THESIS

A COMPARISON OF SUICIDE LOSS AND NON-SUICIDE LOSS: THE IMPACT ON FAMILY COMMUNICATION AND AFFECT

Submitted by

Eva Belzil

Department of Human Development and Family Studies

In partial fulfillment of the requirements

For the Degree of Master of Science

Colorado State University

Fort Collins, Colorado

Spring 2023

Master's Committee:

Advisor: Kelley Quirk

Lilyana Ortega
Danielle Willis

ABSTRACT

A COMPARISON OF SUICIDE LOSS AND NON-SUICIDE LOSS:

THE IMPACT ON FAMILY COMMUNICATION AND AFFECT

Suicide loss and non-suicide loss impact thousands of people globally each year. Literature to date has identified ways suicide-loss can impact individuals and families in unique ways but has not indicated what specific aspects of family function are impacted for suicide-bereaved family members. Further, it is unclear whether family members can turn to each other to provide and receive support after their loss. The purpose of this study was to understand how suicide loss of a family member impacts individuals when compared to suicide loss of a non-family member. Additionally, this study aimed to understand how suicide loss of a family member impacts family dynamics on specific levels of communication, affect expression, affect connection, and general family functioning when compared to non-suicide family member loss. Perceived familial support was predicted to moderate the relationship between type of loss and these family function variables. Participants (N = 174) filled out 4 self-report measures that assessed family function prior to their loss, grief experiences, family communication, affect expression, affect connection, and family function after their loss. An independent samples t-test and a hierarchical multiple regression with a moderation analysis were run to examine the relationships between the predictor and outcome variables described above. When compared to individuals who experienced a non-family member suicide loss, individuals who experienced family member suicide loss reported more intense grief experiences (p = .03) but did not report significantly different family function. When compared to non-suicide family member loss, individuals who

lost a family member to suicide reported lower family affect connection ($p < .05$) and lower family affect connection ($p < .05$), but did not report significantly different family function or family communication. Perceived familial support did not moderate these main effects.

TABLE OF CONTENTS

A Comparison of Suicide Loss and Non-Suicide Loss:

The Impact on Family Communication and Affect

The loss of a loved one is a common human experience. With nearly 3.4 million deaths per year in the United States (Center for Disease Control and Prevention, 2022), the number of individuals significantly impacted by grief and loss are even greater. Grief is a non-linear process that individuals experience at varying levels of intensity (Al-Gamal et al., 2018). Those bereaved by the death of a loved one might experience a range of emotions including depression, distress, confusion, anger, sadness, and avoidance (Al-Gamal et al., 2018; Ogrodniczuk et al., 2003). Further adding to this complex process, the type of loss a person grieves impacts their grief experiences (Barrett & Scott, 1989).

Literature Review

Suicide Loss

Suicide, ending one's life intentionally, is a phenomenon impacting thousands of people globally each year. The World Health Organization (WHO) reports that 703,000 people end their life worldwide every year (2021). In the United States alone, 45,855 individuals died by suicide in 2020 (Curtin et al., 2021). Suicide death can create powerful, tragic, and painful impacts in the lives of family members, friends, loved ones, and communities (WHO, 2021). Cerel et al. (2019) estimate that for every death by suicide, 135 people are exposed to the death. That is, 135 people know or identify with the individual who died by suicide. After conducting a meta-analysis of 18 studies assessing suicide exposure, Andriessen et al. (2017) estimated that 4.3% of the general population have been exposed to suicide in the past year, and 21.8% have been exposed in their lifetime. Applying these percentages to U.S. Census data from February 2022, approximately 260 million individuals have been exposed to a suicide death in their lifetime.

Grief Experiences

Grief experiences are defined as physical, behavioral, psychological, and emotional reactions individuals experience after the death of someone in their life (Barrett & Scott, 1989). The type of loss an individual grieves may impact their grief experiences. Individuals experience loss in a variety of ways, ranging from sudden loss, such as losing someone to a car accident, to somewhat expected loss, such as losing a loved one to a terminal illness. Another factor that may impact grief experiences is how close an individual feels to the person they lost (Cerel et al., 2013). For instance, losing an acquaintance might impact a person differently than losing an immediate family member. Those affected by suicide loss often have significantly different grief experiences than those grieving other types of losses, and suicide loss in general is significantly different than other types of losses (Barrett & Scott, 1989; Bailley et al., 2000; Maple et al., 2014).

Survivors of Suicide Loss

A survivor of suicide loss is defined as anyone who knows of or identifies with an individual who dies by suicide (Cerel et al., 2013). Similar to other types of loss and subsequent impact, survivors of suicide loss often feel deeply affected by the death (Andriessen, 2009; Jordan & McIntosh, 2011 as cited by Andriessen et al., 2017). A systematic review of suicide bereavement experiences found that in addition to common reactions to loss, such as sadness and despair, losing someone by suicide often evokes additional complicated and intense feelings due to the type of death (Shields et al., 2017). Those bereaving a suicide loss may feel they could have done something to prevent the loss, and others' perceptions of the suicide may impact individuals' ability to talk about their loved one (Shields et al., 2017). In addition to guilt and stigmatization, survivors of suicide loss may also experience a plethora of other complicated emotions including, shame, feelings of responsibility for the death, rejection, isolation,

loneliness, loss of control, and confusion related to why the death has happened (McKinnon & Chonody, 2014; Oexle & Sheehan, 2020; Bailley et al., 1999; Nic an Fhailí et al., 2016; Shields et al., 2017; Hunt et al., 2019). These heightened emotions compounded with the traumatic nature of suicide may make processing grief experiences more painful for individuals bereaved by this type of loss. Due to these challenges, suicide loss survivors may be at heightened risk for complicated grieving, suicidal ideation, and completion of suicide themselves (McKinnon & Chonody, 2014; Oexle & Sheehan, 2020; Nic an Fhailí et al., 2016; Hunt et al., 2019). For the context of this study, survivors of suicide loss will be referred to as suicide-bereaved individuals and suicide-bereaved families.

Suicide Loss of an Immediate Family Member

Although loss of a loved one to suicide is difficult for most individuals, losing a family member to suicide may create even more distress and complicated reactions. Those bereaving the suicide of an immediate family member often experience disruption, dysfunction, and conflict within their family system (Ratnarajah et al., 2014; Lee et al., 2021). Suicide bereaved families are also faced with the challenge of renegotiating their roles within the family system to adjust for the abrupt gap left behind by their loved one (Ratnarajah et al., 2014). Compared to individuals who lost an immediate family member to sudden death (e.g., heart attack), suicide-bereaved individuals can have more intense grief experiences related to searching for explanation of the death, stigmatization, guilt, responsibility, shame, and rejection (Kõlves et al., 2019). Given that suicide loss of an immediate family member can have more intense impacts on grief experiences, it is likely that several family processes are impacted as well, including the ways in which family members communicate after the death of their loved one.

Family Communication

The ways in which family members cope with a suicide loss likely manifests within their communication. In the context of a family system, communication is defined as information exchanged between family members (Epstein et al., 1983). More specifically, communication is defined as whether exchanged messages between individuals are clear and direct (Epstein et al., 1983). Related to grief, family members likely differ in how they express, experience, and cope with grief, which can impact how they communicate with one another amidst their grief experiences (Liew & Servaty-Seib, 2018). For instance, family communication may become more hostile and blaming when family members manage their grief experiences while other families might become more expressive, supportive, and emotionally communicative.

More specifically, suicide-bereaved families' styles of communication can be open or reserved which can result in unclear messages between family members (Lee et al., 2017). Because each family member may have different needs, some family systems might reach out for help while others withdraw from one another following a suicide loss in the family (Ratnarjah et al., 2014). In other instances, family members may become so overwhelmed by their own guilt or blame that it becomes difficult to offer support to others (Shields et al., 2017). Since adequate support can decrease difficulties with grief (Oexle & Sheehan, 2020), communication seems important for the family to be able to function as a system following this type of loss, regardless of how a family's communication style changes. Other family processes that may change after the suicide loss of an immediate family member are affective expression and involvement.

Family Affect

Affect often plays an important and dynamic role in family (Szcześniak & Tułecka, 2020), especially while members manage grief. Family affect has been conceptualized as encompassing two domains: affect responsiveness and affect involvement. For the context of this

study, affect responsiveness will be referred to as affect expression, and affect involvement will be referred to as affect connection. Affect expression can be defined as a family's ability to respond to stimuli (e.g., a problem, request, or loss) by expressing felt emotions (e.g., concern, understanding, or sadness) (Epstein et al., 1983). Suicide-bereaved individuals are at a heightened risk for experiencing complicated grieving and are often faced with several difficult emotions such as guilt, shame, confusion, and feelings of responsibility for the death (McKinnon & Chonody, 2014; Oexle & Sheehan, 2020; Bailley et al., 1999; Nic an Fhailí et al., 2016; Shields et al., 2017). The literature indicates that suicide-bereaved family members certainly experience affective reactions after their loss, but similar to communication, it is of interest whether family members openly express or show these emotions to one another. Felt stigma in addition to feelings of shame and blame (Azornia et al., 2019; Shields et al., 2017) may impact how comfortable family members feel to express the emotions related to their grief experiences. Additionally, some family members, such as children who have lost a sibling, might feel reluctant to express their emotions to their parents for fear of worsening the parents' grief experiences. In addition to affect expression, affect connection may also become more challenging for suicide-bereaved families.

Affect connection can be defined as the extent to which family members acknowledge and value other family members' activities and concerns (Epstein et al., 1983). This domain has been thought to encompass how family members might take action to support each other in times of hardship and assesses how involved family members are in each other's lives. Similar to affect expression, it is of interest whether families are able to be attuned to each other's needs, interests, and concerns following the loss of an immediate family member to suicide. Felt stigma following a suicide loss can impact help-seeking behaviors and connection to other people

(McKinnon & Chonody, 2014; Nic an Fhailí et al., 2016). This impacted connection to others may also inhibit family members' ability to connect to each other after a suicide loss. While some family members find their grief experiences are aided by social types of support, the ability to offer emotional support and express connection can become challenging within the family system (Shields et al., 2017; Ratnarajah et al., 2014). Some family members find it best to withdraw to process their grief (Ratnarajah et al., 2014), further distancing from affect connection with other family members. With communication, affect expression, and affect connection expected to be more challenging for suicide-bereaved family members, general family function may become an additional area of difficulty.

General Family Functioning

General family functioning is defined as the overall ability for a family to trust, support, and accept one another (Epstein et al., 1983; Szcześniak & Tułecka, 2020). Additionally, general family functioning addresses aspects of communication and emotional expression (Epstein et al., 1983). As discussed above, areas of communication and emotional expression may become negatively impacted within the suicide-bereaved family system. In addition to managing grief experiences, families must renegotiate their roles and relationships within the system (Ratnarajah et al., 2014). In the midst of adjusting to the sudden gap in the family (Ratnarajah at al., 2014), trust, support, and acceptance may not be as easily accessible to the family. Relationships with close family members often change after suicide loss, and suicide-bereaved families may become more fearful that they will lose another family member to suicide (Azornia et al., 2019). Abrupt change and new fears following a suicide loss of a family member have the potential to add further complexity to the previously described experiences of stigma, isolation, and guilt.

Though these complex emotions can present unique challenges to suicide-bereaved families, support has the potential to mitigate some of these grief experiences.

Perceived Support

Given the negative emotions often associated with tragic loss, adequate social support can play an important role in coping and improving mental health outcomes for suicide-bereaved individuals (Oexle & Sheehan, 2020; Nic an Fhailí et al., 2016; Ratnarajah et al., 2014). Perceived social support is defined as the amount of support one person feels they actually receive from another person, whereas desired support is defined as the level of support a person would prefer to receive from another person (Xu & Burleson, 2001). Support can be categorized as emotional, esteem, tangible, network, and informational (Xu & Burleson, 2001), and can come from a partner, significant person, friend, or family member (Ogrodniczuk et al., 2003). More perceived social support has been found to be associated with significantly less grief difficulties and suicidality in suicide-bereaved individuals (Oexle & Sheehan, 2020). Suicide-bereaved individuals have also identified helpful social support as non-judgmental communication (McKinnon & Chonody, 2014), interaction with others experiencing the same type of loss (Jordan & McMenamy, 2004, Ratnarajah et al., 2014), willingness to listen, and acknowledgment of both the suicide and the life their loved one lived prior to dying by suicide (Fhailí et al., 2016).

With the complicated emotions some suicide-bereaved individuals experience, it is common to desire these types of support from others throughout the grieving process. Despite this desire that may be present, those bereaved by suicide may not access social support often. Social support in general is less prevalent and more problematic for suicide-bereaved individuals (Shields et al., 2017). Though suicide-bereaved individuals find comfort in suicide-bereavement

support groups (Jordan & McMenamy, 2004; Ratnarajah et al., 2014), stigma coupled with the intense feelings can be brought on by this type of loss have the potential to inhibit help-seeking behaviors and connection to others (McKinnon & Chonody, 2014; Nic an Fhailí et al., 2016; Shields et al., 2017). Social interactions could also cause further inner turmoil for suicide-bereaved individuals (Begley & Quayle, 2007). For example, parents bereaved by their child's suicide loss disclosed that telling others about the suicide was distressing (Fielden, 2003). Because suicide-bereaved individuals are more hesitant to seek social support in addition to support being more variable for this community in general, less is known about whether suicide-bereaved individuals feel they can turn to their family system for the support they desire (Oexle & Sheehan, 2020; McKinnon & Chonody, 2014).

Rationale for the Study

Current research discusses the experiences of suicide-bereaved individuals when compared to other types of loss, such as sudden loss (Kõlves et al., 2019; Shields et al., 2017). Literature indicates that social support is often problematic for this population (McKinnon & Chonody, 2014), but it is unclear whether those bereaved by suicide turn to their family for support after the loss. Though some research has been dedicated to understanding how families are impacted by suicide loss (Ratnarjah et al., 2014; Lee et al., 2021), it has not focused specifically on individuals within the family system and has not identified specific aspects of family function that may be impacted after the loss.

With the family system being the most important system that is impacted by loss, the degree to which the family is impacted likely varies by the support an individual feels they receive from their family system. Though we know the family can benefit from support (Oexle & Sheehan, 2020; Jordan & McMenamy, 2004; Ratnarajah et al., 2014), less is known about where

this support comes from within the family or the type of support the family members give to each other (e.g., emotional vs. informational). To address these gaps in the literature, the purpose of this study is to understand how suicide loss of a family member impacts family function on specific levels of communication, affect expression, affect connection, and general family functioning with perceived support moderating the relationship between type of loss and family function variables. By focusing on specific aspects of the family system that change after suicide loss and measuring perceived support, this study hopes to contribute to postvention effectiveness by identifying specific communication and emotional support needs of suicide-bereaved families.

Hypotheses

This study aims to closely examine the ways suicide loss impacts family dynamics. In particular, the researchers propose that compared to individuals experiencing suicide loss of a non-family member (e.g., suicide loss of a friend or acquaintance), individuals bereaved by the suicide loss of an immediate family member (e.g., parent, child, sibling, partner, aunt, uncle, grandparent, cousin, direct in-law) will report more intense grief experiences (h1a). Additionally, it is predicted that individuals bereaved by the suicide of an immediate family member will report lower general family functioning (h1b). The researchers also predict that individuals who have lost a family member to suicide will report lower communication (h2a), affect connection (h2b), affect expression (h2c), and general family functioning (h2d) compared to individuals who have lost a family member to non-suicide. Overall perceived support is proposed as a moderator for the main effects of family communication (h3a), affective expression (h3b), affect connection (h3c), and general family functioning (h3d). Hypotheses figures can be found in Appendix A.

Methods

Participants

Participant Recruitment

This study utilized convenience sampling as well as purposive sampling. Participants were recruited in two ways. First, a western United States university email list serv was used to invite eligible students to participate. In addition, the researchers reached out to mental health community organizations, suicide prevention organizations, and networks that support suicide-bereaved individuals and families. The researchers distributed flyers with QR codes in addition to emailing study information to these organizations. Recruitment materials included a direct electronic link to the survey.

Eligibility Criteria

This study compared suicide loss and other types of loss. Participants must have experienced one of the following types of losses: the loss of a person in their life to suicide (e.g., family member or any other person) or loss of a family member to any other cause of death (e.g., sudden loss, non-sudden loss). For the purpose of this study, participants were allowed to define if the person they lost is considered their immediate member. For example, a participant may identify an aunt who lives with them as an immediate family member. Individuals were excluded from the study if they were younger than 18 years old, did not consent to the study, or did not experience any of the losses described above.

Participants

In total, we collected responses from 243 participants. 12 participants were removed due to incomplete consent, 7 due to an invalid response, and 50 due to incomplete responses. After condensing our dataset due to these eligibility considerations, we had a total of 174 participants who either experienced a loss of someone in their life to suicide, or loss of a family member to

non-suicide cause of death. Among the respondents, 90.8% (*n* = 158) identified as female, 8% (*n* = 14) identified as male, and 1.1% (*n* = 2) identified as trans non-binary. The sample consisted of the following racial identities: 82.2% (*n* = 143) White or European, 9.2% (*n* = 16) Latino/a/x, 3.4% (*n* = 6) mixed race, 2.9% (*n* = 5) Black or African American, and 1.1% (*n* = 2) other, including Spanish/ Italian and Middle Eastern. Additionally, 79.3% (*n* = 138) of our sample identified as heterosexual, 10.3% (*n* = 18) bisexual, 3.4 (*n* = 6) pansexual, 3.4 (*n* = 6) queer, 1.7% (*n* = 3) asexual, 1.1% (*n* = 2) lesbian, and 0.6% (*n* = 1) gay. In regards to living area, 56.9% (*n* = 99) reported living in a suburban area, 30.5% (*n* = 53) in an urban area, and 12.6% (*n* = 22) in a rural area. In the context of types of loss, 44.4% of participants responded to the survey based on a suicide loss, and 55.6% responded based on another type of loss. Of the 44.4% of suicide losses (*n* = 75), 53.3% were coded as family members, and 46.7% were coded as non-family members.

Measures

Grief Experiences Questionnaire

To assess for differences in grief experiences between groups, participants received the Grief Experiences Questionnaire (GEQ). Barret & Scott (1989) developed the GEQ to identify how suicide bereavement differs from bereavement related to other types of sudden loss. This scale consists of 55 items that measure 11 grief dimensions including somatic reactions, loss of support, general grief reactions, responsibility, shame, and rejection (Barret & Scott, 1989). For the purposes of this study, participants were asked to respond to this measure based on their experiences in the year after their loss. Participants responded to questions such as, “Since the death of your [loved one], how often did you find you couldn’t stop thinking about how the death occurred?” and “Since the death of your [loved one], how often did you feel deserted by your

[loved one]?" (Barret & Scott, 1989). Participants chose from five responses ranging from "never" to "almost always" (Barrett & Scott, 1989, p. 208). The higher the score, the higher the likelihood that a certain grief reaction has been experienced (Barrett & Scott, 1989). The GEQ has moderately high to high reliability and has been proven to be a valid measure (Barrett & Scott, 1989; Bailley et al., 2000). A reliability analysis was run for this measure, resulting in $\alpha = 0.96$.

Family Adaptability, Partnership, Growth, Affection, & Resolve

To assess family function pre-loss, participants received the Family Adaptability, Partnership, Growth, Affection, and Resolve (APGAR) Scale. The APGAR was designed to assess family function in the context of physician interviews (Smilkstein, 1978). This scale consists of 5 items that measure 5 areas of family function. For the purposes of this study, participants were asked to respond to this measure based on their family experiences in the year prior to their loss. Participants responded to questions such as, "I am satisfied with the help that I receive from my family when something is troubling me" and "I am satisfied with the way my family expresses affection and responds to my feelings such as anger, sorrow, and love" (Smilkstein, 1978). Participant responses ranged from: "almost always" (2 points), "some of the time" (1 point), and "hardly ever" (Smilkstein, 1978). The APGAR has evidence of validity and moderately high reliability (Smilkstein, 1982). A reliability analysis was run for this measure, resulting in $\alpha = 0.87$.

Family Assessment Device

To assess communication, affect expression, affect connection, and general family functioning, participants received the Family Assessment Device (FAD). The FAD was designed to measure patterns and interactions among family members (Epstein et al., 1983). This scale

includes a general functioning subscale in addition to other subscales addressing different dimensions of family functioning (Epstein et al., 1983). This study is particularly interested in the following 4 of the 7 subscales of this measure: general family function, communication, affect responsiveness (expression), and affect involvement (connection). Participants were asked to respond to this measure based on their experiences in the year after their loss. Questions on these subscales include: "We don't talk to each other when we are angry" and, "We are reluctant to show our affection to each other" (Epstein et al., 1983). Participants can choose from four responses ranging from "strongly agree" to "strongly disagree" (Epstein et al., 1983). After analysis, Epstein et al. (1983) report that the FAD is both a reliable and valid measurement of family functioning. A reliability analysis was run for this measure, resulting in $\alpha = 0.92$.

Desired and Experienced Social Support

To assess perceived support of an individual after a loss, participants received the Desired and Experienced Social Support scale (DESS). The DESS was designed to measure desired and actual support in romantic relationships (Xu & Burleson, 2001). This scale includes 35 items that participants were asked to respond to based on experienced, or perceived, support they received from their family as a whole in the year after their loss. This scale has evidence of reliability and validity (Xu, 2000 as cited in Xu & Burleson, 2001). The DESS includes five subscales to measure esteem, network, informational, and tangible support items. Participants responded based on a 5-point Likert scale ranging from 1 ("do not receive (or desire) at all") to 5 ("receive (or desire) a great deal") (Xu & Burleson, 2001). Participants were asked to respond to this measure based on their experiences in the year after their loss. Sample items of this measure include, "how often did your [family] express understanding of a situation that is bothering you or disclose a similar situation that [they] experienced before" and "how effective was your

[family] at trying to reduce your feelings of guilt about a problem situation" (Xu & Burleson, 2001). A reliability analysis was run for this measure, resulting in $\alpha = 0.97$.

Procedure

Study Design

The researchers used a comparison research design in the form of a structured online questionnaire. This design allowed the researchers to collect self-report data in a consistent way to effectively identify group differences. Participants received identical measures and responded to each item by selecting a point on a Likert scale. Scale responses varied based on each measure throughout the questionnaire. The survey took approximately 15-30 minutes to complete.

Study Procedure

After following the survey link or QR code and completing the informed consent form, participants completed a series of background questions including topics such as demographics, the type of loss they have experienced, their age at the time of the loss, and their relationship to the deceased person. When participants were asked about the type of loss they experienced, examples were given for each type of loss. For suicide loss, participants were informed suicide could include events that are ambiguous, but that the participant considers suicide, such as a drug overdose. For other types of loss, participants were given examples such as natural causes, an accident, or any other cause of death. Participants were informed that these questions can be emotionally challenging to answer and were reminded they can stop the survey if they begin experiencing distress. After this information was completed, participants began to fill out a series of self-report measures. As mentioned above, all participants received identical measures. Participants responded to items on the APGAR first, GEQ second, items on the FAD third, and items on the DESS fourth.

The last page of the survey provided resources for participants who may be experiencing distress after completing the self-report measures. The participants could access multiple supportive services including: a guided meditation, a link to find a therapist by zip code, a phone number to call a mental health hotline, a link to an online forum to chat with other survivors of suicide loss, and a link through the American Foundation of Suicide Prevention to get personally connected with a survivor of suicide loss. Student participants from the subject pool were given a code to use for extra credit points as provided by their professor(s). All participants were offered the opportunity to enter a drawing for one of four $25 gift cards, as disclosed in the informed consent. Participants who opted in for the drawing were offered a link to share their email to enter, which remained separate from survey responses.

Results

Data Analysis

An independent samples t-test was conducted to detect differences between those reporting on the suicide loss of a family member compared to those reporting on the suicide of a non-family member on the outcome variables of on overall grief experiences and general family functioning. An independent samples t-test is appropriate since two groups are being compared on two outcome variables. Compared to participants who lost an immediate family member to a non-suicide cause (M = 2.4, S = 0.68), those who lost an immediate family member to suicide (M = 2.7, S = 0.7) reported significantly higher grief experiences, $t(73) = -2.2$, $p = 0.03$, thus hypothesis 1a was supported. There was no significant effect for general family function, $t(73) = -0.66$, $p = .51$, between those who lost an immediate family member to suicide (M = 2.3, S = 0.6) and those who lost an immediate family member to a non-suicide cause (M = 2.2, S = 0.5), thus hypothesis 1b was not supported. See Table 4 in Appendix B.

Next, we sought to test the difference in individuals belonging to a family where a member was lost by suicide versus lost by non-suicide means on 4 outcome variables. First, hierarchical regression analyses revealed that the covariate of "time-since" the loss explained less than 1% of the variance in family outcome variables, thus not contributing significant variance to any models. Next, we examined our main effect hypotheses using hierarchical regression analyses, which revealed that and there were no significant group differences in the variable of general family communication (suicide loss: $\beta = .06$, $p = .15$, non-suicide loss: $\beta = .04$, $p = .21$). Therefore, hypothesis 2a is unsupported. Next, we explored group differences in affect expression, with hierarchical regression analyses revealing significant group differences were found, with individuals in the suicide-loss group reporting significantly lower affective expression, as compared to individuals reporting from the non-suicide loss group, (suicide loss: $\beta = .21$, $p < .05$, non-suicide loss: $\beta = .09$, $p = .08$). Therefore, hypothesis H2b was supported. Next, we explored group differences in affect connection, with hierarchical regression analyses revealing significant group differences found, as those individuals in the suicide-loss group reporting significantly lower affective connection, as compared to individuals reporting from the non-suicide loss group, (suicide loss: $\beta = .32$, $p < .01$, non-suicide loss: $\beta = .11$, $p = .07$). Therefore, hypothesis H2c was supported. Finally, we explored group differences in general family functioning, with hierarchical regression analyses revealing no significant group differences, with those individuals in the suicide-loss group and those individuals in the non-suicide loss group reporting no statistically significant differences in general family functioning, (suicide loss: $\beta = .11$, $p = .15$, non-suicide loss: $\beta = .12$, $p = .09$). Therefore, hypothesis H2d is not supported. See Table 5 in Appendix B.

Lastly, perceived support was proposed as a moderator for the impact of family member suicide loss on family communication (h3a), affect expression (h3b), affect connection (h3c), and general family function (h3d). Our analyses above indicated insignificant effects of family suicide loss on family communication (h3a) and general family functioning (h3d) when compared to non-suicide family loss. For this reason, a moderation analysis was not performed to further investigate these hypotheses.

A moderation analysis was performed using PROCESS to examine if perceived support buffered the significant self-reported differences in family affect expression (h3b) and affect connection (h3c) when family suicide loss was compared to family non-suicide loss. Two interaction terms were created that paired family affect expression with perceived support and family affect connection with perceived support. Results revealed no support for the significant influence of this moderator on the main effect associations. See table 5 in Appendix B.

Discussion

This study sought to identify how suicide loss impacts family systems in the form of family function, communication, affect expression, and affect connection. First, we explored whether family suicide loss is more impactful on a family system's general functioning than non-family suicide loss. Participants self-reported whether they considered the person they lost an immediate family member or not. We found that there were no group differences in self-reported general family function between those in the family member suicide loss group and those in the non-family member suicide loss group. This might be because suicide loss is impactful on the family system whether the person who died was an immediate family member or not. Suicide loss is known to be an emotionally turbulent experience, with suicide-bereaved individuals reporting feelings of guilt, confusion, shame, anxiety, and even feelings of responsibility for the loss (Bailley et al., 1999; McKinnon & Chonody, 2014; Lee et al., 2021). In the context of the

family system, individual family members have their own ways to process and cope with these grief experiences (Lee et al., 2017), but the processing that happens on this individual level does not impact overall family functioning. Though a family system often exhibits inevitable and unanticipated changes following this type of loss (Ratnarajah et al., 2014; Azornia et al., 2019), overall family function is thought of as a long-developed way of operating (Bengston & Allen, 1993). Therefore, although a sudden loss likely jolts a family system into diverse ways of functioning, it is highly likely that family members and the system as a whole return to homeostasis and long enduring differences are not found.

Differences in grief experiences were explored between immediate family member suicide loss and non-family member suicide loss. Individuals who lost an immediate family member to suicide reported significantly higher ratings of grief experiences than those who lost a non-family member to suicide. In addition to the uniquely challenging emotional experiences that come with this type of loss, suicide-bereaved individuals often enter a period of renegotiating their self-identity (Lee et al., 2017). For example, a person who lost a sibling they had a close relationship with and turned to for advice frequently throughout their life might struggle with self-esteem and spend time questioning what it means to trust their own decision-making processes. Felt social stigma can further exacerbate these grief experiences and make it more challenging for individuals to open up to others (Sheehan et al., 2018; Shields et al., 2017). It is possible that the inward questioning and processing that comes with this type of grief overshadows, or lasts longer than, abrupt shifts in the way the family system functions after the loss.

After examining group differences between family and non-family suicide loss, group differences between types of family loss and family communication were explored. We found no

differences in general family function based on whether an individual lost a family member to suicide or to another cause of death. General family functioning is referred to as the overall ability for a family to trust, support, and accept one another (Epstein et al., 1983; Szcześniak & Tułecka, 2020). Family function can also encompass the ways a family moves through homeostasis and adaptation throughout the life span (Bengston & Allen, 1993). Family patterns of functioning in the domains of trust, support, acceptance, homeostasis, and adaptation are not likely to undergo deep-rooted, long-lasting changes, as these characteristics are indicative of family interactions over time (Bengston & Allen 1993). Additionally, family loss is a common experience throughout the life course, and families are capable of resilience when they are faced with loss-related stress or crisis (Rosino, 2016). Although loss does cause an abrupt change in the family system, the family is able to depend on well-established aspects of functioning to either return to homeostasis or adapt to a new homeostasis.

Continuing to compare types of family member loss, no differences were found in self-reported family communication when examining family member suicide loss versus non-suicide family member loss. Communication in a family system is defined as whether exchanged messages between individuals are clear and direct (Epstein et al., 1983). As mentioned previously, family members respond to loss in different ways (Liew & Servaty-Seib, 2018). Some family members may become more open, while others become more reserved (Lee et al., 2017). Though communication styles may change on an individual level, the ways that these communication styles are expressed to other family members might remain clear and direct since the family system experienced the same loss. For example, if a family member that used to have open communication suddenly becomes more reserved, they might withdraw from the family by speaking less frequently and spending less time with other family members. In this example,

unspoken signals still communicate a clear and direct message to other members of the family even though the family might not be connecting in the same way. Similarly, there is no significant difference in the clarity and directness of messages exchanged in a family after losing a family member to suicide or non-suicide.

We were also interested in group differences in both family affect expression and family affect connection between family suicide loss and non-suicide family loss. We found that individuals grieving the loss of a family member reported significantly lower family affect expression compared to those grieving a non-suicide family member loss. Affect expression refers to a family's ability to respond to stimuli (e.g., a problem, request, or loss) by expressing felt emotions (e.g., concern, understanding, or sadness) (Epstein et al., 1983). Lee et al. (2017) found that when family communication adapts to the crisis of a suicide loss, the adapted styles of communication can result in weakened relationships between family members who lost the same person. Part of this weakened relationship might be attributed to lack of emotional expression between family members after a suicide loss. For example, a family member who has the role as the peacemaker may keep this role after adjusting to the crisis of a family suicide loss, but remaining in that role would feel worse than it did before the loss due changes in affect expression from the family system. Additionally, the more intense grief reactions that individuals experience after the suicide loss of an immediate family member might make it more difficult for a family member in this role to reach out to others in the family, and other family members might also be difficult to connect with due to the overwhelm of their own grief experiences.

In addition to family affect expression being reported as significantly less, individuals grieving the suicide loss of a family member also reported significant changes in family affect connection compared to individuals bereaving other types of family loss. Affect connection can

be defined as the extent to which family members acknowledge and value other family members' activities and concerns (Epstein et al., 1983). Previously mentioned grief reactions such as felt shame, blame, and stigma impact help-seeking behaviors and make it more difficult for individuals to connect with others after losing a family member to suicide (McKinnon & Chonody, 2014; Nic an Fhailí et al., 2016). Knowing this, our findings align with previous literature that indicates difficulty for suicide-bereaved individuals to offer emotional support and express connection (Shields et al., 2017; Ratnarajah et al., 2014), and further add to the literature by identifying that these experiences happen specifically impact the family system.

After finding significant main effects between family member suicide loss and affect expression and affect connection, we explored the relationship of perceived support as a moderating variable for these effects. We found that perceived family support did not significantly moderate the relationship between family suicide loss and affect expression or affect connection. One possible reason for this insignificant finding might connects back to the aforementioned intensity of grief experiences suicide-bereaved individuals are faced with. Due to the self-reflective and self-blaming nature of these grief reactions (Bailley et al., 1999; Oexle & Sheehan, 2020; Shields et al., 2017), help-seeking behaviors can be negatively impacted (Nic an Fhailí et al., 2016), making the isolation family members experience more extreme. This commonly experienced loneliness in addition to discordant grieving that can occur in suicide-bereaved families (Lee et al., 2017) may make it more difficult for family members to provide support and receive support from other family members.

Limitations and Future Directions

Although the results of this study generate compelling implications for understanding the nuanced impact of loss and suicide loss on a family system, the study must be understood within

the context of several limitations. First, the participants predominantly identified as female, which is not representative of the broader population that experiences loss and suicide loss. Though this unbalanced demographic is common in the literature (Cerel et al., 2013; Wagner et al., 2020), it leaves the experiences and self-reported family perceptions of suicide-bereaved individuals with other gender identities unexplored. Similarly, our sample is predominantly heterosexual and Caucasian, further adding to the gap in information we know about grief experiences of marginalized racial ethnic identities. In the future, it would be informative to know how the added stress and emotional challenges of grief might compound minority stress that is often experienced by marginalized populations (Simon & Farr, 2021), such as the ways identity-related stigma might exacerbate the suicide-related stigma, grief experiences, and support systems available to suicide-bereaved individuals and families that holds marginalized identities.

Second, when exploring the relationship between family suicide loss and family non-suicide loss on different outcome variables, the data was condensed based on participant responses to their relationship to the deceased person. Doing this forced all "other" relationships (e.g., in-laws, non-relative kinship) into one category that was not included in this dataset. As a result, we might have missed consideration of loss of other impactful relationships on family functioning. In the future, it could be helpful to include a question that allows participants to rate their level of closeness to the person they lost to improve the consideration of these impactful relationships. This could further probe the main effects of affect expression and affect connection that are impacted by suicide loss.

Third, our study was based on self-report. We asked participants to reflect on the year prior to and after their loss as they responded to several specific questions related to grief

experiences and family function. Even though grief experiences seem to be most impactful in this first year (Liew & Servaty-Sieb, 2018; Kristiansen et al., 2018), time that has passed since the loss happened could influence how people remember and report on these questions because people might report their family experiences as unchanged and perceive change as less impactful. To address this, we could have recruited participants who lost a family member to suicide more recently which could have given us more enriched information about family communication and family affect. However, given what we know about the sensitive nature and intense emotional period that comes directly after a suicide loss, recruiting a sample in this time frame would become ethically challenging and might feel intrusive to individuals' grief processing. Ultimately, although self-report and self-reflection may not be as consistent as quantitative methods of research, it does give us direct access to participants' internal processes and allows us to contribute to suicide bereavement literature in a meaningful way. Additionally, our research adds to a foundation of knowledge that future research can continue to improve on and learn from.

Conclusions and Clinical Implications

Our study identified that there were no group differences in general family functioning when family suicide loss was compared to non-family suicide loss, but there were significant group differences in grief experiences. This suggests that the loss of a family member to suicide may leave a greater or more complex imprint on grief experiences compared to other types of loss. We also found no group differences in family communication and general family functioning when family suicide loss was compared to family non-suicide loss. This suggests that bereaved families may engage in similar communication styles and strategies when navigating the loss, no matter the type of loss. Significant group differences were found in the

ways in which families engage in affect expression and affect connection, wherein suicide-bereaved families exhibited lower emotional expression and connection when compared to non-suicide bereaved families. The loss of a family member to suicide often generates strong and unique feelings such as shame guilt, and confusion, which may lead family members to retreat from the system to focus inward on meaning-making and emotional processing. Finally, perceived support did not significantly moderate these main effects, highlighting the idea that family members may feel compelled to withdraw and process the sudden loss in their own matter and time.

To our knowledge, this study is the first to identify specific areas of family function that are impacted by family member suicide loss. Our findings provide useful guidance for future support services for suicide-bereaved individuals and families. For clinicians working with suicide-bereaved individuals, broadening an understanding of the intensity of grief experiences, and learning how suicide grief differs from other types of grief can be useful in helping clients process difficult emotions. In particular, it could be useful for clinicians to focus on interventions that help their clients process guilt and self-blame through Emotion Focused, Internal Family Systems, or Trauma-Informed lenses. Focused interventions have the potential to positively impact self-esteem for suicide-bereaved individuals and can be a useful resource to tend to this population's increased risk for suicide (Hunt et al., 2019). Additionally, what we know about suicide-related grief experiences can also help inform topics in group therapy that help individuals process how grief is impacting different areas of their lives and relationships. Of most important consideration for individual therapists is giving a voice to suicide-bereaved clients of marginalized identities whose experiences with suicide grief might be different, or even more exacerbated, than what was found from our sample. It is important to note that

although the field of research is missing data on marginalized populations, therapists and other individuals in position of power still have great capability to get to know these experiences in meaningful, intentional, and thoughtful ways.

Though it may be rare that families seek therapy together after a suicide loss due to discordant grieving (Lee et al., 2017), knowing specific areas of family affect that are impacted by suicide loss gives individual, couple, and family therapists direction in grief work with clients, even if the therapist is not working with the whole system. Though we found that communication is not significantly different for suicide-bereaved families when compared to non-suicide bereaved families, clinicians can help suicide-bereaved families build specific communication skills, such as clear boundary-setting and scheduled check-ins, that could buffer against the higher rates of grief experiences reported in this study. Similarly, therapists can work with family members on how to assess their own support needs, ask for support, and provide support following a suicide loss. These types of interventions may lead to different results in future studies, wherein family members could report higher quality support and support specific to suicide loss, which could buffer against impacted areas of family function.

The ways in which affect expression, affect connection, and grief experiences are impacted by a family member suicide loss can also further inform psychoeducation to provide to suicide-bereaved individuals and families as they process and heal from the loss of their loved one(s). Suicide grief can be an isolating experience, and it becomes difficult to connect with others, feel understood, and make meaning of the loss itself. Highlighting what specific family and individual experiences are common with this type of loss can normalize the experiences of suicide-bereaved people. Additionally, knowing these areas of impact emphasizes opportunities for clinicians and community support services to identify skill-building, connection-based

activities targeted towards improving affect expression and connection. It may also be helpful to name barriers and challenges suicide-bereaved people may face in skill-building while offering language that could be helpful in communicating boundaries around discordant grief processing. Ultimately, our findings bring more meaning, understanding, and empowerment to suicide-bereaved individuals, families, and communities.

Appendix A
Hypotheses Figures

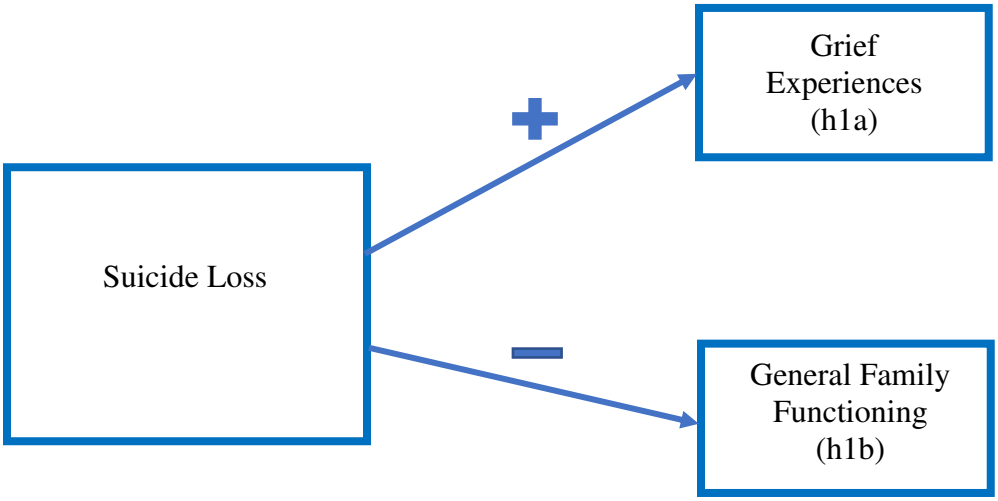

Figure A1. Diagram of group differences (hypotheses 1a & 1b).

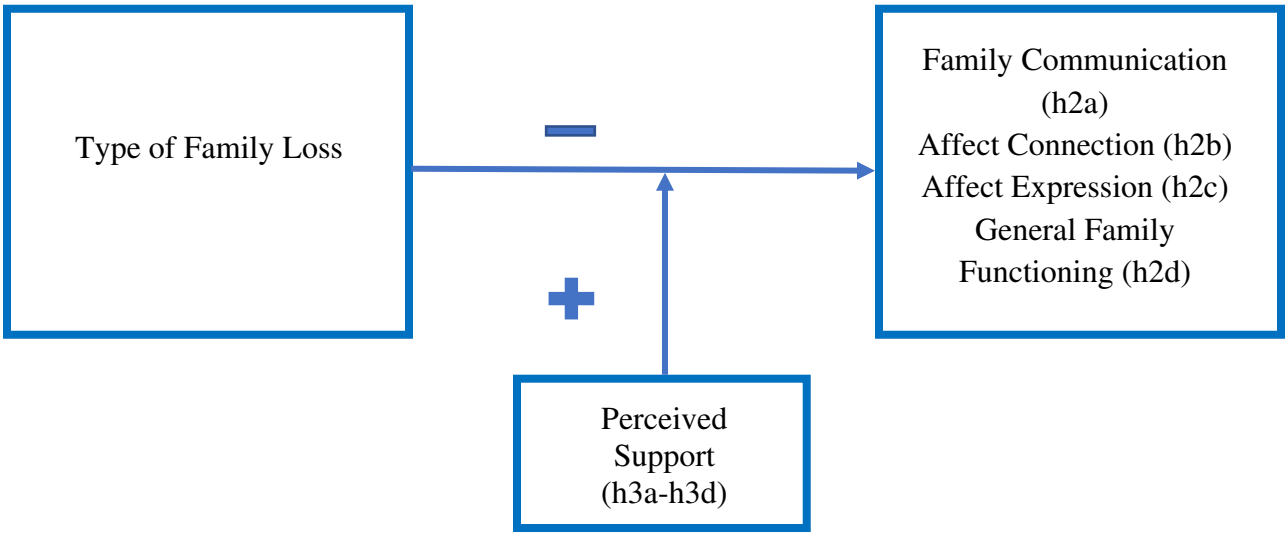

Figure A2. Diagram of main effects (hypotheses 2a-2d) and moderating analysis (hypotheses 3a-3d).

Appendix B
Tables

Table 1

Participant Demographics

Age	Minimum	Maximum	Mean	St. Deviation
	18	68	23.99	8.33
		Frequency	Percent	
Gender Identity	Female	158	90.8	
	Male	14	8.0	
	Trans Non-Binary	2	1.1	
Sexual Orientation	Heterosexual	138	79.3	
	Lesbian	2	1.1	
	Gay	1	0.6	
	Bisexual	18	10.3	
	Pansexual	6	3.4	
	Asexual	3	1.7	
	Queer	6	3.4	
Race	Black or African American	5	2.9	
	American Indian or Alaska Native	1	0.6	
	Native Hawaiian or Other Pacific Islander	1	0.6	
	Latino, Latina, Latinx	16	9.2	
	White, European	143	82.2	
	Mixed Race	6	3.4	
	Other	2	1.1	

Table 2

Participant Demographics

		Frequency	Percent
Living Area	Urban	53	30.5
	Rural	22	12.6
	Suburban	99	56.9
Socioeconomic Status	$10,000-$50,000	73	42
	$50,001-$100,000	32	18.4
	$100,001-$150,000	21	12.1
	$150,001 or above	17	9.8
	Unknown	31	17.8

Table 3

Types of Loss

		Frequency	Percent
Participant Relationship to the Deceased (Coded)	Non-Family Member	46	26.7
	Family Member	126	73.3
Participant Relationship to the Deceased (Reported)	Immediate Family Member	93	54.4
	Non-Immediate Family Member	78	54.4
Type of Loss	Suicide Loss	75	45.6
	Other	94	55.6

Table 4

Independent Samples t-test Results Comparing Immediate Family Member Loss and Non-Family Member Loss on Grief Experiences and General Family Function

	Immediate Family Member Suicide Loss			Non-Immediate Family Member Suicide Loss			*t*-test		
	N	M	SD	N	M	SD	t	df	p
General Family Function	32	2.33	0.59	43	2.25	0.49	-0.66	73	0.51
Grief Experiences	32	2.74	0.70	43	2.39	0.68	-2.17	73	.03*

*p<.05

Note. M = Mean. SD = Standard Deviation. General family function ranges from 1 (strongly agree) to 4 (strongly disagree). Greif experiences range from 1 (never) to 5 (almost always).

Table 5

Hierarchical Regression Analysis Results Comparing Family Member Suicide Loss and Non-Suicide Family Member Loss

	Suicide Loss Group			Non-Suicide Loss Group		
	B	β	p	B	β	p
Family Comm	.23	.06	.15	.19	.04	.21
Affect Conn	.36	.32	<.01*	.21	.39	.08
Affect Expre	.39	.22	<.05*	.31	.29	.10
Fam Func	.21	.11	.15	.22	.12	.14
AffCommXsupp	.19	.09	.20	.23	.11	.11
AffExpXsupp	.21	.07	.22	.21	.09	.12

Notes: Family Comm refers to the variable Family Communication. Affect conn refers to the variable Affect Connection. Affect Expre refers to the variables Affect Expression. Fam Func refers to the variable General Family Functioning. AffCommXsupp refers to the interaction term created by combining the grand means of Affective Communication and Perceived Support.

AffExpXsupp refers to the interaction term created by combining the grand means of Affective Expression and Perceived Support.

Table 6

Descriptive Statistics for Self-Report Measures

Scales	N	M	SD	Minimum	Maximum	Range	α
Family Function Pre-Loss	174	1.63	0.56	1	3	2.00	0.87
Grief Experiences	174	2.24	0.69	1	4.20	3.20	0.96
Family Communication	174	2.39	0.41	1.17	3.67	2.50	0.92[a]
Family Affect Expression	172	2.29	0.54	1	3.50	2.50	-
Family Affect Connection	174	2.19	0.45	1	3.57	2.57	-
General Family Function	174	2.21	0.52	1.17	3.67	2.50	-
Perceived Support	169	3.15	0.8	1.12	5	3.88	0.97

Notes: N = number of participants. M = mean. SD = standard deviation. α = Cronbach's Alpha statistic. Family Function Pre-Loss was measured on a scale from 1-3. Grief Experiences was measured on a scale from 1-5. Family Communication, Affect Expression, Affect Connection, and General Family Function were measured on a scale from 1-4. Perceived Support was measured on a scale from 1-5. Further definition of scales can be found in the Measures section.

[a]This Cronbach's Alpha statistic reflects a combination of the following subscales of the Family Assessment Device: family communication, family affect expression, family affect connection, and general family function.

References

Al-Gamal, E., Saeed, S. B., Victor, A., & Long, T. (2018). Prolonged grief disorder and its relationship with perceived social support and depression among university students. *Journal of Psychosocial Nursing and Mental Health Services, 57*(2), 44-51.

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. https://dx.doi.org/10.1016/j.psychires.2017.01.017

Azornia, V., Morant, N., Nesse, H., Stevenson, F., Osborn, D., King, M., & Pitman, A. (2019). The perceived impact of suicide bereavement on specific interpersonal relationships: A qualitative study of survey data. *Environmental Research and Public Health, 16*(1801), 1-15. doi:10.3390/ijerph16101801

Bailley, S. E., Kral, M. J., Dunham, K. (1999). Survivors of suicide do grieve differently: Empirical support for a common sense proposition. *Suicide and Life-Threatening Behavior, 29*(3), 256-271.

Barret, T. W. & Scott, T. B. (1989). Development of the grief experience questionnaire. *Suicide and Life-Threatening Behavior, 19*(2), 201-215.

Begley, M., & Quayle, E. (2007). The lived experience of adults bereaved by suicide: A phenomenological study. *Crisis, 28*, 26-34. https://doi.org/10.1027/0887-5910.28.1.26

Bengston, V. L., & Allen, K. R. (1993). The life course perspective applied to families overtime. *Sourcebook of family theories and methods: A contextual approach* (pp. 469-504).

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 and Life-Threatening Behavior, 42*(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 a survivor. *Crisis, 34*(6), 413-419. https://doi.org/10.1027/0227-5910/a000220

Center for Disease Control and Prevention. (2022). *Deaths and Mortality*. https://www.cdc.gov/nchs/fastats/deaths.htm

Curtin, S. C., Hedegaard, H., & Ahmad F. B. (2021) Provisional numbers and rates of suicide by month and demographic characteristics: United states, 2020. *Vital Statistics Rapid Release, 16*, 1-13. https://dx.doi.org/10.15620/cdc:110369

Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster family assessment device. *Journal of Marital and Family Therapy, 9*(2), 171-180.

Fielden, J. M. (2003). Grief as a transformative experience: Weaving through different lifeworlds after a loved one has completed suicide. *International Journal of Mental Health Nursing, 2003* (12), 74-85.

Hunt, Q. A., Young, T. A., Hertlein, K. M. (2019). The process of long-term suicide bereavement: Responsibility, familial support, and meaning making. *Contemporary Family Therapy 41*(4), 335-346. https://doi.org/10.1007/s10591-019-09499-5

Jordan, J. R., & McIntosh, J. L. (Eds.). (2011). *Grief after suicide: Understanding the Consequences and caring for the survivors.* Routledge.

Jordan, J. R., & McMenamy, J. (2004). Interventions for suicide survivors: A review of the literature. *Suicide and Life-Threatening Behavior, 34*(4), 337-349. https://doi-org.ezproxy2.library.colostate.edu/10.1521/suli.34.4.337.53742

Kõlves, K., Zhao, Q., Ross, V., Hawgood, J., Spence, S. H., de Leo, D. (2019). Suicide and other sudden death bereavement of immediate family members: An analysis of grief reactions

six-months after death. *Journal of Affective Disorders, 243*, 96-102. https://doi.org/10.1016/j.jad.2018.09.018

Kristiansen, C. B., Kjær, J. N., Hjorth, P., Andersen, K., & Prina, A. M. (2018) The association of time since spousal loss and depression in widowhood: a systemic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 54,* 781-792. https://doi.org/10.1007/s00127-019-01680-3

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. https://doi.org/10.1080/15325024.2017.1388344

Liew, C. H., & Servaty-Seib, H. L. (2018). College student grief, grief differences, family communication, and family satisfaction. *Death Studies, 42*(4), 228-238. https://doi.org/10.1080/07481187.2017.1334014

Maple, M., Cerel, J., Jordan, J. R., & McKay, K. (2014). Uncovering and identifying the missing voices in suicide bereavement. *Suicidology Online, 5,* 1-12.

McKinnon, J. M., Chonody, J. (2014). Exploring the formal supports used by people bereaved through suicide: A qualitative study. *Social Work in Mental Health 12*(3)*,* 231-248. https://doi.org/ 10.1080/15332985.2014.889637

Nic an Fhailí, M., Flynn, N., & Dowling, S. (2016). Experiences of suicide bereavement: a qualitative study exploring the role of GP. *British Journal of General Practice, 66*(643), e92-e98. https://doi-org.ezproxy2.library.colostate.edu/10.3399/bjgp16X683413

Oexle, N. & Sheehan, L. (2020). Perceived social support and mental health after suicide loss. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 41*(1), 65-69. https://doi-org.exproxy2.library.colostate.edu/10.1027/0227-5910/a000594

Ogrodniczuk, J. S., Joyce, A. S., & Piper, W. E. (2003). Changes in perceived social support after group therapy for complicated grief. *The Journal of Nervous and Mental Disease, 191* (8), 524-530.

Ratnarajah, D., Maple, M., Minichiello, V. (2014). Understanding family member suicide narratives by investigating family history. *Omega: Journal of Death and Dying, 69*(1), 41-57. https://dx.doi.org/10.2190/OM.69.1.c

Rosino, M. (2016). ABC-X model of family stress and coping. *Encyclopedia of family studies*. 1-6.

Shields, C., Kavanagh, M., & Russo, K. (2017). A qualitative systematic review of the bereavement process following suicide. *Journal of Death and Dying, 74*(4), 426-454. https://doi.org/ 10.1177/0030222815612281

Simon, K. A. & Farr, R. H. (2021). Development of the conceptual future parent grief (CFPG) scale for lgbtq+ people. *Journal of Family Psychology, 35*(3), 299-310. http://dx.doi.org/10.1037/fam0000790

Smilkstein, G. (1978). The family APGAR: A proposal for family function test and its use by physicians. *Journal of Family Practice, 6*(6), 1231-1239.

Smilkstein, G., Ashworth, C, & Montano, D. (1982). Validity and reliability of the family APGAR as a test of family function. *The Journal of Family Practice, 15* (2), 303-311.

Szcześniak, M., & Tułecka, M. (2020). Family functioning and life satisfaction: The mediatory role of emotional intelligence. *Psychology Research and Behavior Management, 2020* (13), 223-232.

United States Census Bureau. (2022). *U.S. and world population clock*. U.S. Department of Commerce. Retrieved February 21, 2022, from https://www.census.gov/popclock/

Wagner, B., Hofmann, L., & Grafiadeli, R. (2020). The relationship between guilt, depression, prolonged grief, and posttraumatic stress symptoms after suicide bereavement. *Journal of Clinical Psychology, 77,* 2545-2558. https://doi.org/10.1002/jclp.23192

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

Xu, Y., & Burleson, B. R. (2001). Effects of sex, culture, and support type on perceptions of spousal social support: An assessment of the "support gap" hypothesis in early marriage. *Human Connection Research, 27*(4), 535-566.