LGBTQ+ Bereavement by Suicide Research Study

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Contents

Definitions

1. Executive Summary
   1.1 Overview
   1.2 Key findings and recommendations.

2. Why is this research important?
   2.1 Rationale
   2.2 Aims of the study

3. How did we carry out the research?

4. Who took part?

5. What are the findings?

5.1 Summary of thematic analysis

5.2 The impact of bereavement: disenfranchised grief

5.3 Difficulty finding support, no safe spaces to talk

5.4 Where do LGBTQ+ people find support?

5.5 LGBTQ+ communities

5.6 Trans and non-binary experiences

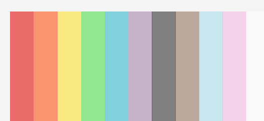
5.7 Prejudice within the Coroner's Court

6. Recommendations

7. References

Warning, this document discusses distressing material related to death by suicide, loss and bereavement.

All names have been changed to protect participants' identities.



Definitions

LGBTQ+

LGBTQ+ stands for lesbian, gay, bi, trans, queer and/or questioning with the '+' representing minoritised sexual and gender identities not included in the initials. For this work, we have used LGBTQ+ as an umbrella term in order to include those who do not usually use this term to describe themselves, for example men who have sex with men, women who have sex with women, people who previously identified as LGBTQ+ and those who are questioning their sexual and/or gender identities. The term queer is sometimes used in this report as a similarly inclusive term.

Transgender

Trans is an umbrella term that encompasses people whose gender or sex is not the same as the one they were assigned at birth. There is a diversity of terms that people use to describe their identity. This includes (but isn't limited to) transgender, transexual, gender-queer, non-binary, gender non-conforming, cross dresser, trans man, trans woman.

Non-binary

Non-binary is an umbrella term for people whose gender identity is not man or woman. Non-binary identities are varied and include people who may identify with aspects of binary identities and people who completely reject binary identities. Non-binary people may identify as both male and female, with a fluid or in between identity or an identity which is outside of the male/female binary.

Cisgender

The terms cisgender or cis is used to denote people who do not experience dissonance between their gender identity and that which they were assigned at birth.

Heteronormative

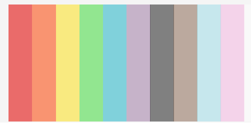
Heteronormative refers to the assumption that heterosexuality is the normal and/or preferred sexual orientation and that people are heterosexual until proved otherwise. It assumes that gender is binary and that intimate relationships take place between people of opposite genders. Heteronormativity, heterosexism, homophobia, biphobia and transphobia often occur together. Similarly, the term cisnormative refers to the assumption that everyone identifies, or should identify, as the gender they were assigned at birth, and that people who do not are not normal. Heteronormativity and cisnormativity represent the dominantly held view that sex, gender and sexual orientation are all congruent.

Deadname

Deadname refers to a former name, for example the birth name of a trans or non-binary person.

Chosen family

Chosen family refers to nonbiological kinship bonds chosen for the purpose of mutual support and love, whether legally recognised or not.



1. Executive Summary

1.1 Overview

This paper presents findings from a 6 month research study into the experiences of suicide bereavement amongst people who identify as LGBTQ+. This research is much needed given that those who are bereaved by suicide and those that identify as LGBTQ+ are at an increased risk of suicide. 20 people participated in the study from a range of backgrounds, experiences and identities.The study highlights experiences of discrimination, exclusion, isolation, guilt, shame, and poor responses from primary care services, bereavement services and the coroner's court. Participants spoke of the value of peer support, LGBTQ+ specific support and community responses to bereavement.

1.2 Key Findings

This report presents our findings as 6 main themes:

- **The impact of bereavement: disenfranchised grief**
  This theme highlights distinct experiences of bereavement by LGBTQ+ people, unique to their identities and circumstances as part of minoritised communities. The personal impact of bereavement is complicated by exclusion, stigma, guilt and shame. This theme touches on how the loss of friends can be highly significant for LGBTQ+ people.

- **Difficulty finding support, no safe spaces to talk**
  This theme explores the isolation of LGBTQ+ experiences of bereavement, the prejudice and discrimination experienced by participants who used statutory health and bereavement support and the lack of affirmative, accessible support services.

- **Where do LGBTQ+ people find support?**
  This theme describes the importance of, and desire for, LGBTQ+ specific bereavement support, the value of peer support and chosen family. The majority of participants had sought affirmative one-to-one therapeutic interventions.

- **LGBTQ+ communities**
  This theme illustrates both beneficial and, for some, excluding experiences of belonging to a minoritised group and the value and limitations of collective mourning. This theme also describes how giving back and community activism can be important in the bereavement process and how some participants are engaging in improvements to bereavement support.

- **Trans and non-binary experiences**
  This theme describes the experiences of trans and non-binary people bereaved by suicide in a context of increasing social hostility and politicisation.

- **Prejudice within the Coroner's Court**
  This theme describes experiences of homophobia and transphobia within the coronial system and the impact this has had for participants.

Summary of Recommendations

The report concludes with a series of recommendations for greater understanding system-wide to improve the accessibility of support and mitigate risk of further harms. This needs to be done alongside investment in local and national LGBTQ+ run support services. We also call for further research. We include recommendations to:

- Provide LGBTQ+ specific support and accessible opportunities for peer support, locally and nationally
- Provide affirmative and accessible mainstream bereavement support and primary care
- Review and improve the conduct of the coroner's court in relation to deaths by suicide of LGBTQ+ and trans people
- Commission further research into intersectional experiences of LGBTQ+ bereavement by suicide

2. Why is this research important?

2.1 Rationale

This study was commissioned by the Support After Suicide Partnership (SASP) to look at the experiences of LGBTQ+ people who had experienced bereavement by suicide with a focus on what support they found most useful and their likelihood to engage with suicide bereavement support services. SASP's vision is that everyone bereaved or affected by suicide is offered timely and appropriate support.

SASP is aware that there is little research into the specific experiences of LGBTQ+ people who are bereaved by suicide, as most research concentrates on heterosexual and cisgender populations.

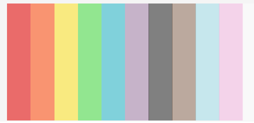
Support agencies and LGBTQ+ individuals report that the discrimination towards and marginalisation of LGBTQ+ communities have an impact on the grief process. Bereavement research into other causes of death, including cancer, highlights the persistence of stigmatised, heteronormative attitudes to same-sex relationships (Herek 2007).

2.1.1 LGBTQ+ Mental Health

Research shows marked inequality in health outcomes and in experiences of healthcare for LGBTQ+ people (National LGBT Survey 2017). LGBTQ+ people experience elevated rates of depression, anxiety and distress compared to heterosexual and cisgender populations (Stonewall 2018). This study also found significantly higher suicide risk across all LGBTQ+ groups. 1 in 4 LGBTQ+ people had experienced lack of understanding of their needs by healthcare staff, rising to 1/3 of BAME LGBTQ+ people. 1 in 7 avoided treatment for fear of discrimination.

Semlyen et al (2016) found that poorer mental health was twice as high for lesbian, gay and bisexual people, with higher rates amongst younger and older LGBTQ+ people, with higher rates still for BAME LGBTQ+ people and for trans and non-binary groups.

Causes of these elevated rates of mental distress are the outcome of the marginalisation faced by LGBTQ+ people, the on-going prejudice, discrimination, family rejection, hate crime, bullying and harassment they endure. This is compounded by the complexity of intersectional experiences for people who are marginalised by multiple factors including: race and ethnicity, religion, age, disability, geography, class, culture, income, educational background, employment etc.



Minority stress theory goes some way to explain disparities in mental health experienced by LGBTQ+ groups, see Meyer (2003). The minority stress model describes the chronic effects of ongoing everyday and acute experiences of stigma, prejudice, hetero- and cis- normativity on members of minoritised groups and the resulting internalised shame, low self-esteem, risk-taking behaviours and reluctance to seek help.

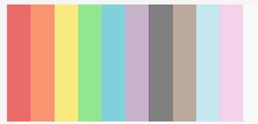
A recent (2021) review of UK evidence on LGBT+ health inequalities by McDermott et al found a ‘depoliticised ‘it’s getting better’ narrative’ which is not underpinned by evidence that things are indeed getting any better. The NHS England LGBT+ Action Plan (2018) priorities include a commitment to developing the evidence base for LGBT health inequalities and using this evidence to inform policy change.

2.1.2 Bereavement by suicide

The suicide of a significant other is a distressing, traumatic experience causing great psychological pain in those left behind. Exposure to the suicide of someone important, whether partner, ex-partner, family member or friend, can be a powerful, life-changing event for the bereaved person. For many, the impact affects interpersonal relationships and may relate to financial and employment problems alongside a rise in depression, anxiety and suicidal distress.For LGBTQ+ people this is compounded by the minority stress and additional social and psychological pressures they face (Ferlatte 2019).

A UK wide survey of over 7,000 people who had been bereaved by suicide (McDonnell et al 2022) found that half of them reported mental health and physical health issues associated with the bereavement. They found increased risk taking, suicidal distress (over 1/3) and adverse social outcomes. The majority of respondents had not accessed bereavement support or other support services.This study highlights the significance for some of the loss of a friend by suicide. McDonell (et al 2022) also found that few people knew about support services.

"*Few respondents in the current study were aware of suicide bereavement services, particularly local services, and the majority viewed provision of support as inadequate. Given the difficulties participants reported in identifying bereavement support services, a proactive support model should facilitate timely access to essential information and care pathways. International experience suggests that “active postvention” is needed where support is brought to those bereaved rather than the bereaved finding support themselves.*" (Cerel & Campbell 2008; Ross et al 2018). Expanding the reach of services to those outside of the deceased's immediate family is also advocated, particularly as individuals who have lost a friend to suicide are known to suffer mental distress that will go untreated (Feigelman et al 2019).



2.1.3 Complicated grief

LGBTQ+ people who are bereaved by suicide are likely to have a complex and complicated grief reaction due to the combined experiences of traumatic bereavement, LGBTQ+ related minority stress, pre-existing mental and physical health issues and intersectional identities. Complicated grief is not the same for all LGBTQ+ people, individual circumstances, intersectional experiences and access to valued support all make a difference, as our participants revealed.

Taboos and prejudicial views around suicide can lead to self-stigmatising amongst the bereaved (Feigelman et al 2019). Stigma surrounding bereavement by suicide is a factor in complicated grief and the persistence and severity of mental health issues in those bereaved (Scocco et al 2019).This is in part due to social prohibition on death by suicide and the suppression of associated grief (Chapple et al 2015).

‘Bereavement following suicide is complicated by the complex psychological impact of the act on those close to the victim. It is further complicated by the societal perception that the act of suicide is a failure by the victim and the family to deal with some emotional issue and ultimately society affixes blame for the loss on the survivors. This individual or societal stigma introduces a unique stress on the bereavement process that in some cases requires clinical intervention.’ Civnar (2005)

The study of ‘disenfranchised grief’ (Doka 1989, Attig 2004) explores the effects on those who are denied the right to socially legitimised grief, including where the relationship to the deceased was not traditional, not deemed to be close or kept secret. The added stigma of death by suicide compounds the disenfranchisement. Ferlatte (2019) writes about the ‘disenfranchised and/or complicated grief’ within LGBTQ+ communities due to experiences of stigma on the impact of death by suicide of gay men on their male partners. O’Connell et al (2022) investigated the impact on people who experience suicide loss as part of their professional role. LGBTQ+ workers working within the LGBTQ+ community may be particularly at risk.

McDonell et al (2022) recommended that mental health and postvention services need to recognise the vulnerabilities in friends who have lost someone to suicide, and address any associated disenfranchised grief.

For some LGBTQ+ people the deaths by suicide of prominent community figures, celebrities and icons can have emotional impact akin to bereavement for those we are personally connected to. The importance of role models is heightened in LGBTQ+ communities where people are unlikely to have biological, familial or other role modelling.

2.1.4 Intersectionality

We use the term 'intersectionality' to refer to how oppressions and inequalities interact and overlap with each other. Intersectional understandings originated in Black feminist thought, largely thanks to Crenshaw (1991). (See also page 2 for Definitions and Terminology.)

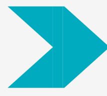
The use of the terms LGBT, LGBTQ, LGBTQ+, LGBTQI conflate the range of LGBTQ+ identities by using a single category which hides the different experiences of identity. Most of the existing research into LGBTQ+ mental health and experiences of bereavement are generalised. There is a lack of research into the effect of race, ethnicity, class, disability, ageing, poverty etc on the mental health of minoritised LGBTQ+ communities (see McDermott et al 2021). However, there is data showing that bisexual, trans and/or non-binary people have elevated rates of poor mental health, suicidal distress and self-harm compared to cisgender heterosexual populations and lesbian and gay populations (McNeil et al 2012).

We use the term 'LGBTQ+ communities' throughout in the plural to indicate that there is no one LGBTQ+ community nor any definitive experience of LGBTQ+ community membership. Many of the participants in this research have intersectional identities and may feel that they belong to a number of LGBTQ+ communities, or none. Community is often associated with location, and for some their communities are geographical whereas for some participants an online or virtual community is important. For some, the most meaningful community is their personal friendship network. Some of our participants do not experience any sense of community and are socially isolated. In many instances the experience of being part of any LGBTQ+ community is functional, e.g. when considering LGBTQ+ human or civil rights, or around anniversaries such as Trans Day of Remembrance or at events such as Pride.

The experiences of trans and non-binary people are highlighted in our report, as is the increasing visibility and vulnerability of trans people both nationally and internationally. The National LGBT Survey (2018) found that the majority of trans respondents avoid expressing their gender identity for fear of negative reactions. Trans equality is considerably behind that of cisgender LGB+ people (Todd 2021).

2.2 Aims of the study

The aim of the study is to better understand the nature of bereavement by suicide among LGBTQ+ communities, with a specific focus on engagement with support. The study explores what support people did and didn't receive and what could be provided in the future. The overarching aim of the research is to guide how services can become more accessible and better able to offer support to LGBTQ+ people bereaved by suicide. The final report, executive summary and recommendations will be disseminated by the Support After Suicide Partnership and Samaritans and through LGBTQ+ networks. The recommendations will seek to improve practice within mainstream health and social care, the coronial system and in LGBTQ+ service provision.



3. How did we carry out the research?

3.1 Lived Experience and Co-production

The research was commissioned by the Support After Suicide Partnership and co-produced with LGBTQ+ people with lived experience of bereavement by suicide. Recruitment of the researchers, development of the research methodology, ethics application and participant recruitment were co-produced with the Lived Experience Panel.

The researchers are Helen Jones and Casey Crossland. Both Helen and Casey have lived experience of LGBTQ+ mental health and of intersectional identities and Helen has lived experience of bereavement by suicide. Helen (she/her) is a cisgender lesbian aged over 60, Casey (they/them) is non-binary. Both researchers are white British. Both have worked in LGBTQ+ run and mainstream health and social care and have used services. Both researchers have a background in counselling and psychotherapy. Helen was the lead researcher and conducted the interviews.

3.2 Ethical Considerations

Ethics approval was granted by the Samaritans Research Ethics Board which included risk assessment and a distress protocol. Potential participants were given information about the project and what participation involved. Researchers contacted potential participants by phone to check eligibility criteria and wellbeing. Participants signed a detailed consent form and had the option to withdraw at any point.Anonymity was ensured with the use of pseudonyms and by removing identifying detail. Participants were given information about sources of support post-interview. Participants were offered a £25 high street voucher as a thank you for taking part.

3.3 Recruitment

We publicised the opportunity through: SASP member organisations, Samaritans lived experience network, National Suicide Prevention Alliance (NSPA) Lived Experience Influencers, Survivors of Bereavement by Suicide (SOBS), the National LGBT Partnership, the NHS LGBT Health Advisor, key LGBTQ+ and trans organisations, newsletters, social media and word of mouth. All participants identified as LGBTQ+, lived in England and were aged over 18. Their experience of bereavement was over 6 months ago. Participants needed to have good personal support and not be currently experiencing acute distress.

3.4 Data Collection

Participants were interviewed online, lasting between 45 minutes and 1.5 hours. We had prepared questions, but participants guided the conversation in a semi-structured interview format. Questions covered the experience/s of bereavement, the impact of the loss, what support they had received, what support was most helpful, what was missing and suggestions for people in similar circumstances in the future.

Participants were offered the opportunity to send us additional information after the interview, and to speak again if they wished.

3.5 Thematic Analysis

The interviews were recorded and transcribed. Analysis of the themes raised was iterative. We read the transcripts of the interviews, identifying commonly occurring themes and shared experiences, as well as noting any exceptions. We then identified overarching themes and associated sub-themes. (See summary table in section 5 below.)

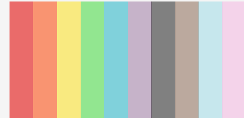
Back to contents

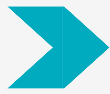
4. Who took part?

Our aim was to recruit as wide a range of people with LGBTQ+ identities and experiences as possible. LGBTQ+ communities are intersectional and encompass a vast range of individual life experiences, relationships and identities interweaved with socio-economic determinants. The participants in this study brought a wealth of varied experiences of bereavement by suicide which reflects some of the current conditions of LGBTQ+ lives in the UK but is by no means definitive.

- 20 LGBTQ+ people were interviewed.
- 4 had experience of more than one bereavement by suicide.
- Relationship to the bereaved included parents, children, spouses, current partner, ex-partner, friends, clients and community contacts.
- 4 participants experienced bereavement by suicide of their partner
- 4 participants experienced bereavement by suicide of biological family (father, daughter, brother, cousin)
- 4 participants experienced bereavement by suicide of ex partners
- 9 participants experienced bereavement by suicide of friends
- 1 participant experienced bereavement by suicide of 5 close friends
- 1 participant experienced bereavement by suicide of a work colleague
- 1 participant experienced bereavement by suicide of a client
- 40% women, 40% men 20% non-binary
- 25% transgender
- 21% bisexual, 30% gay, 15% lesbian, 20% queer
- 20% under 30, 40% 31 – 50, 10% 51 – 70, 15% 0ver 71
- 70% white British, 15% Black British*, 5% white other
- 20% Christian
- 40% with significant disability of which 35% have mental health disability, 30% long-standing illness, 5% developmental condition, 7% physical impairment, 5% autism, 7% learning disability/difficulty

* Black British participants did not discuss race in relation to bereavement by suicide. This may in part be because the researchers are white.





5. What are the findings?

5.1 Summary of the thematic analysis

Below is a table which summarises the overarching and related sub-themes raised in the interviews. These themes and sub-themes are then explored in detail.

Overarching theme	Sub-themes			
The impact of bereavement: disenfranchised grief	Exclusion from mourning rites	Impact on mental health, self-esteem and identity	Guilt and shame	Stigma around suicide
Difficulty finding support, no safe spaces to talk	Isolation	Lack of/poor response from statutory services	Access to bereavement services	
Where do LGBTQ+ people find support?	Desire for and value of LGBTQ+ specific support	Peer support	One-to-one therapeutic support	Chosen family
LGBTQ+ communities	Protective and healing but can be excluding	Giving back and activism		
Trans and non-binary experiences	Impact of deaths in an intersectional community	Politicisation of trans identities and trans deaths	Lack of access to support	
Prejudice within the Coroner's Court	Homophobic, transphobic, heteronormative and cisnormative attitudes and beahviours			

5.2 The impact of bereavement: disenfranchised grief

This report does not attempt to convey the deep and lasting impact of bereavement by suicide on the research participants lives, nor the complexity of the lived experience of LGBTQ+ people who have been bereaved by suicide. What follows is a summary of some of the common experiences of the people we talked to.

5.2.1 Exclusion from mourning rites

LGBTQ+ people are vulnerable to being excluded from shared mourning in the wake of death by suicide, which for some had a massive impact on their experiences of bereavement. Several participants spoke of how a lack of understanding of the importance of their relationship to the person who had died led to questioning by others of the impact of their loss.

Vivien's husband died by suicide and although Vivien was his next of kin, his husband's mother took over the funeral arrangements. Vivien did not feel able to assert his wishes at the time, though he did insist that instead of flowers donations were given to a suicide prevention charity. The coroner deferred to the mother's wishes and treated her as the main interested person at the Inquest.

> **“Oh I know that you've lost your husband, but you need to understand she's lost her son.” (Vivien)**

Some experienced overt hostility from other mourners. This was perceived to be based on homophobia, biphobia and transphobia and led to participants doubting their entitlement to grieve. Other participants were not told about the date of funerals or memorial services or found out about the death too late to attend.

Zack had experienced two bereavements by suicide. One was a close friend who lived nearby, part of his chosen family. Zack was fully involved in his friend's funeral, mourning his loss with family and friends. He carried the coffin and scattered his friend's ashes. This helped him have closure. By contrast, he found out about the suicide of an ex-partner after his funeral, finding out on social media that his ex had died. His ex had kept their relationship secret. He found this loss hard to come to terms with.

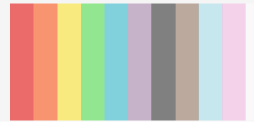
Gee, who is bisexual, lost their partner. They had been together for a few months and Gee was not acknowledged as his partner. This fed into her feeling of lack of importance, she was not a 'widow'. Her partner's biological family did not tell her when the funeral was.

> **I said, will you let me know when the funeral is? And they never did so I didn't get to go to his funeral or anything... and I think that their attitude kind of fed into my own, like oh, you don't really count kind of thing, that made me feel like I couldn't access services.**
> **(Gee)**

Andi learnt of the death by suicide of a client at a previous workplace. She had no-one else to acknowledge the importance of the relationship with and no-one else who knew the deceased. Others had been excluded from collective mourning because of the nature of the complexity of their relationship to the deceased, especially where there had been difficulties. Aje, whose housemate and close friend died, said:

> **I think it was just kind of because I'd had a rocky relationship with some of the person's friends, and her, before she passed away. It did kind of mean that some of that community wasn't there for me… I'd fallen out with the person's partner recently before it happened, and so I think part of that was why I didn't [go to her funeral].**
> **(Aje)**

> **Well, I wasn't welcome at the funeral. I.. I think that definitely made it worse, I think, especially because the other partner, like, blamed me.**
> **(Steph)**



For some, the exclusion was because the next of kin or biological family did not accept or acknowledge the person's identity. This was particularly so for trans people (see Trans & Non-binary Experiences). Sigita spoke about the sadness of not being accepted as a trans woman at a trans friend's funeral. Their family had not accepted the person's transition and had cut her off completely. Sigita said this:

> **… makes it so much harder to resolve in your mind.**
> **(Sigita)**

Those who had been fully included as LGBTQ+ people in collective mourning spoke about how healing this had been for them. Charlie met P in a homeless hostel. P had lost his home, wife and children after coming out later in life, similar to the experiences Charlie had had after P died.

> **There was open grieving, and it was encouraged because, although I was no longer a resident at the hostel, I do pop in and out. There was an evening of poetry and prose and discussion. The hostel put it on, and they invited other people to come and join us if you wanted to… there was this evening of coming together, and then there was a funeral and there was this family who hadn't seen him for years, because they'd disowned him.**
> **(Charlie)**

5.2.2 Impact on mental health, self-esteem and identity

Participants spoke very eloquently of the sadness, anger, despair and distress of their loss. For half of the participants, their own experiences of suicidal distress increased significantly or began as a result of the loss.

The shock of the death was a massive factor, even for those where the person who died had been struggling with their mental health and/or spoken about their suicidal distress. For some, the death by suicide was completely unexpected. For some, bereavement by suicide came along with other recent bereavements which compounded the shock and grief.

Rosie lost her father in adolescence, she reflected on how this had affected her exploration of her sexual orientation:

> **I wasn't interested in romance with anyone for a long time, you know. So I do think had that not happened, it [my sexual identity] might have been something that I would have, you know, fully understood and accepted earlier, looking back. (Rosie)**

For Pete their ex partner was the first really loving gay relationship he had, which had helped him develop his own positive sense of self as a gay man. Micha lost a close friend who:

> **really helped me out around the time that I was coming out…he was always close to me. He was close to my family and that made him really special to me. (Micha)**

This was especially true where the person who died had a successful career, social life, financial stability, supportive family etc. For some, the death represented the loss of a significant role model and their identification with the person who died was important. Three participants felt that this put their own resilience and likelihood to have a happy life in question.

> **...he had his career going for him, he had friends, he had support, he had a family...you'd never put that person in that scenario, I'm trying to come to terms with it... (Zack)**

For a minority of participants, their proximity to suicide strengthened their own wish to live and could be a protective factor.

> **Seeing that someone else had taken that option really kind of made me actually realise what happens when someone does that and made me less [likely to attempt suicide]...I think it kind of made me realise how real the fact of someone dying that way is...**
> **(Aje)**

For others, there is the converse.

> **When I first got the news I got so depressed… and I thought I will also commit suicide, because my friend has died**
> **(Wayne)**

> **...it's exposed me to the grief that is caused by suicide... within a small community, one person's suicide, how that sends such ripples through everybody. But also it does kind of normalise it. In a way, it is more...it is more of an accessible option because someone else has done that. Someone else has made that step. And so you could.**
> **(Sigita)**

For many, the impact of their bereavement was long lasting. Jody lost a close friend 24 years ago, Rosie lost a parent 13 years ago, four others have been living with bereavement for at least 10 years. Some talked about flashbacks. People experienced the impact in different ways over time and needed different types or degrees of support over time (see 5.4 Where do LGBTQ+ people find support?).

> **The second year was a lot worse than the first year in many respects, I think because of shock. I think you start to live alongside all the mishmash of feelings and they… they don't go way…they haven't gone away or subsided.**
> **(Tasha)**

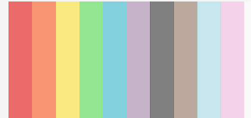
A few participants talked about the impact of bereavement on their physical health as well as mental health, and the links between the two. 40% of participants had a significant disability. One participant developed a disabling neurological condition related to trauma. Two participants talked about the impact of long- term illness on their mental health and their experiences of bereavement.

5.2.3 Guilt and shame

The majority of participants felt guilt that they could have done more, or done something, to prevent the death. The depth of guilt was complicated by whether the suicide was anticipated or not, and all participants felt shock. For some, the shock persisted over several years. Participants felt responsible as they had not been 'good enough' to live for. One participant was actively blamed by close associates for the suicide, others blamed themselves.

Riko, who had lost his partner, said:

> **...to be a survivor of somebody that's actually taken their own life. How that leaves you feeling guilty, massively guilty, massively. That I didn't do enough to stop it from happening. So... so... so you're left with not only grieving, but this real feeling that you can't, you can't get through to other people what it feels like, you know.**
> **(Riko)**



The shock of an unanticipated death was mixed with questions about how responsible participants were and how they might have failed the person who died.

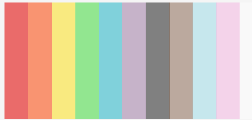
> **"He was not even suicidal. We were just hanging out... and we had a good time. He didn't tell anyone about anything that he was going through we didn't know what made him to take his own life... We still want to know what happened, and why did he think that we can't help or we can't figure out the problem together? We were his support group, we were his support system...But then he goes on and takes his own life like he doesn't even care about how I can handle it. There's something going on... and why didn't he trust us to help him with it?" (Lesley)**

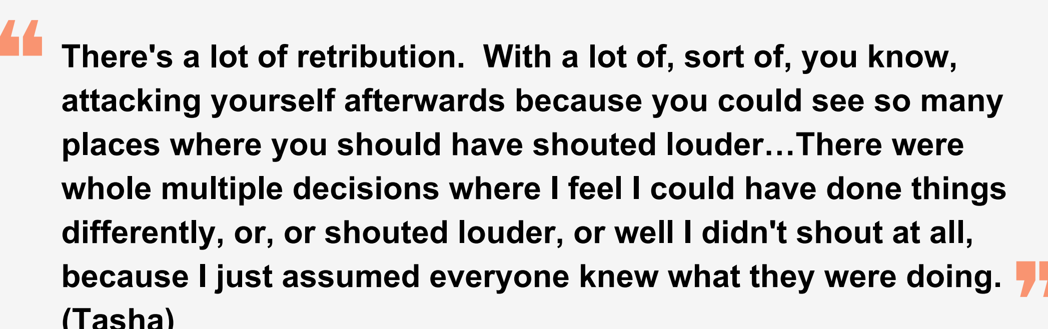
Jody lost a close friend to suicide 24 years ago and since then has known 13 trans people who have died by suicide, including 4 very close friends. She always thinks she could have done more. Following news of a suicide she withdraws and thinks about what she could have done.

> **"At the time I kind of felt responsible personally, in a few ways, because we'd had a complicated relationship close to it happening you know. I now know that wasn't anything to do with it...but yeah, at the time, I just felt quite responsible." (Aje)**

Riko feels that he could never have another relationship because of his guilt that he did not do enough to stop his partner from dying. Some, such as Steph, were blamed by others.
For several participants, the person who had died had been under the care of statutory services or had been trying to get support from primary and/or secondary care at the time of their death. Some spoke of their anger. Others were left feeling that they were to blame because they had not done enough, or the right thing, to get services to respond.

> **"[I am] massively angry with the powers that be that they didn't do enough to stop it from happening, you know." (Riko)**



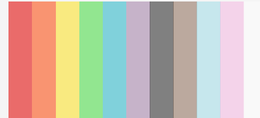

There's a lot of retribution. With a lot of, sort of, you know, attacking yourself afterwards because you could see so many places where you should have shouted louder…There were whole multiple decisions where I feel I could have done things differently, or, or shouted louder, or well I didn't shout at all, because I just assumed everyone knew what they were doing.
(Tasha)

5.2.4 Stigma around suicide

Some participants found people close to them were uncomfortable hearing about suicide and/or were explicitly judgemental about the person who had taken their life, including one person's GP who described the person who died as 'selfish'. This was true of interactions with other LGBTQ+ people and non-LGBTQ+. Sam, who had two experiences of bereavement by suicide, is trying to speak more about their loss in order to combat stigma:

> **…lots of people just won't be comfortable with talking about it openly, and I even notice how I like sensor myself, not wanting to like, be open about it. And I know that that's wrong, because I think that only perpetuates the stigma of this being real, and it being an issue particularly for queer people and that if we don't talk about it people won't access support and that's the opposite of what we need to have happen. So I have challenged myself sometimes to like be as open as possible with people.**
> **(Sam)**

(See also 5.6 Trans and Non-binary Experiences for discussion of the politicisation of trans deaths by suicide.)



5.3 Difficulty finding support, no safe spaces to talk

5.3.1 Isolation

> **I wish there was somewhere, somewhere for me to go to, really.**
> **(Zack)**

> **I would have liked someone to talk to and I didn't necessarily feel safe to do that...I went quite internal...**
> **(Andi)**

Many of the participants shared Vivien's sense of isolation.

> **I felt as though I was the only person in the world that this had happened to, because I couldn't find anyone else who understood everything. I still to this day haven't found another LGBT person who has been bereaved to suicide, and I find that unbelievable.**
> **(Vivien)**

Participants spoke of the isolation they felt when the person who died was not out at the time of their death, or at the time they had been close, eg with ex partners. Pete's first boyfriend died during the Covid pandemic lockdown, and their relationship had been secret. Pete was in isolation when he heard.

> **He wasn't out to his family, so the relationship was a complete secret…it was the first relationship I had where I really felt the kind of the love that we felt for each was very pure… an incredibly important relationship. I was also in quarantine at the time, because of Covid, so I found that … I just I really couldn't, really struggled with kind of the isolation. At the time I was living on my own. So when I found out it was, I was not in a good head space.**
> **(Pete)**

For some, their isolation was compounded because the person who had died was a key part of their personal support network and/or their chosen family.

Some participants were estranged from the person who had died or had lost contact with anyone else who knew the person, or their relationship had been secret.

Others spoke of added isolation relating to intersectional experiences, for example being bereaved as an LGBTQ+ young person. For two bisexual participants they felt the isolation of heteronormative assumptions by both LGBTQ+ and non-LGBTQ+ people. Two of our participants lived in rural areas and felt geographically isolated from contact with other LGBTQ+ people.

One participant was bereaved by the suicide of a client and felt very isolated as a worker, and that more support might have been available if it had been a personal rather than professional relationship.

Some had experienced helpful but limited support, for example from work colleagues who were sympathetic for a day or two, and this left them feeling increasingly isolated.

5.3.2 Lack of response and poor response from statutory services

Participants spoke of the isolation they felt when the person who died was not out at the time of their death, or at the time they had been close, eg with ex partners. Aje was 18 and at University when they lost a close friend. They wished someone had told them what support was available:

> **“I feel like if I had been offered it, even if I hadn't wanted it, that still would have felt quite like...maybe I don't know... validating or like, yeah, they are taking this seriously, and they understand that I'm going through something, even if it's you know, they're offering something that maybe the person might not want.” (Aje)**

Less than half (8 in total) of the participants had received support from primary or secondary health services. Several participants had been to their GPs in distress and found them unsympathetic about their bereavement by suicide and/or the impact on them as LGBTQ+. Others had decided not to go to their GP because they anticipated a lack of understanding about LGBTQ+ lives and needs. GP services were experienced as heteronormative, cisnormative, not trauma-informed nor person-centred.

Of those who had been to their GP, most found them unhelpful.

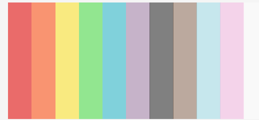
> **“My GP said I'll give you some diazepam to help you sleep…and it's like, I've literally just told you that my husband died four days ago, and your solution to that is to give me sleeping tablets, you know, and even in that there was no signposting… it was, it was very much go and sort this out yourself.”**
> **(Vivien)**

Zack thought about going to his GP for counselling or medication for flashbacks but did not feel comfortable talking to his GP as he felt they would not understand:

> **“…especially when it comes to like a gay situation as well… to talk about deeply personal stuff about yourself…they will not be personalised and will be like very heteronormative towards me…”**
> **(Zack)**

This was echoed in Tasha’s experience of homophobic responses from mental health services involved in her daughter’s care:

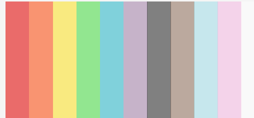
> **“There were many instances where you felt there was a sort of disapproval. Almost saying, “Oh, it's not surprising she’s unwell; she's got a lesbian mother…” and there was the same feeling of judgement from the [medical] notes… there was a lot more [prejudice] than I realised at the time.”**
> **(Tasha)**



Geri did not see her grief as a medical issue and would not have considered going to her GP for support. By contrast, Wayne and Riko had positive experiences with their GPs. Riko's GP was an out gay man who had been involved in the care of his partner. Riko defended the ir GP against an implication at the Inquest that they were responsible for the suicide of his partner.

Tasha added context with her mixed experience of mainstream service improvements:

> **I would say, however, that so much more could be done just to make services, in general, more inclusive, which would perhaps lessen the need for LGBTQ+-specific support…some of the longer-term support options now available in our area are beginning to feel more inclusive, in this respect. While this type of support remains under the umbrella of the NHS at the moment, there is a move towards forming partnerships with the voluntary sector to continue providing these services. This makes sense in the new era of integrated care and may be more cost-effective with less bureaucracy (apparently, there can still be lots of hurdles to jump by those trying to provide these services within the NHS). (Tasha)**

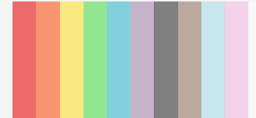


5.3.3 Access to bereavement services

Some participants had not sought support from bereavement services, were not aware that they existed and/or did not think that they wanted or needed specific bereavement support. Some wished that there had been better signposting as they might have wanted to access bereavement services in the past. Where participants were not part of the biological family of the person who had died, they did not feel that bereavement services would take their grief seriously as the relationship would not be deemed close enough. Some felt that they were not worthy of support or worthy of what they assumed were limited resources. Some participants who did have experience of using mainstream bereavement support had found it did not answer their needs as LGBTQ+ people, and for some risked making them feel more vulnerable, more isolated and more distressed.

> **I was desperately looking for support within the LGBT community to sort of be able to talk about what had happened and how I felt, and there just wasn't anything there. There was nothing you know, and I joined a couple of {bereavement group} meetings... Where I just felt really uneasy. I just really felt with the other people that were there, that I wasn't able to express what I was feeling about being a gay man and stuff like that. I mean that, you know, maybe, is there something wrong with me that I wasn't able to to use that? But I just didn't feel comfortable, and what I desperately felt I needed was some sort of LGBTQ bereavement group that... that I could have gone to, and there just there was just nothing there was nothing there. I just thought this was such a... a sad thing that there wasn't anything out there, you know, because I can't... I can't be the only person.**
> **(Riko)**

> **…a lot of people wouldn’t even understand why this was so important to me… its like I would have needed an explicitly queer space to support me…but I didn’t even think there would be a bereavement by suicide group…**
> **(Sam)**



Vivien attended bereavement support groups, but there was nothing specifically for LGBTQ+ people and no pathway that fitted his needs:

> **The difference between being accepted and being with people who do really get where you are coming from? There's a big difference. (Vivien)**

Tasha attended an NHS grief education course which was described as a 'safe space':

> **The trouble was that it wasn't a psychologically safe space for me...I should stress that there is nothing wrong with the course, and this type of support does help many people. This just emphasises that 'no one size fits all', and we need a range of support options, sometimes tailored to specific needs. (Tasha)**

Zack was mistrustful of services which say they are for 'everyone':

> **When something says it's open to everyone, how are we supposed to know we can trust that actually…I don't take it at face value, I wouldn't assume that it was for me. I think things that are for everybody aren't necessarily the answer. They may be very good, but they may not, and that's the trouble, you don't know. (Zack)**

One participant, Tasha, had received positive one-to-one support from a suicide bereavement service. She found it very helpful, particularly the long-term nature of the support which included support through the Inquest and afterwards. She found the expertise of the worker was calming, informative, offering good emotional and practical support. She experienced no discriminatory behaviours or attitudes at all.

5.4 Where do LGBTQ+ people find support?

Participants were asked what had been most supportive for them in their bereavement, to which there was a range of responses, grouped into themes below. Overall, there was strong evidence that there is no 'one-size fits all' response to LGBTQ+ bereavement by suicide, but rather a need for a variety of accessible, affirmative support services, both mainstream and LGBTQ+ specific. People wanted to access both short-term and longer-term support.

5.4.1 Desire for and value of LGBTQ+ specific support

> **I can't underestimate the importance of being in an environment where everybody's LGBTQ…there wasn't any questioning of like why was this person important to you? …without having to explain relationships, or why you are affected by this particular death, I think that's really important. (Sam)**

The majority of participants would like, or had received, LGBTQ+ specific support from voluntary and community sector organisations. People wanted a range of types of support: group support, or one-to-one, formal and informal. Aje spoke about their need for support from workers who are LGBTQ+ as it is so much easier to open up:

> **You don't have to kind of explain your existence then, before you even get to what's wrong. Yeah, I kind of had that happen in like non mental health related medical settings where I've gone in for like an injury to the doctor, and I've had to explain my entire identity to them before I get to what's wrong with me. (Aje)**

> **We need a specific LGBTQ person that people can go to, not just a general person, but a specific person.... I feel that if you're of the LGBT community you've got an added issue there... and my experience is that not only was it the guilt and the feelings that I had, but then also having to deal with the rejection of from like the parents and things like that and so... so there was an added dimension that that maybe isn't part and parcel of, say, when a heterosexual person has taken their own life. There's an added issue there... I really, I really feel that that SOBS should have a dedicated part of its organisation, that LGBTQ people can go to...and you know feel safe to go to, which is not there at the moment.**
> **(Riko)**

Helplines need to have clear signposting for LGBTQ+ people:

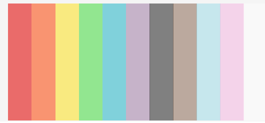
> **Maybe it should be kind of shouted from the rooftops that these services are available for these minorities, because, yeah, they're not easy to find, these positive services.**
> **(Pete)**

Trans participants spoke of the value of trans specific peer support and the importance of having trans and non-binary affirmative space (see 5.6 Trans and Non-binary Experiences).

5.4.2 Peer support

The majority of participants would like, or had, peer support opportunities. The majority of participants wanted and highly valued peer support from others in the same situation, i.e. other LGBTQ+ people who have been bereaved by suicide. Borthwick et al 2020 found that professionally run LGBTQ+ peer support is an effective model for delivering mental health services to LGBTQ+ communities. It offers a safe space, provided LGBTQ+ VCS organisations run it.

People benefitted from or wanted both informal and formal peer support. People who had been bereaved in the workplace wanted peer support from other workers bereaved by suicide. All felt that it was important for peer support to be longer-term and ongoing. For the two participants, the age of other group participants was important. They felt better able to relate to people of their own age (younger) and to meet in a relaxed environment where they could get to know people in person.



Anna pointed out how hard it can be to join a group and described how much she had benefitted from individual co-counselling:

> **I don't know if I actually want to deal with other people's stuff. (Anna)**

One participant, Gee, was part of an ongoing LGBTQ+ digital support network which had grown out of meeting others with similar interests, not initially about bereavement by suicide. This group were understanding, supportive and accessible for her as she was living in a rural area with her parents after the death of her partner.

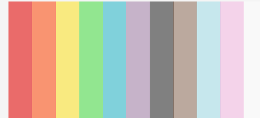
Pete found LGBTQ+ peer support through listening to podcasts made by LGBTQ+ people who were experiencing bereavement. Podcasts were accessible for him both day and night. Listening to other people's stories at different stages of their grieving process was helpful.

Rosie also talked about the value of peer support as an opportunity to meet people who are further on in their bereavement:

> **It gives me hope, shows that the pain can ease, that I can live with it. (Rosie)**

5.4.3 One-to-one therapeutic support

60% of respondents had received one-to-one counselling or therapy following their bereavement. Most had found it helpful. Those who had accessed NHS talking treatments reported long waiting lists and too few sessions. Those who had paid for private therapy found it very helpful, with the exception of two people who found their therapist unaware of LGBTQ+ identity issues.One person had received counselling from an LGBTQ+ organisation, which they found accessible, affirmative and effective.



5.4.4 Chosen Family

> **…the real support system that I've had are my friends. (Micha)**

Many of our participants had friendship networks which were enormously helpful, especially those who were connected to others who had known the person who died. The majority of participants spoke about the importance of 'chosen family'. Some had also received support from their biological families and/or the biological families of the person who died.

Lesley is part of a close group of LGBTQ+ friends who are supporting each other with the shock and grief after the suicide of a close friend.

> **So we just shared. We stayed together, and then we ended up saying that if anyone has a problem, no matter how big it is, it's always best to share, you know, and we'll be there for each other...just don't take your own life, please. (Lesley)**

Pete was supported by a close circle of LGBTQ+ friends after the death of his ex-partner, but he was unable to share his grief with his biological family. A minority of participants experienced difficult dynamics within their chosen family networks following the bereavement.

> **...especially because the other partner like blamed me. I found that a lot of people didn't want to talk about it....which is like really hard. (Steph)**

5.5 LGBTQ+ Communities

5.5.1 Protective and healing but can be excluding

People's experiences of the supportive nature of LGBTQ+ communities and sense of belonging varied, with some finding it helpful, some less so.

Two participants took part in community memorials for the person who had died. Both found that public, shared mourning and shared celebration of the person's life were helpful and supportive. One event was run by and for the LGBTQ+ community local to the participant, they felt this was an important opportunity to educate LGBTQ+ people about suicide, suicide prevention and postvention.

Conversely, some were excluded from community acts of mourning and found this hurtful. This included participants with intersectional identities, specifically bisexual and trans people, and those who had complicated relationships with other mourners.

One participant talked about the importance of memorials in public places:

> **There is an LGBTQ suicide memorial tree planted in the park and we held vigils in memory of everyone who had died and the council marked the tree on the map of the park. It felt like the deaths were important.**
> **(Anna)**

Trans and non-binary participants spoke of the importance of trans community events which include an element of mourning, such as Trans Day of Remembrance (TDOR), International Day against Homophobia, Transphobia and Biphobia (IDAHOBIT) and Trans Pride. These were experienced as validating, informative and good for improving resilience. However, one person felt that community events such as these lack the offer of direct support to people affected by suicide. (See also Trans & Non-binary Experiences).

Some participants spoke of feeling excluded from sites of community such as pubs, clubs and Pride events where their experiences of bereavement would not be acknowledged or acceptable.

5.5.2 Giving back and activism

Half of our participants spoke about supporting other people who had been bereaved and/or community activism, many of them choosing to support other LGBTQ+ people. This was a significant part of making sense of and processing their grief. This is echoed in a study by Zavrou et al 2023, which found that helping others can alleviate guilt and shame and reduce PTSD following bereavement.

> **“You know, like, I want do this for queer people who are in a bad place...I just want to be present for them because I think that's so important and so it absolutely did drive me... doing that work did come out of [X’s] death because I just wanted to like do my part, I guess.” (Sam)**

> **“It's not purely altruistic in that I feel like I'm doing good, which I hope I am doing good in many ways, but it's also become a survival strategy.” (Tasha)**

Zack volunteers with a charity set up in memory of his best friend who died by suicide. The group provides open access for people bereaved by suicide and is LGBTQ+ affirmative.This support was not available before he was bereaved:

> **“I didn't even know that was a problem really, like I didn't know there was a problem with people taking their lives or suicide…I didn't know that there was such a problem in my own community.” (Zack)**

Riko met someone else who was bereaved by suicide and together they decided to set up a local SOBS group.

> **“I feel I want to help other people, but at the same time, you know, I feel that maybe it will help me as well. I don't know whether that is a selfish thing to think, I don't know.” (Riko)**

Some are employed and/or volunteer for suicide prevention services, two are working to improve inclusion in suicide prevention and postvention services, to train health and social care professionals and to influence policy. Several people spoke about their motivation for taking part in this research because it is a way to make a difference for others.

Jody was one of the founders of Trans Day of Remembrance (TDOR) and has run trans social support groups and peer support groups for the families of young trans people.

For others, their activism was less formal and they would seek opportunities to reduce stigma and educate others as and when they felt able to do so. Pitman et al 2018 found that addressing the stigma around suicide loss can help to reduce isolation for the bereaved.

Not all activism and anti-stigma interventions were successful or experienced as positive. Riko and some friends made leaflets to hand out at a Pride event to raise awareness of bereavement by suicide in their local LGBTQ+ community. They found that not many people were interested.

5.6 Trans and non-binary experiences

5.6.1 Impact of deaths in an intersectional community

> **I find that when I see it's happened in the news halfway across the country or not even in the same country even, there is kind of feeling of loss, because this is something that is just happening to so many {trans} people it kind of feels like a real threat I guess...**
> **(Aje)**

Participants raised urgent concerns that the very high rate of suicidal distress in trans communities is in part due to the very high rate of bereavement by suicide. Jody spoke of the poor mental health of some trans women ‘who are isolated, lonely, living in poverty and living in fear of the hostility of the outside world’ for whom loss of friends to suicide can be devastating.

Kiran spoke about two recent local to them deaths by suicide of well-known, prominent trans people. They had witnessed the effect on other trans people and the increase in people’s suicidal distress as a result.

In common with cis-gender participants, trans and non-binary people felt guilty for not doing more and/or for being more resilient than others:

> **...there is that survivor guilt thing that sits on top of it all as well. (Sigita)**

5.6.2 Politicisation of trans identities and trans deaths

Participants spoke of the impact of minority stress on the mental and physical health of trans communities in the context of political debate, hostility, aggressive media and increases in hate crime. Participants had experience of how this compounds their grief and the grief of other trans and non-binary friends and community members. This contributes to a lack of personal and community resilience.

One participant voiced their despair that health services are not interested in the harms done by political, social and media attacks on trans lives. This feeds into negative stereotypes of trans lives and into stigma around suicide.

> **...its seen as a thing that happens to transgender people...there's a statistic that the right-wing like to use against trans people, that is, you know, 40% of you attempt and stuff like that. I think that transgender people, in general, don't see older trans people and don't realise that they might live a full life cause, you know, there aren't many out older trans people. I think that gives a lot of younger trans people kind of the thought that what is there for me? (Aje)**

5.6.3 Lack of access to support

Trans participants spoke of the impact of long waiting lists for gender related services, which have worsened considerably over the last few years. This was highlighted as another significant pressure on people also facing the trauma of loss by suicide. In addition, people spoke of the lack of understanding of health professionals about the needs of trans and non-binary people and the reasons that they do not use services.

> **"They need to know about the fragility of the trans community...is it safe to go and talk to someone?"**
> **(Jody)**

Kiran spoke about the inadequacy of GPs to respond to trans suicide risk:

> **"GPs do not have enough in-depth knowledge about how prominent suicide is in trans and non-binary communities, they are not trained."**
> **(Kiran)**

Some participants felt excluded from LGBTQ+ sources of support and sites of community. This underpins the need for trans and non-binary specific affirmative space in which to grieve, and how little there is currently available:

> **"...its political, the need for space for people who are not cis."**
> **(Kiran)**

One person spoke about the value of LGBTQ+ services for trans people:

> **"There needs to be a specific number where there would be people who are trained and also from within the community that you can talk to. And I think it is very different to suicide outside of the LGBT community...I think if you have to spend all of your time explaining to somebody about minority stress and what it's like to be trans then you're not talking about your feelings and not dealing with the issue that's inside."**
> **(Sigita)**

5.7 Prejudice within the Coroner's Court

5.7.1 Homophobic, transphobic, heteronormative and cisnormative attitudes and behaviours

A minority of our participants had experience of the inquest process. Of those who did, there are compelling examples of how inadequately the coroner's court responds to LGBTQ+ bereaved people.

Vivien, quoted above in 5.2.1, found that at the inquest into his husband's suicide, the coroner deferred to his partner's mother's preferences as to how the death was recorded. Another participant spoke of the overtly homophobic behaviour of the coroner, picked up by other attendees, which contributed to the already profound distress they were suffering at the time, and since.This shows the detrimental impact of heteronormative, cisnormative assumptions and behaviours of people in public office, on the health and wellbeing of LGBTQ+ people.

> **When we went through the inquest we had a Coroner who was… he was homophobic. He behaved in an absolutely appalling manner. And I remember {my bereavement support worker} being so shocked that that she wrote to the Coroner's office afterwards about my distress... It was particularly obvious to people around, that we were two women sat there, and this… Coroner was really not comfortable with the fact that we were a couple... it makes me actually really angry when I think about it. I had a barrister with me and he was absolutely appalled... there's no question in other people's mind that it was definitely an LGBTQ issue… and that is traumatic. The Coroner can get away with it as well, even when you've got a barrister who is recognising what's going on.**
> **(Tasha)**

By contrast, one participant found the Coroner's Court affirmative and very supportive following the death of his male partner who had been disowned by his biological family.

> **I was left to be the one that went to the inquest. I must admit the coroner's office were brilliant. I mean, they really treated me really well and they just they totally accepted me as, you know, the relevant party, the person to go to for information... I mean, his parents just wouldn't have anything to do with it.**
> **(Riko)**

Trans participants spoke about the denial of trans identities and breaches of confidentiality in the Coronial system, where biological relatives' wishes are prioritised over those of the deceased person. One person had found on several occasions that misgendering by the Coroner means that trans mourners cannot find information after death if the person's deadname is not known.

> **"But her family had not accepted her transition at all in any way. So we have absolutely no idea what name she was buried in, where she was buried… and that's enormously difficult. Coroner's reports need to be truthful and honest, otherwise we are just hidden."**
> **(Sigita)**

6.Recommendations

Affirmative, accessible support is urgently needed in order to ameliorate the damaging effects of bereavement by suicide and to maximise the opportunity for LGBTQ+ people to develop coping strategies and post-traumatic personal growth.

All the recommendations below need to be delivered with a co-production ethos, involving LGBTQ+ people who have experience of bereavement by suicide.

6.1 Bereavement services need to demonstrate their understanding of the inequalities faced by LGBTQ+ communities. They need to actively address stigma, improve representation of LGBTQ+ lives and show how they are working to ensure that they offer equitable services in order to remove barriers to access for LGBTQ+ people.

6.2 Bereavement services need to demonstrate their understanding of the specific circumstances and barriers faced by **trans and non-binary people.**

6.3 Primary care services need to have training and education on how to talk about bereavement by suicide and about the differential effects of bereavement by suicide on minoritised communities, so that they can offer affirmative, non-pathologising and accessible interventions. As above, primary care needs to actively address stigma around LGBTQ+ identities and bereavement by suicide.

6.4 LGBTQ+ run peer support and trans specific peer support needs to be rolled out nationwide, this could be done in partnership between bereavement services and trusted LGBTQ+ and trans community organisations.

6.6 A national LGBTQ+ bereavement by suicide resource needs to be developed giving specific information relevant for LGBTQ+ people, summarising the findings of this research project and giving suggested sources of support.

6.7 Peer support for LGBTQ+ workers who are bereaved by suicide in the workplace needs to be provided.

6.8 Existing sources of specific LGBTQ+ and specific trans support need to be highlighted by mainstream organisations so that they are easier for LGBTQ+ people to find.

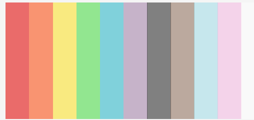
6.9 Coroners need to demonstrably honour the significance of LGBTQ+ identities and relationships, even where this could conflict with biological relatives perceived sensibilities. Coroners need to understand the importance of not mis-gendering the person who has died or their mourners. Coroners need to prevent deadnaming of the person who has died. Coroners and their staff need to undertake LGBTQ+ affirmative practice training.The Coronial system needs to develop inclusive practice planning as a matter of urgency, in order to prevent further traumatisation.

6.10 Coroners and primary and secondary health services need to accurately monitor and report LGBTQ+ bereavement by suicide.

6.11 The importance of chosen family in LGBTQ+ communities needs to be acknowledged by all those in contact with LGBTQ+ people bereaved by suicide.

6.12 Further research is needed into the experiences of:

- LGBTQ+ groups with intersectional identities, particularly people of colour
- LGBTQ+ refugees and asylum seekers
- LGBTQ+ people of different religions or faiths
- neurodiverse LGBTQ+ people
- LGBTQ+ workers who are bereaved by suicide in the workplace
- the effects of bereavement on the physical health of LGBTQ+ people.



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Back to contents

Whittle, S & Turner, L (2007) Bereavement: A guide for Transexual, Transgender people and their loved ones DH

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