J., Moore, M., & Flaherty, C. (2019). How many people are exposed to suicide? Not six. *Suicide & Life-Threatening Behavior*, *49*(2), 529–534. https://doi.org/10.1111/sltb.12450

Cerel, J., Maple, M., Aldrich, R., & van de Venne, J. (2013). Exposure to suicide and identification as survivor. Results from a random-digit dial survey. *Crisis*, *34*(6), 413–419. https://doi.org/10.1027/0227-5910/a000220

Chapple, A., Ziebland, S., & Hawton, K. (2015). Taboo and the different death? Perceptions of those bereaved by suicide or other traumatic death. *Sociology of Health & Illness*, *37*, 610–625. https://doi.org/10.1111/1467-9566.12224

Cvinar, J. G. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care*, *41*, 14–21. https://doi.org/10.1111/j.0031-5990.2005.00004

de Groot, M., de Keijser, J., Neeleman, J., Kerkhof, A., Nolen, W., & Burger, H. (2007). Cognitive behaviour therapy to prevent complicated grief among relatives and spouses bereaved by suicide: Cluster randomised controlled trial. *BMJ*, *334*(7601), 994.

Dixon-Woods, M., Shaw, R. L., Agarwal, S., & Smith, J. A. (2004). The problem of appraising qualitative research. *Quality and Safety in Health Care*, *13*, 223–225. https://doi.org/10.1136/qshc.2003.008714

Dunn, R., & Morrish-Vidners, D. (1987). The psychological and social experience of suicide survivors. *Omega*, *18*(3), 175–215.

Dutra, K., Preis, L. C., Caetano, J., Santos, J. L. G. D., & Lessa, G. (2018). Experiencing suicide in the family: From mourning to the quest for overcoming. *Revista Brasileira de Enfermagem*, *71*, 2146–2153. https://doi.org/10.1590/0034-7167-2017-0679

Entilli, L., Ross, V., De Leo, D., Cipolletta, S., & Kõlves, K. (2021). Experiences of parental suicide-bereavement: A longitudinal qualitative analysis over two years. *International Journal of Environmental Research and Public Health*, *18*(2), 564. https://doi.org/10.3390/ijerph18020564

Erlangsen, A., & Pitman, A. (2017). Effects of suicide bereavement on mental and physical health. In K. Andriessen, K. Krysinska, & O. T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 17–26). Hogrefe Publishing.

Feigelman, W., Gorman, B. S., & Jordan, J. R. (2009). Stigmatization and suicide bereavement. *Death Studies*, *33*(7), 591–608. https://doi.org/10.1080/07481180902979973

Feigelman, W., Jordan, J. R., & Gorman, B. S. (2011). Parental grief after a child's drug death compared to other death causes: Investigating a greatly neglected bereavement population. *OMEGA-Journal of Death and Dying*, *63*(4), 291–316.

Ferlatte, O., Oliffe, J. L., Salway, T., & Knight, R. (2019). Stigma in the bereavement experiences of gay men who have lost a partner to suicide. *Culture, Health & Sexuality*, *21*(11), 1273–1289.

Fukumitsu, K. O., & Kovács, M. J. (2016). Especificidades sobre processo de luto frente ao suicídio. *Psico*, *47*(1), 3–12.

Gaynes, B. N., West, S. L., Ford, C. A., Frame, P., Klein, J., & Lohr, K. N. (2004). Screening for suicide risk in adults: A summary of the evidence for the US preventive services task force. *Annals of Internal Medicine*, *140*(10), 822–835.

Gill, C. J. (2000). Health professionals, disability, and assisted suicide: An examination of relevant empirical evidence and reply to Batavia. *Psychology, Public Policy, and Law*, *6*(2), 526–545.

Gunnell, D., Appleby, L., Arensman, E., Hawton, K., John, A., Kapur, N., Khan, M., O'Connor, R. C., & Pirkis, J. (2020). COVID-19 suicide prevention research collaboration. Suicide risk and prevention during the COVID-19 pandemic. *Lancet Psychiatry*, *7*(6), 468–471. https://doi.org/10.1016/S2215-0366(20)30171-1

Hatzioannou, A., Chatzittofis, A., Koutroubas, V. S., Papastavrou, E., & Karanikola, M. (2021). Combined use of web-based and in-person education on ill health self-management skills in adults with bipolar disorder: Protocol for a mixed methods study. *JMIR Research Protocols*, *10*(9), e25168. https://doi.org/10.2196/25168

Hensley, P. L., Slonimski, C. K., Uhlenhuth, E. H., & Clayton, P. J. (2009). Escitalopram: An open-label study of bereavement-related depression and grief. *Journal of Affective Disorders*, *113*(1–2), 142–149.

Hybholt, L., Berring, L. L., Erlangsen, A., Fleischer, E., Toftegaard, J., Kristensen, E., Toftegaard, V., Havn, J., & Buus, N. (2020). Older

Adults' conduct of everyday life after bereavement by suicide: A qualitative study. *Frontiers in Psychology*, *19*, 1131. https://doi.org/10.3389/fpsyg.2020.01131

Jordan, J. R., & McIntosh, J. L. (2011). Is suicide bereavement different? Perspectives from research and practice. In R. A. Neimeyer, D. L. Harris, H. R. Winokuer, & G. F. Thornton (Eds.), *Grief and bereavement in contemporary society: Bridging research and practice* (pp. 223–234). Routledge/Taylor & Francis Group.

Kawashima, D., & Kawano, K. (2017). Meaning reconstruction process after suicide: Life-story of a Japanese woman who lost her son to suicide. *OMEGA-Journal of Death and Dying*, *75*(4), 360–375. https://doi.org/10.1177/0030222816652805

Lee, E., Kim, S. W., & Enright, R. D. (2019). Beyond grief and survival: Posttraumatic growth through immediate family suicide loss in South Korea. *OMEGA-Journal of Death and Dying*, *79*(4), 414–435.

Lee, E., Kim, S. W., Kim, J. J., & Enright, R. D. (2017). Family conflict and forgiveness among survivors of suicide. *Journal of Loss and Trauma*, *22*(8), 689–697.

Levi-Belz, Y., Krysinska, K., & Andriessen, K. (2021). "Turning personal tragedy into triumph": A systematic review and meta-analysis of studies on posttraumatic growth among suicide-loss survivors. *Psychological Trauma: Theory, Research, Practice, and Policy*, *13*(3), 322–332.

Li, X. Y., Phillips, M. R., Zhang, Y. P., Xu, D., & Yang, G. H. (2008). Risk factors for suicide in China's youth: A case-control study. *Psychological Medicine*, *38*(3), 397–406.

Lindqvist, P., Johansson, L., & Karlsson, U. (2008). In the aftermath of teenage suicide: A qualitative study of the psychosocial consequences for the surviving family members. *BMC Psychiatry*, *8*(1), 1–7.

Maple, M., Edwards, H., Plummer, D., & Minichiello, V. (2010). Silenced voices: Hearing the stories of parents bereaved through the suicide death of a young adult child. *Health Social Care Community*, *18*(3), 241–248. https://doi.org/10.1111/j.1365-2524.2009.00886.x

Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer, M. K. (2005). Complicated grief and suicidal ideation in adult survivors of suicide. *Suicide and Life-Threatening Behavior*, *35*(5), 498–506.

Neimeyer, R. A., Baldwin, S. A., & Gillies, J. (2006). Continuing bonds and reconstructing meaning: Mitigating complications in bereavement. *Death Studies*, *30*(8), 715–738.

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Sage Publications.

Norton, K. (2017). Responding to a suicide death: The role of first responders. *Death Studies*, *41*, 639–647.

Nunes, F. D. D., Pinto, J. A. F., Lopes, M. E. C. L., & Botti, N. C. L. (2016). The phenomenon of suicide among surviving family members: An integrative review. *Revista portuguesa de enfermagem de saúde mental*, *15*, 17–22.

Oexle, N., & Sheehan, L. (2020). Perceived social support and mental health after suicide loss. *Crisis*, *41*(1), 65–69.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *Systematic Reviews*, *10*(1), 1–11.

Paterson, C. (2011). Convergence in the news wholesalers: Trends in international news agencies. In *Making online news: Newsroom ethnography in the second decade of internet journalism* (pp. 129–140). Peter Lang.

Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *Lancet Psychiatry*, *1*(1), 86–94. https://doi.org/10.1016/S2215-0366(14)70224-X

Pitman, A. L., Osborn, D. P., Rantell, K., & King, M. B. (2016). The stigma perceived by people bereaved by suicide and other sudden deaths: A cross-sectional UK study of 3432 bereaved adults. *Journal of Psychosomatic Research*, *87*, 22–29.

Pitman, A. L., Stevenson, F., Osborn, D. P., & King, M. B. (2018). The stigma associated with bereavement by suicide and other sudden deaths: A qualitative interview study. *Social Science & Medicine*, *198*, 121–129.

Pohontsch, N. J., Meyer, T., Eisenmann, Y., Metzendorf, M. I., Leve, V., Lentsch, V., & working group 'Qualitative Methods in Health Services Research' of the German Network of Health Services Research. (2021). Study protocol of a systematic review and qualitative evidence synthesis using two different approaches: Healthcare related needs and desires of older people with post-stroke aphasia. *BMJ Open*, *11*(4), e039348.

Pritchard, T. R., & Buckle, J. L. (2018). Meaning-making after partner suicide: A narrative exploration using the meaning of loss codebook. *Death Studies*, *42*(1), 35–44. https://doi.org/10.1080/07481187.2017.1334007

Ross, V., Kõlves, K., Kunde, L., & De Leo, D. (2018). Parents' experiences of suicide bereavement: A qualitative study at 6 and 12 months after loss. *International Journal of Environmental Research and Public Health*, *15*(4), 618.

Sanford, R., Cerel, J., McGann, V., & Maple, M. (2016). Suicide loss survivors' experiences with therapy: Implications for clinical practice. *Community Mental Health Journal*, *52*(5), 551–558.

Shear, M. K., & Zisook, S. (2014). Suicide-related bereavement and grief. In S. H. Koslow, P. Ruiz, & C. B. Nemeroff (Eds.), *A concise guide to understanding suicide: Epidemiology, pathophysiology and prevention* (pp. 66–73). Cambridge University Press.

Shields, C., Russo, K., & Kavanagh, M. (2019). Angels of courage: The experiences of mothers who have been bereaved by suicide. *OMEGA-Journal of Death and Dying*, *80*(2), 175–201. https://doi.org/10.1177/0030222817725180

Skehan, J., Maple, M., Fisher, J., & Sharrock, G. (2013). Suicide bereavement and the media: A qualitative study. *Advances in Mental Health*, *11*(3), 223–237.

Spillane, A., Larkin, C., Corcoran, P., Matvienko-Sikar, K., Riordan, F., & Arensman, E. (2017). Physical and psychosomatic health outcomes in people bereaved by suicide compared to people bereaved by other modes of death: A systematic review. *BMC Public Health*, *17*, 939.

Spillane, A., Matvienko-Sikar, K., Larkin, C., Corcoran, P., & Arensman, E. (2018). What are the physical and psychological health effects of suicide bereavement on family members? An observational and interview mixed-methods study in Ireland. *BMJ Open*, *7*(3), e014707.

Sugrue, J. L., McGilloway, S., & Keegan, O. (2014). The experiences of mothers bereaved by suicide: An exploratory study. *Death Studies*, *38*(2), 118–124. https://doi.org/10.1080/07481187.2012.738765

Sveen, C. A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. *Suicide and Life-Threatening Behavior*, *38*(1), 13–29.

Tal, I., Mauro, C., Reynolds, C. F., 3rd, Shear, M. K., Simon, N., Lebowitz, B., Skritskaya, N., Wang, Y., Qiu, X., Iglewicz, A., Glorioso, D., Avanzino, J., Wetherell, J. L., Karp, J. F., Robinaugh, D., & Zisook, S. (2017). Complicated grief after suicide bereavement and other causes of death. *Death Studies*, *41*(5), 267–275.

Tzeng, W. C., Su, P. Y., Chiang, H. H., Kuan, P. Y., & Lee, J. F. (2010). The invisible family: A qualitative study of suicide survivors in Taiwan. *Western Journal of Nursing Research*, *32*(2), 185–198.

Wagner, B., Rosenberg, N., Hofmann, L., & Maass, U. (2020). Web-based bereavement care: A systematic review and meta-analysis. *Frontiers in Psychiatry*, *11*, 525.

Wainwright, V., Cordingley, L., Chew-Graham, C. A., Kapur, N., Shaw, J., Smith, S., McGale, B., & McDonnell, S. (2020). Experiences of support from primary care and perceived needs of parents bereaved

by suicide: a qualitative study. *British Journal of General Practice.*, *70*(691), e102–e110. https://doi.org/10.3399/bjgp20X707849

Wittouck, C., Van Autreve, S., Portzky, G., & van Heeringen, K. (2014). A CBT-based psychoeducational intervention for suicide survivors: A cluster randomized controlled study. *Crisis*, *35*(3), 193–201. https://doi.org/10.1027/0227-5910/a000252

World Health Organization (WHO). (2021). Suicide. https://www.who.int/news-room/fact-sheets/detail/suicide

Young, I. T., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience*, *14*(2), 177–186.

How to cite this article: Zavrou, R., Charalambous, A., Papastavrou, E., Koutrouba, A., & Karanikola, M. (2023). *Trying to keep alive a non-traumatizing memory of the deceased*: A meta-synthesis on the interpretation of loss in suicide-bereaved family members, their coping strategies and the effects on them. *Journal of Psychiatric and Mental Health Nursing*, *30*, 182–207. https://doi.org/10.1111/jpm.12866